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‘I felt paralysed to ask for help for myself’: domestic abuse experienced by healthcare professionals

Domestic abuse is widespread and disproportionately affects women. However, it can affect anybody, regardless of gender, sexuality, and socioeconomic status. This includes healthcare professionals, who are often tasked with the responsibility to identify and respond to domestic abuse among their patients. Recent research suggests that healthcare professionals may be more likely to experience domestic abuse than people in the general population: this research also indicates that healthcare staff are less able to seek support.

Case scenario

Nina is a 57-year-old GP. As her colleague, you notice that she is looking tired and that she often seems distracted. Nina used to join in with conversations at work, but for the last couple of years, she has interacted less and does not attend practice social events. Nina appears to receive a lot of text messages at work, and she usually replies immediately, even when she is in the middle of something else. You sometimes see her partner waiting outside to pick her up, and when the reception team say how lovely this is, Nina looks anxious and struggles to maintain eye contact. Throughout training on domestic abuse, Nina is very quiet and withdrawn. You wonder if she is experiencing domestic abuse, but instantly dismiss the idea: ‘Surely this would not happen to a doctor?’

Introduction

The UK Home Office (2022) definition of domestic abuse includes physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse (i.e., abuse that affects a person’s ability to acquire, use, or maintain money or other property, or to obtain goods or services), and psychological abuse, emotional abuse, or other forms of abuse. Abuse from one person to another is considered to be domestic abuse if both the survivor and the abuser are aged 16 or above, and if the abuser is the survivor’s partner, ex-partner, relative, or in-law relative. There may be one, or more than one, abuser, and the abuse might be a single incident, or more commonly, a pattern of abuse.

Latest estimates show that in England and Wales, 21% of adults aged 16 to 74 have experienced domestic abuse since the age of 16 years. That percentage equates to 8.8 million people (Office for National Statistics, 2020). Between the year ending 2018 and 2020, there were 362 domestic homicides: most of these (n=269) were women killed by a male suspect, followed by men killed by male suspects (n=55) (Office for National Statistics, 2021). In Scotland, where national data focuses on partner abuse only, 16.5% of adults have experienced at least one incident of

partner abuse (Scottish Crime and Justice Survey, 2020), and in Northern Ireland, police report that there were over 31,000 incidents of domestic abuse in 2020-2021 alone (Police Service of Northern Ireland, 2021).

Our 2022 systematic review and meta-analysis (Dheensa et al., 2022) has indicated that a higher proportion of healthcare professionals may experience abuse than people in the general population. The reasons for this are unclear: it may be that people who have experienced abuse in the past are drawn to altruistic professions where they can care for others who have experienced trauma (Gilbert, 2020). Another suggestion is that experiences of workplace violence and abuse, which are not uncommon among healthcare professionals, may lead healthcare staff to normalise such behaviours making it harder for a healthcare professional to identify a partner or family member's behaviours as abusive. Our review also showed that healthcare professionals feel less able to seek support. Without support, many people who are experiencing abuse feel unable to leave or to end a relationship. (Anderson and Sanders, 2003).

Can domestic abuse really happen to anyone?

Many people still hold stereotypical or myth-based views about what domestic abuse looks like and who experiences it. If we ask people to imagine a person who is experiencing domestic abuse, the majority envisage a young woman in a heterosexual relationship, with visible bruises. People also make assumptions about her financial position, level of education, and employment. Most demographic and social characteristics are *not* consistently associated with increased risk, apart from female gender, younger age, and relative poverty (which is *not* the same as low income).

We know that many people still hold these perceptions because of the questions we get asked as researchers, trainers, and practitioners. We have also received incredulous comments since deciding to research the domestic abuse experiences of medical students and healthcare professionals—medics, academics, and funders alike have queried whether healthcare staff, especially medical students and doctors, would really be experiencing domestic abuse. Even the survivors that we have spoken to who are healthcare professionals struggle with the idea that their experiences are ones of abuse, and particularly with the notion that domestic abuse has happened to someone 'like them'.

What we know so far

More than a decade ago, when we began training GP practice staff in the identification and referral of women who were experiencing domestic abuse as part of the IRIS study (Feder et al., 2011), we started to receive disclosures from staff, and to recognise that it was particularly hard for clinicians to reach out for support:

Having training on domestic violence and seeing cases at work helped me recognise when my own relationship became abusive. I recognised that 'walking on eggshells' feeling. Even though as a clinician I would encourage and refer people for support, I felt paralysed to ask for help for myself (Sarah, GP)

At the time, whilst supporting the people who came forward, we realised how difficult, and potentially triggering, survivors might find interactions with patients who were experiencing domestic abuse, and also the level of distress caused by hearing colleagues express assumptions and judgements about what domestic abuse looks like, and who experiences it.

Five years ago, a healthcare professional challenged us that the experiences of healthcare staff were, in fact, something we should be researching. She pointed to a report from the Cavell Nurses Trust (2019) which indicated that nursing professionals in the UK were three times more likely to have experienced domestic abuse in the past year than members of the general population. This motivated us to conduct a systematic review of the literature (Dheensa et al., 2022) to explore the existing evidence. A meta-analysis of the data in 51 reports from across the globe indicated a high lifetime prevalence of domestic abuse victimisation among healthcare staff, with an indication that country-by-country, the prevalence was higher for healthcare staff than for the general population. And, just to be clear, many of these studies did include doctors as participants, not 'just' other healthcare professionals (for example McLindon at al., 2018).

Whilst few of the included studies looked at why this might be, there were indications about aspects of healthcare professionals' roles which might put staff in a unique position of vulnerability, and which might make it harder for people in these jobs to seek help. In particular, a pioneering study in the UK by Dr Emily Donovan and colleagues (2020) found that the internalised stigma of abuse affected people's sense of identity and belonging as a doctor and caused social and professional isolation. Many of the doctors interviewed in this study felt that the acute stress of experiencing domestic abuse had impacted their work, but they often felt unable to take time off.

They also described barriers to help-seeking including a lack of confidentiality, especially where the abusive partner was also a doctor. And of course, we know that domestic abuse is happening to staff who work in contexts where the rates of burnout, stress, poor mental health, and abuse by patients and colleagues are high and rising (NHS Staff Survey, 2021):

After a particularly bad weekend with my partner, I came into work completely emotionally exhausted and couldn't stop crying. I could see patients on my screen were backing up and I just couldn't pull myself together...I felt my patients and the surgery needed me to just be strong and keep going (Vicky, GP)

Our current research

The PRESSURE study is an NIHR School for Primary Care Research funded project which is about primary and community healthcare professionals' own experiences of domestic abuse. The study is being led by Dr Alison Gregory and Dr Sandi Dheensa, specialist violence and abuse researchers at the University of Bristol. In brief, the study includes (i) a review of policies for staff who have experienced domestic abuse from primary and community healthcare settings in England, and (ii) surveys and interviews with survivors who are primary and community-based healthcare professionals, and with staff in roles that involve supporting colleagues, such as line management, human resources, and occupational health.

The study runs until May 2023 and, with the findings, we plan to improve policy and practice regarding support for healthcare professionals who have experienced domestic abuse. If you are interested in finding out more about the study, would like to share your staff policy, or would like to take part, please get in touch with us. More information is available on the study webpage: www.bristol.ac.uk/pressure-study

Meanwhile, how can you help?

Our initial findings suggest that very few general practices have a domestic abuse policy for staff, even if they have good policies, training, and practices regarding patient experiences of abuse. The existence of such a policy indicates to staff-survivors that they are not alone in their experiences of domestic abuse, and that the practice places importance on their safety and wellbeing. So, the first thing you can do, is encourage and champion a domestic abuse policy for staff members.

The second thing you can do (and we all need to do this from time-to-time) is to reflect on, and challenge, any preconceptions and biases you may have about what domestic abuse looks like, and who experiences it. The media continues to give us a very particular picture of domestic abuse, and it can be hard not to give credence to it. We also slip into inaccurate beliefs as a protective mechanism – if we believe that experiences of domestic abuse are prevalent among our colleagues, then it means that it could happen to 'someone like me', and that makes us feel vulnerable. The downside of inaccurate beliefs is that we may fail to notice when it is happening to the people around us, when we could be providing support. It is therefore important to get information from credible sources —from expert specialists.

You can also equip yourself ready to notice (see Box 1), listen well, and respond supportively. This is similar to how you would respond to a patient experiencing domestic abuse (Standen, 2022), but perhaps with even greater tact and sensitivity. (If you have not received training around domestic abuse, you could ask whether your practice is part of the IRIS programme, which is recommended by the Department of Health and Social Care as best practice – see irisi.org). Responding to any disclosure of abuse, including one from a colleague, is a key moment of huge

significance. When responding to a colleague, do anticipate that it may *feel* different—for both of you—from similar conversations with patients, because you have a different type of relationship. It is therefore important, in situations where you are supporting a colleague, to consider any effects on yourself (Gregory et al., 2017a; Gregory et al, 2017b), to practice self-care, and to remember that specialist support is available. Seeking support is especially important if you, yourself, are a survivor of domestic abuse. If your own life experiences make it feel unsafe or uncomfortable for you to support a colleague directly, then reaching out to people you trust or to specialist support services are good options. Many services can support people who are survivors themselves, as they support a friend, family member, or colleague. Box 2 contains details of some of the UK-wide services available.

{insert box 1 here}

{insert box 2 here}

KEY POINTS

- Domestic abuse is prevalent and research suggests healthcare professionals, including doctors, experience domestic abuse at higher rates and seek less help
- Doctors who are experiencing domestic abuse experience greater internalised stigma, professional isolation, and barriers to help-seeking
- Difficult experiences can overlap or have a cumulative effect for healthcare professionals - many work in contexts where rates of burnout, stress, poor mental health, and abuse by patients and colleagues are high.
- Supporting patients who are experiencing domestic abuse may be difficult, or triggering, for healthcare staff with lived experiences of abuse.
- GPs can be supportive of colleagues who are experiencing domestic abuse by (i) championing domestic abuse policies for staff members, (ii) reflecting on and challenging inaccurate beliefs about domestic abuse, and obtaining information from credible sources, (iii) noticing, listening well, and responding appropriately to colleagues who are survivors, and (iv) accessing specialist support.
- The PRESSURE study aims to inform policy and shape good practice around support for healthcare staff-survivors. For more information, please see the study webpage.

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Box 1 – What you may notice if a colleague is experiencing domestic abuse

- Any impact on their work—for example, arriving late or leaving very punctually; being distracted or less able to concentrate; taking more time off or spending a lot more time at work
- Any injuries—for example, bruises, cuts, burns, bite marks—and wearing clothing that does not seem right for the temperature or occasion
- Behaviours by the abuser—including verbal abuse, such as criticising your colleague; making fun of their opinions, beliefs and appearance; saying disrespectful things about them; or calling them rude names. And including stalking behaviours, such as turning up unexpectedly at your colleague's workplace; calling or messaging them with unreasonable frequency; or calling the practice for information about their schedule or whereabouts

- Your colleague’s behaviour—including changes in their demeanour or their interactions with others; becoming quieter or seeming nervous, anxious, or scared; receiving lots of texts or calls which they may not be able to stop answering; big changes to their style of clothing or make-up; signs of distress or poor physical or mental health (for example, feeling low, tired, anxious, or increasing their alcohol use; substance use; reduced confidence, ambition, or sense of self-worth; or asking you to keep information secret from the abuser (for example, who they have worked with)

Box 2 – Domestic abuse support services

Please note that details may have changed since publication of this article:

National Domestic Abuse Helpline
• Website: https://www.nationaldahelpline.org.uk/
• Helpline: 0808 2000 247 (24 hours).
• Chat to someone online: https://www.nationaldahelpline.org.uk/en/Chat-to-us-online (Monday - Friday, 3 pm - 10 pm)

Galop: support for LGBT+ people who have experienced abuse or violence
• Website: https://galop.org.uk/
• Helpline: National LGBT+ Domestic Abuse line: 0800 999 5428 (Monday - Friday, 10 am - 5 pm, and open until 8 pm Wednesday and Thursday).
• Chat to someone online: https://galop.org.uk/get-help/helplines/ - click 'Specialist web chat service in the webpage's bottom right corner (Wednesday and Thursday, 5 pm - 8 pm).

Men's Advice Line: support for male victim-survivors of domestic abuse
• Website: https://mensadviceline.org.uk/male-victims/
• Helpline: 0808 801 0327 (Monday - Friday, 10 am - 8 pm)