

Health professionals' responses to women's disclosure of domestic violence

Introduction

The United Nations (UN) (1993) Declaration on the Elimination of Violence provides a salient definition of gender based violence:

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 (Declaration No: A/RES/48/104).

Globally, approximately one in three women has been physically assaulted, abused or coerced into sex at some stage in her life by a known perpetrator in the majority of incidences, making domestic violence a significant public health issue (World Health Organisation (WHO), (2011). The WHO (2005) also highlights the strong commonalities shared by women across the globe in terms of their experiences of domestic violence, regardless of the country of residence, cultural or socio economic background. Strengthening the health sector response to this violence is advocated by Garcia-Moreno & Jansen et al, (2005) through their assertion that the health sector has unique potential to deal with violence against women, particularly through reproductive health services, which most women will access at some point in their lives. Moats, Edwards et al. (2014) highlight the change in US policy (United States Preventive Service Task Force (USPSTF) in reversing its earlier recommendation against screening for domestic violence. Findings indicate, however, that this potential is far from being realized partly because stigma and fear make many women reluctant to disclose their experiences (Garcia-Moreno et al., 2005). It is, however, also because few doctors, nurses or other health personnel have the awareness and the training to

identify violence as the underlying cause of a range of women's health problems, or can provide help, particularly in settings where other services for follow-up care or protection are not available (World Health Organisation, 2014). The health sector can certainly not do this alone, but it should increasingly fulfil its potential to take a proactive role in violence prevention.

In the UK, the Department of Health's (DH) recent document 'Responding to violence against women and children' notes that the role of the NHS advocates is to ensure that 'women and children disclosing violence or abuse should feel assured that their information will be treated appropriately' (DH, 2010). Similarly, in the United States, emphasis is placed on the development of a productive relationship with a client who is threatened by domestic violence (Keeling & Wormer, 2011).

Background

Within the literature, it is evident that domestic violence negatively affects the biopsychosocial aspects of a woman's life, as the different facets of domestic violence include physical, sexual, emotional and economic abuse (Walby, 2004). This multi-faceted nature of domestic violence has been extensively documented and high prevalence rates are cited (Bacchus, Mezey, & Bewley, 2004a; Basile, 2002; Bradley, Smith, Long, & O'Dowd, 2002). Additionally, there are known detrimental effects on both the mental health (Dienemann et al., 2000) and physical health (Coker, Smith, Bethea, King, & McKeown, 2000) of individuals resulting from its experience.

The physical health effects include increased odds of experiencing respiratory conditions, chronic lung conditions, cardiovascular disorders, bowel problems, pain and fatigue, surgical menopause, vaginal discharge and diagnosis of cervical cancer (Loxton, Schofield, Hussain, & Mishra, 2006) among victims compared to women who have not experienced domestic

violence. In terms of their mental health, women who have experienced domestic violence are at increased odds of experiencing anxiety and depression than women who have not experienced violence (K. Hegarty, Gunn, Chondros, & Small, 2004; Parker & Lee, 2002). Women who have experienced sexual forms of domestic violence have both physical harm sequelae and reproductive health consequences (Taft, 2002).

Despite the health implications for women who have experienced domestic violence and the plethora of research undertaken around the feasibility and/or appropriateness, or otherwise, of routine screening for domestic violence in health settings (Barata, 2011; Hawkins, Pearce, Skeith, Dimitruk, & Roche, 2009; Klevens & Saltzman, 2009; MacMillan et al., 2006; Moracco & Cole, 2009; Wathen, Jamieson, & MacMillan, 2008), and barriers to it (Colarossi, Breitbart, & Betancourt, 2010; Minsky-Kelly, Hamberger, Pape, & Wolff, 2005), only a minority of women experiencing violence are identified by health professionals (Feder, Hutson, Ramsay, & Taket, 2006a). The absence of a strategic screening program (Edin & Hogberg, 2002; Shadigian & Bauer, 2004) in many countries including the United Kingdom may be a contributory factor in this low rate of identification. This remains the case despite a policy environment which purports to enable women to disclose in a confidential manner and be assured they will be supported appropriately.

However, it is apparent that there are many other issues that also contribute to the low rates of identification of domestic violence in health care settings as the choice to disclose domestic violence is complex. Although the barriers to disclosing may be different across health settings, common elements reported in the literature include fear of the perpetrator of violence becoming aware of the disclosure and the implications of this for the woman's safety and wellbeing (Harne & Radford, 2008; Kelly, 2006; Robinson & Spilsbury, 2008); concerns about the implications for their children if health workers or child protection workers became aware of the abuse (Kelly, 2006; Robinson & Spilsbury, 2008; Yam, 2000);

a belief that health professionals do not understand the dynamics of a violent relationship (Bacchus, Mezey, & Bewley, 2004b); concern that appropriate referrals will not be made or options given (Rhodes et al., 2007); the desire for a trusting and ongoing relationship between the woman and health professional before abuse is disclosed (Liebschutz, Battaglia, Finley, & Averbuch, 2008; Robinson & Spilsbury, 2008) and lack of assurances that the health professional will treat the information in confidence (Feder, Hutson, Ramsay, & Taket, 2006b). Having a male health professional has also been highlighted in the literature as an issue in terms of disclosing domestic violence for some women (Robinson & Spilsbury, 2008). The notion of routine enquiry about domestic violence for women who access health care continues to be debated. It is also noteworthy that the focus of much contemporary research lies within the health service personnel and the reasons for them not wanting to enquire about domestic violence.

What is not apparent in the literature, however, is an in depth understanding of how health providers respond to disclosure of domestic violence. Through undertaking this study we attempted to fill this void.

Research Aim

The aim of this study was to gain a deeper understanding of women's experiences of disclosure of domestic violence to health providers.

Design

The qualitative study was underpinned by a feminist standpoint epistemology and used narrative interviews with women who contemporaneously had experienced domestic violence and accessed a health service. Our epistemological stance facilitated the making visible of women's experiences (Brooks, 2007) and through their narratives we were able to explore

how they had constructed their experiences of disclosure of domestic violence: for exploring their meanings from an emic perspective and also the interaction from a wider social position, narrative was an ideal method to gain this insight into the women's lives. Narratives were considered as a medium through which the women could transmit their stories, understandings, events, and contexts and encouraged an open exploration of their experiences, rather than through the linear questioning approach of other interview approaches (Ribbens & Edwards, 1998). Raven's (1992) elaboration on the theory of social power (J. R. P. J. French & Raven, 1959) provided the theoretical basis for the analysis. This theory was valuable in understanding the exercise of power in violent relationships as it viewed power as dynamic and distinguished six discrete bases of power: coercive power, used to force someone to do something against their will; legitimate power, investing in a role such as a partner and then using that as a legitimate reason for a certain behaviour; referent power, afforded to a person due to affection; expert power, as an expert or someone very knowledgeable; and reward power, being the ability to give another person what they want but on the premise of a return favour; and informational power (J. P. R. French & Raven, 1960).

Participants

Fifteen women participated in the study and were recruited from two different geographical locations within the North West of England, UK. They were aged between 21 and 54 years and had lived with domestic violence perpetrated by a male partner. Two women's refuges within the UK supported the study by making available the participation information sheet to all residents. The recruitment strategy was self-nomination, ensuring participation remained a woman's autonomous decision. All the women who responded to the invitation to participate were included in the study. The duration of experienced violence lasted between twelve months and thirty six years. The women varied in age and life experience; seven were in their

twenties, five in their thirties, one in her forties, one in her fifties and one woman chose not to disclose her age.

Data Collection

Data were collected using a narrative approach to interviewing (McLeod, 2001) which afforded the women themselves the control over their interview by maintaining an autonomous choice of which experiences to narrate within the interview and at which juncture to commence their stories. Discussion with the women was initiated by inviting them to commence their narrative where they chose, with no direction from the researcher, and as such, the majority of women began with how they met their partner. The women themselves chose what to disclose and the interview followed the woman's agenda. However, all the women had accessed health care on many occasions, and they shared many of these experiences during the course of their narration. Following consent, interviews were audio-recorded and then transcribed verbatim by the primary researcher.

Ethical Considerations

The World Health Organisation (1999) advocates attention to methodological and ethical considerations when researching violence against women, including protecting confidentially and ensuring the safety of the participant. These considerations were integral to the development of the study. Ethical approval was granted by the first author's academic institution prior to commencement of the study. There was no compensation offered for participation and opt out was an option at any stage. Factors ensuring safety of the women participants included interviews being conducted within a refuge providing 24 hour security, confidentiality, anonymity, and provision of continued psychological and practical support from the refuge.

Data Analysis

Following interviews with fifteen women, data saturation was reached (Guest, Bunce, & Johnson, 2006). The research team individually read each transcript several times to obtain familiarity with, and an overall feeling for them which then led to initial codes being generated within the transcripts (Braun & Clarke 2006). A constant movement between all the transcripts then continued until all the data extracts were coded across all transcripts. This continuous and iterative process resulted in all codes being gathered into themes which were then checked for their relevance to the coded data and entire data set. Using a thematic map, themes continued to develop from the initial codes, building the relationship between themes, and considering what constituted an overarching theme and what constituted a sub-theme (Braun & Clarke, 2006). Regular team meetings were held to discuss the developing analysis and to achieve consensus where differences in coding occurred. The final stage of the analysis resulted in the research team joining and reviewing their themes together to ensure consistency and that the final themes were both internally homogenous and externally heterogeneous.

Rigour

Due to the interpretive nature of qualitative research the narratives presented are only sections of the whole chosen by the researchers, and the issue of misrepresenting the woman's words or feelings needed consideration. The process of ensuring trustworthiness of the data included member checking, offered to all participants; each individual research team member maintaining an audit trail throughout the research process and a clear and transparent approach to thematic analysis and the development of thematic maps to assist in the clarity of analysis.

Results

The research findings that emerged from the data are presented as three themes rotating around women's disclosure of domestic violence to health professionals. The first two themes reveal how the attending health professional can inadvertently mirror the behaviours of the abusive partner through inappropriate action or inaction. The third theme then presents women's narratives in which their experiences of domestic violence have been acknowledged, and progressed through the provision of an appropriate response.

Dismissing women's disclosure

The notion of routine enquiry about domestic violence for women who access health care continues to be debated and protagonists to this approach accept the premise that health providers are fully equipped to sensitively ask and respond to survivors of domestic violence. It is noteworthy that the focus of much contemporary research is on health service personnel and the reasons for *them* not wanting to enquire about domestic violence. This study however, revealed that far from being sensitive, some health providers' responses to women experiencing domestic violence may unintentionally mirror that of the perpetrator of the violence. The following quotes illustrated this:

My solicitors were sending letters to my doctor. My doctor wasn't doing nothing for me though, you know tests for the courts and stuff, he wouldn't do nothing like that... He has not done nothing for me, you know what I mean, and that's what caused me problems...*He* [doctor] is my problem, he won't listen to me (25 year old mother of 1)

I went to see the nurse at the health centre she wasn't any use. I told her like erm, I was depressed which I am on depression tablets for. Erm, she wasn't very useful at all...well, she wasn't really interested. I told her that was why I was like a bag

of nerves and I was depressed because of him but she never did anything, and that was it! You know she never asked why or anything like that you know none of those things really. She wasn't bothered (41 year old mother of 4)

I told the GP and he wasn't bothered (Long silence)...Once you say you are depressed then that is it they give you tablets. You know they don't really ask why. They have never bothered at all (40 year old mother of 4).

Dismissing women's disclosure when they did talk of their experiences aligned to the behaviour of the perpetrator and the minimisation of the violence. Health professionals' dismissal validated women's concerns. The negative responses from health professionals to the women 'I told the GP and he wasn't bothered' and 'He [doctor] is my problem' were experienced by the women as further minimising of their experiences, in this instance from a professional in a position of power. This exemplifies Raven's (1992) theorising that the expert, legitimate and referential power afforded to the health professional as an expert, or very knowledgeable can serve to silence others (social silencing of women's voices). The dismissing of the women's concerns through deflection or not probing further, essentially achieved this. Hegarty and Taft (2009) highlight the existence of women's internal barriers to disclosure, as women perceive the problem of domestic violence as their own. This notion was further reinforced through living with a coercive and abusive partner, but also through having experienced societal 'silencing' of the responses by these health providers.

Recognition and denial

Despite policies on the effective pathway of support for health professionals to respond to survivors of domestic violence, the health professionals' renunciation of the women's experiences following disclosure, reinforced the perpetrator's threats.

Following an acknowledgement of the women's experiences, the responding professional failed to act on this information.

They asked me in hospital, I think I got took in for something, I had a bruise on my neck there and I had bruises on my legs as well and they asked me where they were from and I just started saying things. And they turned round and said 'you don't deserve that' and stuff and that was it. It wasn't mentioned again (21 year old mother of 3).

By the time I managed to get him [husband] out the room the doctor said there was nothing we can do 'I can't help you, I can't help you, it is not our field' so I ended up having to threaten to jump out like a first-floor window in doctor's surgery before they would call, before they would do anything, so then eventually they got the police on *me!* (40 year old mother of 1).

In these women's excerpts, the attending health professional fed into the perpetrator's discourse around the violence being something to do with the woman, by failing to acknowledge the experiences and act appropriately. The referent and expert power (Raven, 1992) afforded to a person such as a health professional, because they were perceived as an expert or very knowledgeable, was imprudent given their responses to the women. Dutton & Goodman (2005) elaborating on Raven's theory of social power, suggest that the perpetrator has already created an anticipation in the woman of being hurt, physically and/or emotionally, as part of his process of coercion and control in the violent relationship. In the second excerpt, this anticipation was in the form of psychological injury, with the woman threatening to jump out of a window in desperation of having her voice heard.

Positive responses to disclosure

Although in the minority, some women talked of a positive interaction with health professionals, thereby affecting the trajectory of their violent relationship. Appropriate support and advice was offered, leading to the women leaving the violent relationship.

There was a lady at the hospital that I saw, I can't remember but I think she was a domestic violence officer and she got me a planned escape route when he was at work and she organised me... she was just a really nice lady. I'm so thankful to that lady and she help me escape (29 year old mother of 1).

I didn't know about the refuge until someone gave me, one of the nurses in the walk-in centre gave me a leaflet (39 year old mother of 3)

I think I told him [Doctor] (about the violence)...if I go in he says "is everything okay " and he will say, because he has met my new husband, he will say 'he's alright this one he is not as ugly as the last one' is. You know it is just like a nice conversation I think, and I think he says that in a way to let me know that I [the Doctor] am here if you want to talk about things, or I [Doctor] have not forgotten about what's happened. Yes it [disclosing the violence] has been useful with the GP I think (30 year old mother of 4)

From these excerpts equality within the interpersonal relationship was evident, as was advocacy for the survivor. There was no evidence of coercion, domination or minimisation of the women's injuries. The health professionals' legitimate power (Raven, 1992) comes from recognition of one's formal position but also draws on norms of reciprocity, equity and responsibility; in this latter sense, legitimate power draws on a social norm suggesting obligation to help those who are dependent on us. The proactive approach of the female attending health professional in the first two excerpts had provided that level of expected

care, and thus positively affected the trajectory of their relationship for these women. Whilst the male family Doctor in the third excerpt did not verbalise 'domestic violence' it was evident that the woman felt supported. The relationship trajectory following these positive interactions with health providers were significantly different than for those who experienced a negative response to their disclosure. These women left their violent relationship.

Discussion

Listening to the women's voices, a domination appeared to exist emanating from the health professionals themselves, evident in their actions (and inaction) invalidating the women's disclosure of domestic violence. Making inappropriate referrals (or no referrals) may have equated to the invalidation of their experiences. Essentially, the behaviours of the health professionals fed into perpetrators' discourse around the violence being something to do with the woman. It was evident that a plethora of factors affected disclosure of domestic violence to attending health professionals. These included the provision of a safe and confidential arena, and being non-judgmental and caring (Battaglia, Finley, & Liebschutz, 2003). Feder et al (2006a) argue that a woman's decision to disclose is affected by the way she feels about her experiences. The health professional, thus, needs to confirm the violence as unacceptable. In the excerpts provided in the first two themes in our study, it was evident that despite disclosure, the health professionals failed to acknowledge and thereby validate the women's experiences. This feeds into the discourse of perpetrators, who often also claim that a survivor who chooses to disclose will not be believed. The importance is clear about the necessity for health professionals to validate the women's experiences and offer appropriate support, thereby providing a real opportunity to change the trajectory of the violent relationship.

Health professionals' dismissal of women's disclosure or their complacent approach to bruising may also mirror perpetrators' minimisation of the violence, a tactic that is widely reported in the literature (Anderson & Umberson, 2001; Stark, 2009). The perpetrators' complacency to their infliction of injuries (Anderson & Umberson, 2010) and the minimisation of violence (Stark, 2009) serve to disempower the women.

Moreover, the refraining from enquiry in the first place rendered the women's experiences invisible even when physical signs are apparent. Whilst existing literature reveals some of the reasons for non-disclosure of domestic violence (Fisher, Keeling, Gausia, & Tsou, 2014; Keeling & Wormer, 2011), the women in our study have contributed to our knowledge of the issue through their discussion of their experiences of being spurned by health professionals when they attempted to disclose the violence they were experiencing.

We argue that the acquiescent approach of the health service to violence against women by an intimate partner served to reinforce the subjugation of the woman. The women's stories revealed the reactions of health professionals to them when they either actively disclosed violence, or when there was suspicion of the occurrence of domestic violence.

Limitations

The main limitation is the narrow context of the study as the sample was drawn from a predominantly white British population and is therefore limiting in the generalisability of the results. Although the limited sample population was not the intention of the study, it raises broader questions about accessibility of women's refuges to minority cultures. However, it is acknowledged that these findings may still be applicable internationally given the prolific nature of domestic violence.

Conclusion and Recommendations

This paper centred on women's experience of their interaction with health professionals and issues surrounding disclosure of domestic violence. Despite the many global policies that illuminate the expected support to be offered to women experiencing domestic violence when accessing health care services (for example: No.9 of the UK's Department of Health document 'Responding to violence against women and children'), it is evident from the women in this study that this provision is not universally enacted. These policies will only be effective if health professionals understand the dynamics of violent relationships. There is evidence in the literature (Taket et al., 2003) and evidence from this current study to suggest otherwise. If health professionals respond inappropriately to women they may inadvertently mirror the power and control tactics used by perpetrators in violent relationships.

It is recommended that health care services regularly review their policies in supporting women experiencing domestic violence to ensure that staff in all areas of health and social care provision are engaging with, and implementing, these policies. Service users should be supported to positively engage in reviews and audits through a process of formal induction and mentorship. The inclusion of service users in the training of health professionals may illuminate barriers to disclosure, including the importance of positive responses from health professionals.

In the UK, a policy exists that supports health professionals' proactive approach to supporting women who disclose domestic violence. This stance is only effective if health professionals understand the dynamics of violent relationships. Through the health professionals' (inappropriate) dealings with women, they may inadvertently mirror the perpetrator's power and control tactics used in the violent relationship. Stark (2006) asserts that the lack of spatial boundaries in coercive control offers a unique dimension of serving to reinforce the notion

that the intransitive omnipotent control renders separation from the perpetrator [or in this study, health professionals] even less effective.

Future studies that could extend this knowledge for wider application should be encouraged to engage a broad range of health professionals and policy makers in ensuring an appropriate response to women who wish or attempt to disclose domestic violence and, have their disclosure acted on in a sensitive and informed way. A more appropriate response from health professionals could include, for example, taking a proactive stance in investigating a causative effect when women disclose feelings of depression or anxiety, or present with physical injuries. They should be aware of how to make appropriate inquiry about experiences of domestic violence and be aware of the necessity of a multidisciplinary and multiagency approach to support women's needs, including their immediate safety and in the longer term. An understanding of available services would enable them to make appropriate referrals or provide handouts and leaflets with telephone numbers for sources of support.

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