Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation

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Aims. To investigate the dynamics of domestic abuse awareness and recognition among primary healthcare professionals and abused women.
Background. Domestic abuse is a serious, public health issue that crosses geographical and demographic boundaries. Health professionals are well-placed to recognise and respond to domestic abuse, but empirical evidence suggests that they are reluctant to broach the issue. Moreover, research has shown that women are reluctant to disclose abuse.
Design. A two-phase, qualitative study was conducted in Scotland.
Methods. Twenty nine primary health professionals (Midwives, Health Visitors and General Practitioners) participated in the first phase of the study and 14 abused women took part in phase two. Data were collected in 2011. Semi-structured, individual interviews were conducted with the health professionals and three focus groups were facilitated with the abused women. Data were analysed using a framework analysis approach.
Findings. Differing levels of awareness of the nature and existence of abuse are held by abused women and primary healthcare professionals. Specifically, many women do not identify their experiences as abusive. A conceptual representation of domestic abuse - The 'Abused Women, Awareness, Recognition and Empowerment' framework - arising from the study – presents a new way of capturing the complexity of the disclosure process.
Conclusion. Further research is necessary to test and empirically validate the framework but it has potential pedagogical use for the training and education of health professionals and clinical use with abused women.
Relevance to clinical practice. The framework may be used in clinical practice by nurses and other health professionals to facilitate open discussion between professionals and women. In turn, this may empower women to make choices regarding disclosure and safety planning.

Key words

Awareness, domestic abuse, domestic violence, disclosure, empowerment, health visitors, interpersonal violence, Johari window, midwives, nurses, recognition.

Summary Box

What does this paper contribute to the wider global clinical community?

- A conceptual representation of domestic abuse - The 'Abused Women, Awareness, Recognition and Empowerment' (AWARE) framework presents a new way of capturing the complexity of the disclosure process.
- The framework can be used as a pedagogical tool for nurses and other health professionals.
- The framework could be used to facilitate open discussion between health professionals and women and empower women to make choices regarding disclosure and safety planning.

INTRODUCTION

Domestic abuse is a universal phenomenon that indiscriminately crosses demographic and social boundaries (*author reference*). It is of particularly significance to nurses who may be first to suspect, detect or support families where domestic abuse is an issue. Domestic abuse occurs in a multiplicity of relationship configurations and contexts. It is defined as: 'Any incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial [or] emotional' (Home Office 2012). Reflected in this definition is acknowledgement that domestic abuse occurs in many relationship configurations. It can be perpetrated by men against women, women against men and it also occurs in same-sex relationships. The extent of the problem among each of these relationship configurations is subject to debate. However, it is likely that 90% of domestic abuse is committed by men against women (Department of Health 2005). Our research – as reported in this paper – is concerned with women survivors, with the abuse perpetrated by an existing or previous intimate partner.

Domestic abuse tends to be under-reported which makes assessment of its prevalence problematic. A 10-country study on women's health and domestic abuse conducted by the World Health Organization (WHO) reported that between 15% and 71% of women had experienced physical or sexual violence by their husband or partner (WHO 2009). The significant variance in these figures is indicative of the challenges of attempting to measure the extent of this phenomenon. At a national level, evidence indicates that one in four women in the UK is likely to suffer domestic abuse at some point in her life (Lazenbatt *et al.* 2009). In Scotland – where the study was conducted - this ratio increases to one in three (Scottish

Government 2008). In terms of statistics, there were 59,847 incidents of domestic abuse recorded in Scotland for the period 2011-12, compared to the 55,698 incidents in 2010-11 (Scottish Government 2012). This represents a 7% increase.

Domestic abuse has serious, long term health and wellbeing consequences. The cumulative impact of mortality and morbidity mean that the health burden contributed by domestic abuse is greater than more commonly accepted public health priorities (Garcia-Moreno & Watts 2011), such as smoking and obesity (Vos *et al.* 2006, Humphreys *et al.* 2008). It is thus considered to be a major public health concern (Gutmanis *et al.* 2007, Lazenbatt *et al.* 2009, Bacchus *et al.* 2012, Beynon *et al.* 2012). Health professionals play a central role in recognising and responding to domestic abuse but there is a double-edged problem. It is well-known that abused women are reluctant to disclose (Ahmad *et al.* 2009, Feder *et al.* 2009, Montalvo-Liendo 2009) and over 20% will never tell anyone about it (Spangaro *et al.* 2011). There are numerous reasons for this that will be discussed later.

It is accepted that disclosure is more likely when women are asked directly about abuse (Bacchus *et al.* 2002, Taket *et al.* 2003, Feder *et al.* 2011), particularly when asked repeatedly (Spangaro *et al.* 2011). Yet paradoxically, studies have highlighted consistently, health professionals' reluctance to discuss abuse, specifically midwives (Lazenbatt & Thompson-Cree 2009) and physicians and nurses (Gutmanis *et al.* 2007, Beynon *et al.* 2012). Moreover, many health professionals do not know how to assess accurately or respond appropriately to domestic abuse (Edin & Högberg 2002, McCloskey & Grigsby 2005, *insert author reference*). This dual relationship of non-disclosure and non-enquiry means that many women and their children remain at risk of the consequences of abuse.

BACKGROUND

In 2011 we undertook a two phase, qualitative study in Scotland that investigated health professionals' beliefs about domestic abuse and the issue of disclosure. The study was funded by the Chief Scientist Office. In phase one, health professionals (midwives; health visitors (public health nurses); and general practitioners/family physicians) were interviewed to elicit their beliefs about domestic abuse. In the second phase, the perspectives of women with domestic abuse experiences were sought. The study provided useful insights into the points of convergence and divergence between abused women's and health professionals' beliefs about abuse and the dynamic interaction between their beliefs and readiness to discuss and respond to the abuse (for full details see *insert author reference*). However, we were not satisfied that the complexity of domestic abuse awareness, recognition and disclosure had been fully captured. Yet, we knew that our data had much to offer regarding these issues. To develop a more refined understanding, we therefore embarked on a secondary analysis of phase one data, which went beyond our prior analysis. We formulated new questions (see below) that focused on awareness, recognition and disclosure and interrogated the data accordingly. This paper presents the findings of this secondary analysis.

A recent scoping study explored innovative domestic violence interventions in primary and maternity health care settings in seven European countries (Bacchus *et al.* 2012). It identified that health professionals use different approaches to the identification of domestic abuse, but that more studies are required to assess the application of these approaches in different health care settings. Our study was undertaken in the context of primary healthcare and is thus both timely and relevant. Moreover, because it addresses an issue that is endemic worldwide, the paper and the implications for practice that arise from it are likely to hold international relevance.

STUDY AIM

The aim of the study was to explore primary healthcare professionals' beliefs about domestic abuse and the issue of disclosure. For the post-study, secondary analysis, our aim was to focus the investigation on the dynamics of domestic abuse awareness and recognition between primary healthcare professionals and abused women. The newly formulated questions were as follows:

1. How do women describe, identify and attribute their own experiences as abusive?
2. What practices do health professionals adopt in order to identify domestic abuse among women in their care?
3. How do health professionals describe the situations where they have been unaware that a woman in their care has experienced domestic abuse?
4. What understandings do abused women and health professionals have of the different manifestations of domestic abuse?
5. What strategies can be developed to improve domestic abuse awareness and recognition among abused women and health professionals?

METHODS

Design

This qualitative, two-phase study was conducted over a 12 month period in Scotland during 2011.

Sample/Participants

In phase one, health professionals (midwives; health visitors (public health nurses); and general practitioners/family physicians) were recruited from two health boards (regions/districts) in Scotland using purposive sampling. They were purposively selected on the basis of having current/recent experience of working in a community setting and practice

experience of responding to domestic abuse. In other words, they had supported women in the post-disclosure period.

In the second phase, we used purposive sampling to recruit women through two non-statutory organisations, Scottish Women's Aid and Shakti Women's Aid (supporting Black and Minority Ethnic women). To take part, the women must have experienced domestic and disclosed this to a health professional.

Data collection

In phase one, data were generated through semi-structured, individual interviews. We chose individual, rather than group interviews with health professionals because we were asking about particular incidents and we were concerned about issues of confidentiality. Participants were asked to recall incidents from practice where a woman had disclosed domestic abuse. This was followed by a number of prompt questions (see Table 1). Length of interviews ranged between 25-95 minutes. They were audio-recorded and transcribed verbatim.

Insert Table 1

Selected incidents were then transformed into anonymised 'vignettes' for use in phase two (for an example see Table 2). To protect participants' anonymity they were assigned a code and number to denote their discipline (MW, HV and GP).

Insert Table 2

In phase two, we facilitated three focus group interviews with abused women. They were presented with the vignettes and invited to explore health professionals' decisions and responses in relation to domestic abuse. There is an argument that using vignettes that focus on the actions of others provide a safe, supportive space for discussion (Bradbury-Jones *et al.*, 2012). In this study we allowed women to discuss the issue of domestic abuse in a manner that focused on other people, rather than themselves. We considered that this was an

important mechanism to protect the potentially vulnerable women in the study. In fact, most women (with the exception of a few) were forthcoming and were more than willing to share their own experiences. Duration of the focus groups ranged between 55-90 minutes. Each focus group was assigned a code from FG1 to FG 3.

Ethical considerations

Ethical approval was granted via the NHS National Patient Safety Agency Research Ethics Service (East of Scotland REC, ref 10/S1402/49). Full signed and informed consent was gained from all participants following distribution of participant information sheets. There are ethical issues associated with any research, but women who have experienced abuse are particularly vulnerable (Hague & Mullender 2005). Unsurprisingly, safety is a particular issue (World Health Organization 2001, Spangaro, Zwi & Poulos 2009). In this study, the physical and emotional wellbeing of the abused women who took part was our primary concern. To promote their safety in both these areas we conducted all interviews with them at Women's Aid centres because these provided a physically safe environment. In line with best practice in domestic abuse research, all interviews were conducted by a female member of the research team (Skinner *et al.* 2005). In order to protect women's anonymity, no demographic data were collected. In terms of emotional safety, following each focus group we provided time for debrief and identification of potential distress or upset among participants.

The health professionals in the study needed protecting too and we were aware of potential upset among them as a result of discussing the issue of abuse. Additionally, we were mindful that some may have had personal experiences of domestic abuse. We therefore provided time

for debrief post-interview and contact numbers for support (such as Women's Aid) were available, had they been required.

Data analysis

Data analysis for both phases of the study was guided by the framework approach which involved five key stages, including familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer 1994). The initial framework was informed and guided by the research questions. The secondary analysis presented in this paper drew on framework analysis but involved a re-coding and analysis of the transcripts in terms of abuse awareness and recognition among women and primary healthcare professionals.

Reliability/Rigour

To enhance reliability, the revised framework was applied independently to the transcribed data by two research team members (*insert author initials*). Differences were discussed and resolved through team discussions among the whole team and revised until consensus was achieved. In phase two, data analysis and reliability checks mirrored those of phase one to ensure fidelity in the approach and robustness of interpretation. A reflexive journal kept by the lead author (*insert author initials*) was further used in terms of confirmatory, contradictory and complementary evidence. This information was included in the team discussions. This type of reflexive approach in qualitative research has been advocated as an important means of enhancing rigour (Bradbury-Jones 2007).

FINDINGS

Sample description

Twenty nine health professionals were recruited to phase one (midwives (MW) n = 11; health visitors (HV) n = 16; general practitioners (GP) n = 2). The three focus groups interviews in phase two comprised a total of 14 women: Group 1 (FG1), n = 4; Group 2 (FG2), n = 7; Group 3 (FG3), n = 3.

The re-analysis produced three themes relating to domestic abuse awareness:

1) Health professional and woman recognise the nature and existence of domestic abuse (Q. 1 & Q.4);

2) Health professional recognises the abuse, but woman does not (Q.2);

3) Woman recognises the nature and existence of domestic abuse, but health professional unaware (Q.3);

During our team discussions we perceived congruence between our emerging understandings arising from the analysis and the Johari window – a framework for exploring awareness in social relationships (Luft 1969) (Figure 1). We therefore applied it a posteriori to represent our findings diagrammatically and to organise our findings and discussion. Our utilisation of the framework is to capture the levels of awareness regarding abuse held by health professionals and women in the study, but also to show the dynamic interactions associated with such awareness.

Insert Figure 1

The Johari window was developed by Luft and Ingham in the 1950s. It comprises four quadrants that represent the total person in relation to other persons. An act, a feeling or a motive is assigned to a particular quadrant based on who knows about it (Luft 1969). Quadrant 1, the open area, is known to self and to others; Quadrant 2, the blind area, is known to others but not to self; Quadrant 3, the hidden area, is known to self but not to

others; Quadrant 4, the unknown area, is known neither to self nor to others (Luft 1969). We feel more comfortable re-naming Quadrant 2 as 'closed', rather than 'blind' in the context of domestic abuse awareness. Luft argued that the Johari window can be applied to a spectrum of human interactions, ranging for example, from gangs fighting to friends talking. In a health context, Sullivan and Wyatt (2005) used the Johari window to show how one or both individuals in a consultation (clinician and patient) may be aware - or not - of all the relevant information necessary to bring about a satisfactory outcome to the consultation. Halpern (2009) also used the Johari window in a health context to explore the relationships between supervisor and supervisee in the context of educational and clinical supervision.

We have utilised it to conceptualise the interactions between health professionals and women regarding domestic abuse awareness and disclosure. In this paper 'awareness' is understood as comprising two elements, *consciousness* and *recognition*. Consciousness refers to taking sensory note of the presence of the phenomenon of abuse (e.g. pain, fear, sadness) and having the sense of it occurring. Recognition refers to understanding the recurrent nature of the abusive situation and the identification and naming of the situation as abusive. In this understanding, simple consciousness is not enough for domestic abuse awareness. The process of recognition is critical to ascertain the 'identity' of domestic abuse, i.e. 'this is what it feels like when one is abused' or 'this is what abuse looks like'.

The study findings - understood with reference to the Johari window - show that within a domestic abuse situation, awareness and recognition between health professional and a woman has four possibilities. With a woman on the horizontal axis and health professional on the vertical (Figure 2) dynamics may involve: both woman and health professional recognise the nature and existence of domestic abuse (open area); health professional recognises abuse

but woman does not (closed area), woman recognises the existence of abuse, but health professional is unaware (hidden area). The unknown quadrant, where neither woman nor health professional recognises the abuse, is also a possibility (this will be discussed later). It reflects scenarios where consciousness may or may not exist with regard to the abuse, but in any case, recognition does not take place. This domestic abuse awareness dynamic is captured in Figure 2. We have termed it the 'Abused Women, Awareness, Recognition and Empowerment' (AWARE) framework.

Insert Figure 2

1) Open area: health professional and woman recognise the nature and existence of domestic abuse

In their descriptions of supporting abused women, most health professionals were aware of the different manifestations of domestic abuse. Almost all talked of women in their care where emotional abuse had been present:

> There was never anything physical, it was all emotional abuse…he kept her under the thumb and made her feel insignificant and that she wasn't able to cope and always made her feel that if she couldn't cope then there was something wrong with her. MW8

This converges with the findings from the focus groups with women where emotional abuse and controlling behavior were discussed a great deal, for example:

> Woman 1: He didn't hit me like that… this kind of abuse… I mean verbal abuse is terrible, it is sometimes emotional.

Woman 2: Yes.

Woman 1: He just forced me to work, I mean overnight 12 hours and study and things like that. Abuse is also emotional abuse. It is the worst one….

Woman 3: You are always a 'stupid woman, stupid woman' FG3

Our findings indicate that both health professionals and women in the study understood that domestic abuse has multiple guises. This shared understanding is important because it creates opportunity for open discussion and 'naming' of the abuse:

> She explained how wicked he [partner] was and then I said "So you have been abused?" and I explained to her that… it includes things like being raped, sexually abused, serious verbal abuse, intimidation, being locked in the house" and I went through all the things. It was like every box was being ticked with her and I think she realised. MW1

> She said "Well, he's very controlling and he always puts me down, whatever I ask the child to do, he says they don't need to do it"… and I asked about physical violence and she said there was no physical violence but… when we went back over what was happening I was saying "Well that sounds like abuse to me. HV3

Overall, in our study participants recounted many examples where they had experienced openness, that is, where domestic abuse was recognised, understood and discussed between woman and health professional. We have termed this the 'open area'.

2) Closed area: health professional recognises domestic abuse, but woman does not

Conversely, there was a shared perception by health professionals and women that at times women fail to identify their experiences as abusive. In many ways they are 'blind' to the nature of the abuse or in our understanding they may have temporal consciousness of it, but do not recognise the abusive character, cannot identify and name it, nor understand its recurrent nature. For example:

> A woman said to me "Sometimes I feel scared, I feel I'm being controlled but there's nothing I can put my finger on". So I said to her… "If you ever feel that you just want to have a chat, this is my number" … there was obviously something going on but she wasn't sure what it was. MW5

The health professional perspectives converge with those of women, many of whom acknowledged that they had failed to recognise the abusive nature of their relationships, hence:

> You have to come to the stage that you have realised that you are being abused, I mean I never had black eyes or anything, so I had nothing on the outside, but it is in here that I cried [gesturing to heart]. See if you don't know that you are being abused you cannot tell somebody that you are being abused. FG1

Evident within the focus group discussions was the part that health professionals play in supporting women to 'name' the abuse:

> It was horrible for me to open up. As a patient, I was having some problem, with mentioning the domestic violence, when my GP started asking me more questions,

then I can't help but explain. She was the person who helped me put things into perspective and said look this is a very typical example of domestic violence. I didn't, I couldn't identify it. I was not in a state to identify exactly what's going on with me. FG3

Women stated clearly that health professionals have a responsibility to ask about abuse because this assists with the naming process. Moreover, they *want* to be asked. However, they were critical of some health professionals' reluctance to broach the issue of abuse:

Woman 1: The doctors can't handle it.

Woman 2: But they should know how to handle it! These people are supposed to be professional… they have to deal with telling people every day of the week that they've got cancer or something like that. FG2

Overall, what we term the 'closed area', relates to situations where a health professional recognises domestic abuse, but the woman does not. It highlights the place that health professionals play in creating an environment in which domestic abuse is openly discussed.

<u>3) Hidden area: woman recognises the nature and existence of domestic abuse, but health professional is unaware</u>

Even when women recognise that their experiences are abusive, our findings highlight women's propensity towards concealment. In such situations it is health professionals that lack awareness:

I had no idea in her pregnancy that her partner was violent…she never disclosed

anything. MW9

On the issue of reluctance towards disclosure, there was agreement among most women that they would be inclined to deny abuse:

> Nobody… nobody can come and say to you, "Are you being abused?", because you would deny it; 'Who? Me?!' FG1

> When I was with [ex-partner] I used to keep cancelling appointments, and I wouldn't be in. She [health visitor] would phone and just be like 'is everything okay?' 'Aye, fine, sorry I had to cancel you, blah, blah, blah', but when I left, she says 'I never knew, I would never have known because he is such a nice guy' FG1

> You know to keep your mouth shut and don't say anything… I was thinking I cannot talk to anyone about my life. I am not allowed to do that, this is something wrong. FG3

In terms of the hidden area, in contrast to the closed area, our findings show that many women recognise the abusive nature of their relationship, but for numerous reasons the health professional is unaware. Overall, our findings show that health professionals and abused women have varying levels of awareness and recognition of the nature and existence of domestic abuse. At any given time it is likely that a dynamic interplay of domestic abuse awareness and communication exists between an abused woman and the health professionals with whom she has contact. The underpinning reasons and implications of this are critiqued in the ensuing discussion.

DISCUSSION

Our study showed that health professionals and women have converging views regarding the different manifestations of abuse. Their understandings are also shared regarding some women's need for help in recognising their experiences as abuse. In achieving this, our third focus group in particular highlighted the desire among many abused women for health professionals to be direct and to help them 'see' the abuse. This supports the findings of other studies, where abused women have asked for help in 'naming the abuse' (Spangaro *et al.* 2011). It also aligns with considerable international evidence that women find it acceptable to be asked about domestic abuse (Bacchus *et al.* 2002, Tacket *et al.* 2003, Keeling & Birch 2004, Koziol-McLain *et al.* 2008, Feder *et al.* 2009). From healthcare professionals' perspectives, there is agreement among many, that women should be asked about abuse (Barnett 2005, Lazenbatt & Thompson-Cree 2009, Lazenbatt *et al.* 2009). It is ironic then, that findings from our study and those of others' point to their resistance to do so (Mezey *et al.* 2003, Gutmanis *et al.* 2007, Lazenbatt *et al.* 2009, Montalvo-Liendo 2009, Beynon *et al.* 2012).

In terms of the hidden area, there was mutual recognition that women are likely to conceal abuse. Indeed, they go to extraordinary lengths to hide it. This concurs with findings of a study by Peckover (2003) who reported that some women concealed their abuse from health visitors. Reasons for non-disclosure include feelings of shame and stigmatisation (Ahmad *et al.* 2009, Feder *et al.* 2009, Montalvo-Liendo 2009, Spangaro *et al.* 2011); anxiety about removal of children (Peckover 2003, Montalvo-Liendo *et al.* 2009) and fear of further abuse (Robinson & Spilsbury 2008, Spangaro *et al.* 2011). Overall, evidence from our study and those of others, indicates that it is often easier for women to hide their abuse from health

professionals, than to disclose. But there is an array of complex issues associated with this apparent propensity to 'hide', including lack of recognition. So, a women may: not 'see' the abuse; not understand it; not be able to label or name it; not want to see it; not want to admit it; not want to express it; want to express it but is afraid; want to admit it but is unable to find the right time and person. Whatever the reasons, we contend that while women remain metaphorically within the hidden area (Figure 2), they are exposed to risk of further violence.

The Johari window is based on the principle that change in one quadrant will affect all other quadrants (Luft 1969). The smaller the open quadrant the poorer the communication, thus increased awareness results in it becoming larger and one or more of the other quadrants, becoming smaller. Representing domestic abuse in this way provides a means of capturing it as a moveable, dynamic process (Figure 3). As indicated by the direction of the arrows in Figure 3, the closed area (where a woman lacks awareness) has potential to be reduced through health professionals enquiring about abuse and similarly, the hidden area (where the health professional lacks awareness) can be reduced through a woman's readiness to disclose. The resulting openness creates an environment in which a woman can be empowered to recognise and identify domestic abuse and then appraise her options regarding safety.

Insert Figure 3

So far we have focused on three areas of awareness, but the fourth quadrant – the unknown area - needs to be acknowledged. There is universal curiosity about the unknown area because it relates to that which is known neither to self nor to others (Luft 1969). Given that we had examples of women who did not recognise they were being abused and also health professionals who did not recognise it, there is likelihood that this fourth quadrant is

populated in domestic abuse. Henderson (2001) pointed out that nurses' actions in relation to domestic abuse do not occur in a vacuum. Decisions and actions occur as a result of multiple influences, including unrecognised biases and prejudices. Similarly, our previous research has shown that some midwives and health visitors make assumptions about which women are likely – or not – to experience domestic abuse (*insert author reference*). In effect they make assumptions based on stereotype. Thus, using the AWARE framework for discussion may result in some shifts from this quadrant. For example, it might prompt reflection on current or future cases where domestic abuse had not been considered. It also needs to be acknowledged that is some cases, health professionals may suspect the abuse but lack 'motivation' to identify it as such, because it would set off a cascade of emotions, activities and interventions. Similarly, the woman may (a) not communicate abuse for the same reasons and/or (b) not label a situation as abuse even though it is experienced as such.

Our findings and those of earlier research show that for a number of reasons a dual silence often exists, whereby neither abused women nor health professionals broach the issue of domestic abuse. This may leave women and their children at risk of further abuse. We have suggested two means of widening the open area: enquire about domestic abuse and facilitate disclosure (Figure 3). However, we acknowledge that such acts need to take place within a supportive and safe environment. The time has to be right to encourage disclosure; forced awareness (exposure) is tantamount to psychological rape (Luft 1969). It is noteworthy, that on the issue of self-disclosure there is an element of control in the third quadrant, the hidden area (Figure 1). What is revealed is up to the individual involved (Luft 1969). From this perspective, the covert, hidden areas of a woman's life are to be respected, but opportunities for openness put in place.

Specifically in the context of domestic abuse, a non-judgemental attitude is important in facilitating the disclosure process (Bacchus *et al.* 2002, Feder *et al.* 2006, Ahmad *et al.* 2009). As already discussed, domestic abuse is a stigmatised, taboo issue (Tacket 2004, Buck & Collins 2007). Thus in order to facilitate disclosure, building supportive relationships is important and particularly those that pave the way for open discussions about abuse. The AWARE framework has potential to achieve this by acting as a prompt for discussion. In turn, this can empower women to make decisions about whether - or not - to disclose and choices about exiting – or not – the abusive relationship.

Limitations

A number of study limitations need to be noted, which may have had an impact on our findings. The study reported in this paper was a secondary analysis of existing data that we returned to after having generated them with different research questions in mind. We may have gleaned deeper insights into the issue of domestic abuse awareness had we set out to generate data according to the research questions used for the secondary analysis. Additionally, this may have focused our enquiry more sharply. However, the revised research questions assisted in shaping our re-interrogation of data. Crucially, the secondary analysis relating to the issue of domestic abuse awareness provided rich insights and new knowledge that would have been lost to the archives had we failed to investigate the issue further. A second limitation is that women were recruited through a domestic abuse service which may have influenced the insights gained. Coupled with the small sample size, it is important to temper over-zealous claims regarding transferability.

Finally, regarding implications for practice, the domestic abuse awareness framework that we have developed requires refinement, modification and testing beyond the parameters of the

study. Although not a limitation in itself, this means that caution needs to be exercised when considering its use and transference. To date, we have presented the findings from the study at two international conferences and via one web-based dissemination event. Feedback from attendees regarding the potential impact of the AWARE framework has been encouraging. However, independent verification is required to operationalise the framework for specific practice purposes, such as training of nurses and midwives and development of conversation algorithms for practitioners to use with women.

CONCLUSIONS

In 1970, Luft and Ingham expressed surprise that so many people had been 'tinkering' with the Johari window since it was first presented in the 1950s (Luft 1970). We have developed it yet further to understand the complex, dynamic awareness and disclosure processes regarding domestic abuse. To date we have had some feedback from nurses on the potential positive impact of the AWARE framework on practice. However, we acknowledge that it requires further refinement and empirical testing. Overall, increased understanding of domestic abuse awareness and recognition is important and in this, we hope to have contributed theoretically and empirically.

RELEVANCE TO CLINICAL PRACTICE

In terms of addressing Q.5 of the revised research questions, the Johari window-inspired representation of domestic abuse – the AWARE framework - provides a means of capturing the complexity of the disclosure process and the dynamics of disclosure, concealment and enquiry. This has potential to inform the development of strategies to improve domestic abuse awareness and recognition among abused women and health professionals. This could include, for example, the development and evaluation of training/educational materials in

relation to domestic abuse. Routine enquiry (asking all women routinely about domestic abuse) is now implemented in many clinical contexts. However, while some health professionals are confident about asking about domestic abuse, some need more support (Bacchus *et al.* 2012). Training has been identified repeatedly as an important factor in promoting health professionals' confidence in addressing and responding to domestic abuse (Hegarty & Taft 2001, Bacchus *et al.* 2003, Chang *et al.* 2008, Feder *et al.* 2011, Beynon *et al.* 2012), specifically in the contexts of midwifery (Hardacre 2005, Buck & Collins 2007, Mezey *et al.* 2003, Salmon *et al.* 2006, Lazenbatt & Thompson-Cree 2009) and public health nursing (Dickson & Tutty 1996). The issue is no longer so much one of whether routine enquiry should take place but how it will be carried out. The AWARE framework could be used as a point of discussion and reflection among nurses or nursing students, so help them 'see' the complexity of domestic abuse and the part that they can play in recognising and responding to domestic abuse. Its practical value may lie in the framing of team discussions and reflections rather than in guidance for in situ routine enquiry situations.

Importantly, the framework could also be used to frame the development of guided conversation support tools. The abused woman who told us 'if you don't know that you are being abused you cannot tell somebody that you are being abused' serves as a poignant reminder of how important it is to help women to recognise their experiences as abusive. Women in our third focus group in particular, articulated the need for health professionals to enquire about abuse as part of the naming process. Thus, during safe, private consultations the AWARE framework could be used to 'help them see' the abusive nature of relationships. This is something that the abused women in our study called for repeatedly and nurses might bear it in mind when prevaricating about asking. In sum, it may facilitate a shift away from domestic abuse being closed, hidden or unknown, towards it being a more open issue.

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Table 1: Example Prompt Interview Questions for Phase 1

- Tell me about an incident where you have responded to domestic abuse.
- What led you to suspect/identify the abuse?
- What prompted you to respond?
- Why did you respond in the way you describe?
- What were the consequences of this response?'
- On reflection how do you feel about the way the incident was managed?

Table 2: Example vignettes

Example 1: One client that I went to see... she ended up in hospital actually eventually because he kicked her so badly but initially when I went to see her, it all appeared cozy [homely/comfortable]. You could tell the guy was a bit of an aggressive guy just by his manner... eventually she did disclose, you know, she said that he was controlling her, he was destroying her things because he knew that they were important to her, by throwing them across the room.
Example 2: Usually the way I approach it is to start a conversation, you know, I say "How are you?" and "How are things going?" and "You look a bit tired" or ... there's something I'm a wee bit worried about, you know''… I could say "Look I'm kind of wondering, are you experiencing domestic abuse?" but I wouldn't usually say that. I explain what domestic abuse is because often the woman doesn't even see it as domestic abuse.

Figure 1. The Johari Window: original representation

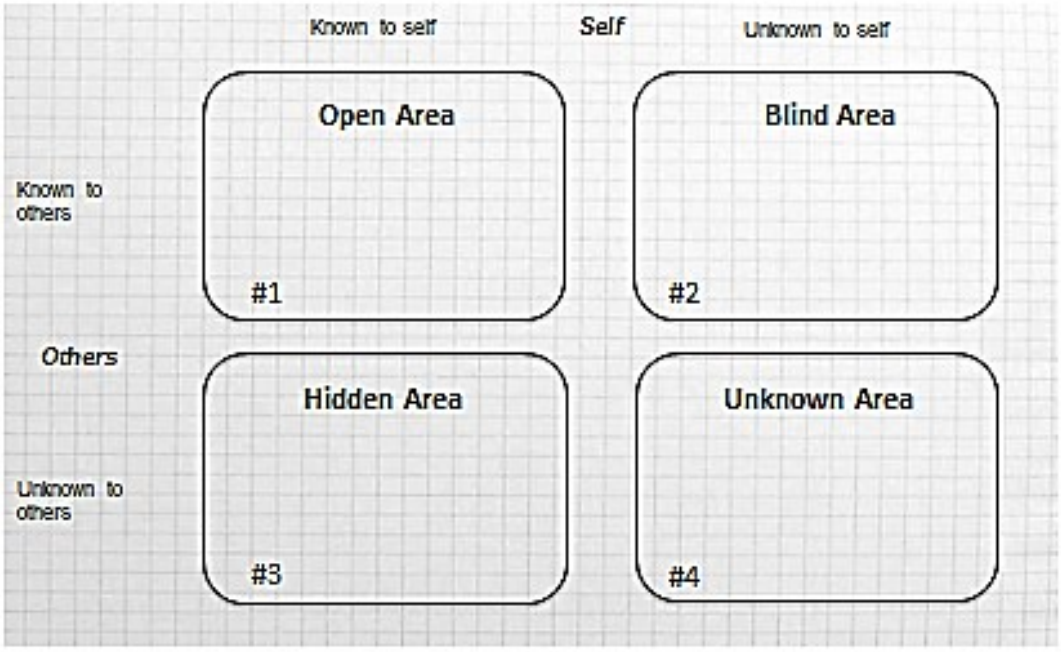

Figure 2. Abused Women, Awareness, Recognition and Empowerment (AWARE) framework : potential dynamics.

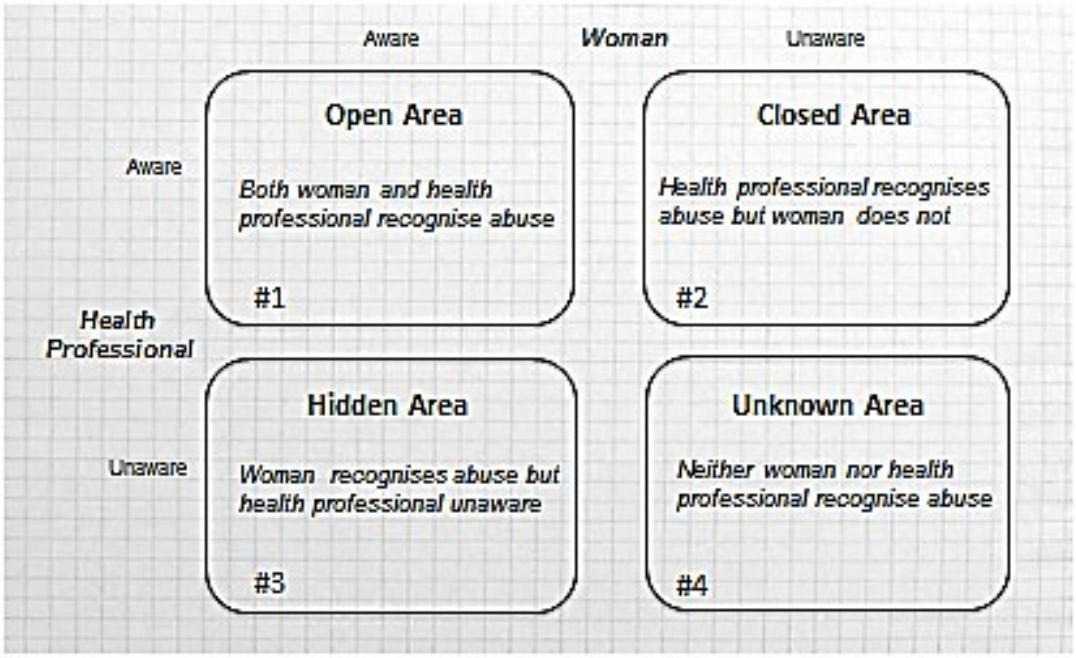

Figure 3: (AWARE) framework - increasing the open area