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How health visitors from one healthcare organisation in the north of England endeavour to meet the perceived needs to Pakistani mothers living with violence and abuse and the challenges they encounter in keeping such women safe

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**HOW HEALTH VISITORS FROM ONE  
HEALTHCARE ORGANISATION IN THE NORTH OF  
ENGLAND ENDEAVOUR TO MEET THE PERCEIVED  
NEEDS OF PAKISTANI MOTHERS LIVING WITH  
VIOLENCE AND ABUSE, AND THE CHALLENGES  
THEY ENCOUNTER IN KEEPING SUCH WOMEN  
SAFE**

**CATHERINE JANE SMYTH**

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements  
for the degree of Doctor of Nursing

The University of Huddersfield

July 2016

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## Abstract

Domestic abuse is a public health issue with long term health and social consequences for its victims. The prevalence of domestic abuse among women seeking healthcare is higher than in the general UK population and often begins or worsens in pregnancy. Health visitors, because of their role with pregnant women and mothers are in a key position to offer both supportive interventions and to play a preventative role in domestic abuse.

The aim of this research is to improve understanding of issues health visitors face when working with Pakistani mothers living with domestic abuse. The study is set in the north of Britain in an area that has experienced chain migration and settlement from the Mirpur and Faisalabad regions of Pakistan since the 1970s. Taking a qualitative approach and informed by a critical realist perspective, first-hand accounts from health visitors working in the area are used.

The findings of the study confirm that domestic abuse perpetrated against some Pakistani mothers is a complex aspect of health visiting practice compounded by deep rooted cultural and social practices within many Pakistani families. The key challenge health visitors face appears to be non-disclosure of abuse by many Pakistani women and the main approach taken by health visitors in this situation is predominantly one of harm minimisation. Inconsistencies in practice were however noted.

Three overarching themes were found from the analysis of the data which depict the challenges health visitors face and the endeavours they take to keep women safe. The theme of *Presence* depicts a range of actions linked to 'seeing' or 'being with' women and includes carrying out repeated enquiry into abuse. *Role Strain* describes how the health visitors express difficulty in fulfilling the various demands and expectations of the role. The term *Covert Actions* encompasses a range of seemingly hidden or concealed activities undertaken by health visitors in an endeavour to maintain *Presence*.

The study provides useful insight into the forms of evidence many health visitors deem can legitimately inform their clinical interventions when working with this population group and succeeds in extending current understanding of the types of knowledge health visitors draw from to inform their decisions in this specific area of practice. It also provides awareness of the wider challenges health visitors can encounter when working more generally among collectivist and honour-based communities and raises questions about some of the philosophical assumptions usually associated with Western models of healthcare.

Implications for practice are that mainstream domestic abuse interventions should be used with sensitivity to the different cultural contexts in which many Pakistani mothers live, and attempts should be made to develop appropriate interventions that derive from those contexts. This includes holistic assessment tools that are flexible enough to allow clinical judgements to be informed by the more subjective elements of evidence gathering and which take into consideration the impact of the multiple oppressions some women encounter.

Recommendations for service providers are that they should take a broader view of domestic violence that recognises 'difference' and therefore enables health visiting interventions to be flexible and responsive to differing need. This includes considering more community-based interventions among certain population groups.

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## **Dedications and Acknowledgements**

I would like to thank my family for the support and encouragement to undertake this work, and Michael Crowther for his trust in allowing me to do it. I dedicate the work to those women still living with violence and abuse and to 'silenced' women everywhere.

# **Chapter 1 Introduction**

The purpose of this introductory chapter is to provide a personal, professional and the beginning of an academic rationale for an in-depth study of health visitors' work with Pakistani women living with violence and abuse. In this chapter the background and context of the study are described. My position as a researcher is stated so how this may have shaped the research process and outcome can be understood. The role that reflexivity plays throughout the study is explained. Definitions and a rationale for the choice of certain words and terminology used within the thesis are provided. The chapter ends by stating the broad aims of the study.

## **1.1 Background and context**

This research was undertaken as a result of my own experience as a health visitor working for many years amid a south Asian, predominantly Pakistani, population in the north of England. Much of the family structure and many social patterns I observed during that time were indicative of, and an exemplar of, a collectivist, honour-based cultural group. Throughout that period I was also aware of numerous women who were victims of domestic violence and abuse. For many of these women, like countless other women worldwide (Garcia-Moreno et al., 2006), the violence was frequently perpetrated by an intimate partner. Within this particular population, however domestic abuse was often reported to be being effected by one or more members of the extended family, which frequently included other women living in the same household.

Throughout that time I found it difficult to know how to effectively support those women experiencing this type of violence, or indeed what good outcomes for such women might be. Those who spoke out often later retracted the disclosure and women who chose to share their unhappiness with me frequently felt they had no choice but to accept their situation and rejected any intervention I was able to offer.

The sense of impotence I felt at the time as a practitioner has remained with me and prompted this research. I want therefore, by the application of academic rigour, to bring about a better understanding of the issues facing health visitors working with this population group. I hope to add to the overall knowledge base of health visiting interventions with Pakistani women experiencing abuse and contribute to finding more effective ways of keeping such women safe.

I am aware however that Pakistani women are not one homogenous group and I acknowledge that some may question the legitimacy of a white, western woman writing

about Pakistani violence. I am mindful that cultural relativists might suggest that the practices of a minority ethnic group cannot be criticised by anyone outside that group. Anti-racists might argue that my writing deflects attention from the oppression of racism and perpetuates stereotypes, and some feminists might propose such research propagates constructions of Pakistani women as passive victims.

While I recognise such dangers, the focus of my research is on health visiting practice and not why such violence might occur. I also however agree with those academics (see e.g. Afshar, 1994; Macey, 1999) who say that fear of such criticism should not detract from scholarly pursuits aiming to improve policy and practice.

## **1.2 *Lexicon***

This section provides definitions and a rationale for the choice of certain words and terminology used within the remainder of the thesis.

### **1.2.1 Mothers**

As the focus of contemporary health visiting practice lies predominantly with mothers, fathers and their infants and pre-school children (Department of Health, 2010a), the term woman or women in this thesis frequently refers to mothers with pre-school children, or pregnant women.

### **1.2.2 Pakistani**

The term Pakistani refers to someone whose ancestral roots lie in what is now the modern State of Pakistan. This includes British born Pakistanis. I acknowledge that Pakistani people are a mixture of several ethnic sub-groups, however I use the term Pakistani as an overarching term to include all these groups.

Whilst every effort has been made within this thesis to draw on literature specific to this group, some authors and certain policy documents bracket the Pakistani population with other south Asian ethnic groups and use the broader term south Asian. Where this is the case, for accuracy, I have also used this terminology when referring to those specific works or references. Likewise, when certain statements are made that may be generalisable to the wider group of south Asian women or communities, the overarching term is used.

### **1.2.3 Health visiting practice**

At the time of this research national health visiting practice was underpinned by the Healthy Child Programme (Department of Health, 2009). In February 2014 The National Institute for Health and Care Excellence produced guidance on domestic violence and abuse for those working in health and social care which had implications for health visiting practice (NICE, 2014). The guidance, however, though referenced within this thesis, was not fully embedded into the local policy of the healthcare provider under study during the period this research was undertaken. Routine enquiry of pregnant and postnatal women about domestic violence by health visitors was however established practice within the organisation at the time.

### **1.2.4 Domestic violence and abuse**

Within health visiting practice the overarching term domestic violence refers to violence that is perpetrated in the home (Robotham & Frost, 2005). Within this thesis the following United Kingdom (UK) cross-government definition of domestic violence and abuse is used:

*Any incident or pattern of incidents of controlling, coercive, threatening behaviour, 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*
- *emotional*

(Home Office, 2013)

Throughout the thesis, in order to avoid what might seem to be tedious repetition, I use the terms violence and abuse interchangeably as opposed to the longer, combined phrase 'domestic violence and abuse'. I recognise however that the term 'violence against women' is preferred by some and is often used in a political context by governments, organisations and pressure groups who work to combat all violence against women.

Some feminist researchers, for example Dobash and Dobash (1992) point out that domestic violence is a gender-neutral term and as such fails to clarify who is the victim and who is the perpetrator, masking the fact that, in heterosexual relationships, women

are most frequently subjected to violence by men. I more frequently choose to use the words 'violence' and 'abuse' however because they are the terms generally employed within the professional literature and UK domestic violence policy documents. Both terms includes violence that is not necessarily intimate partner perpetrated, including female to female violence. The phrase 'violence against women' is occasionally used as a general term to include all acts of violence, not just that which is perpetrated in the home.

### **1.2.5 Survivors and victims**

A survivor in the context of this research describes someone who has experienced domestic violence and has been able to exercise their agency and make choices that mean they are no longer victimised. The term victim is used to define those who remain living with violence and abuse.

Whilst it is acknowledged that certain feminist groups dislike the term victim suggesting it implies passivity and acceptance (Nichols, 2014), it is a word widely used in the literature to describe those harmed, injured, or killed as a result of domestic violence.

It is my view that it must be up to those who have experience of violence and abuse to make the decisions as to how to identify themselves. For the purpose of this research however the terms 'survivor' and 'victim' are used in the context described above.

### **1.2.6 North of England**

This research was undertaken within a specific geographical region in the north of England. It is an area that has experienced ongoing migration from India and Pakistan since the 1970's, predominantly from the Pakistani districts of Mirpur and Faisalabad. Evidence from the 2011 census suggests the Pakistani population of the region continues to grow and is currently estimated at 10% of the total population (University of Manchester, 2013).

In order to maintain the anonymity of those who have contributed towards this work, the actual borough and region alluded to in the study is not named, neither is the healthcare organisation that participated in the research. Every effort however has been made within the thesis to differentiate between statements made about the actual region, those which are more generalisable to the north of England, and those which are relevant to the UK as a whole.

It is acknowledged that certain findings and conclusions drawn from the study will only be applicable to the region where the study was conducted. Certain links and similarities between this population and others in the north of Britain are however made in the

literature review in Chapter Three. Similarly, whilst the research focuses on one particular community and their experience is unique, the findings and implications may be seen as an exemplar of the many challenges health visitors face when working more generally with collectivist and honour-based communities. It is anticipated therefore that insight gained from the issues explored in this study will have relevance and be transferable to health visitors working in other parts of the UK with similar population groups.

### **1.3 Positioning myself**

It has been suggested (e.g. Kahn & Fawcett, 1995) that all observations are viewed through an existing frame of reference with the prospect that many expectations are associated with it. In order for my approach to this research to be better understood, I will therefore state my position as a researcher and how I feel my personal perspective may have influenced this work.

#### **1.3.1 Professional perspective**

I am a health visitor and general nurse and most recently worked as a senior manager in a community healthcare organisation. Certain preconceptions arising from my own personal experience as a health visitor were brought to this study indeed these assumptions were integral to the study aim and design. They were however tested and examined throughout the research process and in particular at the very onset of the study by carrying out a scoping exercise so that the research was not *automatically* shaped by these perceived notions. This is discussed in more detail in the Methods Chapter. Similarly, within the Methods Chapter, my role as a senior manager of the organisation where the research was conducted is also explored in terms of how this might have influenced the research process. How I have attempted to mitigate any effects of this is also detailed within the chapter.

#### **1.3.2 Epistemological perspective**

Creswell (2013) states that we always bring certain beliefs and philosophical assumptions to our research whether we are aware of it or not. Chapter 4 of this study which looks at methodology and methods, describes in more detail the theoretical framework whereby my own philosophical assumptions were applied to this research. In this section however, in order to provide clarity on the ideas and beliefs that informed

the research process, I begin by describing my epistemological orientation and my stance with regards to the nature of reality.

### *Critical realism*

The epistemological framework underpinning this study is critical realism. Though not the author of the phrase, Roy Bhaskar (1944-2014) is more generally associated with the thinking behind the philosophical movement of critical realism (Collier, 1994) which is built on earlier work in the realist philosophy of science, particularly that of Rom Harré (Sayer, 2000).

A critical realist philosophy is based on an assumption that reality exists independently of human consciousness. It sees reality as layered and seeks to explore causative mechanisms for what is experienced and observed (Walsh & Evans, 2014). This layered (or stratified) ontology is used to distinguish between different strata of knowledge – the 'real' the 'actual' and the 'empirical'. The empirical is constituted only by that which is experienced by individuals, the actual is constituted by events which may or may not be experienced, while the real is constituted by 'generative mechanisms' that contribute to our understanding of the 'actual' but which are not fully explanatory - rather, they are 'tendencies' or causative agents (Danermark, Ekström, Jakobsen, & Karlsson, 2002; Sayer, 2000; Walsh & Evans, 2014). Critical realists conceive that individuals have the power or agency to make decisions and change, but that decisions are also constrained by structural factors, and that structure and agency are given equal weight. To understand determinants of health, critical realism suggests that the interaction of underlying agency and structural factors must be understood (Harwood & Clark, 2012)

Realism has been described as a philosophy of, and for, the whole of the natural and social sciences (Sayer, 1992). Indeed the literature offers numerous examples of its use for theory and research in a range of disciplines including economics, evaluation and health (Harwood & Clark, 2012). Wainwright (1997) suggests that realism can provide "an ontological and epistemological basis for nursing" (p.1268) and Walsh and Evans (2014) claim that critical realism can offer an important theoretical perspective for many complex healthcare interventions.

Several interpretations of critical realist philosophy have however been developed. Fox, Martin, and Green (2007) for example define critical realism as a *mid-point* between positivism and social constructivism, whereas Wainwright (1997) describes it as a meta-theory that is an *alternative* to variations of positivism and constructivism. My approach to critical realism and its application in this study is drawn on ideas and principles from

several authors, though is predominantly based on the definition below proposed by Maxwell (2012). He describes critical realism as *combining*:

*"a realist ontology (the belief that there is a real world that exists independently of our beliefs and constructions) with a constructivist epistemology (the belief that our knowledge of this world is inevitably our own construction, created from a specific vantage point, and that there is no possibility of our achieving a purely 'objective' account that is independent of all particular perspectives)"*

(Maxwell, 2012, p. vii)

Research underpinned by a critical realist approach will therefore explore meaning and be interpretive. The task of the researcher will be more about constructing a narrative than discovering the truth (Cruickshank, 2003). It will involve decision making, but does not claim to capture decision making objectively (Harwood & Clark, 2012). Hence it can be argued that when taking a critical realist perspective the researcher becomes part of the narrative of the research and as a consequence reflexivity within this approach is key to ensuring candour and rigour. What became critical in this study therefore was my ability to cast a backward gaze at my own subjective positioning and engage in ongoing reflexivity.

#### *Reflexivity*

Throughout the development and undertaking of this study I have kept a reflexive research diary in which my own thoughts about the research process were recorded (Appendix A). In doing this I have been able to see and demonstrate how certain decisions were reached and choices were made throughout the process. This provides transparency and also insight into the impact that my experience and presence as a researcher, a woman and a health visitor has had on this study. In doing so however I agree with Freshwater (2005) who argues that a researcher's bias can never be fully known and we can only articulate that which we are aware of.

### **1.4 Rationale and broad aims of the study**

In undertaking this study I aim to provide a better understanding of the issues health visitors face when working with Pakistani mothers living with domestic violence. Doing so will add to the overall knowledge base of health visiting interventions with women experiencing abuse and therefore contribute to finding more effective ways of keeping women safe. Findings from the research can also be used to inform future policy and developments in health visiting practice.



The approach is to use first person accounts so that personal experience can be explored. By obtaining the perspectives of those with intimate knowledge of the issues, powerful insight is provided into factors that might otherwise remain unknown. First however, the subject areas are each considered in terms of current understanding of the broader issues. The following chapter therefore contains a detailed discussion on the topics of health visiting and domestic violence. The theory underpinning and influencing these subjects is described, as are relevant policy and statute. The chapter also includes an analysis of prevalence and the specific nature of violence towards Pakistani women. A review of the academic literature on these topics, with a focus on any gaps in current knowledge, can be found in Chapter Three.

## Chapter 2

# Health Visiting, Violence and Pakistani Women

### 2.1 Health visiting

The focus of this study is about the perception of a group of health visitors on a specific area of practice, how they address the subject, the barriers they encounter and the way they endeavour to overcome those challenges. In order for issues to be seen in context, the following section provides a brief description of contemporary health visiting practice, the theory underpinning and influencing practice and relevant aspects of the health visitors' role with people who are generally considered hard to reach.

Health visiting has been described as a long standing yet "contested" profession and field of nursing practice in that, whilst there is broad agreement about the phenomenon, there are continuing debates about its nature, form and purpose (Cowley et al., 2015a, p. 30). It is a profession whose roots lie in public health and is today a specialist branch of nursing providing universal services to families with young children (Peckover, 2013). Health visitors are frequently linked to General Practice forming part of the multidisciplinary primary healthcare team. As public health practitioners they operate in a way that is similar to public health or community health nurses in some other countries through home visiting and community outreach (Cowley, Caan, Dowling, & Weir, 2007). Whilst the focus of the profession has changed many times, the principles of health visiting have not varied since they were first articulated four decades ago by the then Council for the Education and Training of Health Visitors, these being:

- *The search for health needs*
- *The stimulation of an awareness of health needs*
- *The influence on policies affecting health*
- *The facilitation of health enhancing activities*

(CETHV, 1977)

The long history of the health visitors' specific role with children and families has remained constant over the years with the health visitor being seen as the key health professional for pre-school children and women with children under five years of age (Luker, Orr, & McHugh, 2012). The service is currently underpinned by the Healthy Child Programme (Department of Health, 2009), the engagement of health visitors within safeguarding children being a key feature. The Healthy Child Programme sets out a universal schedule which is offered to all children and families together with additional

tailored packages of care and support as required. Health need is identified through assessment and screening.

Health visitors are therefore likely to encounter abused women in pregnancy or at key points in the first five years of a child's life as part of the 'Universal' provision to mothers and families. In addition to this, the 'Universal Partnership Plus' level of the Healthy Child Programme, which is for families dealing with complex issues, provides another opportunity for health visitors to assess need and identify women at risk of harm.

### **2.1.1 Health visiting theory**

Peckover (2013) has suggested that despite various attempts to develop a theoretical or conceptual basis for health visiting, the profession is caught between various disciplines such as nursing, medicine and social work, and has struggled to establish itself as a discrete discipline underpinned by a scholarly body of work. She therefore describes health visiting as being epistemologically "dislocated" (Peckover, 2013, p. 122). Burrell (2011) however claims health visiting has an "eclectic mix of underpinning epistemologies and discourses" in that it is grounded in sociology, epidemiology, psychology, biology as well as medicine and nursing (p.18).

It has been suggested that most of the nursing models that guide practice and the development of theory are not compatible with health visiting practice as they generally imply a state of ill health rather than health, and that this is irreconcilable with the health emphasis of health visiting (Carnwell, 2005). Porter (2005) states that health visitors therefore tend to work within two models of health, the medical model and the social model. Others, however, for example Elkan, Blair, and Robinson (2000), have cited several models, but have attempted to broadly group the models into disease models and structural approaches.

Alternatively, Robinson (1982) describes two modes of practice relating to two distinct priorities for health visiting, each of which relies on a different theoretical structure. The first is the problem orientated approach, which is related to screening techniques and is generated by the medical model of health. The second is the relationship approach which Robinson relates to psychotherapeutic intervention techniques derived from psychological notions of normal human growth and development.

Billingham (1991) cited in Elkan et al. (2000) suggests three models of health visiting - the preventive, radical-political and self-empowerment models. The preventative focuses on behaviour change, the radical political is concerned with the promotion of social and

environmental change by political action to address the causes of ill-health and the self-empowerment model aims to empower individuals and communities to achieve change.

The contemporary focus of health visiting theorists however appears to be debating the merits of evidence based practice, which is said to be the current “knowledge protocol” in the NHS (Robinson, 2012, p. 10). An approach to clinical decision making driven by measuring ‘effectiveness’ and demonstrating ‘outcome’ however has its critics among health visiting scholars. Elkan et al. (2000) for example argue that health visiting cannot be viewed merely as a technology through which scientific solutions are applied to social problems, rather needs to be viewed as a political movement, based on a particular model of society, which shapes the goals which health visitors pursue and influences the strategies they adopt to achieve their goals.

It is not the intention here to describe and analyse the full range of models or theories pertaining to health visiting practice. My purpose is simply to demonstrate that there is, as Peckover (2013) describes, an “ambiguous and contested knowledge base” (p.123), which has resulted in adding complexity and perhaps contradiction to health visiting practice over several decades. This alleged ambiguity however means that variations in practice almost inevitably exist and consequently research using individual health visitors’ perspectives will be heavily influenced by their personal interpretation of how theory and knowledge should be applied to practice. Paradoxically however, it could also be argued that ongoing empirical research is therefore crucial in order to uncover and highlight any such adverse variance and address contradiction. It is argued therefore that research which includes talking to professionals would be particularly useful in helping elucidate their current perspective on some of this apparent lack of clarity.

### **2.1.2 Health visiting and hard to reach groups**

The umbrella term ‘hard to reach’ is often used to refer to people who choose not to engage to any significant extent with health and social care systems, or to people for whom services may be hard to reach, although it could imply people who are hard for services to engage (Cowley et al., 2015a). The term frequently includes those from minority ethnic groups (Wilkinson, Stockl, Taggart, & Franks, 2009) and Pakistani women have been described as a “socially excluded” population (Bowes & Meehan Domokos, 1998, p. 489). The consequence of the phenomenon is felt to contribute towards inequalities in health and is classed by some as an injustice (Almond & Lathlean, 2011). Language or literacy barriers and a lack of cultural competence in practitioners

are frequently cited as the largest causes of inequality of access to services for clients from black and minority ethnic backgrounds (Latif, 2010).

Health visiting has for many decades been a profession which aims to identify and reduce the impact of health inequalities, and all health visitors are required to comply with the UK Human Rights Act 1998 (Smith & Horne, 2012). With their pivotal role in the public health agenda and work with mothers and the under-fives health visitors are said to be in a key position to advocate for and raise specific concerns about the numerous vulnerabilities facing many women and children (Peckover, 2013). Not only is there a legislative requirement for health visitors to uphold human rights, but it could also be argued from an ethical standpoint that health visitors have a moral duty to promote and protect human rights as a means to securing health (Smith & Horne, 2012). NICE Public Health Guidance 50 - Domestic Violence and Abuse (NICE, 2014) which is aimed at health and social care organisation makes specific reference to helping people who find it difficult to access services and includes those from ethnic minorities as an example of those groups.

Over the years, healthcare organisations, in an attempt to provide what they perceive to be more equitable services, or achieve equal outcomes for ethnic minority groups, have invested in schemes or specific roles to complement health visiting teams. Typical examples are cultural awareness training (e.g. Almond & Lathlean, 2011) and the employment of interpreters (Tribe & Tunariu, 2009). The challenge organisations face however when advocating approaches to practice which value ethnic diversity, is to ensure that practitioners are able to distinguish between valid cultural demands and fundamental human rights. It could be argued that without careful consideration, for those working with abused women from ethnic minority groups, the fear of not wanting to be seen as racist may blind those who feel they must tolerate difference.

## **2.2 Domestic abuse**

In this section the broad concept of domestic violence is introduced, its prevalence worldwide and in the UK described, and the situation with women pertinent to this study put in context within those demographics. The health impacts of domestic violence are briefly discussed so that the significance of the role of the health visitor with abused women can be understood. Health visiting theory and policy with regards to domestic violence is also described in this section however the empirical literature which looks at research into health visiting practice and domestic abuse is discussed in the literature review in Chapter Three.

Violence against women was recognised as a fundamental infringement of human rights in the 1993 United Nations Declaration on the Elimination of Violence against Women (United Nations, 1993) and was a major topic at the 1995 Beijing Fourth World Conference on Women (UN Women, 1995). Although anyone can be a victim of violence, including children and women and men of all ages, recent figures from the World Health Organisation indicate that one in three women globally have experienced physical and, or sexual violence by an intimate partner or sexual violence by someone other than a partner in their lifetime (WHO, 2015). Most commonly, abuse is perpetrated on women by men (Dennis, 2014b), and rates increase during pregnancy (Bacchus, Mezey, & Bewley, 2002; Steen & Keeling, 2012). The British Crime Survey (BCS) in 2011/12 (now called Crime Survey for England and Wales) suggested that around 1.2 million women in England and Wales were victims of domestic abuse and around 400,000 were victims of sexual assault (Home Office, 2013).

Difficulties in establishing with certainty the prevalence of domestic abuse due to under reporting however is acknowledged (Chaplin, Flatley, & Smith, 2011; Hester & Westmarland, 2005; NICE, 2014). Available police incident data therefore do not adequately reflect either the prevalence of domestic violence, or the continuum of violence and abuse suffered by victims. A key finding of the most recent BCS was that, of those surveyed, only 23% had reported their experiences to the police (Leaman, 2015). The Pennine Domestic Violence Unit which operates in the north of England suggests domestic violence is largely a hidden problem and cites numerous barriers that prevent those who are experiencing violence from reporting it. For some ethnic minority groups these include language barriers, fear of deportation, fear of bringing shame to one's community and fear that professionals from the same ethnicity will breach confidentiality (PDVG, 2015).

Salter (2014) suggests that a significant proportion of reports of domestic violence against women involve multiple perpetrators and that these incidents are frequently treated as single-perpetrator incidents. Girls and women from certain ethnic minority communities are thought to be particularly vulnerable to multi-perpetrator violence (Gill, 2008; Latif, 2011). Perpetrators are said to include extended kin networks, friends and associates who may collude in the collective victimisation of a woman or girl (Salter, 2014).

### **2.2.1 Domestic abuse as a health issue**

Domestic abuse is widely considered a public health issue with long term health and social consequences for its victims (Bradbury-Jones & Taylor, 2013; Ellsberg et al., 2008; Evanson, 2006). Women who experience partner violence are twice as likely to suffer from depression and 1.5 times more likely to have a sexually transmitted infection including HIV, compared to those who have never been exposed to such violence. They are also more likely to have unwanted pregnancies, unsafe abortions and when the violence occurs during pregnancy to suffer miscarriages, stillbirths, premature births and to have low birth weight babies (WHO, 2015). The most predominant effect is on mental health (Gregory et al., 2009; Trevillion, Oram, Feder, & Howard, 2012).

The prevalence of domestic violence among women seeking healthcare is higher than in the general population (Gregory et al., 2009) and the healthcare system has become recognised as an important site for domestic violence programmes (Haggerty & Goodman, 2003). Whilst all nurses play a key role in recognising and responding to domestic violence (Bradbury-Jones & Taylor, 2013) and most are required to undertake mandatory training in safeguarding vulnerable adults and children (Potter, 2005), the fact that many community nurses<sup>1</sup> work within patients own homes puts them in a unique position to recognise abuse (Griffith, 2014). They may also be able to spot the potential for violence before it begins or worsens (Department of Health, 2013b; Evanson, 2006). This would suggest that community nurses such as health visitors have more opportunity than other specialisms within nursing to offer both supportive interventions and play a preventative role in domestic violence.

### **2.2.2 Theories of violence against women**

Whilst the focus of this study is on health visiting practice, the work includes a subtext which is violence towards Pakistani women. In order to bring about an enhanced insight into the way the issues are understood by health visitors working with this population group and add to the overall knowledge base of health visiting interventions, it is felt necessary to explore how theories of violence against women have developed and appear to influence contemporary health visiting practice. In doing so, the way health visitors perceive the issues and respond to them can be better interpreted. The literature pertaining specifically to theoretical approaches to explaining domestic violence is explored in Chapter Three.

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<sup>1</sup> Community nursing is a generic term covering a whole range of nursing specialisms working within Primary Care and a range of Public Health settings, including the home.

There have been many theories put forward for the phenomenon of violence towards women with resulting differences in professional responses advocated to address the problem. These include individual/athological theories, a family system approach, structuralism theories, and more recently post structuralist theories arguing that the language of violence against women lies at the root of social and professional construction of the discourse (Lombard & McMillan, 2013).

Cavanaugh (2012) advocates that a full understanding of violence requires a multi-layered theoretical approach, as no one paradigm has emerged thus far to explain the overall 'causes'. Theoretical explanations of violence against women can however be broadly divided into individualistic perspectives and social perspectives (Jeevan, 2009; Lawson, 2012).

Individualistic explanations suggest a possible genetic predisposition towards violence, (e.g. Guille, 2004) or that violence towards women is as a result of learned behaviour (e.g. Hague & Malos, 1998). Until recently, the most common research approach to intimate partner violence was to investigate the personal characteristics of the perpetrator or the victim (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Those critical of taking an individualistic approach to understanding violence towards women suggest such perspectives fail to recognise structural and cultural barriers, and the wider social, political and economic contexts involved in violence (Burman & Chantler, 2005). Social perspectives include the social-structural theory and feminist writings on violence.

The current dominant UK discourse about domestic violence is said to come from the feminist perspective (Peckover, 2014) which treats violence as an issue fundamentally related to gender and specifically to the patriarchal domination of men over women (Lawson, 2012). Indeed for over two decades women's advocacy groups have been working to draw more attention to the physical, psychological, and sexual abuse of women and to stress the need for action (Heise, Ellsberg, & Gottmoeller, 2002). A second major influence in the emergence of the feminist perspective on violence against women in the UK is thought to be the election of New Labour in 1997 which brought to government a more gendered approach to public policy (Annesley, Gains, & Rummery, 2007; Skinner, Hester, & Malos, 2005).

Throughout the 1990s and the 2000s, the cumulative outcome of both of these factors began to drive a reform agenda across health and other public services which brought certain expectations about how agencies must respond to gender-based violence. One example was the policy document *Living Without Fear* (Women's Unit, 1999) which



advocated an integrated approach to tackling violence against women by health and other public services. This is considered one of many attempts by the government of the day to move gender violence towards the mainstream (Skinner et al., 2005).

In 2010, following the election of a Coalition government (Conservatives and Liberal Democrats), there was a further shift in policy direction with a broad gender-based agenda to end violence against women and girls (Home Office, 2013). It is said that the body of evidence that was born out of these early feminist discourses went on to influence future health visiting policy and practice (Peckover, 2014). Indeed one key health visiting text written during that decade suggests that violent behaviour in private spaces is “intrinsically interwoven with male subordination of women” (Robotham & Frost, 2005, p. 248) suggesting that patriarchy within society is a significant factor in the phenomenon.

Domestic violence is however also a crime with public health consequences, suggesting more of an individualistic approach to the issue. The Department of Health Professional Guidance on Domestic Violence and Abuse for Health Visitors and School Nurses describes the violence as preventable, abusers are spoken of as ‘perpetrators’ and recipients of violence classed as ‘victims’ (Department of Health, 2013a) reflecting language used within the criminal justice system. Professional guidance reminds practitioners of perpetrator education programmes and preventative interventions, again suggesting a behavioural explanation for domestic violence and reflecting more of a disease based model of practice.

Similarly, the recent Rapid Review to Update Evidence for the Healthy Child Programme (Public Health England, 2015) suggests to practitioners that prevention and screening efforts for female genital mutilation are best framed in relation to benefits for women’s health, rather than opposing traditional practices or beliefs about women’s rights, and one recent peer reviewed professional paper for health visitors speaks of domestic violence as an unacceptable “means of resolving conflict” (Dennis, 2014b, p. 29). This again, indicates a move away from a social-structural approach to the issue to more of an individualist perspective on violence.

Such examples reflect how the ever changing nature of health visiting policy and practice on violence against women is influenced by differing theoretical perspectives and the prevailing political climate. This seemingly constant shift in approach could on one hand be seen as the profession being responsive to the changing landscape, however alternatively could be, as Pritchard (2005) suggests, indicative of a profession where

long standing debates about its function and purpose brings confusion to individual practitioners.

### **2.2.3 The health visitor's role within domestic violence and abuse**

By the nature of their role, health visitors are often one of the first professionals to become aware of domestic violence or abuse occurring within a family (Department of Health, 2013b). Studies have shown that health visiting services are among the most accessible for abused women (Peckover, 2002b, 2003b). Pregnancy and early parenthood, which is a time when health visitors engage with women, is when statistically women are most vulnerable to domestic violence (Cowley et al., 2015b; Department of Health, 2005).

In the past many practitioners have been said to be slow to respond to domestic violence through lack of education and training, embarrassment about asking direct questions and concerns about upsetting relationships (Robotham, 2005b). From 2004 the regulatory body for nurses and midwives, the Nursing and Midwifery Council (NMC) have required that Specialist Community Public Health Nurses<sup>2</sup> meet stated standards of proficiency around the prevention, identification and minimisation of the risk of interpersonal abuse or violence before they can be considered "fit for practice" (NMC, 2004, p. 5). Health visitors are therefore being made aware of the need to increase their knowledge of the many aspects of violence they might encounter.

Recognising the significant part the health visitor, along with the midwife and school nurse, can play in the identification and early intervention of abuse within families, the Department of Health has in recent years produced detailed professional guidance which sets out main principles and actions for effective practice. At the time of this study the most recent publication was in 2013 (Department of Health, 2013b). Key recommendations for practice in this guidance are to act immediately on disclosure and respond to risk. Routine enquiry is advocated and child safety is considered paramount. This document cites certain "cultural factors" as specific risks (p.2) and references associated guidance on the use of interpreters.

NICE Public Health Guidance 50 was published in February 2014 and recommends how health services, social care and the organisations they work with can respond effectively to domestic abuse (NICE, 2014). This guidance describes the cost of domestic abuse in both human and economic terms as being significant and how working in a multi-agency

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<sup>2</sup> The Specialist Community Public Health Nursing (SCPHN) part of the nursing register contains registered nurses and midwives who are working in public health roles and who have undertaken NMC approved SCPHN courses.

partnership is the most effective way to approach the issue at both an operational and strategic level. Recommendation six is particularly pertinent to health visiting practice:

*Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse*

*(NICE, 2014, p.12)*

Much of health visiting policy on domestic violence developed since 2000 however pertains to safeguarding children recognising the inter-relationship between domestic violence and the abuse and neglect of children. The National Service Framework for Children, Young People and Maternity Services (2004) highlighted the serious effects on children who witness domestic violence (Department for Education and Skills, 2004) and The Framework for the Assessment of Children in Need and their Families (Department of Health, 2000) noted the impact of domestic abuse on parenting capacity. The Every Child Matters Outcomes Framework (Department of Children Schools and Family, 2003) set targets that children affected by domestic violence are identified, protected and supported. The interagency document Working Together (2006, revised 2010, 2015) contains statutory and non-statutory guidance to public agencies to work together in relation to domestic violence to protect children, including unborn children (Department for Education, 2015).

Health visiting practice therefore is underpinned by a plethora of policy documents which sets out the responsibilities of healthcare organisations, operational services and practitioners in relation to domestic violence. There are statutory duties for health visitors with regards to safeguarding children and consequently meeting the needs of any child or children within the household would always be considered paramount. It is noted however that, with such a strong focus on families, the voice of the childless or older woman experiencing domestic abuse appears absent from contemporary health visiting discourses.

#### **2.2.4 Measuring effectiveness in domestic abuse work**

Measuring health outcomes is a broad concept and can be difficult for health visitors and other community nurses who have public health, prevention and health promotion as the major focus of practice, and where measures are scarce (Dolan & Kitson, 1997; Rowe, 2008). Indeed the Health Visitor Association stated in 1995 that there are outcomes in health visiting practice which cannot be measured (HVA, 1995). Others have commented that the need to define measurable outcomes by which to evaluate their work may be

perceived by some health visitors as a threat (Elkan et al., 2000). Whittaker and Cornthwaite (2000) suggest that owing to the difficulty in demonstrating quantitatively the effects of health visiting on positive parenting, it has mainly persisted as “silent work” (p.189). Nevertheless, in recent times we have witnessed an increasing emphasis on the need to identify the outcomes of all healthcare interventions (Murphy, 2012). The Department of Health has acknowledged that it is difficult to gauge the level of success of domestic violence assessment and interventions, however has suggested certain quantitative measures that can be used by organisations to consider the impact of implementing professional guidance. Indicators include:

- Increased numbers of disclosures
- Increased confidence and awareness by professionals
- Numbers of referrals to local services / programmes
- Numbers of referrals to MARAC<sup>3</sup> and IDVA<sup>4</sup> services

(Department of Health, 2013b)

These measures however clearly refer to service or process outcomes as opposed to demonstrating effectiveness in terms of behaviour change, or from the perspective of the service user. Similarly, the Department of Health Guide for Commissioners of Services for Women and Children who Experience Violence focuses on factors such as value for money and social return on investment as well as effectiveness (Department of Health, 2011a). Positive health outcomes are cited as a rationale for intervention in a recent rapid review of the evidence undertaken for the Department of Health (Public Health England, 2015). Pressure groups, activists and some domestic violence community projects however do often focus on outcomes for women, such as reducing recurrent incidents or levels of violence, access to specialist services or transition to independence (e.g. Batsleer et al., 2002; Hester & Westmarland, 2005).

It can be seen therefore that measuring success in domestic violence work is described in numerous ways depending upon the perspective and objectives of the organisation. It is however often the lack of robust evidence on effectiveness that is cited within the empirical literature (Williamson & Abrahams, 2014) suggesting that more research is required. Data which describe the effectiveness of interventions from the perspective of the practitioners could, for example, contribute towards service evaluation or provide insight into the usefulness of current domestic violence pathways and protocols.

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<sup>3</sup> Multi Agency Risk Assessment Conference

<sup>4</sup> Independent Domestic Violence Advocates

## **2.3 Violence and Pakistani women**

Haj-Yahia (2011) has described how societies vary in their approaches toward violence as well as in their attitudes and responses toward abused women and violent men. In this section the prevalence and specific nature of violence towards Pakistani women is discussed. The purpose of this is to elucidate how Pakistani women frequently experience abuse differently to many other population groups and therefore how health visiting practice is perhaps challenged in different ways compared to the mainstream.

This study relates to Pakistani women from the north of Britain and was carried out in one specific geographical region in the north. It is therefore considered necessary to understand not just the demographics of the area, but also how immigration patterns may have influenced family life and certain behaviours in those communities. In doing so, some of the issues experienced by health visitors serving those populations can be better understood. The subject of collectivist communities residing in countries where the majority society is considered individualist e.g. south Asian immigrants in Western Europe (Haj-Yahia, 2011) is considered an important factor in some of these issues.

### **2.3.1 Immigration and settlement in the north of Britain**

The primary motive for Pakistani migration to Britain in the late 50s and early 60s was socio-economic (Department of Communities and Local Government, 2009). Single men, and many married men with wives and children, left their family in Pakistan to come to Britain which was suffering from an acute shortage of labour (Alam & Husband, 2006; Azam, 2006) and where labouring jobs offered thirty times more than similar jobs in Pakistan (Shaw, 2000). During that period Commonwealth citizens had an unrestricted right of entry into Britain.

Most Pakistani migrants were of peasant background and came in large numbers from a few compact areas, notably the Punjab and rural Mirpur District of Azad Jammu and the Kashmir region of Pakistan (Department of Communities and Local Government, 2009). At that point the migration itself was generally regarded as a means of improving the status of the close kin 'at home' rather than as a route to individual social advancement (Shaw, 2000; Werbner, 2009). Many, however, tempted by the relatively high incomes began to bring their wives and children to join them (Ballard, 1982; Shaw, 2001).

From 1962 legal changes made it more difficult for adult men to enter Britain, but men already here were entitled to be joined by their families (Werbner, 2009). Paradoxically therefore, as an unexpected consequence of the introduction of immigration controls,

there was a sudden influx of women and children arriving from Pakistan (Alam & Husband, 2006; Shaw, 2000).

More recent changes in immigration legislation have made it much less easy for spouses to settle permanently in Britain. Evidence is now required of having lived together for two years to demonstrate that the marriage was not solely motivated by a desire to live in the UK. Wives have a probationary year in which their immigration status is insecure and during which time they have no entitlement to state benefits. If the marriage fails during that period the woman has no right to remain in the country and faces deportation back to the country of origin (Anitha, 2010; Sharma & Gill, 2010; Wilson, 2006).

The settlement pattern in the north of Britain to a large extent reflected the labour shortages of the 1950s onward (Peach, 2006) and from 1962 work vouchers brought workers to many northern cities. As was occurring elsewhere in the country each settlement had a distinctive regional character with the Pakistani Mirpuris and Faisalabadis being a significant presence in the north (Shaw, 2000). Mirpur particularly, was a relatively economically backward region of Pakistan, and many migrants were content to work in largely unskilled, low paid jobs (Ballard, 1990). The 'chain migration' process which followed over the next few years had the subsequent effect of recreating the village structure left behind (Peach, 2006). Collectivist culture, the prevailing ideology within many Pakistani communities in south Asia continued to reside in the behaviour patterns of many family members living in northern towns and cities (Alam & Husband, 2006).

Subsequent years of migration into the north of Britain endured and saw familial growth and consolidation in the settlement areas followed by encroachment outwards in response to successive waves of migrants (Werbner, 2009). This was accompanied by a so called 'white flight' which resulted in the domination in the region, both physically and numerically, of Pakistani families (Ballard, 1990). Today many Pakistani groups in the north of Britain continue to live excluded lives (Abbas, 2009), are badly housed and poorly educated (Peach, 2005) existing near or at the bottom of local area economic and social contexts (Abbas, 2009; Department of Communities and Local Government, 2009). Ballard (1990) noted that Mirpuris, in common with other Muslim groups, tend to sustain much tighter and more inward-looking social networks than some other south Asian populations, even in diaspora.

Information from The Office for National Statistics suggests birth rates among Pakistani populations living in certain areas in the north of England are higher than elsewhere in

the UK (ONS, 2012). By British definition (Housing Act, 1985) many Pakistani families live in overcrowded conditions with several generations of the family living in the same house.

### **2.3.2 Prevalence and typology of violence against Pakistani women**

Oxfam International assert that in the state of Punjab it is estimated that one in five girl children is missing due to selective abortions, 80% of Pakistani women experience violence in their homes and in 2002 more than 450 Pakistani women or girls were killed by relatives in so-called 'honour killings'<sup>5</sup>, and at least as many were raped (Oxfam International, 2004). 'Honour' crimes have been part of Pakistan's social and legal history for centuries (Warraich, 2005) and Oxfam International suggest many such crimes go unreported (Oxfam International, 2004) as women are discouraged from speaking out (Warraich, 2005). This silencing of women's voices is said to be reflected in the largely absent public discourse about domestic abuse in some south Asian communities (Guzder, 2011) including those in living Britain (Ahmed, Reavey, & Majumdar, 2009; Latif, 2011; Wilson, 2006).

A recent Domestic Abuse Needs Assessment carried out in the north of England concluded that there is little meaningful local data available to establish trends over time by ethnicity breakdown (Leaman, 2015). Indeed it has been suggested that very little domestic violence research has been sought to explore the situations of different groups of women in the UK (Thiara & Gill, 2010a). There is little empirical evidence therefore about similar atrocities to those in Pakistan occurring among Pakistani populations in the north Britain, and violence against women is certainly not unique to any particular cultural group. There are however some well documented cases of forced marriage and 'honour' based violence within south Asian communities in the north of Britain (Gill, 2009; Siddiqui, 2005) and Crown Prosecution Service figures state approximately 12 'honour' killings take place in the UK every year (Gill, 2009). There is some indication that south Asian women in the UK are likely to experience more severe abuse and over a longer period of time than white women (Thiara & Gill, 2010a). There are also suggestions within the literature that the nature of abuse suffered by many south Asian women is impacted by particular cultural practices and compounded by extended family living (Idriss & Abbas, 2011). Perpetrators of domestic abuse are said to be sometimes wider family members, including other women, as well as intimate partners (Thiara & Gill, 2010b).

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<sup>5</sup> In this context the word 'honour' carries connotations that could encourage perpetrators to view their actions as morally defensible so is enclosed in inverted commas to stress the problems inherent in using this term

### *Violence against women from collectivist and honour based cultures*

It is accepted to view collectivism as a cultural pattern and sometimes as a political and economic pattern which prevails in the Middle East and in certain countries around the Mediterranean Sea as well as in Africa, Asia, South America, the Pacific, and many Eastern European countries (Haj-Yahia & Sadan, 2008; Triandis, 2001). By contrast, one classic work by Hofstede (1980) described Britain as one of the most individualist countries and Pakistan one of the least. Members of collectivist communities are usually characterised by a sense of emotional, moral, economic, social, and political commitment to their collective. That commitment is reflected in a strong desire by members to meet the needs and expectations of their collective and in their own wish to be in harmony with their collective as well as to maintain harmony. Members will often sacrifice personal needs, aspirations, goals and expectations for the benefit of their collective (Haj-Yahia, 2011). Honour in some collectivist and honour-based cultures can be associated with dignity and integrity; however honour is generally seen as residing in the bodies of women. Frameworks of honour and its corollary shame therefore operate within the family or community to control, direct and regulate women's sexuality and freedom of movement by male members of the family (Coomaraswamy, 2005). An 'honour' crime is one of a range of violent or abusive acts committed in the name of honour to justify violence against women in the name of religion and culture and is essentially about defending family honour or the honour of the community (Siddiqui, 2005).

In collectivist societies there is a tendency to relate to violence against women more as a personal and family issue than as a social and criminal problem and members of the collective will often strongly prefer that domestic violence is kept within the family (Haj-Yahia & Sadan, 2008). 'Honour' crimes perpetrated against individuals by family members can be seen as being justified in order to conserve family reputation or status within the community and can be the reason why some women are unable to leave abusive situations (Siddiqui, 2005). Abused women in many collectivist societies therefore tend to conceal their suffering and ask for help only in the most severe and ongoing cases of violence, and after they have made every attempt to deal with the situation on their own (Haj-Yahia & Sadan, 2008; Lee & Hadeed, 2009). Request of assistance from healthcare practitioners and the practitioner's desire to intervene can be seen as an attempt to undermine the harmony of the family and arouse intense anger towards the woman and there may often be tremendous pressure exerted on the women by the family to sever connections with the practitioner (Haj-Yahia, 2011).



Health visitors working with abused women from collectivist and honour based populations in the north of Britain therefore appear to face complex issues, particularly as intervention models tend to be based on ideologies for application in Western individualist societies. It could be argued that from an ethical and professional perspective certain health visiting interventions may appear to be in the woman's best interest however, as the literature suggests (e.g. Haj-Yahia, 2011), could ultimately lead to a perpetuation of violence towards her.

## **2.4 Conclusion**

Health visitors as community nurses with a public health remit are seen as one of the key health professionals to identify and provide interventions aimed at preventing domestic abuse. It has been suggested however that, as a result of shifting policy and numerous influences on the profession over recent years, at times practitioners lack clarity about their remit and role. At the same time we have seen how claims have been made about the nature and prevalence of the abuse some Pakistani women living in the north of England suffer in that it often differs from that encountered within many other ethnic groups. The women's experience, and consequently their health needs, are therefore likely to be complex and cannot necessarily be met by taking a unidimensional approach to health visiting interventions. However whilst flexibility may allow responsive practice to flourish, variance and inconsistency is likely to prove unhelpful. It also seems that inappropriate intervention in the case of some cultural groups might cause further distress or even harm to women.

Gaining understanding of how this alleged 'difference' impacts on health visiting practice and how health visitors perceive they are able to respond to the needs of abused Pakistani women would, it seems, provide useful insight into how knowledge, theory and policy are being currently managed in this complex practice area. It could also offer valuable information to those practitioners and policy makers working in the wider and more general field of domestic abuse in the UK.

The study continues with a review of the empirical literature on many of the key issues discussed thus far.

## **Chapter 3 Review of the Literature**

### **3.1 Introduction**

In the following review of the academic literature, the topics and issues introduced in the previous chapters are further examined and considered. What is already known empirically about each, and any current gaps in knowledge are considered with particular emphasis on their relevance to contemporary health visiting practice. The chapter concludes with an additional rationale for the thesis further informed by the literature review, and ends by describing the aim and objectives of the ensuing study which are based on an analysis of the evidence.

#### **3.1.1 Search strategy**

The approach to the exploration of the empirical literature for this study was iterative as opposed to linear so that the search could be refined and reworked as understanding of the issues was gained. Whilst the intention was not to assume a traditional systematic review or follow a pre-defined sequence, a systematic process was undertaken. This began with a broad overview of the literature relating to women and domestic violence so that the global and national context was understood. The review then progressively focused towards the research aim, and concluded in a detailed search for studies pertaining specifically to health visitors' work with abused Pakistani mothers. This overall approach was comparable to the framework described by Merriam and Simpson (2000) that depicts how the literature review is used to gradually refine and narrow the research topic to an identifiable gap in what is known about the issue. The gap is then articulated into a problem statement that clearly delineates what the field needs to investigate (Merriam & Simpson, 2000). This process takes the reader "along to the point where it is obvious what needs to be done" (p.19).

For this study the literature searches were undertaken using the search engine Summon which incorporates an electronic search of the main databases relating to healthcare. In addition individual databases such as Medline and Cinahl were examined; however in the main they yielded a similar output. The Cochrane Database was searched specifically for relevant systematic reviews. The grey literature was viewed via the e-thesis on-line service EThOS which provides access to recent Doctoral theses through the British Library.

The databases were searched using the defining attributes and characteristics of topics addressed, as key words or word combinations. This topic based search was also used as a means to categorise and organise the ensuing large literature base. Initially the broader searches relating to women and domestic violence/abuse undertaken to identify the main trends and issues yielded thousands of papers, however the more recent population studies were felt to give a higher accuracy of the current global and national situation with regards to prevalence, so were prioritised. No date restrictions were applied to searches focusing on health visiting and domestic violence/abuse as the historical practice and policy context was considered important to this study.

Searches relating to Pakistani and/or south Asian women and violence generated several hundred studies however many of those were carried out among Indian or Bangladeshi groups therefore were not considered relevant to this study. Certain other papers retrieved referred specifically to 'Muslim' women and were also regarded as not relevant to this research when they included women from beyond the subcontinent, e.g. northern Africa or Iran, in that population group. The term 'Muslim' was also considered to relate to people who share a common faith (i.e. Islam) as opposed to an ethnic group e.g. Pakistani, so was treated with caution. Much of the empirical work found pertaining to Pakistani immigration, diaspora and cultural practices appears to have been carried out in the US and Canada, therefore, again, these particular papers were not considered relevant to the aim of this study.

As the literature review progressed and became more focused, the search terms were limited to key words and combinations of the phrases 'health visiting', 'health visitors', 'Pakistani women', 'Pakistani mothers', 'south Asian women', 'south Asian mothers', 'domestic violence' and 'domestic abuse' (the '\*' wildcard allowing simultaneous searches for phrases such as health visit-s, health visit-or, health visit-ing). This was to ensure that a thorough and robust search for any previous work relating to this study's explicit purpose was carried out. No date restrictions were applied at this point due to the paucity of papers found. Some studies found at this later stage, on reading, were considered of poor quality, however collectively contributed towards the depth of understanding on certain issues. Certain papers cited early work considered by their authors as seminal to the topics which had not been identified via the initial searches. These were therefore also retrieved and included – often using the inter-library loan facility and via the British Library.

Details of further and more specific ways the literature search was managed are contained within each of the following sections.

## **3.2 Women and domestic violence**

Much of the academic literature on violence against women focuses on intimate partner violence (IPV) which has been defined as physical and, or sexual assaults by a current or former partner (Ellsberg et al., 2008), physical, sexual, and psychological violence by an intimate partner (Taft et al., 2013) and violence between current or former spouse or cohabiting couples (Coker et al., 2002). Battering tends to be a term used more within the American literature (e.g. McHugh & Frieze, 2006). Whilst women can be perpetrators of IPV much of the literature centres on women as victims (Lucarini, 2008; Venis & Horton, 2002).

A large body of literature exists and studies have been undertaken from a broad range of perspectives. The major source of studies into violence against women however appear to come from the disciplines associated with health and the social sciences. Many are prevalence studies, and are summarised below. This section also includes a summary of systematic reviews on domestic violence where these appear to have relevance for health visiting practice. The section however begins with a look at what the academic literature tells us about theoretical approaches to domestic violence.

### **3.2.1 Theoretical approaches to domestic violence**

The literature contains a large body of work undertaken from the perspective that domestic violence is a gendered crime which functions within a broader continuum of violence against women, predominantly perpetrated by men. Theories associated with power imbalance between genders are frequently used in those works that seek to explore causality of domestic violence (see e.g. Rodríguez-Menés & Safranoff, 2012) and mainly take a feminist perspective.

Early feminist work on 'wife beating' can be traced back to Dobash and Dobash (1979). The "sexism" perspective of feminism (Rodríguez-Menés & Safranoff, 2012, p. 585) asserts that sexist cultural systems of domination subjugate women to men. This is done directly, through cultural norms of deference and obedience backed if necessary by the use of force, or indirectly, by shaping women's opportunities and constraints. Critics of the feminist emphasis on patriarchy as the ultimate causal factor of domestic violence see this explanation as one directional and simplistic (e.g. Dutton, 2006) ignoring other factors such as class, age and unemployment (e.g. Anderson, 1997).

Much of the feminist literature places discussion about patriarchy in the context of male to female violence, or in terms of IPV, casting women as victims or survivors rather than

agents of violence. Paradoxically feminist theory found within the literature could however also be used to elucidate why some women can be perpetrators of violence towards other women in the domestic situation for example mother-in-law to daughter-in-law abuse, a phenomenon for which there is a growing body of evidence (Gangoli & Rew, 2011; Raj et al., 2011; Rew, Gangoli, & Gill, 2013). Using the work of Kandiyoti (1988) and applying a feminist perspective, violence from elder women in the home can be seen as a form of 'patriarchal bargaining' between them and the extended household. In such households the culture is often structured by a model of patriarchy that stresses "corporate male-headed entities" rather than more autonomous mother and child units (Kandiyoti, 1988, p. 275). Writing specifically about Middle Eastern, and South and South-East Asian familial systems, Kandiyoti suggests that many women derive power from being mothers of sons and that this is inextricably connected with their role in the house in maintaining male honour and prestige. This behaviour is conceptualised as a form of proxy male violence against women. The assumption accompanying this theory is that women are on the whole unaware of the degree of their participation and co-option within the classic patriarchal model.

Dependency theory for violence against women is linked in the literature to this wider 'bargaining' perspective (Rodríguez-Menés & Safranoff, 2012). Dependency theory is also heavily associated with the concept of patriarchy and analyses how low opportunities and multiple constraints stemming from women's positions in the socio-economic structure affect women's control over their lives, making them dependent on their male partners, and raising the probability of experiencing violence (Harway & Hanson, 2004; Kim & Gray, 2008).

The status inconsistency perspective which is sometimes referred to as exchange theory (Rodríguez-Menés & Safranoff, 2012) can be traced back to work by O'Brien (1971) and Rodman (1972) and describes how differences in occupational and educational attainment favouring women in intimate relations disrupt traditional patriarchal roles, leading to violence against women. This theory which is also feminist and built around the concept of patriarchy, describes how when the male partner has lower socio-economic status or fewer resources than his wife, violence serves to restore the traditional order.

The feminist perspective on domestic violence is frequently assumed in the health visiting literature. The "gendered nature" of health visiting is often alluded to in those discourses that point to the fact that much health visiting work is mediated through women as mothers and undertaken by a mainly female workforce (Peckover, 2002a, p.

254). Indeed much of the current knowledge base utilised by health visitors about the extent and nature of domestic violence, and of women's support needs and experiences has been accumulated by feminist academics and activists (e.g. Hester & Westmarland, 2005). Earlier health visiting scholarship was influenced by those such as Orr (1986) who argued that health visiting work should be informed by a feminist perspective and suggested that domestic violence is an important practice issue. Much less appears within the health visiting literature about alternative theories of domestic violence or which discusses violence perpetrated by female non-intimates. Further research therefore appears to be required to enhance knowledge about areas of practice less frequently studied, such as domestic violence executed against women by women.

### **3.2.2 Prevalence of domestic violence**

Prevalence studies seem to be mainly generated by organisations associated with public health and are frequently population based-surveys. Many authors however recognise discrepancies in prevalence rates arising from differences in definitions of IPV, sensitivity of tools, modes of data collection, reporting time frames, and risk variation in the populations sampled (WHO, 2013).

In what seems to have been the largest prevalence study undertaken in recent years, the World Health Organisation (WHO) in 2006 carried out a multi-country investigation which looked at 15 diverse sites in 10 countries (Garcia-Moreno et al., 2006). Whilst acknowledging methodological differences among studies reviewed, and that most evidence came from the larger industrialised settings, the authors felt there was sufficient evidence to say that physical and sexual partner violence against women is widespread. The study did not however include other types of violence against women. A systematic review of worldwide evidence on the prevalence of *all* types of violence against women concluded that such violence has reached epidemic proportions in many societies (Alhabib, Nur, & Jones, 2010).

Fewer UK studies into the prevalence and the epidemiology of domestic violence appear to have been undertaken. The main source of incidence and prevalence data used in the academic literature comes from British Crime Survey (now referred to as Crime Survey for England and Wales) reports. The BCS in 2011/12 suggested that around 1.2 million women in England and Wales were victims of domestic abuse and around 400,000 were victims of sexual assault (Home Office, 2013).

Some UK prevalence studies have however been undertaken in Accident and Emergency departments (e.g. Boyle & Todd, 2003), midwifery services (e.g. Bacchus, Mezey, Bewley, & Haworth, 2004) and among those receiving psychiatric care (e.g. Trevillion et al., 2012). In a systematic review of prevalence studies Alhabib et al. (2010) found a high proportion of women attending these services are likely to have experienced domestic abuse. These however will only represent a proportion of the total problem, as will those women reporting the crime.

Many of the UK public health prevalence studies also cite the cost of violence against women in terms of not only human and emotional cost but also the associated public sector expenditure (e.g. Garcia-Moreno, Heise, Ellsberg, & Watts, 2005). NICE (2014) suggest domestic violence and abuse cost the UK an estimated £15.7 billion in 2008. It could be argued that such public health studies on domestic violence have particular significance for the health visiting profession which historically has always been heavily influenced by the broader societal and political public health agenda. A recent government investment in increasing the numbers of health visitors (Department of Health, 2011c) could be seen as one way of addressing what was described as a depleted health visitor workforce (Dennis, 2014b) in an effort to address the associated cost to the treasury of domestic violence.

### **3.2.3 Systematic reviews of domestic violence**

A search for systematic reviews was undertaken in order to gain an overview of the empirical work that is often used to influence domestic abuse policy decisions in the UK and consequently health visiting practice. Systematic reviews on domestic violence generally fall into two broad categories:

#### *Risk factors and associated health disorders*

Several of these reviews focus on the impact of violence against women on health, particularly mental health (e.g. Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Devries et al., 2013) concluding that there is an increased risk of depressive symptoms among women exposed to IPV relative to non-exposed women. Risk factors are of relevance to health visitors as knowledge of these could influence assessment and routine enquiry. The authors of one systematic review into IPV grouped risk factors into a) contextual characteristics b) developmental characteristics and behaviour c) relationship influences and interactional patterns (Capaldi, Knoble, Shortt, & Kim, 2012). They also note that the weight of findings indicate that being a member of a minority group is a risk factor for IPV.

### *Screening and routine enquiry*

The second category of systematic reviews is those that evaluate domestic violence interventions, for example screening<sup>6</sup>, or focus on the experience of those who encounter domestic violence services. The following summary of this group of reviews is not exhaustive, however studies that might have significance for health visiting practice are included and their perceived relevance highlighted.

The effectiveness of screening tools for the identification of IPV is the subject of several systematic reviews (O'Reilly, Beale, & Gillies, 2010; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; Taft et al., 2013; Todahl & Walters, 2011). The most recent review (Taft et al, 2013) examined universal screening of women by healthcare professionals for IPV in a range of healthcare settings. The review included eleven studies, nine of which were Randomised Control Trials (RCT), and extended the focus of screening to include not only identification of victims but also referrals to and the take-up of support services and women's experience of violence following screening.

The reviewers found that screening increased the identification of victims, particularly in antenatal settings. The evidence from the three studies that examined referrals to support services suggests that screening does not significantly increase referrals for support, and there was insufficient evidence to judge whether it resulted in increased uptake of specialist services. Significantly, the two studies that measured women's experience of violence after screening found no effect in terms of a reduction in levels of abuse at 6, 12 or 18 months (Public Health England, 2015).

The study by Todahl and Walters (2011) found recipients of healthcare service, including victims of violence, are generally supportive of IPV universal screening provided it is done with a non-judgmental attitude, privacy, and a rationale is provided for screening. O'Campo et al. (2011) found screening is more likely to be successful when there are support services to enable the victim to address their short and long-term health, social and safety needs.

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<sup>6</sup>**Screening** is where members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications. The use of the term 'screening' refers to the application of a standardised question or test according to a procedure that does not vary from place to place

**Routine enquiry**, as it pertains to IPV, refers to asking all people within certain parameters about the experience of domestic violence, regardless of whether or not there are signs of abuse, or whether domestic violence is suspected



The NICE guidance on responding to domestic violence and abuse (NICE, 2014) is based on several reviews of the evidence, including a review of intervention effectiveness, one cost effectiveness review, one economic modelling study, and five expert reviews. Although insufficient evidence was found to recommend screening or routine enquiry within all healthcare settings it was noted that routine enquiry is viewed as best practice by some professionals (Public Health England, 2015).

Interventions to address IPV in pregnancy and after the child's birth are the subject of four systematic reviews (Jahanfar, Howard, & Medley, 2014; Ramsay et al., 2009; Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008; Van Parys, Verhamme, Temmerman, & Verstraelen, 2014). One examined a range of interventions, two examined home visiting programmes and one examined the effectiveness of advocacy programmes. Reviewing the findings from these four reviews Public Health England (2015) suggested that screening is insufficient on its own, and that the addition of a specific IPV component or intervention to perinatal home visiting programmes is needed to reduce IPV and improve maternal and infant health.

Another key finding for health visiting services that undertake routine antenatal visiting came from the systematic review carried out by O'Reilly et al (2010) who looked at interventions for domestic violence during pregnancy care. The authors of this study drew attention to the need for antenatal care providers to develop rapport with pregnant women. The review emphasised the importance of the ongoing relationship between practitioner and victim to enable women to feel safe reporting violence. This could be an important issue for those health visiting services that provide minimal contacts during this period and would suggest close liaison with midwifery colleagues would be beneficial.

Significantly, none of the systematic reviews highlighted above considered domestic abuse perpetrated by wider family members or looked at woman to woman violence where the women were not in an intimate partner relationship. Few systematic reviews were found during the search on violence against women that differentiated between cultural groups in terms of screening, interventions or service user experience of domestic violence services.

One systematic review looked at the effectiveness of interventions designed to prevent female genital mutilation (FGM) (Berg & Denison, 2012). The World Health Organisation has calculated that 100-130 million girls and women have been subjected to some form of FGM in Africa, Asia, and the Middle East (WHO, 2008). The authors examined eight evaluation studies of preventative interventions all from African countries, however there

was low relevance to the UK. All studies were judged to be of low quality, making conclusions difficult. Three different prevention approaches in this field were however identified - empowerment, health education, and community activities.

Another systematic review undertaken in the Middle East and North Africa was an overview of the literature on 'honour' killings. (Kulczycki & Windle, 2011). This practice is described by the authors of the review as a "woefully underreported phenomenon" (p.1442). Studies revealed victims were found to be mostly young females who were murdered by their male kin. It was acknowledged the many of the studies included in the review had persistent methodological limitations which restrict the generalisability of some of their findings. Interestingly however comments were made by the authors of the systematic review on the general paucity of studies into the issue relative to the presumed magnitude of the problem, claiming an estimated 5,000 women and girls are killed in the name of 'honour' each year worldwide (United Nations Population Fund, 2000). Despite their limitations, the Kulczycki and Windle (2011) and Berg and Denison (2012) studies might suggest ongoing vigilance is required among health visitors when working among certain population groups.

In conclusion to this section of the literature review we have seen how there is a large body of empirical work relating to violence against women. Though this is not an exhaustive search, it seems that most of these studies refer to IPV and to violence where men are the perpetrators. Fewer systematic reviews seem to have been undertaken about domestic violence among different cultural groups or which focus on abusive practices more common among specific ethnic groups in the UK.

Whilst it is acknowledged that the focus of this examination of systematic reviews has been on those studies with particular relevance to health visiting practice, many of the UK reviews found were in relation to the various aspects of screening for domestic abuse. The literature suggests screening for IPV by healthcare workers in the UK appears to be generally acceptable to victims and does seem to increase disclosure rates, particularly in the antenatal setting and when carried out during home visiting programmes. Screening however does not ultimately appear to reduce levels of abuse without additional interventions.

Screening is the process of identifying healthy people who may be at increased risk of disease or condition (UK National Screening Committee, 2013). However to view domestic violence as a 'condition', as if it can be diagnosed and eradicated serves, seems, to heavily medicalise the issue. The public health perspective frequently taken within the literature inevitably acts to shift the focus from the individual to the risks

posed to wider population groups. The health *consequences* and public sector cost of domestic abuse highlighted then become the concern for policy makers rather than raising alarm about issues more associated with injustice, human rights, or the role that social factors might be playing in the prevalence of IPV.

The literature suggests that the approach to domestic abuse most commonly taken relies on disclosure as an important requirement of detection - the number of disclosures often measuring the success of the activity. Interestingly, the UK National Screening Committee do not recommend screening for domestic violence on the grounds that there is insufficient evidence on the benefit of interventions (UK National Screening Committee, 2013). As health visitors are required to play a key role in the prevention and identification of domestic abuse, the question arises as to how they feel they are able to support women following detection when the evidence suggests increased identification does not lead to increased referrals to specialist services.

### **3.3 *Pakistani women and domestic abuse***

This section of the literature review focuses on what is known empirically about Pakistani women and domestic violence. Whilst the purpose of this study is to look at health visiting interventions with Pakistani women in the north of England it was felt that certain studies from the small body of literature on violence against women in Pakistan could be useful to this literature review. We know that chain migration and settlement patterns in Britain over the last 40 years have led to residential clustering in certain UK urban towns and cities (Peach, 2006) and that family structure together with certain cultural and social practices have been maintained to a considerable degree in these populations (Abbas, 2011). Knowledge gained from studies carried out in the country of origin could therefore be said to have relevance to British Pakistani communities and have consequently been considered as pertinent to this research. The initial section therefore looks at those studies. The literature review then looks specifically at studies carried out among south Asian women living in the UK to elicit what is known about domestic abuse among this population. Though each of the UK studies discussed included Pakistani women in the sample group, many studies do not differentiate between populations within that generalised term, so for the UK section of the review the overarching definition is more frequently used.

The last section of this part of the literature review is an overview of the general themes that have emerged thus far. Issues that might have relevance for a study of health visiting practice are highlighted, as are gaps in the evidence.

### **3.3.1 Violence against women in Pakistan**

Several studies researching violence towards women in Pakistan look at the health consequences. These are cited as predominantly mental health problems (Critelli, 2012) which includes suicide (Guzder, 2011) and reproductive health issues (Hussain & Khan, 2008; Kapadia, Saleem, & Karim, 2010). One study discusses associated psychosocial factors and showed high levels of unhappiness and anger among Pakistani women in abusive relationships (Naeem, Irfan, Zaidi, Kingdon, & Ayub, 2008).

Other studies looked at the wider forces that hold Pakistani women in abusive relationships (Chaudhuri, Yingling, & Morash, 2014; Zakar, Zakar, & Krämer, 2012). These are said to be lack of financial or community support for women who wish to leave, judgemental and victim blaming attitudes of the wider community, notions of family honour and the stigmatisation of divorce, and perceptions of violence as a normal part of marriage (Critelli, 2012; Naved et al., 2006).

The role that religion plays in these issues is also discussed and debated in some studies (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003; Hajjar, 2004). The general consensus appears to be that while selective excerpts from the Koran are often used to prove that men who beat their wives are following God's commandments, a fair reading of the Koran shows that wife abuse, like genital mutilation and so called 'honour' killings are a result of culture rather than religion.

Many of these studies take a feminist perspective in claiming that gender violence is deeply rooted in Pakistani society (e.g. Critelli, 2012) and focus on patriarchy, power and how the culture privileges men over women (e.g. Khan & Hussain, 2008). Whilst most studies refer to violence against women in Pakistan as being perpetrated by intimate partners, some look at the role the wider family plays in the perpetration of violence towards younger women (Kapadia et al., 2010; Niaz, 2003). These studies reveal that family members at times reinforce the abusive behaviour perpetrated by intimate partners.

The limitation of this body of work is that few studies included interviews with the women victims themselves. One that did spoke to women living in shelters and the authors acknowledge sample sizes were small (Critelli, 2012). Other researchers carried out surveys in healthcare settings (Ali et al., 2011; Kapadia et al., 2010) or used community based health workers to identify participants (Zakar, Zakar, & Krämer, 2012). All these studies portray leaving violence as extremely challenging for Pakistani women, and the "silencing" of women (Latif, 2011, p. 29) means that the voices of most victims are never heard. As a consequence it could be suggested that even this small

body of first hand testimonies fails to completely reflect the lived experience of most women because they are never able to escape their violent situation therefore can never speak of it.

This section of the review has also further highlighted how the focus in the literature on intimate partner violence noted above (section 3.2) can exclude violence in the home towards women arising from a range of other perpetrators.

### **3.3.2 South Asian women living in the UK**

Six recent empirical studies have been carried out in the UK relating to forced marriage, and include south Asian women in the population group. These studies were discussed in a published literature review which aimed to highlight the importance of recognising forced marriage as a form of domestic violence (Chantler, 2012). In the conclusion of the review the author claimed that there is a tension between the conceptualisation of forced marriage as purely cultural, and forced marriage as a form of gender based violence. She also found that there is a lack of reporting of forced marriage due partially to the absence of professional knowledge on the subject, and also because of fear of intervention.

Several studies have been carried out which explored various aspects of UK domestic abuse provision for south Asian women. Included in this definition are shelters, refuges and counselling. One study carried out in Manchester looked at the experiences of a range of "minoritised" women in the area and found service provision failed to meet the specific needs of such women and was also under resourced (Chantler, 2006, p. 27). Wilson, writing in 2007 found generic women's refuges neither provided for the cultural needs of south Asians nor offered a "racism-free atmosphere" where deeply traumatised women can recover (Wilson, 2007, p. 27).

Two further studies considered how 'culture' is constructed by domestic abuse service providers and found that it is often constructed as either the problem, or the reason for non-intervention (Batsleer et al., 2002) and that certain constructions of culture within services can potentially serve as a barrier to adequate service provision (Burman, Smailes, & Chantler, 2004).

Looking specifically at sexual violence, and in particularly IPV, Ahmed et al. (2009) were interested in examining how British south Asian women draw on notions of culture in relation to seeking support and, or solutions. This study is one of the few British studies that looked at domestic abuse from the perspective of south Asian women 'survivors'.

The research found that the women in this study may have reproduced a dominant discourse of "culture as problematic and unchangeable" to make sense of their experiences, but they also showed resistance to these discourses and had challenged ideas regarding their roles as daughters who embody responsibility for family honour (Ahmed et al., 2009, p. 23). Limitations of this study were however that it was conducted among educated English speaking women who had the resources to attempt to tackle the problem by either physically escaping the abuse, or by trying to access services as a way of seeking help.

A very different study was carried out by Latif (2011) in which she explored the nature and dynamics of domestic violence within the British Pakistani Mirpuri community. The study found that the concept of familial honour provides domestic violence perpetrators with opportunity to enforce a culture of submission upon certain female family members. The author also speaks of the "silencing" of British Pakistani women experiencing domestic abuse, which she suggests could partly account for the paucity of research on violence within this specific population group (Latif, 2011, p. 29).

Ahmed et al. (2009) have advocated that the dearth of UK research among south Asian survivors is partly because of difficulties in accessing women. This can, they claim be partially explained by women's reluctance to come forward and access services through fear of discrimination or fear sometimes grounded in the delivery of racist clinical and social work practices. It could however also be suggested that there is a variance in how domestic violence is experienced and conceptualised among those different ethnic groups bracketed under the umbrella term 'South Asian'. Further, that this variation of experience also impacts on their differing ability or willingness to speak out about the issue.

Whilst it is acknowledged that victims are often never able to tell their stories and survivors can be difficult to access, research which furthers understanding on how some of the above issues impact on health visiting work could provide ways of informing future practice so that women can be better supported. First-hand accounts from those practitioners with knowledge and experience of working with Pakistani women could illuminate the key barriers to keeping women safe and shed light on how some of these challenges are currently being met.

### **3.3.3 Recurrent themes across the literature on violence and south Asian<sup>7</sup> women**

This section provides an overview of the general themes found in the literature pertaining to violence and south Asian women. Some of the issues have been introduced in earlier sections with specific reference to the subject under discussion. Here they are set in context within the broader bodies of work. In a similar manner to previous sections, issues of specific relevance to health visiting practice are prioritised.

The themes of 'silence', 'invisibility' and 'hidden' seem to appear frequently within the literature relating to violence in south Asian families. Many authors refer to how either the women are silenced from speaking out and seeking help (Ahmad, Driver, McNally, & Stewart, 2009; Gill, 2004; Latif, 2011; Thiara & Gill, 2010a) or that the community themselves are silent on the issue of violence (Kulwicki, Aswad, Carmona, & Ballout, 2010; Payton, 2011). A third view is that politically, in Britain, south Asian women's voices are not heard (Patel, 2008) or that women victims are 'hidden' (Chakraborti, Spalek, & Garland, 2006; Gangoli, McCarry, & Razak, 2008; Natarajan, 2002). For health visitors in the UK this 'silence' has major significance for practice where disclosure of abuse is considered a successful outcome of routine enquiry (Department of Health, 2013b).

This concept of silence is often linked within the literature to issues relating to collectivist cultures and the impact of living within such population groups has on women and their apparent reluctance to speak out or leave (Haj-Yahia, 2011). The term "collective stigmatisation" (Ryan, 2011, p. 1045) has been used to describe how incidents and certain behaviours among group members in collectivist societies are seen to reflect on the entire community or population group and not just the individual who acts out those behaviours. Haj-Yahia and Sadan (2008), in a study looking at interventions with battered women in collectivist societies, describe how among these groups, which includes some south Asian populations, there is a tendency to relate to violence against women more as a personal and family problem than as a social and criminal problem.

This notion links closely with another recurrent theme within the literature, that of honour and the fear some south Asian women are said to have of bringing shame or dishonour to the family. Several studies refer to shame as a contributing factor in the perpetuation of violence towards south Asian women (e.g. Gill, 2004; Zakar, Zakar, Faist,

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<sup>7</sup> In this section, for accuracy, the broader term south Asian is used. This is because much of the literature relating to the topics discussed does not differentiate between the various ethnic sub-groups included in that study.

& Kraemer, 2012). Telling, it is claimed, would dishonour the family by making public something that it is felt ought to remain private. Shame is also portrayed as a reason for failure to speak out or report the violence (Anitha, 2011; Lee & Hadeed, 2009).

Research in the field of 'honour' crimes has been said to have been complicated by a lack of agreement regarding the definition of the term (Gill, 2008). Many of the British studies on honour are in relation to 'honour' killings (Gill, 2008, 2009; Meeto & Mirza, 2011). Whilst this literature search revealed several academic essays and peer reviewed commentary relating to the subject, there were fewer papers describing actual empirical research. Many of the academic commentaries were found to focus on the characteristics of 'honour' related violence, and discuss issues of race, gender, class and religion in terms of being contributory factors in violent acts. For health visiting and other health services for example midwifery, these findings have clinical significance in that this culture of secrecy and silence are likely to impact on the outcome of routine enquiry into domestic abuse. Little appears to be discussed or explored within the empirical literature about how to support or help keep safe women who, for cultural or other reasons, choose not to disclose the violence they are experiencing.

Another of the themes within the literature is the growing body of evidence of in-law violence towards younger south Asian women living within extended family situations. Examples cited include burning and starving (Chaudhuri et al., 2014; Lee & Hadeed, 2009; Raj et al., 2011). Several studies focused specifically on the role other women within the household often play in the condoning of, or as perpetrators themselves of the abuse. (Rew et al., 2013). Many of these studies are carried out in India and Pakistan however authors writing specifically about violence against south Asian women in Britain also refer to this phenomenon (Abbas, 2011; Meeto & Mirza, 2011).

One British study carried out within the discipline of midwifery, cites mothers-in-law as a specific barrier to south Asian women reporting intimate partner violence (Wellock, 2010). Issues of maintaining family honour and avoiding shame are said to be strongly associated. Several other studies look at barriers south Asian women face in seeking help. These include high acceptance of violence, stigma and fear of greater harm (Naved et al., 2006), fear of deportation and fear of the introduction of a second wife (Chaudhuri et al., 2014), social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration, limited knowledge about available resources and myths about partner abuse (Ahmad et al., 2009).



Many studies differentiate between the help-seeking behaviour of immigrant and non-immigrant women recognising the different factors affecting each group, for example welfare support<sup>8</sup> (Burman et al., 2004) or describe the influence of "immigration related abuse" on help-seeking behaviour (Ammar, Couture-Carron, Alvi, & San Antonio, 2013, p. 1452). Although research findings have examined the nature and extent of help-seeking behaviour among IPV victims, a theory of help-seeking that provides a framework for such findings has yet to be developed. Liang et al. (2005) however drew from more general models of help-seeking to develop a conceptual framework for understanding the processes of help-seeking among survivors of IPV. Using cognitive behaviour theory from the general literature on help-seeking in "stigmatizing" situations, three relevant processes or stages are suggested on seeking help in the IPV context. These are defining the problem, deciding to seek help, and selecting a source of support (Liang et al., 2005, p. 71).

A decision of whether to seek help is however also influenced by how the woman views her situation and conceptualises the behaviours she is subjected to. Applying the logic of help-seeking to the approaches described above, the woman must first recognise her circumstances as undesirable, and there are several studies among the literature that suggest south Asian women tend to report abuse incidents and seek help only when the violence reached a severe or crisis level (e.g. Abraham, 2002; Ahmad et al., 2009; Haj-Yahia, 2011; Lee & Hadeed, 2009). Alternatively, applying what we already know from the literature about the hidden nature of abuse, it could be that women living within cultures where speaking out is considered taboo are finding more secretive ways of seeking help, however there is currently not enough research for us to know this for sure.

'Coping' therefore, that is finding day-to-day strategies for dealing with the abuse and remaining in the family, appears from the literature to be the choice many south Asian women make. Coping could be viewed as passive, and Gill (2013) suggests that this is the way many such women are portrayed in the UK by the state and public services. Alternatively, and as is described within some of the literature, coping can be seen as a form of resistance in the context of gender arrangements in the family (e.g. Abraham, 2002; Zakar, Zakar, & Krämer, 2012).

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<sup>8</sup> Women subject to the 'two year rule' who have uncertain leave to stay in Britain (because their marriage to a British citizen, or with residency rights, has broken up) have 'no recourse to public funds', i.e. their entitlement to welfare benefits or claim on public funds is disallowed. This often places them in a situation of absolute exclusion from all systems of support.

The Patriarchal Bargaining Framework (Kandiyoti, 1988) has been used by some researchers and theorists to explain why women will often accommodate certain gendered practices, for example veiling. The framework highlights the issue of agency as women strive to achieve their goals within the constraints of family and culture. Chaudhuri et al. (2014) used the framework in one study of abused immigrant south Asian women in the U.S. to examine the women's coping strategies. The authors concluded that, judged against a comparison group, the women confronting abuse and extreme patriarchy most often used three strategies in their efforts to manage it. They became unnoticeable, obeyed their husbands, and prayed and relied on their faith.

Several authors of the literature on violence against south Asian women refer to the concept of intersectionality within their work. Intersectional theorists reject the notion that there is a single, key oppression from which all other types of oppression against women derive. They also refute the additive model of oppression which assumes that ethnic minority women are subject to racial and gendered 'double jeopardy' (Gill, 2013). Instead they talk of the multiple intersecting inequalities many women face (Strid, Walby, & Armstrong, 2013). Lee and Hadeed (2009) describe the combined effects of the intersectionality of gender, race, and class, and the marginalization of battered Asian women as 'multiple jeopardy'. Others (e.g. Ahmad, Rai, Petrovic, Erickson, & Stewart, 2013) have described how immigrant south Asian women face the 'triple jeopardy' of economic challenge, limited social support and ethnic minority status. Irrespective of the definition, the literature is clear that many south Asian women face hardships that are often magnified several folds. It could also be argued that another layer of complexity is added in some communities, for example certain collectivist Pakistani populations in the UK, where personal needs and human rights are often sacrificed in favour of the group, or family. The implication for health visitors working with this community is that these multiple layers of intersecting issues are likely to make the task of supporting women much more complex than the mainstream.

This section of the review has described what the empirical literature tells us about the many issues south Asian women living with violence face, and the different ways they respond. Complex and intersecting factors are evident and there is little doubt many Pakistani women in the UK experiencing abuse live with hardship and injustice. In the next section the academic literature pertaining to role of the health visitor in supporting these women is explored. It first begins however by looking at the broader research topic of health visiting practice and domestic abuse.

### **3.4 Health visiting and domestic abuse**

In a recent review of the literature, Cowley et al. (2015a), noted that there have been a dearth of studies on health visiting and domestic violence undertaken in the last decade, and little exploration within the literature as to the reasons why. This section therefore draws on early empirical work on the health visiting role and domestic violence and looks at how this has influenced contemporary policy, practice and research. A review of the small body of later studies will then highlight what appear to have to been the issues, challenges and priorities for practitioners working with abused women in more recent years. Relevant studies are included which look at what the literature tells us about these issues from the perspective of women victims and survivors. A small number of studies are carried out in disciplines other than health visiting but are included because findings have implications for health visiting practice.

Health visitors, according to Dennis (2014b) and Hester and Westmarland (2005) can make an important contribution to tackling domestic abuse. They do this by focusing on the woman's<sup>9</sup> safety and that of her children and by providing information, advice and intervention strategies that enable women to access specialised services. The literature however suggests that historically, women have been reluctant to talk to health visitors about domestic violence feeling they did not receive adequate support or protection from the service. The evidence also suggested that health visitors at the time felt ill-equipped to address the issue (Peckover, 1998, 2003a, 2003b).

Peckover's seminal study in 1998 and subsequent papers were among the first to identify gaps in practitioner understanding of the extent and the nature of domestic abuse, variance in their knowledge about the topic and to illuminate what was described as a "professional silence" about the issue (Peckover, 2003a, p. 205). Work by Frost, published at a similar time identified health visitors' concerns about safety when undertaking home visiting and, like Peckover, cited lack of training about domestic violence as a concern (Frost, 1999).

Since the publication of those earlier studies a number of tools, guidelines and information resources have been put in place for health visitors working with abused women (e.g. Dennis, 2014a; Department of Health, 2005; Department of Health, 2013a). The subsequent evidence suggests that there is now increasing professional recognition that abuse is occurring (Peckover, 2014) however it seems that confidence in domestic

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<sup>9</sup> In much of this section the term 'woman' more frequently refers to mothers

abuse work among practitioners does not appear to have improved. One Scottish study found many health professionals, including health visitors, still do not feel confident or at ease discussing the issue (Taylor, Bradbury-Jones, Kroll, & Duncan, 2013). This apparent ongoing reluctance of health professionals to inquire directly about abuse has been attributed to a number of factors, including lack of knowledge and training, time constraints and fear of offending women (Salmon, Murphy, Baird, & Price, 2006), lack of confidence, time, competing priorities and resources (Hester & Westmarland, 2005). Insufficient time to handle domestic violence cases, a lack of knowledge about dealing with disclosure, and subsequent knowledge of interventions or services were suggested as possible contributory factors by Robinson and Spilsbury (2008). It is disappointing to note that several of these issues are consistent with those found more than two decades ago, suggesting that recent efforts to provide practitioners with better resources from which to inform their practice with abused women, have to some extent been ineffective.

As well as looking at health visitors' understanding of domestic abuse, Peckover's earlier work (Peckover, 2003b) also explored the experiences of women victims and survivors of abuse. The findings suggested that although abused women are reluctant to disclose abuse they still want the issue to be discussed. More recent research concurs with Peckover's conclusion that abused women want to be asked about their experiences of domestic violence (e.g. Feder et al., 2009; Robinson & Spilsbury, 2008; Spangaro, Poulos, & Zwi, 2011).

Studies looking at routine enquiry into domestic abuse have more frequently been carried out in the field of midwifery where women have been shown to have a positive view of enquiry carried out in the antenatal period (Salmon, Baird, & White, 2015). Recent health visiting interventions set in other healthcare settings appear to be less well researched, however the few studies undertaken have identified similar findings (e.g. Bateman & Whitehead, 2004). Raising the issue of domestic abuse, it has been suggested, creates a culture in which women are made aware of the impact of abuse and understand there are avenues of support available to them. Women, it is claimed, may choose not to disclose the abuse at the initial time of asking, but asking signifies a woman can disclose at a later contact (Salmon et al., 2015). Pregnancy, it is claimed by Bacchus et al. (2002) is seen by some women as an opportune time to ask about domestic violence as it makes them think seriously about their future and how their children might be affected in the long term.

Frost (1999) found women are more likely to disclose abuse to health visitors with whom they have a supportive relationship. Forming a relationship with the woman, Frost noted, could also help alert the health visitor to domestic violence by observing change in the woman's conduct. Other studies have since highlighted the nature of the relationship between an abused woman and the health professional as being an important factor in successful domestic violence interventions. Bacchus et al. (2002), for example, albeit looking specifically at women's perceptions and experiences of routine enquiry for domestic abuse in a maternity service, found that trusting relationships were important, as were factors such as the empathy and compassion of the clinician. Bacchus, Mezey, and Bewley (2003), exploring women's experiences of seeking help from a range of health professionals, talked about how women valued the 'helpfulness' of the health visitor. They also found that most women thought that it was "appropriate" for health visitors to enquire about domestic abuse (p.11). Women in the study described their contacts with health visitors as less formal than with GPs, and felt that health visitors were better able to provide them with continuing support. The women felt that health visitors were attuned to their needs, and they trusted them to act in their best interests. Home visits were considered important.

There is other contemporary evidence within the literature of the positive impact that home visiting schemes can have in domestic violence interventions. One example is the Family Nurse Partnership programme (FNP) which is an evidence-based nurse<sup>10</sup> home visitation program for socially disadvantaged first-time mothers (Davidov & Jack, 2014). Evaluation of the programme is said to hold promise in preventing IPV and improving outcomes for women exposed to violence. The evidence behind the FNP comes from three large scale RCTs carried out in the U.S. which tested the programme with diverse populations in different contexts. There is reported to be an emerging evidence base in the UK (Department of Health, 2011b).

Other research findings suggest visiting women in their homes has several advantages from the perspective of identifying domestic violence and, or, enabling disclosure as visitors to the home are said to be more likely to pick up social problems (Bacchus et al., 2003) which often coexist with domestic violence (Cowley et al., 2015a). A systematic review by Sharps et al. (2008) which looked at home visiting programmes that included screening for IPV and which found high rates of prevalence concluded that home visiting may provide a good opportunity to screen for IPV but this demands training and networking capacities for those who deliver home visiting programmes. Van Parys et al. (2014) who reviewed nine RCTs of home visiting programmes found home visiting for

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<sup>10</sup> Many FNP schemes in the UK employ health visitors to carry out home visiting

IPV interventions to be more effective when it is delivered by trained nurses rather than by paraprofessionals. This may have significance for those organisations that employ health visiting assistants.

Robinson and Spilsbury (2008) suggest that the personal location of home visits facilitate disclosure because it reduces the potential for shame and embarrassment. Some of the respondents in their study however suggested that in some circumstances home visits were not helpful because the focus of the health professional (usually a health visitor) was on the child's need rather than the victim. Bacchus et al. (2003) conducted a qualitative study interviewing 16 women who had experienced domestic violence who were seen at a London hospital. They identified that women were hesitant to discuss domestic violence in a hospital Accident and Emergency department because of a lack of privacy. Evanson (2006) however points out that there is no conclusive evidence that indicates the effect of home visiting on the prevalence of domestic abuse.

Looking at perceptions of domestic abuse work from the perspective of the health professional, one study on clinical practice with abused women used Critical Incident Technique to explore the relationship between the health professionals' beliefs about domestic abuse and how these align with the perspectives of abused women (Taylor et al., 2013). Participants included 11 health visitors. Findings were similar to those of previous studies in that discussing abuse with women is something that health professionals find difficult, but women want to be asked. This study also identified however that, irrespective of the type of abuse, some health professionals believed that on occasions, they recognise abuse even when women themselves do not identify that they are being abused. The authors also noted that several practices can be adopted by health professionals to keep women safe post-disclosure, including "code talk" (Taylor et al., 2013, p. 249).

A Home Office study, entitled Violence against Women Initiative, undertaken 2000-2003, aimed to find out which approaches and practices were effective in supporting victims of domestic violence, rape and sexual assault (Hester & Westmarland, 2005). Thirty-four multi-agency victim focused pilot projects were funded aiming to develop and implement a range of interventions for various population groups in a number of different settings and contexts. One of the projects involved evaluating routine enquiry as a method of enabling disclosure of domestic abuse and was carried out among a group of health visitors working in Wakefield, West Yorkshire. The study concluded that although routine enquiry appeared to encourage disclosure, practitioner training was a crucial pre-requisite in alleviating their fears of "opening a can of worms", a concern which has

previously prevented them asking about domestic abuse (pg.40). Routine enquiry was found to be most effectively implemented where practitioners could find ways to incorporate it into their existing patterns of work.

Much of the focus of contemporary health visiting professional and academic interest in domestic abuse relates to aspects of safeguarding children or how violence in the home can impact on the health and wellbeing of children (e.g.Appleton & Cowley, 2008a; Harlow & Smith, 2012; Peckover & Trotter, 2015). Key challenges include difficulties in determining the focus of interventions when the safety and support requirements of women need to be addressed alongside those of their children (Peckover & Trotter, 2015). Recognition that women experiencing domestic abuse often have unrealistic expectations placed upon them by professionals such as leaving the relationship or having sole responsibility for protecting children, has however, more recently shifted attention more towards supporting mothers and providing advocacy (Lapierre, 2008; Radford & Hester, 2006; Ramsay et al., 2009).

In conclusion to this section we have seen how there have been few empirical studies in relation to health visiting and domestic violence carried out in recent years. The small body of contemporary work reviewed has looked predominantly at routine enquiry, and at the confidence and competence of practitioners in asking the question. It has been suggested in the literature that home visiting plays a positive role in enabling disclosure. Another key issue within the health visiting literature is safeguarding children, and there are debates within the literature about balancing the needs and choices of the mother whilst at the same time protecting any children in the household.

The health visiting literature, similar to other academic research on domestic violence appears to consistently view success in domestic violence work as being detection and disclosure. Few studies have been found that explore the experiences of health visitors post-disclosure and little appears known about health visitors work with women who continue to live with violence. There also appear to be a dearth of studies which explore whether the challenges are any different for those health visitors working with abused women from specific ethnic populations.

### ***3.5 Health visiting and Pakistani women experiencing abuse***

For this final section of the literature review a comprehensive search of the empirical literature was undertaken in order to find studies on health visiting and Pakistani women experiencing abuse. An electronic search of the main databases relating to healthcare was undertaken using the search engine Summon. The Cochrane Database was searched

for relevant systematic reviews. The grey literature was viewed via the e-thesis on-line service EThOS. No date restrictions were applied.

No studies were found which looked at health visitors' work with abused Pakistani mothers. The search however found some studies that did reveal issues that might have relevance for health visitors working with abused Pakistani women or which illuminate factors associated with the topic. The following therefore is a description of, and discussion about the relevant elements those studies.

There are several studies that relate to aspects of depression among British Pakistani women (e.g. Chaudhry, Husain, Tomenson, & Creed, 2009; Husain et al., 2011) including one study on assessing risk factors for depression, suicide and self-harm among south Asian mothers living in London which was carried out among health visitors (Baldwin & Griffiths, 2009). Depression is known to be a common factor among Pakistani women experiencing domestic abuse (Critelli, 2012) and has been shown to be occasionally misdiagnosed as homesickness among immigrant women (Guzder, 2011). Some of the findings from these studies therefore may have relevance for health visitors who are responsible for assessing mental health in pregnancy and in the antenatal period (Department of Health, 2009).

One such study carried out in Manchester and East Lancashire was undertaken within midwifery services (Husain et al., 2014) and looked at depression in pregnancy and the efficacy of different screening tools among Pakistani women. Maternal depression was found to be "highly prevalent" among participants of the study (p.1090). The authors however acknowledged certain limitations to the findings, one being potential underreporting of symptoms due to the stigma attached to mental illness among the Pakistani community. Another issue which arose from the study and also holds potential resonance for health visitors undertaking routine enquiry into domestic abuse, was that some family members would insist on being present throughout the interview, even if they were requested to leave the room for confidentiality purposes. Having a family member present particularly a mother-in-law, the authors of the study noted, is seen as the norm in many Asian households. They concluded that the presence of a third party may have also contributed towards underreporting of the depressive symptoms. Similar barriers were also reported in a study by Clifford, Day, Cox, and Werrett (1999) who noted that mothers-in-law would hinder the screening process by being present and also discouraged the further participation of the subjects in case the family would be looked at in a negative way. Health visitors in one study undertaken among the Pakistani community in Glasgow highlighted the importance of relationships within families, and



the need for health visitors to show proper respect for these, including the role of the mother-in-law (Bowes & Meehan Domokos, 1998).

The complexity of the structure and role of the extended family was said to add additional challenge to work with Pakistani families in another study which looked at health visitors' experiences of working with Pakistani mothers, and the views of the women about the health visiting service (Hogg, Kok, Netto, Hanley, & Haycock-Stuart, 2015). Though the study was not looking at domestic violence specifically, the topic was raised within the paper. The authors found health visitors were perceived as supportive by the women, although sometimes their advice and information given was considered culturally inappropriate by the women. The health visitors' role was also said to be often poorly understood.

Cultural competence is the general term used here to describe a range of issues found within the literature that suggest why some practitioners find work with ethnic minority groups challenging. One study carried out among health visitors in the West Midlands (Jackson, 2007) explored health beliefs, knowledge and practice using a Culturally Competent Development Model adapted from Papadopoulos, Tilki, and Taylor (1998). The authors found there to be a dearth of information in relation to empirical research in this topic area in the UK, however concluded from their study that there was a significant difference in health visitors' ability to meet the needs of minority ethnic communities as opposed to their ability to meet the white population needs. Another study which looked at south Asian women's experience of domestic violence found that professionals working with abused women often tolerate violence towards south Asian women or find it difficult to challenge due to lack of knowledge about the culture and not wishing to appear disrespectful (Jeevan, 2009). Chantler (2012), commenting specifically on forced marriage, found that many practitioners struggle to know how to intervene and concluded that it appears that issues of culture and the desire to maintain good community relations are in danger of being given priority over intervention in abuse related work.

Earlier work by Peckover which was carried out in the north of England and included interviews with 24 health visitors looked at their understanding of domestic abuse (Peckover, 2003a). One of the findings from this study was that despite an awareness that domestic violence occurred across the boundaries of race and ethnicity, many health visitors expressed a reluctance to intervene, particularly in relation to Asian women, often because they felt ill equipped to provide effective interventions in this group. The study also highlighted lack of interpreting services as being problematic for health visitors working with this population group.

In conclusion to this final section of the literature review, no studies have been found that related directly to the subject of health visitors work with abused Pakistani mothers. Some useful contributory information was gleaned from studies carried out in other disciplines allied to medicine which give additional insight into some of the challenges many practitioners encounter when working with abused Pakistani women. However, as Cuthill (2014) states, little appears to be known empirically about the day-to-day experiences of health visitors working in diverse community settings.

### **3.6 Conclusion**

This review of the relevant literature has demonstrated how difficult it has been extrapolating evidence about issues specifically relating to health visitors' work with Pakistani mothers experiencing abuse. That which is known so far is frequently included in those works which encompass more general findings relevant to broader groups of women and by a range of clinicians and health professionals. Much effort however has been made to extricate and illuminate current understanding of health visiting practice, domestic abuse and Pakistani women in the UK.

The literature has revealed that many abused Pakistani women in the UK face unique difficulties which may be compounded by certain cultural practices. We have seen how chain migration since the 1970s to some areas in the north of England has resulted in settlement patterns of families from rural areas of Pakistan. Suggestions have been made that family structure together with certain cultural and social practices have been maintained to a considerable degree in these populations. Some of these practices include acts of violence and cruelty to women, and these are often perpetrated by members of the extended family as well as intimate partners.

The literature search has suggested that, by the nature of their role and skills, health visitors are able to play a lead role in the prevention and identification of domestic abuse. However there has been little academic enquiry into domestic violence and health visiting work in recent years, and interventions with abused Pakistani women is an exceptionally under researched area of practice.

The general literature on domestic violence activity among health professionals demonstrates that much of the focus to date has been on screening. Detection in terms of disclosure appears the main success criterion of both screening and routine enquiry. The evidence suggests however that disclosure does not necessarily lead to a reduction of the violence, indeed few outcome studies appear to have been carried out. Coupled

with this, it seems that disclosure is rare among Pakistani women for many reasons including shame and fear of dishonouring the family.

We have also seen in earlier chapters of this thesis how there is a complex and often confusing history of theory and knowledge underpinning health visiting practice which is often influenced simultaneously by several epistemological perspectives. The current dominant protocol in the NHS however, is evidence based practice. This raises the question therefore as to how, in the absence of empirical research from which to inform that evidence base, what knowledge are health visitors currently drawing from during their encounters with abused Pakistani women?

There appears therefore, compelling evidence to suggest that more needs to be understood about how health visitors are meeting the specific needs of Pakistani women living with abuse. Whilst service evaluation or intervention mapping could provide a useful way of doing this, it is suggested that more powerful and insightful data would be obtained by exploring first person accounts from health visitors with existing experience of working with this population group. Knowledge gained from understanding the practitioner perspective about the issues encountered could then be used to better equip future practitioners working with similar population groups. Further research would also add to the existing body of contemporary knowledge of health visiting practice and domestic violence which is currently devoid of culturally relevant evidence.

### **3.7 Study aim and objectives**

Based on the above analysis of the literature, the aim of the study is therefore: *To elicit how health visitors endeavour to meet the perceived needs of Pakistani mothers living with abuse, and explore the challenges health visitors encounter in keeping such women safe.*

This will be done by achieving the following objectives:

1. To explore how the health visitor's role with abuse Pakistani mothers is viewed and experienced among health visitors working with this population group
2. To investigate health visitors' perceptions of the effectiveness of routine enquiry into domestic abuse among Pakistani mothers
3. To find out how health visitors feel they can contribute to keeping abused Pakistani mothers safe
4. To understand what skills and knowledge health visitors draw from when working with this population

The following chapter describes the methodology and methods used to achieve these objectives.

## **Chapter 4 Methodology and Methods**

The purpose of this chapter is to describe in detail and justify the research methodology of the study and the methods used to collect and analyse the data. In doing so the rationales that underlie the chosen research methods are discussed as are the merits and limitations of the approaches taken.

### ***4.1 Introduction***

The methods chosen to answering the research objectives were inductive, interpretive, set within the qualitative paradigm. A critical realist perspective was applied. Semi-structured interviews were carried out with health visitors which focused on first person accounts of their practice. Thematic analysis of the data was undertaken using the approach described by Braun & Clarke (2006, 2013). A non-linear, iterative approach was taken which meant research design changes and adaptations were ongoing. These change and design decisions were influenced productively by the literature, the emerging findings, and by applying a reflexive approach throughout.

### ***4.2 The qualitative paradigm***

Using qualitative methods the words of the participants were used to create an interpretation and conceptual account of the issues, based on the individual's own subjective experience. Their responses were therefore not predictable and no straightforward linear causal explanation was being sought. The interview questions were exploratory, open-ended and about discovery as opposed to being experimental or hypothesis testing. The nature of the questions made no ensuing assumption that one correct answer to each question exists, instead the intention was to describe, explore and understand phenomena from a range of perspectives.

By taking a questioning approach to knowledge and asking open ended questions, there is recognition that the researcher too brings their own subjectivity into the data collection and analysis process. Within qualitative research this is seen as a strength rather than a weakness (Braun & Clarke, 2013). Indeed Patton (1990) argues that one can only ever interpret the meaning of something from some perspective or situational context and that this includes how the findings are reported as well as reporting the perspectives of the people being studied. Similarly Smith, Flowers, and Larkin (2009) describe how bracketing out foreknowledge from data analysis is not always possible or

desirable and at times can result in one's own preconceptions and their relevance simply becoming apparent at a later point in the process.

#### *Applying a critical realist perspective to qualitative research*

It is not my intention here to debate the broader methodological antagonisms of qualitative versus quantitative research, however critical realism as a philosophy has been deliberately constructed to connect (or stand between) the poles of objectivity and subjectivity (Pawson & Tilley, 1997). Pawson and Tilley describe how, within the process of data collection, it is possible therefore to be "empirical without being empiricist so that one can examine subjectivities without being subjectivist" (p.158). Healy and Perry (2000) suggest that when a realist approach is applied to qualitative research the perceptions of the participants are being studied not just for their own sake but because they provide a window on to a reality beyond those perceptions.

Using the definition offered by Fleetwood (2004) that "something is real if it has an effect or makes a difference" (p.29), one specific 'reality' (on an empirical level) in this particular study is the violence/abuse. A critical realist perspective would thus accept the premise that it exists within our discourse however would claim that what denotes or constitutes the phenomenon may exist beyond that discourse. The overall aim of realist research is, to quote Pawson and Tilley (1997), to develop not one, but a "family of answers" to the research questions that cover several contingent contexts (p.123). There is an acknowledgement within this approach however that these answers are fallible, that is, they could be different given different conditions.

While it is often argued that mixed methods may be required for the intense study of the antecedents of social events and experiences when undertaking realist research (e.g. Danermark et al., 2002), I would agree with Angus and Clark (2012) who suggest that there are a rich variety of ways in which interpretations of critical realism can be applied to methodology. The caveat is however that there must be "meticulous attention to the theoretical basis for the selection of methods" (p.2).

#### **4.2.1 Qualitative research**

Qualitative research is a generic term that refers to a group of methods and ways of collecting and analysing data that are explanatory in nature and which focus on meaning. Qualitative research uses words or textual material derived from observation as data (Braun & Clarke, 2013; Malterud, 2001). The findings, understandings and insights that emerge from the data collected and subsequent analysis are the "fruit" of

qualitative inquiry (Patton, 1990, p. 9). Qualitative research has a number of characteristics or common threads that apply to this particular study, those being:

- The researcher is a key instrument in the data collection in terms of conducting semi-structured interviews with the participants
- Data analysis focuses on the participants' perspectives, meaning and subjective views
- The design is not tightly prescribed but is allowed to emerge. It may change or shift once the researcher enters the field and begins to collect the data
- Data from a relatively few participants are analysed in depth rather than recruiting large samples
- The research involves reflexivity and is interpretive

#### **4.2.2 Qualitative research and nursing**

Over the past few decades the value or the place of qualitative research in nursing has been widely debated. Much of this discussion has arisen because traditionally a knowledge base dominated by science and quantitative research was believed to have a higher status and authority (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001). This attempt to strengthen the reliance on empirical theory within nursing practice has been seen by many as an attempt to gain professional status and recognition where a more scientific approach is often viewed as a pathway to academic and professional credibility, similar to medicine and the law (Cash, 1997). The dominant player in the synthesis of clinical evidence over many years has undoubtedly been the quantitative hierarchy (Greenhalgh, 2006) though many scholars for example Munhall (2012) have suggested that there needs to be a shift in nursing research from the positivist perspective. Risjord (2010) however states that nursing knowledge comes from a "patchwork quilt" of research practices (Risjord, 2010, p. 212).

Qualitative research, according to Munhall (2012) emphasises the value of holism, that is care for the whole person, as opposed to simply reducing people or their experiences to parts which require separate investigation. This, she suggests makes this research methodology ideal for examining nursing practice where the approach is also to view the individual as an holistic system.

#### **4.3 Applying reflexivity**

The value of the use of 'self' in research and the acknowledgement of the impact that the presence of the researcher has on the work has become more fully recognised over the

last 25 years (Etherington, 2004). Today reflexivity is said to be a familiar concept in the qualitative tradition of research (Guillemin & Gillam, 2004). Approaches to reflexivity in academic work vary (see e.g. Cromby & Nightingale, 1999; Etherington, 2004; May, 1999). The commonality among most commentators however is that reflexivity is a dynamic process between the researcher and the data, and that it requires self-awareness. Reflexive researchers are aware that they are part of the social world that they are investigating and this is likely to influence the way in which they choose to collect data and the interpretations that they make of it.

My approach to this study is 'personal reflexivity' in which the researcher reflects upon their own personal values, interests, beliefs and social identities and how they have shaped the research. Using this approach reflexivity starts by identifying preconceptions brought to the study by the researcher representing previous personal and professional experience (Malterud, 2001). Throughout this, and the introductory chapter I have therefore made several references to my 'position' and have attempted to place myself within the research process so that my interpretations and assumptions can be assessed according to situated aspects of, what Tim May refers to as, my "social self" (May, 1999).

Throughout the development and undertaking of this study I have also kept a reflexive research diary in which my own thoughts about the research process were recorded. The diary, samples of which can be found in Appendix A, was particularly useful in the data analysis and interpretation phase of the study because as well as providing transparency, it helped me understand *how* I had reached certain conclusions.

#### **4.4 Assumptions**

Certain preconceptions arising from my own personal experience as a health visitor working among the Pakistani community in the north of England for many years were brought to this study. Indeed these assumptions were integral to the study aim and design. Contemporary theory of knowledge acquisition acknowledges the effect of a researcher's position and perspectives and disputes the belief of a neutral observer (Malterud, 2001). My preconceptions were however tested and examined throughout the research process and in particular at the very onset of the study by carrying out a scoping exercise among certain practitioners (section 4.5). This was so that the research was not *automatically* shaped by these perceived notions.

The prior assumptions were that:

- Pakistani mothers often experience a specific kind of abuse that is frequently perpetrated by extended family members as well as intimate partners
- There is often a difference in the types of abuse experienced by some Pakistani mothers compared to women from other ethnic groups
- Existing domestic violence interventions and provision often fail to meet the needs of Pakistani mothers
- Supporting women experiencing domestic violence is considered by nurses to be the role of the health visitor rather than that of other community nurses
- The contemporary role of the health visitor predominantly focuses on women with pre-school children or pregnant women rather than childless or older women

#### **4.5 Scoping exercise**

The conceptual process for developing the research aims began with two focus groups of community nurses held at the very genesis of the study. The purpose of the focus groups was to test out the prior assumptions described above (section 4.4) and therefore, dependent upon the outcome, provide further support to the rationale for undertaking the research or perhaps make changes. This approach is also consistent with realist theory and what Pawson and Tilley (1997) describe as the creating of a “launching pad of empirical enquiry” by developing priorities based on the issues of “what’s to know? who might know? and how to ask?” (p.160).

The major provider of community healthcare to the chosen region was approached. Permission to carry out and record interviews with staff was obtained from the Research and Development Lead for the organisation. Relevant documentation relating to this and other subsequent organisational permissions relating to this study can be found in Appendix B.

The focus groups were held during existing nursing team meetings and broadly followed the method suggested by Krueger and Casey (2000). Group members comprised of health visitors, school nurses, nursery nurses and community interpreters. All members of those teams worked within the south Asian population and did home visits as part of their role. This was a convenience sample as groups were already gathered. After discussion with the team leaders I had considered this approach would be acceptable to the group and provide minimum disruption to clinical time. I was informed that approximately 10-12 nurses would be expected to be present which Krueger and Casey (2000) suggest to be the correct number of people for this method of interviewing.



The focus group approach uses interaction among participants as a source of data. The strength of this method lies in its ability to mobilise participants to respond to and comment on each other's contributions (Willig, 2013). Indeed lively discussion ensued at both focus groups and team members quickly seemed to engage with the subject and share their experiences. A major reported disadvantage of focus groups is that dominant personalities can control the discussion at the expense of others (Parahoo, 1997), however as the moderator of both groups I felt I was able to draw all group members into the discussion and allow most views to be expressed. Parahoo (1997) also states that focus group interviews are not suitable for the study of sensitive and personal issues, but at this point only general issues relating to clinical practice and some points of clarification were being questioned.

Both focus groups were audiotaped with consent. I transcribed the interviews and then drew out and noted the key issues from the data. The outcome appeared to begin to affirm most prior assumptions. The findings were also used to influence the future choice of research participants and the subsequent interview questions. A brief summary of the topics discussed and the findings of the focus group interviews can be found in Appendix C.

#### ***4.6 Research participants***

Having completed the scoping exercise and gained ethical approval to proceed (see section 4.11), all health visitors working within the organisation and among south Asian<sup>11</sup> population groups were contacted via email. Advice from a community nursing team leader was taken to ascertain which geographical health visiting teams specifically to target.

In total 72 health visitors were contacted. They were sent brief details about the nature and aim of the study, and asked to email me if they would be willing to participate. In total 14 health visitors (20%) responded and volunteered to be interviewed. The sample was therefore both targeted and self-selecting.

Although organisation permission for the study had been gained in advance, prior to proceeding further, individual line management approval was obtained once an interview date was arranged. This was to ensure any subsequent workload capacity issues were not compromised by temporarily removing the individual from the workplace.

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<sup>11</sup> The overarching term 'south Asian' is frequently used among many practitioners as opposed to the more specific terms 'Pakistani' or 'Indian'

### 4.6.1 Profile of the research participants

The degree of professional experience of the research participants varied as they were self-selecting. It is worth noting that to qualify as a health visitor one must first be a qualified nurse or midwife, so the health visitor workforce is significantly influenced by the demographic make-up of those professional groups.

#### *Gender*

All the nurses interviewed were female. At the time of the study, no male health visitors were employed by the healthcare organisation and only 3% of the entire nursing workforce was male. Nationally 99% of health visitors are female and approximately 90% of general nurses (Department of Health, 2012).

#### *Ethnicity*

Thirteen of the health visitors interviewed were of White British ethnicity and one was Irish. Nationally approximately 85% of health visitors are White. At the time of the study 96% of health visitors employed by the organisation were White. In England, all qualified nursing, midwifery and health visiting staff in 2010 were more likely to be White than from any other ethnic group (Department of Health, 2012).

#### *Years of experience*

As this study is drawing on knowledge gained from professional experience, the number of years' experience in the field of health visiting each participant had gained at the time of the interviews is considered relevant, and is therefore demonstrated below<sup>12</sup>. Almost half of the health visitors interviewed (42%) had been qualified for more than 20 years and 5 of them (35%) were relatively newly qualified.

*Table 1 Years of Experience*

<b>Health Visitors</b>			
<b>&lt; 5 years of experience</b>	<b>5-10 years of experience</b>	<b>10-20 years of experience</b>	<b>&gt;20 years of experience</b>
Laura	Vanessa	Carol	Ruth
Eve	Rachel		Bev
Jill			Dora
Vivian			Josie
Cathy			Pamela
			Nola

<sup>12</sup> Pseudonyms are used

#### **4.7 Clarification exercise**

Preliminary data emerging from the interviews was confirming that the health visitors see their work among women experiencing domestic abuse as being predominantly with mothers who have pre-school children. Because of this, I became interested in understanding what role other community nurses, for example district nurses might have with women experiencing domestic violence. Could anything be learned or gained by opening up the study wider than just health visitors and possibly speak to nurses who work with victims who are not mothers? First it was felt it would be necessary to clarify what role district nurses perceive themselves to have with domestic violence.

Three district nurses from the same organisation were therefore interviewed. Each was a team leader with over twenty years' experience of working with ethnically diverse populations. The additional participants were contacted in a similar manner to that described above (section 4.6) used to recruit the health visitors. Semi-structured one-to-one interviews were undertaken and each was asked about the role of the wider community nursing team with women experiencing abuse - those that were mothers as well as childless or older women.

An early consensus was reached suggesting district nurses have a narrow and limited involvement in domestic violence. No further district nurse interviews were therefore considered necessary, and the research continued to focus on health visiting interventions. The key issues drawn from the district nurse interviews can be found in Appendix D.

#### **4.8 Searching for survivors**

At the onset of the study it was my intention to also seek out women survivors of abuse to interview. It seemed it would be beneficial to the outcomes of the work that as well as hearing the health visitors' accounts, abused women were allowed to tell their own story. This approach is supported by the recommendations in several studies into violence and south Asian women, where authors have noted the absence of the voices of women victims within existing studies (Ahmed et al., 2009; Contractor, 2012; Latif, 2011; Thiara & Gill, 2010b).

After careful deliberation it was decided that the approach would be to target women who were, at that point, safe and living apart from their abuser/s. The initial Ethics application for this study was therefore focused towards interviewing both women

'survivors' and health visitors. Women were to be recruited via refuges and support groups, not via any NHS services. The application which was approved, carefully addressed all of the issues to be considered when undertaking sensitive research.

The search for women survivors lasted for twelve months and is documented in Appendix E. In all of that time only four women expressed interest on being interviewed and two quickly withdrew. This approach was eventually abandoned due to lack of progress, and the research continued to focus solely on health visiting interventions. Taking a reflexive turn however, looking at these events from a critical realist perspective and applying Bhaskar's stratified ontology of the three different layers of knowledge, on a 'real' level, these encounters will almost inevitably have had some influence on the study and informed elements of the ensuing research, in particularly how the data were interpreted.

#### ***4.9 Reaching saturation point***

Saturation point in the context of this study meant knowing when enough interviews have been carried out in order to be assured that most or all of the perceptions that might be important were uncovered.

The question of how many interviews should be carried out when conducting qualitative research has been described as "perennial" and dependent upon a number of factors namely the research aim, objectives, time and available resources (Baker & Edwards, 2012, p. 3). Sampling, Baker and Edwards conclude, is very dependent upon the methodological and epistemological perspective of the research. In this study, because the processes was not linear, the number of interviews conducted was not predetermined rather was reached at a certain point during the research. This point was influenced by:

- The fact that 14 out of the 72 health visitors (20%) known to be working within south Asian populations had been interviewed and no more came forward
- Approaching non-respondents a second time would have felt like coercion and an abuse of power by me as a senior manager
- As the interviews progressed, data were mainly being verified rather than new categories of data being generated

#### **4.10 Data collection**

Whilst Pawson and Tilley (1997) describe realism as being dedicated to some form of pluralist empirical enquiry, they advocate a type of pluralism they describe as “toolkit selecting” (p.158) which is defined as a commitment to marrying the appropriate method to the appropriate task. Indeed they go as far as suggesting that “pluralism for pluralism’s sake” (p.159) offers no new system for knowledge construction.

Compatible with a qualitative approach to nursing research, and in order to provide a conceptual account of the data, one-to-one, semi-structured interviews were conducted. Each interview lasted approximately one hour. The data were anonymised so that individuals and organisations could not be identified. I was the interviewer throughout.

Semi-structured interviewing as a method of data collection is useful in that it supports a flexible approach which allows for questions to become more pointed as the emerging constructions develop (Guba & Lincoln, 1989) and allows the researcher and participant to engage in dialogue (Smith, 2008). Due to the exploratory nature of this study, it was considered important that the data collection method was not too structured and limited to fixed questions. Using qualitative surveys for instance would not have provided the opportunity of asking unplanned questions. Qualitative interviews are also said to be ideal for getting people to talk about sensitive issues (Braun & Clarke, 2013) and in this study encouraging clinicians to disclose their approach to a complex area of care necessitated careful probing on a one-to-one basis. Focus groups, a possible alternative, may have inhibited the sharing of personal information if practitioners felt they may be being judged by their colleagues and peers.

Other advantages of face-to-face interviews are that they are more natural encounters and body language can be observed during the process. This supported the semi-structured flexible approach, for example I could observe the participant and assess whether they were comfortable for me to probe deeper on an issue, or if I needed to leave it and move on to another question. A risk with carrying out face-to-face interviews however is that individuals may be deterred from being truthful, particularly where any deviant or extreme behaviour is concerned (Vogl, 2013). I believed nevertheless that my prior experience as a clinician asking difficult and challenging questions would help me deal appropriately with that situation should it occur.

#### **4.10.1 Developing the interview schedule**

A schedule of questions was developed for use in the interviews using process-orientated and open-ended questions. The semi-structured nature of the interview was chosen so that it allowed me to depart from the schedule and use a variety of follow up questions. Qualitative research is open to the possibility that the research questions may have to change during the research process (Willig, 2013) and that their order in the interview may vary (Potter & Hepburn, 2005). Using this method enabled me to probe further or change the way a question was asked, depending upon the participant's answer, or their level of clinical experience.

Within a realist approach, whilst there is an underlying assumption that research participants will come to the process bringing their own ideas, beliefs and experiences, the "true test of data" according to Pawson and Tilley (1997, p. 164) is whether they capture correctly those aspects of the subject's understanding which are relevant to the research. In this study therefore, and as is demonstrated below in section 4.10.3, developing an interview schedule which allowed for flexibility was key to enabling the apposite data to be constructed.

No pilot of the schedule was undertaken, the rationale being that as previously stated, the questions were only there to guide the process and were intentionally adaptable and subject to change. Secondly, there was limited opportunity to test out the questions as all available health visitors were research participants. Charmaz (2002) asserts that a qualitative interview guide does not need to be treated as fixed from the start of data collection and can evolve throughout the process. Braun and Clarke (2013) recommend that when this is the case reviewing the schedule after the first few interviews is important. In this research the schedule was re-evaluated throughout and some new lines of enquiry were added. One example of this was to ask about the health visitors' perception about the role of the interpreter within the intervention. The apparent significance of this was not known at the onset of the study and only became apparent as the interviews began.

The initial Interview Schedule can be found in Appendix F. The broad lines of enquiry however were:

With respect to Pakistani women experiencing violence and abuse,

- What do health visitors perceive their role to be?

- How does the abuse perpetrated against women differ to that seen in other population groups?
- How do the women view their situation – what are their expectations from the health visiting service?
- What do health visitors consider to be good outcomes in this area of practice and what stands in the way of this?
- What kinds of training/preparation for this area of practice do health visitors have/need?

#### **4.10.2 Stating the position of the researcher**

At the time this study was undertaken I was employed as a senior manager by the same healthcare organisation as the participants, and prior to that had several years' experience of working in the north of England as a health visitor and as a community nursing team leader. Much of that clinical time was spent working with south Asian population groups, families and individuals.

Great care was therefore taken not to appear to be influencing or persuading colleagues to take part in the study. Correspondence was carefully worded to ensure that participation was seen to be entirely voluntary and nurses were not contacted individually but rather by group email. No one was contacted again if they did not respond. None of the participants were known personally to me other than in a professional capacity.

Before any interview began, and in order to be candid, I clarified my current role, professional qualifications and special interest in the topic. The detail of the consent form was reiterated in terms of issues of clinical practice, confidentiality and anonymity. A copy of the consent form can be found in Appendix G.

It is acknowledged that because the participants then knew of my professional experience, some assumptions might have been made on their part regarding both my knowledge and personal perspective. When it became apparent that this may have been happening during the interview the participant was asked to clarify exactly what *they* meant by the particular statement they had made. Willig (2013) encourages interviewers to express a degree of ignorance when asking questions. This, she states, encourages the participant to "state the obvious" and thus give voice to otherwise implicit assumptions and expectations (Willig, 2013, p. 30). During the interviews for this study therefore I frequently asked for illustrations of events or experiences for clarification of an issue or perspective.

### **4.10.3 Conducting the interviews**

Interviews were conducted at a venue of the participant's choice in all but one interview which was held on university premises, meeting rooms at the site of the healthcare organisation were chosen by the participant. Before the interview date, individuals were sent a Participant Information Sheet (Appendix H) and a copy of the Consent Form to read in advance.

Prior to the commencement of the interview, following preliminary introductions, the aim of the research was reiterated as was the detail of the processes which would be followed to ensure the participant's anonymity. It was stressed to each participant that if they were to inadvertently mentioned the name of a third party or geographical location, those names would be either removed or changed. The participants were reminded that it was their personal views, opinions and experiences that were being sought and not those of colleagues or the organisation in general. Where necessary the aims of the research were reiterated again during the interviews for clarity. Examples of this being on one occasion it became apparent that the participant felt that their response could be being perceived as an indication that they were not following accepted protocol, in another interview the participant was being critical of managers and the values of the organisation. On both occasions I was able to provide reassurance of anonymity to the individual and the interview continued.

The interviews were audio recorded. Written consent was taken before the audiotape was switched on or any notes taken once the individual had indicated they were happy to proceed.

#### *Conducting a realist interview*

Pawson and Tilley (1997) suggest whilst that the information highway in most orthodox interviews is a sequence of "researcher asks questions, subject answers them" (p. 165) there is an assumption within this approach of mutual understanding about the issues underpinning the questions. This effect is particularly noticeable when using standard and/or more structured interviewing tools where there is often no opportunity for context to be taken into consideration, though can also be the case in unstructured interviews which can also lack context for the interview subject. The following section describes how I used the semi-structured interview process to not only collect data, but to maximise the flow of understanding between myself as interviewer, and interviewee. Within the realist model of data collection this has been described as 'chanelling' the information (Pawson & Tilley, 1997).



#### 4.10.4 The interview process

In using a semi-structured interview process, I was able to use the interview schedule to begin with open ended general questions then probe deeper as interesting and important issues arose. Reflecting back and summarising to the participant *my* understanding of their answers to the question allowed mutual understanding to emerge without me 'leading' the individual in the interview or misinterpreting their response. The order of the questions varied and depended upon the respondent's answer and the emerging story.

Due to the fact that I am a clinician, and at the time was a senior manager in the organisation, it was felt important that a few moments were spent to establish rapport and trust, therefore the opening questions focused on the participants work history, years' experience and training. I too shared these facts about myself. It was felt that this would also create empathy which would then allow greater flexibility of coverage and produce richer data. Smith et al. (2009), whilst writing specifically about Interpretative Phenomenological Analysis, make the general comment that analytical interpretation depends on sharing some ground with the person whose experience is being interpreted and that the interpretive analytical process is non-linear and interactive. Similarly, Madill, Jordan, and Shirley (2000) state that empathy imparted by shared humanity and common cultural understanding is an important link between researcher and participants and is a rich analytic resource. As I was using a realist approach to data collection I felt it important at times to elicit *why* individuals made certain choices and, or, decisions in their practice rather than simply ask about what those choices and actions were. This also gave them an opportunity to clarify their thinking and provide critical context. Another feature of critical realism within data collection is the need to identify factors that might constrain an action taken by participants, or to take steps to remove such constraints (Trigg, 2001). Putting them at ease, helping them feel safe and valued was part of that process.

As an experienced clinician I was able to use established interviewing and assessment skills to encourage the person to speak about the topic with as little prompting as possible and without them being led too much by the questions. The questions were often reframed, depending upon the clinical experience of the respondent and as I tested out hunches, ideas and explanations. I was particularly careful for example to ensure that comments made and examples given by health visitors were with reference to Pakistani women. Where anecdotes from health visiting interventions with other ethnic groups (e.g. Indian families) were given, these have been discounted in the final analysis.

The insider/outsider status of the researcher has been explored in many disciplines, particularly in relation to ethnographic and observational studies (Burns, Fenwick, Schmied, & Sheehan, 2012). Nursing researchers who have been prior or are existing members of the group being studied have reported benefits from insider knowledge or status which include ease of access to the study setting and early rapport building (Asselin, 2003; Simmons, 2007). Both these benefits were apparent in this study. The documented challenges are, being known as an insider whilst endeavouring to observe with an outsider lens and over identification with the participants (Allen, 2004; Leslie & McAllister, 2002). Braun and Clarke (2013) however state that in qualitative research we are likely to have multiple insider and outsider positions. In this study, ensuring self-awareness and reflexivity during the process of conducting the interviews was aimed at maintaining an analytical perspective throughout.

#### **4.10.5 Transcribing the interviews**

The interviews were transcribed verbatim by me as the researcher thus allowing greater familiarity with, and increased exposure to the data. The level of transcription performed was at the semantic level. A degree of 'cleaning-up' of the data was undertaken in accordance with the levels of acceptability suggested by Braun and Clarke (2013). Punctuation was used to accentuate readability. Certain features of speech were noted, for example long pauses, intonation and emphasis. Some repetitions and hesitations were removed where it was believed that doing so would not change the meaning of the data. Some comments were also removed which were felt to have no bearing on the issue being discussed. In the final text there are clear indications where words were deleted from the transcripts. Pseudonyms are used to identify the speaker.

#### **4.11 Ethics approval**

Ethics approval from the University School Research and Ethics Panel (SREP) was sought and received in two phases, with additional minor changes later agreed via SREP 'chair's approval'. Correspondence relevant to the approval processes and consent acquired can be found in Appendix I. This information also includes details of the ethical considerations made when planning the research and the risk assessments undertaken.

As the original intention of the study was to interview both health visitors and survivors of domestic violence, the initial Ethics application and approval reflected this approach. This line of enquiry was however later abandoned (see section 4.8 and Appendix E) with the focus of the study changing to centre solely on the accounts of health visitors. A revised ethics application was therefore made and approval for the revisions gained. This

revised application and approval also included some minor changes to the methods chosen, namely a decision to carry out one-to-one interviews and to undertake thematic analysis of the data. A further change was later agreed via chair's approval to open up the study to include other community nurses should this approach be chosen.

None of the individuals involved in the study were NHS employees and no patients were interviewed therefore NHS Ethics approval was not required.

## **4.12 Data analysis**

The following section provides an overview of the data analysis processes undertaken and describes how the overarching themes and subthemes were formed. Much of the methodology described below is not unique to critical realism - many qualitative researchers use similar techniques of data analysis which include going beyond the data to get a deeper understanding. What critical realism does however is bring to the fore that which is often tacit and underdeveloped within other approaches (Parr, 2015).

### **4.12.1 Thematic analysis**

Thematic Analysis, as described by Braun and Clarke (2006, 2013), was the approach chosen to analyse the data because it provides an adaptable yet systematic framework that was felt compatible with the inductive, non-linear study design. Thematic analysis can also be a realist, constructionist, or contextualist method, and as such was felt would fit comfortably with my own critical realist epistemological position and the approach taken to data collection. Both thematic analysis and the philosophy of critical realism value subjectivity in research and each recognises the interpretive understanding of meaning in complex 'social life', which is an important aspect of this study. It was also felt that this method would work well with the top-down/bottom-up approach which would be taken to the analysis of the data, that is to say, the process would be data-driven however informed by theory and the relevant literature. A critical realist approach aims to find the best explanation of reality through engagement with existing (fallible) theories about that reality (Fletcher, 2016).

Pattern based qualitative analysis such as the framework by Braun & Clarke (2006, 2013) uses the data to tell the story of them via decomposition into themes with each theme having a central organising concept which says something meaningful about a pattern in the data. I believed this approach would allow me to meet my research aim by being able to use the themes, draw meaning from them then interpret that meaning to address the research objectives. I also liked the way that within thematic analysis the

process of writing is interwoven with the process of generating ideas. This sits comfortably with my preferred style of analysis. Several other research approaches were however considered before the final decision was made. Further details of these and the rationale for discounting them can be found in Appendix J.

It is acknowledged that there are a number of ways that Thematic Analysis can be approached and that the term is often used in a generic sense to encapsulate the development of themes within a broad range of methodologies (Boyatzis, 1998). Braun & Clarke (2013) describe how Thematic Analysis has only recently been branded as a specific method of data analysis however maintain that if academically applied, and the stated pitfalls avoided, it offers a flexible and robust method for qualitative research which can deliver rich and detailed yet complex accounts.

Willig (2013) however cautions on the way that Braun and Clarke view thematic analysis as allowing “theoretical freedom essentially independent of theory and epistemology” (Braun & Clarke, 2006, p. 78). Willig prefers the use of the term “flexibility” and suggests that thematic analysis needs to be located within an epistemological and theoretical framework (Willig, 2013, p.58). In this study rigour is however imposed by taking a reflexive approach, describing the assumptions made by the researcher, and by following a transparent, systematic process *underpinned* by theory.

Whilst Braun and Clarke’s 2006 paper was targeted at psychology researchers, I felt that it could be used equally as successfully in nursing research due to the similar philosophical traditions of the two disciplines (Risjord, 2010; Rogers, 2005).

#### **4.12.2 Applying the framework**

Braun and Clarke describe six discrete phases of their framework for analysis, however they acknowledge that in practice it is often applied in a flexible way, indeed this is seen as one of the strengths of the framework (Braun & Clarke, 2013).

As the approach to data analysis for this research was iterative, although each of the six phases was completed, there was a degree of free movement between them which resulted in what Braun and Clarke refer to as a “recursive” process (Braun & Clarke, 2006, p. 86) being taken. For the purpose of describing the actions taken in this study however the whole procedure has been broken down into four stages.

### **4.12.3 Familiarisation**

The transcripts were first checked against the tapes for accuracy. The entire data set was then actively read again before the coding process began in order to gain additional familiarity. Some initial ideas were noted of anything relevant to meeting the aim and objectives of the study. As the data were collected interactively some early analytic thoughts had begun to be developed throughout that process, and these had influenced the questioning and probing of the research participants. All of this was recorded in the reflexive diary.

### **4.12.4 Coding and grouping**

The node function in NVivo 10<sup>13</sup> software was used to organise the data set into categories as meaningful units of text that had relevance to the aim and objectives of the research. These units of text were grouped together and categorised with provisional descriptive names (nodes). Detail and definitions of the initial node groupings were recorded in NVivo as node 'attributes' to ensure consistency of the coding. Node summary and example coding summary reports can be found in Appendix K.

Not all of the text was used, for example most respondents provided anecdotal references to particular 'cases' and detail of the circumstances of the women's lives that were not thought to be relevant to the aim of the research. The objectives of the study were used as a reference point during the reading process for deciding which sections of text should be coded and which could be set aside. 'Set aside' data was however revisited several times during the analysis as new lines of enquiry arose, just to ensure nothing relevant had been missed. Notes were kept of ideas and observations throughout the process using the memo function of NVivo. These included any tensions or inconsistencies across the accounts, as well as similarities.

### **4.12.5 Developing themes**

Themes are units of analysis (Braun & Clarke, 2006). Initially, to aid the process of developing themes a graphic representation or 'mind-map' was created which grouped nodes into categories, or themes (Appendix L). Some sub-themes were created where the specific aspects of a theme were captured. Appendices K and L also provide evidence of how a critical realist methodology was broadly applied to the Braun & Clarke's data

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<sup>13</sup> NVivo 10 is commercial software used to organise unstructured research or project information. A 'node' is a collection of references about a specific issue

analysis framework. For example, the coding process identified the initial 'empirical' findings, followed by a process of theoretical redescription or 'abduction' in which empirical data are re-described using theoretical concepts (Danermark et al., 2002).

Several iterations were undertaken in order to identify eventual overarching themes and subthemes that truly represented the main concepts that arose from studying the data patterns. As each new theme was identified previous transcripts were re-examined for relevant material. Many units of text were used in several categories where they were felt to be relevant to more than one element of the study aim and objectives. Care was taken as the data were grouped and coded to consider why I was choosing to group them that way.

One of the factors that determined which themes were chosen and others eventually left out was ensuring that the data related to issues specific to, or predominantly relating to Pakistani women experiencing abuse, as opposed to women in general. For example, a major dynamic in how health visitors said they feel equipped to support women living with violence is by participating in Clinical Supervision. Supervision was therefore initially considered a key theme. This was subsequently removed however as on further reading of the transcripts, it became apparent that this factor was not unique to work with Pakistani women and would not ultimately inform understanding of how health visitors work specifically with Pakistani mothers.

Braun and Clarke state that the "keyness" of a theme is not necessarily dependent on its prevalence but can be determined by its relevance to the research question or by the researcher's judgement (Braun & Clarke, 2006, p.82). Further reflection on initial "noticings" (Braun & Clarke, 2013, p. 205) suggested however that at that point I was perhaps applying a 'clinical' perspective to the way that I had, thus far, read and interpreted the data, and that could be limiting what I was seeing. For example I initially looked for sub-themes that encapsulated causal links or contributory factors - almost as if I were 'diagnosing' the issues. Further reading about thematic analysis allowed me to be more conceptual in my approach and allow the data to speak for themselves.

Whilst the benefit of coming to data with prior knowledge and existing theory means that the researcher is able to get to both the meaning *and logic* underpinning the data responses (Braun & Clarke, 2013); Malterud (2001) cautions investigators undertaking qualitative data analysis not to confuse knowledge present in advance with knowledge gained from the inquiry of systematically obtained material. Consequently I revisited the nodes and tried to critically think about what the data was actually meaning and eventually three distinctive themes were decided upon. Each had a central organising concept that was linked to several sub-themes.

#### **4.12.6 Analysing and interpreting patterns across the data**

This phase was initially about defining the essence of each theme. Braun and Clarke describe this as deep analytic interpretive work involving crucial moulding of the analysis into its "fine grained detail" (Braun & Clarke, 2013, p. 248). The themes were then considered in terms of how they worked together in order to get a rich thematic description of the entire data set.

In practice this involved writing the story of the data linked to each theme, matching this with extractions of data from the transcripts and stating what was interesting or important about each. Themes were linked where such connections became apparent and broader meanings and their implications were considered. The analysis was therefore both descriptive and interpretative. Whilst the analysis was data led, in order to assist the interpretation of the data, relevant scholarly literature relating to each theme or sub-theme was used to further develop my understanding of the meaning and significance of what the research participants were saying and thus I believe allow for even deeper analysis. Convergence and deviation from extant theory and literature and locating the analysis in relation to what already exists is discussed in detail in Chapter 6.

#### **4.13 Methodological challenges to ensuring rigour**

One of the criticisms of qualitative research is that analyses do not generate anything meaningful because there is an absence of fact (Malterud, 2001) and that it is subjective. The aim and objectives of this study however are largely based on the concept of perception, and perception is largely how an individual views the world and its parts and how they think about different phenomena and experiences (Munhall, 2012). When using the concept of perception within research therefore, one would expect no single or right answer to emerge. There are no claims within this study therefore to tell the only or absolute truth. The findings are not intended to be thought of as facts applicable to the population at large, but rather as notions or theories applicable within a specific setting. It is therefore anticipated and considered acceptable (Munhall, 2012) that there more than one possible interpretation exists within any given context. This does not imply however that the application of rigour is not possible, or that research underpinned by a critical realist philosophy lacks reliability or truthfulness. Indeed validity is achieved by providing a firm and coherent philosophical foundation on which to make methodological choices and establish candid claims. One of the underlying principles being that realist researchers are 'value-aware' in that they accept there is a real world to be discover even if it is imperfectly and probabilistically apprehensible (Healy & Perry, 2000).

One of the ways that quality has been assured within the study was through the process of reflexivity. This meant ongoing questioning of process, findings and interpretations, and thinking about the *effect* of context and bias as opposed to attempting to eliminate them from the process. This includes recognising that the setting and the professional roles and relationships of me as the researcher and the participants within the research setting may have altered the conduct of the research, even if that impact was not apparent at the time. This acknowledgement however is not an indication that these factors negatively impacted on the quality of the study, instead my active personal engagement with the participants and the phenomena was purposefully intended to contribute towards, and allow the generation of, rich and useful data.

Other methodological challenges found within this particular study have been highlighted elsewhere by Liamputtong (2007) and Dickinson-Swift, James, and Liamputtong (2008) and are linked to conducting what might be seen as sensitive research. Some, e.g. Patton (1990) see interviews as interventions because, though this is not the primary objective, they affect people. Indeed certain issues did become apparent during the interview process of this study that were associated with what appeared to be some participants' need to 'off-load' details of difficult clinical encounters with abused women. These events have been recorded in the reflexive diary and were I believe dealt with appropriately at the time. Thoughts and feelings expressed by the participant were however felt to be important data as they provided a unique insight into how some situations are perceived by the health visitors so were included in a category (NVivo node) later named as 'feelings'. This is also a further example of how the presence of the researcher can impact on the outcome. Lastly, Yardley's framework (Yardley, 2000) for assessing quality in qualitative research and the Braun and Clarke 15 point checklist of criteria for good thematic analysis (Braun & Clarke, 2006) were used to ensure rigour and quality had been adhered to throughout both the data collection and data analysis processes.

*Table 2 Quality assurance checklist*

<b>Braun &amp; Clarke</b>	<b>Yardley's essential qualities</b>	<b>Self-assessment</b>
Data transcribed to appropriate level of detail, transcript checked against tapes for accuracy	Commitment and rigour	Complies with Braun & Clarke's levels of acceptability
Each data item given equal attention in coding process	Commitment and rigour	Several readings undertaken and ongoing checks made
Themes not generated from a few vivid examples, instead the coding process is thorough,	Impact and importance	Wide range of examples used. No data extracts used more than once



inclusive, comprehensive		
All relevant extracts for each theme collated	Impact and importance	Most relevant selected
Themes checked against each other and back to the original data set	Commitment and rigour	Ongoing checks and improvements carried out
Themes are internally coherent, consistent, distinctive	Sensitivity to context	Distinctive themes however links are also made across themes where this applies
Data analysed & interpreted, made sense of not just paraphrased/described	Sensitivity to context	Good level of interpretation and analysis which continues into the discussion chapter
Analysis and data match each other, extracts illustrate the analytic claims	Sensitivity to context	Good match of data extracts with the analysis (interpretive <i>and</i> descriptive)
Analysis tells a convincing and well-organized story	Impact and importance	Themes well linked. Tells a compelling story about the data
Good balance between analytic narrative and illustrative extracts	Sensitivity to context	Good match of data extracts with the analysis (interpretive <i>and</i> descriptive)
Enough time allocated to complete all phases of the analysis	Commitment and rigour	Completed well within required timescales
Assumptions about, and specific approach to, thematic analysis clearly explicated	Sensitivity to context/transparency and coherence	Assumptions stated from the onset, tested out throughout. Methods described in detail
Good fit between claims about process, and what was done	Transparency and coherence	Outcomes meets stated aim and objectives
Language and concepts used in report consistent with epistemological position	Sensitivity to context	Epistemologically consistent throughout
Researcher is positioned as active in the research process	Transparency and coherence	Evidenced in reflexive diary

# Chapter 5 Research Findings

## 5.1 Introduction

This chapter presents the findings from the data analysis and illustrates how they address the aim and objectives of the research. The approach is interpretive, inductive and data led. Below, the themes and sub-themes are first summarised in Table 3, then described and defined in accordance with the meanings attached to them. Though each theme has a clear focus and scope the narrative reveals how many of the themes are related and linked. Convergence and deviation from extant theory and literature is discussed in Chapter 6.

Table 3 Overarching themes and sub-themes

<b>Presence</b> <ul style="list-style-type: none"><li>• Building trusting relationships</li><li>• Repeated enquiry</li><li>• Intuitive practice</li><li>• Watchful waiting</li></ul>
<b>Role strain</b> <ul style="list-style-type: none"><li>• Feeling ill-equipped</li><li>• Diminishing autonomy</li><li>• Role ambiguity</li><li>• Moral distress</li></ul>
<b>Covert actions</b> <ul style="list-style-type: none"><li>• Elephant in the Room</li><li>• Contrived intervention</li><li>• Surveillance</li></ul>

## 5.2 Presence

The term *Presence* is used to capture the way health visitors talked about “*seeing*” and “*being with*” a woman. Maintaining proximity to women they perceive to be experiencing violence or abuse was described by research participants in terms of an important intervention linked by them to keeping women safe. Many of those interviewed referred

to these interventions colloquially as “*follow-up visits*”. Their comments however suggest that although considered by the health visitors to be of value, these are contacts with often no specific stated or measurable outcome. In other words, the rationale behind the encounter is sometimes founded on the ‘feelings’ or the judgement of the health visitor rather than based on their scheduled programme<sup>14</sup>.

Though *Presence* was sometimes described by respondents in terms of “*seeing*” or “*being with*” the women in situations other than the home, for instance in clinic or at a Children’s Centre, many health visitors implied that them maintaining a physical *Presence* in the home by repeated visiting is key to helping keep the woman safe, or helping her feel safer - for example:

*We’ve provided a safety net there because we’re all aware of what’s happening and we’re going in. (Vivian)*

In the following extract Rachel speaks of a woman abused for many years by her mother-in-law and the impact being seen by health professionals appeared to have:

*She was locked in the bedroom, no clothes, told what to do. It wasn’t until she fell pregnant that we had more to do with her, she was seen more, and you’ve got professionals entering the home - so suddenly, she had a property and she actually moved in with the husband into the property. When she was in the house with the mother-in-law, she had nothing.*

These comments suggest that the *Presence* of the health visitor in the household positively impacted on how the woman was treated by her mother-in-law thus lessening the extent of her abuse. In other words the woman had become ‘visible’. Eve described the function of the follow-up visit in the home in terms of “*checking*” the women to see if she is safe:

*We follow up to see whether mums<sup>15</sup> want anything more, want any more support. So I would go on the visit and just check that mum feels safe, if she’s feeling safe in the home.*

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<sup>14</sup> At the time the health visitor interviews took place the service was working towards the DH (2009) Healthy Child Programme

<sup>15</sup> In many of these extract health visitors are referring to the woman as ‘mother’ or ‘mum’. Similarly the males in the household are frequently called ‘dad’

Dora's account suggested she views these encounters as "*time to discuss how she [the woman] is feeling and to make her feel safe*". For Eve and Dora giving the woman 'time' appeared to be an important feature of *Presence*, and time was described by them and other participants in terms of being an investment of themselves aimed at helping the women feel safe enough to speak out. Vivian for example: "*I think it helped her just knowing we were coming, that she could talk to us, and little bits were coming out each time*".

Below, Bev tells how she feels that continued home visiting is the only thing that she can do until a woman is ready to disclose the violence, but her comment suggests this rarely happens. By repeated visiting Bev hopes women will begin to feel safe with her, but the comment suggests the woman would have to be "*fearful for her life*" before she would ask for help:

*You know the most I feel that I've been able to do is continue going back just to make sure they're OK really and say "look you know we've not forgotten about you" [...] Sometimes it only takes 5 or 10 minutes just to pop in and say "how are you doing?" I think somebody gets to know you that way, and will only get to know you that way, so if things did get bad and you happen to come that day, she might say "actually it's come to the point when I'm really fearful for my life and I really want to do something about it now".*

From these accounts it appears that "*seeing*" and "*being with*" the woman are actually complex activities with many components, all aimed at helping keep the woman safe, or enabling her to feel safe enough to disclose the abuse. *Presence* therefore has been divided into several sub-themes for further analysis.

### **5.2.1 Building trusting relationships**

The data suggest that health visitors perceive by maintaining proximity to a woman a trusting affiliation can be developed which can be key to bringing about disclosure. The inference however is very much on "*building*" the relationship suggesting it is an active process requiring time and personal investment. Bev's comment above implies she feels that by "*popping in*" to the home frequently, the woman will begin to connect with her and eventually feel confident enough to disclose the violence. She describes it as the "*only way*" a woman will get to know her well enough.

When speaking about the importance of *Building Trusting Relationships* with Pakistani women experiencing domestic abuse, health visitors frequently described the activities required in terms of “*providing support*” and “*building rapport*”:

*I think it's about building up that supportive relationship so that women feel that you're a person they can disclose to. Making them aware that there are agencies out there that may be able to support them, and support them into those agencies [...] it's about building up that rapport and just being available to listen.*  
(Laura)

*It's having a trusted adult that you know can possibly help you and who's not going to go straight to Social Services or back to your family or kick up a fuss. It's got to be managed. I think it's somebody they can trust, someone to listen, that is non-judgemental, [provides] a non-knee jerk reaction.* (Carol)

Carol went on to describe the support she would offer in terms of “*walking every step of the way*” with the woman. These two extracts above however hint at a dilemma that is further explored later in this analysis, that of health visitors balancing the support that external agencies can offer the woman with the risk of jeopardising their relationship with her once other agencies are involved. Dora however, in the extract below, whilst acknowledging the value of being able to offer “*safe support*”, warns of not creating a dependency and speaks of the necessity of building an “*honest relationship*”:

*You are in a position to hopefully offer that support and give them a feeling that it is safe support, that they would be able to open up to you [...]. There are some that, if you've been very supportive, maybe built up that dependency on you, and maybe then their expectations are not realistic as how far they can take that relationship because they've come to trust you so much that maybe they want more, but I suppose that's about being honest in that relationship and say, and signpost them to other supportive agencies that can continue or extend that support.*

When working with Pakistani women, especially those who speak little or no English, the data suggest that the role of the community interpreter is particularly important in helping build relationships and gain trust between health visitor and client. Many health visitors interviewed appear to view the interpreter as an integral part of these practices - as opposed to simply a means of aiding communication. Again, gaining the trust of the victim however seems a vital component of the process. For example:

*Where somebody is disclosing a lot of emotional information and you're actually asking fairly in depth - I don't want to say prying, but to get the full assessment it takes some skills, so I've got to trust the interpreter and that person has also got to trust that interpreter. (Nola)*

*I actually find this particular interpreter very good to work with and very supportive, and the families actually do trust her [...] It might be something afterwards - she may say to me "did you notice this?" or "did you notice that?" (Dora)*

*They [interpreters] seem to be able to build up trust [...] Most of the ones I've worked with I think have been very good really and they're prepared to talk about things before and after the visit and explain things to you that perhaps you didn't always understand yourself. We were working almost like conjoined twins really in terms of they would anticipate what I was going to say. (Josie)*

In all of these extracts the interpreter is described as playing a key part in interventions aimed at keeping women safe. *Building Trusting Relationships* appears an important feature in this process and includes both the health visitor and the woman trusting the interpreter. This notion is noteworthy in terms of *Presence* because of the perceived enabling and facilitating function the interpreter seems to fulfil, which the comments suggest can be much greater than just assisting dialogue and often extend beyond the actual encounter with the woman. Not all those interviewed were of the same opinion however, some health visitors considered the interpreter's presence to be a barrier, because, as Eve described, "you're speaking through a triangle". Other respondents appeared to perceive that the success of the encounter is often dependent on how the woman views the presence of the interpreter, again referring to trust as being a key factor. "I think it's about trust, it's about their [the women] feeling that they think this person may gossip about them" said Dora implying that at times the woman may fear the interpreter will discuss her issues with the wider community. Rather than enabling disclosure therefore, this would be an inhibiting factor during the visit.

### **5.2.2 Repeated enquiry**

Disclosure of domestic violence has hitherto been shown to require proximity and a trusting relationship between practitioner and victim and each of the sub-themes described thus far have been activities requiring time and repeated access to the woman. The data suggests that another significant factor is the notion of *Repeated*

*Enquiry* which here means asking recurrent direct questions to women about domestic violence. During the interviews health visitors frequently referred to this process as “*asking the question*”, as demonstrated in some of the following extracts:

*We are supposed to ask the question - "do you feel safe at home?" and "are there any problems with your partner or anybody else in the family who makes you feel under threat or controls you", but it is a difficult thing to ask. I won't pretend we always do ask it. (Josie)*

Eve and Rachel recount their experiences of attempting *Repeated Enquiry*:

*I think you're very rarely going to get a disclosure then and there but I think it just creaks open that door a little bit so that they know that you've got an interest in the mum as well, because I think they might feel sometimes we're very baby focused [...] I've never had anyone turn around and say 'yes'. But I've always asked the question. (Eve)*

*I say to them that I am very aware that you potentially wouldn't tell me, and it might take a few times, and I will repeat this question on more than one occasion, and this lady [...] towards the end she said "can I tell you something?" So she obviously realised that, because it was asked more than once were actually interested in it. (Rachel)*

We have seen how the data imply that for many Pakistani women experiencing abuse, there has to be some kind of trusting relationship in place between client and practitioner before a candid response can be given. Repeated access to the woman and *repeated* enquiry seem also to be considered important factors in encouraging disclosure. There is a suggestion however from the extracts above that not all health visitors feel comfortable asking about domestic abuse in Pakistani households, even those with over twenty years' experience in the role. “*It's a difficult thing to ask*” said Josie, and Ruth admitted “*it does feel uncomfortable sometimes*”. Notwithstanding, most of those interviewed stated that they feel enquiry about domestic abuse is a central part of routine assessment in health visiting “*I try and broach it at nearly every visit [...] so they're aware*” (Ruth). Pamela felt that routine enquiry is not just asking the question, but, as she put it, “*it's that art of asking skilful questions*”, in other words the way the question is asked is considered important.

The extracts above suggest however that disclosure takes time or may never happen. In the case of Eve, no-one has ever answered ‘yes’ to her direct questioning. Significantly,

health visitors appear to feel that asking the question is therefore as important in some ways as the answer, or that the process is of equal value to the outcome in that it raises awareness – “*I think once you start to do an assessment and a [screening] tool with somebody it actually highlights [to them] what’s going on?*” (Carol), “*Just having that gentle introduction to the concept is just as valuable as doing your assessment*” (Pamela). Introducing “*the concept*” to the woman and “*highlighting what’s going on*” both imply that the woman may at that point be unaware that her situation is considered by the health visitors to be abusive.

Many respondents spoke about how, when visiting Pakistani households, they often sense the issue of domestic abuse even if it is denied. This notion was described by them in many ways - sometimes as “*gut feeling*” or as a “*sixth sense*” or getting a “*niggle*” about a situation. The phenomenon is defined here as *Intuitive Practice*.

### **5.2.3 Intuitive Practice**

The sub-theme *Intuitive Practice* is used to capture those components of *Presence* described by the respondents that are associated with feelings, judgement and personal knowledge. Analysis of the data infers that *Intuitive Practice* is considered a key tool of clinical practice by many of the health visitors, however at the same time is also associated with a sense of caution because it is more associated with “*feelings*” as opposed to “*scientific*” evidence. In the extracts below however health visitors describe how they use *Intuitive Practice* in the context of Pakistani women who fail to disclose they are experiencing abuse:

*Sometimes it is nothing that’s obvious but [pause] you have this gut feeling, you can see the dynamics in the family, it’s just a feeling of uneasiness [...]*  
*Sometimes that instinct gets stronger, and you know you’re right.* (Laura)

*Sometimes you don’t have any evidence to suggest that there is any domestic violence within that family, but you have a gut feeling and you can see the dynamics, you may not have a conversation but you might see the dynamics within the family, and in your own mind you have a feeling that, I think something’s happening here, I’m not sure what but I feel that I need to go back in to see that woman again.* (Dora)

*I usually say to students that it’s looking at the obvious and the unseen stuff as well, and it’s looking at, does it marry up? Do you have any niggling thoughts? And I think that we probably don’t always have evidence as to why we’ve got*



*these niggles, but to me, if you've got a niggle, then that's enough for me to think I need to go back to see that family and that's usually what I tell the students. (Jill)*

The data suggest that the health visitors appear to trust their intuition and claim it is often validated "*There is this gut feeling and those gut feelings a lot of times are right*" (Rachel). The comments above by Dora and Jill however imply they do not consider intuition to be legitimate evidence, inferring they believe gut feeling may not be recognised as a justifiable rationale for carrying out an intervention. Despite this, they seem to follow their instincts, and Jill, a Practice Teacher, imparts the value of following up on gut feeling, to her student. Cathy describes how she sometimes feel conflicted by her instincts about a situation and what she feels is her professional requirement to use more scientific methods of assessment:

*But then all the while it is that balance between what you feel and what you can see is going on against that evidence base, isn't it? What do you do? I don't know.*

Eve expresses similar anxieties:

*We are a professional evidence based body aren't we that uses assessment tools. But that family, like I said, my instinct would be there is domestic violence. She displays all the signs, but then she's saying there's no domestic violence. And your gut instinct would be to keep visiting, keep going.*

Eve's trust in her gut instinct appears so strong it convinces her she should "*keep visiting, keep going*". Jill and Dora also talk about the need to "*go back*" and see the woman. Their comments suggest that following up on gut feeling is not just *Repeated Enquiry*, but also repeated "*seeing*", or "*watching*". All these actions appear those components of *Presence* executed in situations where other interventions would be unviable or inappropriate because of non-disclosure.

#### **5.2.4 Watchful Waiting**

Some health visitors spoke of the concept of "*watchful waiting*" or talked of "*monitoring the situation*" when speaking specifically about circumstances where disclosure of abuse is inhibited. The terms appear to be used to mean that although no immediate action is being taken regarding the course of events, health visitors are following developments

intently. *Watchful Waiting* is therefore used as a sub-theme of *Presence* to include the acts of “listening” and “observing”. For example:

*We have to just accept – go with face value, roll with what the client is telling us and then just observe and wait. Because in my experience something further down the line will come to light that will validate what your concerns have been. It’s watchful waiting. (Pamela)*

Listening and watching appear to be considered key health visiting competencies “*I think a big skill in health visiting is listening, listening and watching*” (Rachel), “*I always teach my students to use, almost like 360° vision. Just watch what is going on*” (Bev). They also seem to be deemed important components in providing support to women felt to be at risk in abusive or violent households. The data so far has suggest these are considered actions carried out purposefully. Eve however in the extract below, seems to be suggesting that listening and waiting can also be *passive* activities carried out in the absence of knowing what else to do.

*I say [to the victim] “well I can do some listening visits, but then if you don’t want to take it any further, this is how to get in contact with us”. Then it is the sitting and waiting isn’t it?” [...] “You’d continue to support the mum just through these listening visits. If she wanted any specific work around domestic violence I don’t feel like I [pause] you can listen can’t you - but I wouldn’t feel tooled up enough to know how to move anything forward, it would just be a listening capacity.*

The notion of *Watchful Waiting* also links closely to that of *Intuitive Practice* in that it allows for “*that intuitive sense to pick up that something’s wrong*” (Pamela).

Thus far, the theme of *Presence* and its sub-themes have been used to reflect how health visitors described using more aesthetic or personal abilities and competencies on which to base their actions in this area of practice. The data suggest how they perceive skills such as listening, watching and waiting can contribute towards making women feel safer and sometimes lead to disclosure. *Presence* has also been shown to require more active elements however which include building trusting relationships and *Repeated Enquiry*. The concept of *Intuitive Practice* seems to underpin *Presence*, however is perceived by the health visitors both as a tool and an area of professional concern or anxiety. This apparent anxiety is encapsulated and analysed further under the theme of *Role Strain*.

### **5.3 Role Strain**

Whilst the concept of *Presence* has been used to encompass the personal and relational elements of health visiting practice, the data suggests that this is sometimes at odds with some of the more goal orientated and task focused discourses around the role of the health visitor. The term *Role Strain* is therefore used to describe how health visitors often expressed difficulty in fulfilling the various demands and expectations of, and conflicts within the role, and the impact this appears to have on their endeavours to keep Pakistani women safe. The data intimates that some of the demands health visitors describe are placed upon them by managers or the 'system' they are working within. Other difficulties appear to be lack of what they perceive to be relevant knowledge, lack of clarity about the remit of their role or moral pressures associated with their responsibilities.

The data suggest that the consequences of *Role Strain* for many health visitors interviewed can be frequent feelings of professional concern or worry, and for many reflect a sense of vulnerability.

#### **5.3.1 Feeling ill-equipped**

The concept of *Feeling ill-equipped* is used to describe how several health visitors described having a lack of knowledge in this specific area of practice. The concept of not knowing what to do in certain situations was reiterated many times with comments such as:

*I still, when I go in [to the house] feel a bit, oh I don't know, I don't know really how to handle it. I have that feeling when I'm driving to those [Pakistani households] visits thinking, well how are we going to approach this? (Eve)*

*The actual academic training is quite removed from practice, so practice was again very different, and during the training it was hard to understand where the training fit in with practice [...]. The current guidance doesn't equip you as well as, maybe an older perspective on doing the job. (Cathy)*

The data suggest that whilst guidance and formal training on domestic violence are available to health visitors, these do not always translate usefully to interventions with Pakistani women. Whilst this notion was not reflected in all accounts, there was a strong indication that many of those interviewed perceive themselves to be 'out of their depth' working with this population group. Analysis of the health visitors' comments show how

they feel knowledge is acquired over time (what Cathy, above, refers to as gaining an “older perspective”), and how health visitors draw from different sources of knowledge. Here, Laura talks about how direction and support can come from more experienced colleagues:

*I suppose it's just building up that knowledge [...] because we've got a new health visitor in the team and she hasn't worked with south Asians before so it's all completely new for her. So, on her behalf we will have those discussions if she's been on a visit and she'll say "oh this happened. Is that normal in these households?"*

The extracts below seem to support the suggestion that much of the knowledge in this area of practice comes from experience as opposed to accepted disciplinary knowledge or theory based guidance.

*Regarding the assessments, you get more experience the more that you do them, the questions get easier to ask. I would say that even with experience it's still an area that we need to learn more about. (Nola)*

*To be honest I've not really used a policy to work with. I've just kind of, rightly or wrongly, gone through my own experiences, my own research into it all, and found the best way for me to approach it. (Jill)*

Ruth who has been qualified over 20 years goes so far as to say it is life events that have made her a better health visitor:

*Looking back I think that – I hope this is true – that I am a much better health visitor now than when I was first qualified. It wasn't my fault in a way, you know I was only [newly qualified] I didn't have the experience. I didn't have the life experience you know when I am looking back now.*

The inference in these extracts is that experiential knowledge takes time to develop and more newly qualified health visitors are therefore particularly vulnerable - “they are not prepared for when they go out into practice” said Rachel. Jill, a health visitor qualified less than five years draws on her own life experience to inform her practice. In the extract below Vanessa talks about the skills she feels newly qualified health visitors require and questions how you teach a skill like intuition.

*I think it's [gained by] sort of experience, it's the communication skills that they need to develop. To be picking up on the body language and that wider viewpoint of everything and keeping your eyes and ears open. I think a lot of it is intuition, which you can't teach.*

When asked where intuitive knowledge *does* come from, most health visitors responded "experience". More specifically Ruth said "with the wiseness of age, the wisdom of being". Cathy felt intuition is part of someone's "personality", and Laura stated "it's a nurse thing isn't it?" In many of these extracts the health visitors appear to perceive that the knowledge they seem to value most comes from experience. This experience is sometimes described in terms of years in the role, and at other times the word 'experience' relates to life events.

In the next section, under the theme of *Diminishing Autonomy* we see how *Role Strain* is compounded when the health visitors feel unable to act on their gut feeling and use their experience to direct their practice.

### **5.3.2 Diminishing Autonomy**

Having articulated and described what most health visitors felt to be the clinical value of *Presence* and its defining attributes in helping keep Pakistani women safe, several of those interviewed expressed how *not* being able to offer sufficient home visits causes them concern. Time, seen as a key factor of *Presence* was not considered by many of the health visitors interviewed as currently flexible or negotiable enough to meet the conflicting demands on their role. Their accounts refer to organisational structures that they perceive limit their ability to support women in the way they would consider clinically effective. *Diminishing Autonomy* is therefore a further sub-theme of *Role Strain*, and the term is used to portray the way the health visitors described not being able to act in accordance with their knowledge and professional judgement.

In the following extract Bev speaks of conflicting priorities for her time, and how that causes her concern:

*I would find it very difficult – given what you have to do in a day, and that's not just me, we're all the same – to say "hold on I'll put everything on hold and I'll come and see you straight away" If we had a queue waiting I would have gone "yes, yes, yes" to that mum and not be able to give her the amount of time that she needed to enable her to disclose.*

In the next extracts it appears however that a key issue causing tension appears to be not just lack of time, but the health visitors' lack of autonomy on how they are able to prioritise their available time:

*You feel like you're in a bit of a dilemma because you want to offer that support, you want to go back in to see that family but yet there are constraints made on you and somebody else is questioning your professional decision [...]. Sometimes it is nothing that's obvious - but you have this gut feeling [...] In the early days when I first started health visiting, we were offering a lot more contacts and I would say that I was approached by a lot of the women, mainly because they had come to know me and trust me and see me at clinics and at different health centres. But now because it is so prescriptive, we're not seeing them as much so I don't think you can build that relationship up, you haven't got the capacity to be able to do that because of the restrictions. (Dora)*

*The way this new Healthy Child Programme is structured, I think it's counterproductive because we have got to see the woman before the baby's 14 days old, we do that contact, we then see them in another 8, 9, 10 weeks. There's no chance to build up any sort of rapport or relationship. (Bev)*

*You've got those mums where you think, gut feeling that there's domestic violence, where you might have historically just gone and kept that eye and you can't do that now because you have to evidence that you're doing a piece of work. [...] In an ideal world I'd love to go out and do support visits, but I don't think that's what we're commissioned to do [...]. It's become more of a tick box all the time. I think everything's becoming more of a tick box and you have to evidence it, well you can't evidence your gut. (Eve)*

The frustrations voiced by the health visitors appear to be linked to changes (or "restrictions" according to Dora) they perceive as being imposed upon them. The extracts suggest they feel increasingly less able to spend time in building relationships, "keep an eye" on women at risk (Eve) or invest in gaining trust. "With so few contacts, somebody would have to be pretty desperate to pick up the phone to speak to somebody who they didn't know very well" stated Pamela.

The outcome for Pakistani women, Bev intimates, can be non-disclosure. This sub-theme links strongly to *Intuitive Practice* because *Diminishing Autonomy* often appears associated with health visitors feeling not able to follow their instincts – "you can't evidence your gut" (Eve). Eve's further comment above is particularly revealing as it

suggests that she feels “*keeping an eye on*” (which might also be called *Watchful Waiting* - an activity already shown to be valued by health visitors), is no longer considered as “*work*” or a legitimate clinical intervention. The data infer that the organisational structures which the health visitors feel limit their autonomy to choose more pertinent interventions, are seen by them as also limiting their clinical effectiveness with this population group. A key part of this seems to be the subsequent limitations on their ability to build relationships with Pakistani mothers.

### **5.3.3 Role Ambiguity**

*Role Ambiguity* refers to the range of views and perceptions the health visitors expressed with reference to the boundaries of their role with women experiencing violence and abuse. Comments at times suggest an inconsistency of approach and differing perceptions about how the competing and conflicting aspects of the role should be addressed. *Role Ambiguity* appears an important aspect of *Role Strain* as it helps illuminate why the health visitors at times appear challenged in meeting the requirements of their role and why there seems no consensus on what optimum care for Pakistani women might look like.

When asked to describe their remit and responsibilities towards this population group, a wide range of responses were elicited from the health visitors interviewed. Pamela commented “*I don’t think we can say we’ve got one consistent approach with domestic violence. We should have*”. The most common features of the role noted from the data were “*raising awareness*”, “*support*” and “*referral*” or “*signposting*” however the nature of and extent of the support they thought should be provided divided the respondents.

Bev seemed to feel that because the health visiting service is now target driven “*CQUIN targets<sup>16</sup> drive everything*”, the role is about screening and referral with limited opportunity to support the women any further. Here she goes on to say:

*From my point of view we’re really just a referral agency which is sad because we’ve got much more skills and experience than just that, and we’re probably in a better position to support individuals than a social worker.*

Eve said she felt that support includes making herself “*accessible*” to women, and being led by their expressed needs: “*I’d always go and see what she wants then follow it up*”. Laura viewed support as working with the woman to help her feel “*empowered*” and “*powerful within the situation*”. Josie and Dora described ways they would work with the

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<sup>16</sup> Commissioning for Quality and Innovation payments framework

woman by providing more practical support "another girl who I worked with, she brought in various papers and photographs and a passport and asked me to lock them in a drawer at work" (Josie). Dora goes on to state she would:

*Make her [victim] feel safe so she's got measures she can take should she be in a dangerous situation like contacting the Police and she's got some contact numbers [...] if she does decide that she needs to flee to safety. That she has her passport, she puts things together that she can just quickly get out of that situation and then about her knowing how to contact myself and other agencies.*

The data also suggest however that a major matter of concern in this area of work is safeguarding children. Health visitors described how difficult it can feel for them balancing the perceived needs of the woman and her expressed wishes to remain in the household, with their own statutory duties to protect children. The dilemma they describe facing appears to focus on potentially losing the trust of the woman if a referral to social services is made, and the consequence of that broken relationship in terms of further harm she might suffer.

*It's about protecting the children versus keeping that woman feeling comfortable and trusting in the relationship [with the health visitor]. It's so difficult, you're so torn, in a way. "Maybe I should've stayed a bit longer. Maybe I should've given her chance to talk a bit more, gone back again". But if anything had happened [to the child] in that time and I hadn't [referred], [pause] It's very difficult. (Ruth)*

Ruth, in her account above of deciding to refer a child to social services describes the complexities health visitors encounter when attempting to support the woman by maintaining the practitioner/client relationship and at the same time safeguarding any children. For her it appears a fine balance. Jill however views supporting the woman as a means of protecting the child, however admits that it's a "difficult" area of practice:

*I think you've got to make it clear that when you ask questions, and this is why it's so difficult, because you tell them you might have to discuss with other services, you know Social Services, if it indicates there is a risk to family and children, but then they might not answer the questions fully [...]. It's difficult sometimes if mum's said that they want to stay [with the abuser]. It's just trying to work with them to make sure children are safe. Ultimately that's our responsibility and if we feel that they're not making sure these children are safe then we have an obligation to do something. So it is a difficult one that.*



It is interesting to note that whilst there was a lack of consensus on the exact nature of the health visitors' role with women experiencing abuse, none of the respondents suggested that it was their job to encourage women to separate themselves from the abuser. Whilst a variety of perspectives were expressed on the nature and extent of the support they might offer, in totality the comments suggest that with regards to Pakistani women the most common approach taken by the health visitors is harm minimisation - "we find ways of minimising what is happening" (Rachel). In other words health visitors take a range of measures designed to reduce the harmful consequences of the situation because they are frequently unable to prevent those behaviours that contribute to causing harm. It seems that despite the apparent ambiguities of the role there is a strong desire among most of the health visitors to reduce risk. The inconsistency seen appears to be more associated with how risk is identified and prioritised and in the way the mitigation of the risk is executed.

### **5.3.4 Moral Distress**

The health visitors' perception of being unable to provide what they believe to be optimal care to Pakistani women experiencing violence and abuse has been alluded to several times in this analysis. Thus far it is the impact of external factors that has been shown to be the major contributor to these views, for example systems and managerial matters and perceived lack of autonomy. Further issues however emerged from the data which appear more associated with health visitors struggling to find acceptable solutions to certain ethical dilemmas they face. This notion is described here as *Moral Distress*.

The term *Moral Distress* is employed as a sub-theme of *Role Strain* to illustrate how health visitors express fear that their own, or others' intervention with Pakistani women experiencing abuse may inadvertently cause or contribute towards further harm. *Moral Distress* is considered an aspect of *Role Strain* as it demonstrates another perceived challenge that the health visitors face in their efforts to fully execute their responsibilities with this population group. For example:

*You have that feeling in the back of your mind, "Oh gosh, I hope I don't make trouble here [...] I hope I don't make it worse, cause more upset". Because obviously I know when couples are splitting up that is when they are most at risk of being hurt, killed, especially with things like honour violence, and that really scares me. It's like I'm upsetting an apple cart and I might be causing more trouble than helping. (Ruth)*

The paradox the following extract seems to reveal is that although *Presence* is felt by

health visitors to be a key factor in helping keep women safe, it might also, under certain circumstances, contribute to further harm.

*It's about how to keep that contact without arousing suspicions which then hopefully protects them [victims] from harm, well more than that I hope it doesn't make things worse for them. (Nola)*

Some health visitors suggested that the involvement of other professionals may occasionally make the situation unsafe for a Pakistani woman experiencing domestic violence: "They (GPs) can make it a heck of a lot worse" (Dora), "social services going in might just make it a whole lot worse" (Vivian).

*One of the GPs that I worked with in the area, I found quite difficult. Sometimes this GP was supportive, other times it felt that he didn't have a role, and then other times would say things to the extended family which shouldn't have been said. I think maybe just not understanding the dynamics of what can happen in these families. (Dora)*

*The GP's response was "I'll speak to them both together", and this is where I thought this possibly could've made things worse. He did speak to them both together and basically that's when they [the family] closed ranks. She [victim] went back home [...] the domestic abuse was out in the open because the GP had got involved. (Vivian)*

The extracts above give some indication of the ethical dilemmas health visitors sometimes perceive themselves to be facing. Choosing the wrong intervention or approach, some respondents have suggested, could have a negative outcome and put the woman more at risk "they [family] close ranks a lot and you could do more harm than good" (Vivian). This notion includes referral to the GP and/or social services. The specific issue here however is that there appear situations when health visitors perceive they have no option but to work in a uni-professional manner, as to do otherwise might incur more danger for the woman. This concept also links to the subtheme of *Feeling ill-equipped* in that it reflects the way health visitors describe struggling to find effective yet safe ways of supporting women.

#### **5.4 Covert Actions**

The term *Covert Actions* is used as an overarching theme to encompass a range of hidden or concealed activities the data suggest as being connected to health visitors'

encounters with Pakistani women experiencing abuse. These activities appear to be motivated in part by some of the challenges previously described under the theme of *Role Strain*, for example health visitors talk about fabricating 'legitimate' reasons to see or be with (i.e. maintain *Presence*) women in response to their perceived *Diminishing Autonomy*. Other *Covert Actions* appear to occur in direct response to the seemingly hidden or taboo nature of domestic violence within Pakistani households, and reflect the way health visitors appear to modify their practice in endeavours to cope in that environment in order help keep women safe.

#### **5.4.1 Elephant in the Room**

The data set reveals many references by health visitors to what they observe to be the particularly secret nature of domestic abuse within Pakistani households, and the shame and dishonour women fear inflicting on their family by discussing the issue outside the family – “*they [victim] are told that they can't bring shame upon the family*” (Vanessa), “*I think it's [non-disclosure] about family pride and family honour*” (Bev), “*It's very much taboo*” (Jill), “*there's a lot that's just hidden*” (Vivian), and with reference to one particular mother: “*her family are disowning her now because she has brought that shame of divorce upon the family*” (Vanessa).

Further comments by health visitors suggest they believe this “*silencing*” of women by some Pakistani families frequently leads to non-disclosure of violence and abuse and health visitors therefore in turn feel unwilling or unable to confront or address this unspoken issue. “*You don't get disclosures of violence and abuse from south Asian women very easily*” (Pamela). Eve's metaphor below of the *Elephant in the Room* is used as a subtheme of *Covert Actions* to reflect this notion of mutually unspoken truths and events:

*It's like the elephant in the room isn't it. They know why you're there. You know why you're there [pause]. I think as professionals a lot of us find that really hard, because you have those families that you just keep an eye on really - whether that's any benefit to them or not.*

The data suggest that the health visitors perceive the custom of chaperoning to be a contributing factor to the way that violence remains unspoken or even deliberately concealed. In their accounts, some health visitors spoke of how they rarely see a Pakistani woman without another family member being present. The following extracts describe how this practice can make it difficult for health visitors to address the issue of

domestic abuse overtly, and for the woman to freely and openly answer health visitors' queries.

*It is very, very difficult to get a contact with the mum on her own. You will find that you go into the house and generally its father-in-law, or another male family member, that will sit in on the visit and listen to everything and it is very difficult to ask them to leave. (Dora)*

*I have had people refuse to leave so you do skirt around the issue a little but because you know that mum is not going to answer. And then what we try and arrange is for them to come to clinic, but again, when they come out to clinic they will come with somebody else which tends to be mother-in-law. So it is very difficult to actually speak to them on their own. (Vanessa)*

Further comments suggest that the violence may not always be deliberately concealed in that the health visitors believe some Pakistani women do not associate their experiences with the concept of violence or abuse in the same way they themselves do. This, some participants believed can be another contributor towards non-disclosure and therefore make it difficult for the clinician to target the issue. *"They [women] think it's normal, it's their culture and if their husband wants to beat them then that's their right" (Jill), "they might realise that being hit is not acceptable - but it's all the other stuff isn't it?" (Vivian), "They don't agree that they have been raped sometimes because they think it's his right to be able to use them and that she should be satisfying him as his wife" (Rachel).*

The data suggest health visitors are aware of the often subjective nature of abuse and how cultural norms can influence perceptions of 'normality'. There is also reference to how women's roles within families are sometimes perceived differently across cultures, thus influencing what some Pakistani women might consider to be abusive:

*I think the whole concept of our definition of domestic violence is primarily based on western culture because some of the concepts within that definition – around financial control, and things like not being allowed out, partner wanting to know where they are all the time – within some of the south Asian communities that is a cultural accepted norm and is not perceived by the women to be any form of control or coercion [...] You can't base it on the premise that they're coming from the same page as you are. (Pamela)*

*I'm not saying domestic abuse is accepted within their culture but the way that they live is very different and women's roles are often very different in Asian families. I suppose really it's a fine line between us putting our values into their family. If they're happy with things and everything's fine, it's not for us to go in and say that the way they live is not right. It's identifying if there is some abuse going on. (Vivian)*

Whilst appearing to believe in the importance of accepting 'difference' and acknowledging thresholds of acceptability may vary, Vivian's last comment above suggests that she thinks health visitors still feel duty bound to act if *they* perceive something to be abusive. Other health visitors interviewed referred to some conduct as "unacceptable" and the "fine line" Vivian speaks of appears to be that of balancing respect for the woman's acceptance and tolerance of the situation with her own perceived duty of care. This does suggest however that such subjectivity could lead to very variable health visiting practice.

The 'difference' Vivian describes in this context appears to refer to cultural differences between the health visitors and the perceived lived experiences of many Pakistani women. Another significant finding from the data however is where health visitors define 'difference' in terms of how they perceive that violence is experienced differently within some Pakistani families compared to that experienced by women from other ethnic groups. For example:

*It can be more subtle. And it's not always from the partner, or the husband. It can be from extended members of the family, it can be from mother-in-law who can be quite domineering and quite, well abusive. (Dora)*

*Quite often with mothers-in-law it's controlling and verbal behaviour. There is one family that I have worked with recently and the prime person that is doing the domestic violence is the mother-in-law and is controlling the mum by saying that they will send her back to Pakistan if she doesn't do what she is supposed to be doing, but they will keep the child [...]. With the English community it can be in drink or drug related and it doesn't tend to be with the Asians. There doesn't seem to be a reason for it. The woman doesn't have to wind the partner up by going out and doing anything specific. (Vanessa)*

These accounts of domestic abuse which stress the more controlling elements of the alleged abuse, and the use of words such as "subtle" to describe certain abusive behaviours, appear to add further weight to suggestions that violence in Pakistani

households can be difficult to detect. The subtheme *Elephant in the Room* therefore also links closely with that of *Intuitive Practice* in that the abuse is “sensed” as opposed to revealed “*even if there isn’t disclosure it’s apparent from the non-verbal cues*” (Cathy). Most respondents describe how, despite non-disclosure, in situations where they sense the woman is being abused and, or, at risk, they will maintain contact in an attempt to ensure her safety. When illustrating how they endeavour to help keep such women safe, health visitors explained how they are not always candid about the exact nature and purpose of *their* own actions. Comments suggest this lack of candour can be with managers, within clinical records or with the victims themselves. This concept is discussed in more detail under the sub-theme of *Contrived Intervention*.

#### **5.4.2 Contrived Intervention**

When asked how they respond in situations of non-disclosure many of those interviewed described how they would continue to visit or maintain *Presence* in some way by fabricating reasons to “*follow up*” the woman in an effort to keep her safe. This notion is described here as *Contrived Intervention*, a term chosen to depict how health visitors describe engineering or creating opportunities to see or be with Pakistani women they believe are being abused. For example:

*You can normally find a reason to go in. I just go well, we’ll do an early pre-one [assessment] or, they’ll be due a two year, [assessment] we’ll do that early or we’ll go and talk about weaning so you can tick a box - but that’s not always the reason why you’re there. (Eve)*

*I’ve gone back in to see the family and I’ve possibly made the excuse that I just want to see how mum’s coping with the baby and how the baby’s development is. But actually I am going in with a bit of a remit thinking I want to see if this mum’s emotional wellbeing is OK. (Dora)*

*If I’ve got an inkling that there’s something not right there, I make an excuse to go back. So although we are supposed to go from the Healthy Child Programme and do universal visits, if I think that there’s something not quite right, I’ll make an excuse. Be it that the baby needs to be weighed again or “I just want to come back and check how you’re doing because you’ve had a difficult labour”, I always have an excuse up my sleeve. (Laura)*

The concept of “*making an excuse*” was referred to many times in the data. In this context the term seems to suggest finding justification for the intervention - “*we’ve got to justify what we’re doing haven’t we?*” (Vivian). Often this appears to be due to the perception that home visits are restricted within the formal health visiting programme - “*We are supposedly just doing the bare minimum of visits, and unless you’ve got a natural reason that you need to go back, we are encouraged not to go back just willy-nilly*” (Josie). Again we notice how important “*seeing*” the woman appears to the health visitors.

Below, Jill and Dora describe how they may extend covert behaviour to the way they both record and account for these surreptitious interventions. Once more we see references to the perceived illegitimacy of intuition as a basis for action and a sense of lacking autonomy in the way practice is carried out. For example Jill, below, talks how she feels the need to “*cover*” herself by the way she documents her activity:

*Obviously we need to document the reasons that we want to go back and you can’t say “I think there’s domestic violence”. So I would probably put in their record, rightly or wrongly, that I am concerned about the mum because of health problems, and cover myself that way. And then as I dig a bit further and domestic violence does come out, I can then document in the records that I’m supporting through domestic violence. But in the initial stages where she’s not disclosing anything, I want to get myself back in that door, [so] I would say that it’s to do with poor weight gain, or she needs some advice on weaning, or some other reason to get myself in the door. (Jill)*

*I could have written in the records and said I am unsure about mum’s emotional wellbeing so I am going back in two weeks’ time, well you know, [I would be asked] “why are you unsure?” well I’ve nothing scientific to say, only body language. (Dora)*

Other examples of contrived interventions appear to involve health visitors colluding with external agencies in an attempt to gain access to the woman or get her away from the family. In the following extract Rachel talks about a time that she tried to convince both the woman and her husband that the service she was being offered was no different from routine. In reality it was an enhanced service because the woman was thought to be at risk:

*We said to her that because she was new to the area she needed a Sure Start worker who would make sure that she accessed the right things for her children,*

*and the husband said "is this normal" and we said "yes this is normal" and we then got a Sure Start worker [who] talked about doing a CAF<sup>17</sup>, and she said "is this normal practice" and we said "yes, we offer everybody a CAF".*

We see therefore how health visitors are often contriving reasons to see and be with Pakistani women perceived by them to be at risk, and finding ways to make these visits fit the 'system' or formal programme of interventions - "we'll do an early 'pre-one'" (Eve). Many of the actions described are also ways of being able to "get back in that door" (Jill) or to "find a reason to go in" (Eve). This latter behaviour could be described as a form of covert surveillance in that the health visitors appear to be surreptitiously monitoring household activities as a perceived means of protecting the women or preventing further harm.

### **5.4.3 Surveillance**

*Surveillance* closely links with *Contrived Interventions* in that it describes part of the clinical response to non-disclosure. *Surveillance* is also similar to the sub-theme *Watchful Waiting* - however whilst the latter is more of a passive, open and supporting action, for example listening and watching, the theme of *Surveillance* reflects the way health visitors described more of a monitoring, checking or 'policing' approach to their interventions. The data also suggests that *Surveillance* is an activity 'done to' the woman as opposed to with fully informed consent. For example:

*In that situation [where abuse is suspected] we just increase our visits really. Just to see how things are going. So we make up excuses, or I make up excuses, to go out and visit. (Vanessa)*

*I think I just find some reason to go, something to do with the child or say "I forgot to ask this last time", you know something like that. And a lot of the time I find that people who don't speak English very well and from that sort of background [Pakistani] might not even query it anyway. (Ruth)*

*Surveillance* appears to be strongly associated with health visitors' attempts to safeguard children. For example, in the extract below Ruth talks about "keeping a close eye on" one household, even though she has been told there is no violence occurring. She justifies this by her concerns for the children.

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<sup>17</sup> Common Assessment Framework – at the time of interview this process was considered a pre-requisite for women at risk to be able to receive additional or enhanced support



*The children have seen a lot of violence in the past. So that's one I'm keeping a bit of close eye on at the moment. She tells me there's no violence at the moment but I just think what have the children seen in the past when it was all going off?*

In the following example from Eve she describes being very honest with the woman that the child's needs are paramount:

*If it's affecting the child then it would come out and you'd be open and honest and say "well I can appreciate that [you don't feel you need any support] and I don't want to put you in anymore danger but I can see it's affecting XXX, he's not meeting his milestones, his speech is delayed, poor attachment and things, so we are going to have to do a bit of work with him, but also support you as well".*  
(Eve)

Here, however in order to gain access, Laura talks about failing to disclose the true rationale for the visit:

*I certainly wouldn't disclose that I was coming out to talk about domestic violence. I would come up with an excuse - "oh I've not seen Jonny in clinic for..." or "how about I come out tomorrow". Just let her know I'll be out tomorrow and then obviously that gets you in the doorway again.*

Pamela, below, appears clear why she feels sometimes *Surveillance* is necessary and appears less conflicted about her priorities within domestic abuse than some of the other health visitors seem to be. For her the role is about ensuring "adequate" parenting:

*The role of the health visitor is to make sure that that victim can adequately parent her children [...] and that the child is not at risk of harm from anything that's happening in the household. So once you accept that that's our role then it becomes easier to navigate what we're actually doing.*

The suggestion revealed in most accounts is that in terms of all these *Covert Actions* health visitors consider there to be an ethical rationale behind their activities, that is to say, they believe the end justifies the means in terms of the concealed nature of these actions. We have seen how many justify their behaviour because they deem that by providing *Presence* they are contributing towards keeping women and children safe – "we have to consider if there are any safeguarding implications for children in that

household" (Pamela), "if there was a problem with the child or any of the children that would give you a reason to go back" (Vivian).

Ruth, below, outlines how she sees that sometimes openness and being more "up front" may be counterproductive or even put the individual at more risk:

*Ideally yes, you should be upfront with clients but sometimes it might mean going on another routine visit just to get more information [pause] in the main that is the best approach - direct, to the point, honest. But sometimes that could completely close things down and, I suppose you've got to question, is that putting somebody at more risk?*

Not all however agreed with this approach and some respondents felt honesty and candidness are important features of all practitioner/client relationships:

*If we are expecting clients to be honest with us, the very least we can do is to give the same back. We need to be open and honest and say [pause], and it shows that we care about the clients. You know - "I was a little bit worried about you. I just wanted to come back and see if everything was OK" [...] I know in the past practice was to find some other reason to go back in but I feel that's counterproductive. (Pamela)*

In expressing this view Pamela seems to imply lack of any transparency could have a negative impact on the health visitor/mother relationship – an area of clinical practice which was demonstrated as being a key component of *Presence* in terms of contributing towards safety. These conflicting views could link to the sub-theme *Role Ambiguity* in that they indicate that there is a lack of clarity among the respondents on the correct course of action in certain situations of non-disclosure. There is also a suggestion of *Moral Distress* in that whilst Ruth and Pamela both agree that being honest is the "best approach", Ruth voices concern that it also brings an element of risk.

## **5.5 Conclusion**

This analysis has identified three overarching themes which combine to address the research objectives. Whilst each theme is distinctive, many of the themes and subthemes are linked and inter-related. Broadly speaking however the theme of *Presence* refers to those actions and areas of practice health visitors feel contribute towards keeping Pakistani women safe, *Role Strain* tells the story of the challenges the health visitors perceive themselves to face and *Covert Actions* describes the endeavours they take to overcome barriers they encounter.

The data suggest that *Presence* is viewed by the health visitors as important in terms of *Building Trusting Relationships*. This, they believe, facilitates *Repeated Enquiry*, which combined with *Watchful Waiting* appears a key component in encouraging disclosure of abuse by Pakistani women. *Presence* it seems however can also be a potential factor in increasing risk to the woman if not carried out sensitively and skilfully. The role of the interpreter seems significant in achieving *Presence* however we have seen that referral to others, for example the GP, can be seen as increasing risk to women.

*Role Strain* appears to be exacerbated by a sense of *Feeling ill-equipped* for this area of health visiting practice. We have seen how health visitors rely heavily on experiential knowledge to inform practice against what they perceive to be a void of relevant interventions and concrete background knowledge in this specific area of work. Increasing lack of autonomy in how to prioritise their time and follow their instincts appears to be a contributing feature of *Role Strain* as does lack of clarity on the role and function of the health visiting service among Pakistani women at risk. Feeling of anxiety and vulnerability are voiced throughout many of the data excerpts.

In order to cope, and in endeavours to help keep Pakistani women safe the health visitors describe working in an almost surreptitious way at times by engineering reasons for visiting or getting the woman out of the home in an effort to provide further support or information. There appears to be a fine balance between what is seen as support and what might be considered as *Surveillance*. Feelings of ethical and moral tension are evoked in the accounts of these practices, however safeguarding children was seen by most as justification for many, seemingly, *Covert Actions*. It could be argued however that certain more passive activities of the health visitors, for example *Watchful Waiting* and those linked to fear of doing further harm are symptomatic of some practitioners knowingly or unknowingly colluding with some family's avoidance of addressing the issue of violence towards mothers.

Perhaps the most significant tool or resource that the health visitors appear to utilise is *Intuitive Practice* and this subtheme underpins most of the overarching themes. One of the major challenges for health visitors however, appears to be that despite a strong feeling that their intuitive feeling are right, they perceive that practice based on gut feeling would not necessarily be seen by others, for example managers, as legitimate. In the next chapter many of these issues are discussed further and located in the context of current professional knowledge and theory.

## Chapter 6 Discussion

The following chapter contains a critical discussion about the findings of the research undertaken. Existing theory and research is used to elucidate the results of the study and consideration is given as to how these findings relate to current understanding on the subject areas of health visiting practice and violence against Pakistani women. A critical realist lens is applied.

### 6.1 Health visiting practice

In this initial section the focus of the discussion is on the health visitor's role with abused Pakistani mothers and how this is experienced and viewed by the research participants. The findings are discussed in the context of contemporary health visiting practice using existing knowledge and referring to prior studies. This section of the discussion links predominantly to the research themes of *Role Strain and Presence*<sup>18</sup> and their subthemes.

The principles of health visiting practice have remained constant for decades. The literature suggests however that the way those principles are implemented and the ensuing priorities for practice have, over the years, been influenced simultaneously by the prevailing political climate and numerous models and epistemological perspectives (Burell, 2011; Peckover, 2013). The consequent fluctuating demands on the health visiting role have, at times it seems, resulted in a lack of clarity about the core work and therefore possibly contributed towards a sense of confusion for some individual practitioners (Pritchard, 2005).

The findings of this study appear, in part, to support this view. We have seen how there is variance in the way the health visitors perceive their role with victims of domestic violence, and how a variety of perspectives are expressed on the nature and extent of the support they might offer Pakistani mothers. The Healthy Child Programme is viewed by many of the health visitors as providing a clear framework for intervention however at the same time seems to be perceived by some as prescriptive. Though seemingly well attuned to the changing political landscape of healthcare the health visitors appear to view there to be an overemphasis on the achievement of certain practice based targets resulting in a 'tick-box' approach to domestic violence work. This, some believe, stifles

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<sup>18</sup> Throughout this chapter the theme and subtheme names as identified in study findings are highlighted by the use of italics. Where these same words and phrases are used as part of the general narrative or in different contexts, normal font is used.

innovation and limits more autonomous and flexible practice therefore inhibiting how differing need can be met. Such findings are similar to views expressed by health visitors in a study by Greenway, Entwistle, and terMeulen (2013) who describe ethical tensions experienced by health visitors seeing themselves to be required to balance a public health agenda with the need to be responsive to individual clients.

In the current study, certain perceived structural barriers are cited by the health visitors as unwelcome challenges in their work with abused Pakistani women. Lack of time to carry out the extent of the work considered by them as necessary is one such cause of concern. Feelings of *Role Strain* are depicted and sentiments of disempowerment expressed as practitioners describe how they struggle to fulfil the overall demands of the work. The analysis suggests however that a key factor in this is lack of autonomy in terms of how the health visitors feel their time is allocated and the way their work is prioritised. In other words they have *Diminishing Autonomy* to be able to openly do what they feel is required, and the first-hand accounts reveal consequent feelings of anxiety and unease. These findings are similar to other research conclusions (e.g. Colligan & Higgins, 2006) that suggest a lack of autonomy in the workplace is a major factor in contributing towards stress. Anxiety and uncertainty has been noted in other studies of health visitors working in cross-cultural care (Cuthill, 2014) however this was not with specific reference to domestic abuse work. Autonomy in decision making has been described by Traynor, Boland, and Buus (2010b) as a feature of professional practice, and health visitors particularly have traditionally enjoyed more autonomy than other community nurses (Rose, 2005). Increasing bureaucracy and a tightening of management control on health care workers in recent years is seen therefore by many to be an unwelcome challenge to the professional autonomy of nurses (see e.g. Castledine, 2003) and health visitors (Greenway et al., 2013).

A further challenge to professional autonomy in healthcare has been said to be the rising evidence-based medicine movement (Traynor et al., 2010b). Though described as the "current knowledge protocol" in the NHS (Robinson, 2012, p. 12) the concept of evidence-based practice is often subject to debate and criticism on several grounds (e.g. Hammersley, 2005; Kerridge, Lowe, & Henry, 1998), which include suggesting that it does not account for the highly contextual, subtle and sometimes tacit judgement that professionals draw on in making clinical decisions. The findings of this study suggest that some of the *Role Strain* health visitors describe comes from ambivalent feelings on the both the nature of and role clinical evidence plays in their practice with abused Pakistani women. On one hand the requirement to base their practice on 'evidence' seems to be viewed positively by many health visitors and their comments imply that this is because it gives their practice a degree of legitimacy. At the same time it appears they perceive

their clinical choices are limited to what many participants allude to as 'scientific' evidence. Indeed many theorists attribute a 'hierarchy' to nursing evidence which privileges clinical trials and conceptual models over "intelligent responses" to nursing problems (Risjord, 2010, p. 233). Others, for example Jamous and Pelouille (1970) propose that the work of professionals is distinctive because of its high levels of indeterminacy relative to technicality. Such seemingly polarised, but not incompatible, perspectives could help illuminate why the health visitors frequently represent their work in a way that foregrounds indeterminate aspects of their decision-making, whilst at the same time exercise a sense of caution which is perhaps associated with how others may judge some of these decisions.

What has become to be known as evidence-based practice (EBP) had its foundations in the evidence-based medicine movement which started in the UK in the early 1990s as a way of ensuring that in medicine, only treatments with proven efficacy are used. The movement encouraged practitioners to examine and improve their practice by testing it against scientifically validated external evidence (Robinson, 2012). Predictably, health visiting with its long history of change, evolution and adaptation to the politics of health saw EBP, as Elkan et al. (2000) state, a welcome opportunity for health visitors to demonstrate their efficacy, skills and professionalism. The embracement of EBP also occurred in juxtaposition with the raising of the specialist practice qualification to degree status (Robotham, 2005a), and health visitors now enter the workplace with an understanding of the requirement to integrate theory into their practice (Robinson, 2012). Unsurprisingly therefore, health visitors interviewed for this study appear mindful of the value placed upon the use of 'evidence' in clinical decision making and demonstrate a cognisance with being accountable in their clinical decisions and organisation of care. They however seem to struggle to articulate what they would view as valid evidence in this particular clinical practice area which the literature has portrayed as being highly complicated by a wide range of social and cultural factors.

Paradoxically, whilst expressing a belief that a 'scientific' evidence base is a requirement of their practice with abused Pakistani women, the health visitors describe how *Intuitive Practice* is often a basis for much of their clinical decision making. More so, that what are perceived as positive outcomes frequently validate their intuitive decisions. Though this concept is described by them in several ways, for example having a 'sixth sense' or 'gut feeling' about the issue, this notion generally refers to how they feel they can often detect a woman is being abused even when this fact has not been disclosed by her. This phenomenon has been noted in other studies (e.g. Taylor et al., 2013). In the current context, intuition appears to become a tool of assessment in the same way clinical judgement or wisdom based on experience may be. Such measures however are

generally perceived by the health visitors as lacking validity or authority within their formal clinical assessment process. The consequence of this for some is that they then, by covert means, derive other ways of maintaining *Presence* and proximity to the woman in an attempt to keep her safe. Sometimes this is by fabricating reasons to maintain contact.

*Intuitive Practice* in nursing has been described in many ways, for example as the “direct perception of truths or facts independent of any reasoning process” (McCutcheon & Pincombe, 2001, p. 342), as the “process of using knowledge from experience” (Robotham, 2005a, p. 19) and “understanding without a rationale” (Benner & Tanner, 1987, p. 23). Work by Benner (1984), Benner and Tanner (1987) and Agan (1987) found that intuition forms a significant part of everyday practice of expert nurses, and Goding (2000) and Robotham (2005a) have both suggested that intuition is an important component of health visiting practice.

Critics of Benner, for example Lamond and Thompson (2000) argue that decisions based on intuition lack visibility and that promotions of intuition often rely on the remembered stories of those whose intuitions turned out to be correct, which can be misleading. English (1993) states that because intuition is not amenable to rational explanation it has limited applicability in the nursing profession. Traynor, Boland, and Buus (2010a) have described how the long-standing drive for professionalisation has played a part in attempting to distance nursing from the more indeterminate and ‘irrational’ aspects of decision making, for example tacit judgement and the use of intuition. Others have noted strong links to gender in such arguments that associate aspects of nursing knowledge to ‘woman’s knowledge’ products and therefore lacking the status of more science based products such as medicine (Cash, 1997). Nevertheless, the evidence from this study suggests that intuition is considered by the health visitors to be a valued, though unaccredited tool of assessment in situations of suspected domestic abuse where disclosure is not forthcoming. This finding is perhaps more attuned with those of Ling and Luker (2000) who looked at the importance of intuitive awareness for health visitors carrying out child protection work. They conclude that although intuition was readily identified within the process of decision making among respondents, and was referred to by some as the “silent alarm”, health visitors appear to position intuition on the periphery of more scientific forms of knowledge (p.577).

Describing how intuition is used in broader areas of clinical practice, Benner, Tanner, and Chesla (2009) link intuition with deliberation, stating that in complex situations “the expert deliberates about the appropriateness of his intuitions” (p.269). Time, they go on

to suggest, if it can be afforded, allows the decision maker to put off acting until other compelling evidence is available. For health visitors in this study however, perceived structural barriers for example rigid assessment tools, and what is often viewed by them as a prescribed programme of 'contacts' with mothers appear to impact on time and restrict flexibility. The opportunity to gather other, more seemingly legitimate evidence by maintaining *Presence* and, or carrying out *Repeated Enquiry* about domestic abuse is subsequently limited and we see therefore how decisions based purely on intuition may be contributing towards feelings of vulnerability and seem to encourage covert practice. Moreover, as intuition is frequently cited by the health visitors as being associated with experience in a similar ways that others e.g. Benner et al. (2009) link intuition with "expert practice" (p. 142), such feelings could be further exacerbated for novice practitioners who may be more reliant on standardised assessment tools from which to make confident clinical assessments. Indeed findings from the present study made reference to how less experienced health visitors often speak of *Feeling ill-equipped* for work with abused Pakistani women. It could also be argued however that newly qualified health visitors may well already be 'expert' nurses with highly developed, transferable therapeutic skills. Ling and Luker (2000) for example, in their study into intuitive awareness, remarked that in child protection work some relatively junior health visitors noted and responded to perceptions, later validated, which were entirely based on intuition.

Covert practice is not a term used by health visitors in this study however the phrase *Covert Actions* is employed within the thesis to encompass a range of seemingly hidden or concealed activities that appear to be specifically connected to health visitors' encounters with Pakistani women experiencing abuse. Covert practice is a term used by general nurses to describe situations whereby treatment (usually medication) is concealed so the patient is unaware that they have received it. It is considered controversial practice by bodies such as the Nursing and Midwifery Council (NMC, 2008) and debates within the literature often associate the notion with the concepts of informed consent, concordance and compliance, whereby covert practice frequently sits at odds (e.g. Colloca, Lopiano, Lanotte, & Benedetti, 2004; Griffith, 2007).

In this study, we have seen how some Pakistani women can be inhibited from disclosing abuse when health visitors enquire. Reasons for this have been suggested by the research participants as being shame, fear of dishonouring the wider family, lack of privacy to enable disclosure and a failure to recognise certain behaviours as abusive. *Covert Actions*, such as contrived reasons for carrying out home visits, in this context are therefore associated with detection and *Surveillance*, and a perception by certain



health visitors that seeing and being with the woman contributes towards keeping her safe. Little is seen elsewhere in the literature about this practice in relation to UK health visiting, however one Australian study looking at community nurses' work with abused women found that although a high level of trust between victims and the nurses was considered important, the nurses felt required to work in various ways to mask their true involvement with the family in order to gain access to the home (Cox, Cash, Hanna, D'Arcy-Tehan, & Adams, 2001). Midwives in one study carried out in London also report developing "strategies" for explaining to male partners why it was necessary to see the woman alone, actions which the authors suggest were not always entirely overt (Mezey, Bacchus, Haworth, & Bewley, 2003, p. 752). The rationale behind the covert nature of certain activities in this study is that it was felt by several participants that a more candid approach could put the woman at greater risk. There appears a belief by some health visitors therefore that the 'end' justifies the 'means' a form of consequentialism. In other words, the health visitors are reasoning these actions from a utilitarian perspective (Mill, 2009) suggesting that the course of action is ethical and in that it maximises 'good', or well-being. Indeed the concept of "therapeutic necessity" has been linked to aspects of covert practice in other nursing situations (Griffith, 2007, p. 81), however this has generally been when the patient is unable to consent to treatment.

Whilst recognising that much of health visiting work is unrequested by families (Bloor & McIntosh, 1990; Ling & Luker, 2000), "invisible" (Peckover, 2013; Pritchard, 2005) or "hidden" (Seal, 2013, p. 227), informed consent for any intervention is a fundamental component of nursing care (NMC, 2015). The Code of Professional Standards of Practice and Behaviour for Nurses and Midwives states that they must be "open and candid with all service users about all aspects of care and treatment" (NMC, 2015, p. 11). This raises the question of whether *Contrived Interventions* such as those described by health visitors in this study can ever be justified. Secondly, how do health visitors rationalise certain elements of covert practice with their apparent endeavours to forge trusting relationships with Pakistani women? Perhaps the answer touches on what Bloor and McIntosh (1990) have called one of the "central ambiguities of health visiting" (p. 163), which is that on the one hand health visitors are expected to establish supportive relationships with parents, whilst on the other they are charged with monitoring, or as Peckover (2002b) alludes to it as, "policing" families (p.375).

Relationship building with mothers has been described as a key mechanism or way of working for health visitors (Appleton & Cowley, 2008b) and considered especially important in enabling uptake by those who find services hard to access (Cowley et al., 2015b). Developing trusting relationships may also facilitate health visitors' ability to

identify and respond to their clients' exposure to intimate partner violence (Evanson, 2006). It is unsurprising therefore that health visitors in this study speak of *Building Trusting Relationships* as being an important component of their work with Pakistani mothers living with abuse. Building the relationship is considered by them to be something requiring time and investment however can, most believe, contribute towards encouraging disclosure. These findings are similar to those of Hester and Westmarland (2005) who conducted a study to look at effective interventions and approaches in domestic violence work. They found key issues linked to successful outcomes were building trust, mutual respect and practitioners being flexible as to the pace and direction of the intervention. This study did not however look at whether these issues apply in the same way for all cultural groups or look at whether one-to-one relationships with health professionals have the same significance or efficacy with domestic abuse victims living within collectivist cultures.

Much of the health visiting literature pertaining to relationship building stresses the importance of sensitive communication between practitioner and client (e.g. Chalmers, 1992; Cowley et al., 2015b). Robinson (2012) has described talk as a key performance skill in health visiting practice and Seal (2013) says listening is a critical component of effective communication by nurses. Interestingly however, the findings from this study do not suggest that communication is a significant challenge to health visitors supporting Pakistani women, other than when the woman is actively prohibited from speaking. Some participants noted the value of 'listening visits' in situations where the woman has disclosed living in an abusive situation - listening visits being an intervention more commonly seen among practitioners working with women suffering post-natal depression (Turner, Chew-Graham, Folkes, & Sharp, 2010). What appears to be more noteworthy however is the role the interpreter appears to play in these encounters which seems to be much more than simply assisting dialogue. The data suggest that that it is the presence of the interpreter that is the significant factor and that it is this that can facilitate and contribute towards creating a trusting relationship between health visitor and client.

It is not possible, within the confines of this study, to know how the presence of the interpreter achieves this or indeed to state for certain that it does. The literature also appears unable to help illuminate this perception further. The data intimate however that the added value the presence of the interpreter brings is that as well as being able to translate the dialogue, the individual is also interpreting the dynamics of the encounter. It is suggested here that this facilitates a deeper understanding between health visitor and woman therefore contributes towards the forging of trust. This apparent

phenomenon may however be worthy of further examination at a later date and is one of the recommendations made within this thesis for further research.

Drawing on the work of Archer (2003), a critical realist lens on the discussion of the findings thus far would highlight the role of social structure and the notion that in certain contexts the health visitor is a representation of the 'state' and the woman the 'agent'. Working from the standpoint that there is a recognition that social structure does not fully determine the health of individuals but provides the conditions that constrain or facilitate health-related activities (e.g. Scambler, 2001), the 'structure' or impingement of the programme of interventions available to practitioners is an important feature of the tensions in their work with Pakistani women. The rationale being that as a population group which is part of a collectivist culture, the woman is tied to the collective rather than individual state.

## **6.2 Ways of 'knowing'**

Several health visitors interviewed for this study expressed views associated with frequently *Feeling ill-equipped* when working with Pakistani women living with abuse. In other words, they believe that the guidance and formal training on domestic violence that are available to them, do not translate usefully to their interventions with Pakistani women. Risjord (2010), refers to this concept as the "relevance-gap" (p.3). The theory-practice gap is a familiar phenomenon within nursing and generally means that whilst intellectual knowledge about a subject area is available, the theory is not translated into action. Risjord's use of the term relevance-gap differs in that it calls into question the usefulness or direct relevance of existing research and theory. The suggestion therefore being made in this section of the discussion is that the knowledge required by health visitors working with Pakistani women who are experiencing violence often differs from that which is needed during interventions with abused women from other population groups. The following section therefore explores which specific forms of knowledge the health visitors appear to be drawing from in this area of practice, and look at how this equates with certain theories of 'knowing' in nursing. In particular Carper's (1978) patterns of knowing and Benner's (1984) work on skill acquisition in nursing are used. Though many other theoretical perspectives exist which describe the evolution of nursing knowledge or which define different knowledge types (see e.g. Fawcett, 1992; Risjord, 2010; Robinson, 2012), Carper and Benner are viewed as being particularly helpful in illuminating the differing facets of knowledge health visitors in this study describe utilising or appear to draw from.

Uncertainty in particular situations is frequently associated by the health visitors with expressed feelings of vulnerability and anxiety. We have seen how, in the absence of other perceived means of knowing what to do, clinical assessment based on intuitive feelings can often influence the health visitors' clinical decision making. At the same time however, whilst expressing confidence in those judgements health visitors perceive intuitive decisions as lacking formal legitimacy within their practice. Intuition, together with concepts like judgement, form part of the 'aesthetics' of nursing knowledge as described by Carper (1978). Carper's seminal paper on Fundamental Patterns of Knowing in Nursing drawing on the work of Dewey (1934) and Polanyi (1958) outlines four knowledge approaches adopted in nursing - empirics, ethics, aesthetics and personal knowledge. Further iterations of Carper's model have been suggested in the years since its inception as other researchers and nursing theorists have attempted to add clarity and contemporary relevance (e.g. Jacobs-Kramer & Chinn, 1988; Munhall, 1993; White, 1995).

The term aesthetics is used by Carper to describe "knowledge gained by subjective acquaintance" (Carper, 1978, p. 16). This is also referred to as the art or craft of nursing (Finfgeld-Connett, 2008) and describes how nurses interpret or perceive certain situations. This theory has similarities with Benner et al. (2009) who describe knowing in the expert nurse as a "skilled performance which is linked with judgement" (p.153). In Benner's work (1984, 1987, 2009) she applies the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980, cited in Benner, 1984) to nursing. The model posits that in the acquisition and development of a skill, the student passes through five levels of proficiency: novice, advanced beginner, competent, proficient and expert. Health visitors in this current study refer to how their knowledge in the practice situation frequently comes from more non-quantifiable and naturalistic processes, and many say how they draw from 'experience' to inform clinical decision making with abused Pakistani women. Experience in this context could imply longevity or time spent in the field. Experience is also described as 'life events', and Carper named empathy as an important node in the aesthetic pattern of knowing. Experience may also mean that a health visitor's practice has become refined through several encounters with the same or similar situations and in that sense they know what to do. Interestingly, in her work Pritchard (2005) looking at how life events contribute towards how health visitors respond to women in their professional work, concluded: "invisible private knowledge gained in life events can have a transforming effect for both health visitors and clients. However, there is no educational model which legitimizes private and personal knowledge as a resource for use by health visitors." (p.236). This type of knowledge it therefore seems, is largely un-attributable in contemporary health visiting practice.

The health visitors seem also to be drawing on propositional knowledge, which Eraut (1994) describes as including "discipline based theories and concepts derived from bodies of coherent, systematic knowledge" (pg.103). Propositional knowledge equates to Carper's (1978) 'empirics' and compares with what Benner (1984) describes as "knowing that" events occur (p.2). The findings of this study suggest that this is the kind of knowledge that the health visitors are more comfortable with incorporating into their practice. Examples of domestic violence interventions based on propositional knowledge could be routine enquiry into domestic abuse or the use of evidence-based referral protocols and pathways. The comfort appears to come from the reassurance that these are validated interventions, paradoxically however there is also a perception by some that more rigid tools, such as those often used for assessment and care planning, restrict professional judgement.

These findings hold some semblance with those of Cowley, Mitcheson, and Houston (2004) and Appleton (1997) in their work evaluating structured health needs assessment tools used by health visitors as a way of identifying vulnerability. Though now somewhat dated, the Appleton study raises interesting questions about valuing the role of professional judgement within formal assessment. Assessment tools which were considered effective in Appleton's study were those which included reference to subjective factors, for example "imponderables" (gut feeling), "families who make one feel instinctively uneasy" and "any other factor which makes the health visitor instinctively uneasy" (p.110). Appleton concluded that while guidelines need to be robustly developed, the use of rigid assessment tools with no subjective element could result in vulnerable families being missed by health visitor. Cowley et al. (2004) suggest that the introduction of more structured health visiting assessment tools is occurring in response to the emerging NHS commissioning landscape, subsequent organisational requirements and the gradual "medicalisation" of health visiting (p.520). The study goes on to describe how health visitors often appear to put up a degree of resistance to the use of such tools as they perceive them to impede the relationship-building process with mothers.

The relationships between a nurse and their patient is a component of the 'personal knowing' pattern in Carper's framework. This pattern is said to be the one that allows the patient to "matter", and involves engagement with the person (White, 1995, p. 79). It is also about the nurse knowing themselves. We have seen in this current exploration of health visitors' encounters with abused Pakistani women how trust is perceived to be an important element of the relationship and considered key to encouraging disclosure of abuse. Applying Carper's theory suggests that the development of the relationship is also

a significant factor in enabling the health visitor to know what to do. Benner focuses more on the concept of 'caring' in terms of the nurse/patient relationship however caring in this context has similarities to Carper's pattern of personal knowing because it is considered by Benner as a way of 'knowing' through understanding the patient and sensing something is not right. Benner however, also talks about the nature of power that resides in caring, and how nurses can use their power to empower their patients and encourage them to "engage in painful tasks the patient would not readily undertake on their own" (Benner, 1984, p. 209). Whilst Benner is highly likely to be alluding to physical pain in this comment, the phenomenon may also be synonymous with the health visitor/domestic abuse victim relationship and be a significant enabling factor in encouraging disclosure. In this situation, this could be said to be similar to intuitive practice, however used in this context it is 'unknowingly known' rather than 'knowingly known'. The notions of personal knowing and caring therefore both provide a useful insight into how the health visitors may be utilising the relationship and its attendant emotions to problem solve in complex situations. It may also help us understand why the concept of *Presence* and being with the woman seems so important to them and why these activities appear to be much more than simply monitoring and *Surveillance*.

The moral component of Carper's (1978) framework is the pattern which relates to the ethical dimension of nursing work and focuses on matters of obligation and what nurses feel "ought" to be done (pg. 20). We have seen how health visitors participating in this study appear to display a strong commitment to supporting Pakistani women they perceive as being at risk, even when the woman herself has denied any violence or abuse is occurring. This raises one of the most interesting and intriguing questions in this study, namely why? Undoubtedly part of the answer lies with health visitor's statutory obligations to safeguard children. We have also seen how many health visitors believe some Pakistani women do not always associate their experiences with the concept of violence or abuse in the same way they themselves might do and perceive part of their role includes 'raising awareness' to the fact. A cynic could also suggest that the health visitors are simply 'covering their backs'. We have seen however how certain practitioners describe going to what appear to be extraordinary lengths in terms of contriving or fabricating reasons, just to maintain *Presence*. There appears therefore something in this behaviour that is associated with doing what they deem to be the 'right thing' and a belief that the actions are morally justified. Traynor et al. (2010b), looking specifically at clinical decision making in nurses, observed similar depictions in participants' accounts of how they accomplish moral and influential action in situations where they perceive their professional autonomy to be limited. Concluding, the authors described nurses as seeing themselves as "working heroically and successfully in the

best interests of the patient” constructing themselves as powerful, morally responsible and autonomous professionals promoting their legitimate observations (p.1511).

Similar moral and ethical tensions were found among groups of health visitors in a study by Greenway et al. (2013) where health visitors were expected to direct resources (i.e. time) towards organisational objectives and targets, rather than meeting what they believed to be the needs of individual clients. Health visitors in this study considered their professional judgement and autonomy were at times being compromised. Many therefore adopted a strategy of distancing themselves from requirements they considered inappropriate by informing clients that these were externally imposed. Similar responses have been seen in other studies (e.g. Cowley et al., 2004) when health visitors perceive themselves faced with ethical decisions regarding organisational prerequisites which clash with professional judgement. Both these examples however evidence very different behaviour from what is being seen in this study into health visiting and abused Pakistani women. Using theory drawn from Benner (1984), health visitors in the first two studies are deferring responsibility which Benner would see as characteristic of the ‘advanced beginner’ or nurses with little experience in a particular area of practice. Health visitors in the current study working with Pakistani women appear however to be putting the women’s perceived needs above all other concerns, including their own professional scrutiny. Such actions could equate to what Benner (1984) describes as those of the ‘expert’ practitioner because they seem to be based on complex decisions to do more good than harm. They might also be influenced by scholars such as Volbrecht (2002) who has argued that because patients emerge from multiple cultures and communities, ethical knowledge for nurses must be seen as contextual and dynamic. This apparent emphasis placed by health visitors on their personal agency could also however be, as Traynor et al. (2010b) allude to, part of the desire by some practitioners to sustain a self-image as autonomous professionals.

In this section we have seen how, when working with Pakistani women thought to be experiencing abuse, the clinical decisions health visitors take appear to be influenced by a wide range of knowledge types. Sometimes this is knowingly, at other times perhaps unknowingly, instinctively or intuitively. Carper (1978) acknowledges that within her framework each pattern of knowing, though considered necessary, is not sufficient, and that integration of the patterns is required. According to Chinn and Kramer (1999) failure to recognise this integration and relying on just one pattern results in a fragmented approach known as “patterns gone wild” (p.12). It is argued therefore that working in a complex area of practice, health visitors in this study, though describing themselves in ways that appear they frequently *Feeling ill-equipped*, are recurrently

demonstrating skills and knowledge more commonly associated with what Benner (1984) would describe as 'expert' practice. Whilst it is acknowledged not all participants in the study have equal amounts of longevity in the health visitor role, as experienced nurses, it could be that what we are witnessing is them pulling on transferable skills and other knowledge types acquired elsewhere. In critical realist terms non-observable entities or unacknowledged conditions are recognised contributors towards an effect, as is context. Indeed, Hargreaves and Lane (2001) challenge the linear model of knowledge acquisition posed by Benner suggesting expertise is often grounded in context. In the current study however, whilst most participants appear to be integrating a complex hybrid of both theoretical and practical knowledge, they are seemingly failing to recognise their competence because it is rarely captured by, or reflected in, the day-to-day organisational systems they are working within. This may in some way explain the feelings of anxiety and vulnerability that we see in their accounts.

The remainder of this chapter will focus on discussing further how knowledge is applied when health visitors encounter Pakistani women believed to be living with abuse, and what the health visitors say they do to help keep the women safe.

### **6.3 Harm minimisation**

Though a range of actions aimed at helping women keep safe are found to be being deployed by the health visitors, the results of the study suggest that the overall approach taken is one of harm minimisation. In other words, health visitors employ a variety of measures designed to reduce the harmful consequences of the situation because they are frequently unable to prevent those behaviours that they perceive contribute to causing the woman harm.

Harm minimisation as an approach to healthcare interventions is most commonly seen within the field of substance misuse and addiction and has more recently been associated with other forms of high risk behaviour, including self-harm (Fish, Woodward, & Duperouzel, 2012) and gambling (Blankers, Wilkinson, Gainsbury, Cousijn, & Schelleman-Offermans, 2013). Harm minimisation methods of working with victims of domestic violence are also sometimes taken by the police in attempts to reduce repeat victimisation. Such strategies include increasing home security and supplying panic alarms (Hester & Westmarland, 2005). A harm minimisation approach to interventions recognises that there will always be people who take risks, and so gives them information and help to promote their safety, with the hope of reducing any further harmful consequences.



Recent healthcare policy on domestic abuse does not advocate harm minimisation as a specific formal approach. The term "safety strategies" however is used to describe a range of interventions that enable women in current or past violent relationships to reduce their risk of re-victimisation (Parker & Gielen, 2014, p. 584). The 2014 NICE guidance that supports current health visiting practice speaks about "safety planning" with women to mean interventions which help people judge their risk of violence, identify the warning signs and develop plans on what to do when violence is imminent or is happening (NICE, 2014, p. 50). All of these approaches however rely on the victim acknowledging the risk. In this study, non-disclosure of the abuse is identified by health visitors as a particular challenge when working with Pakistani women. Within this context therefore the notion of harm minimisation refers to specific interventions frequently taken by the health visitor in an attempt to keep the woman safe or help her feel safer. The difference in approach between safety planning and harm minimisation therefore is that the actions associated with the latter refer to those taken by the practitioner rather than by the victim.

Harm minimisation however as conceptualised within the study findings, was not a term used, or referred to, by any of the research participants to account for their approach or actions. Indeed, using critical realist terminology, the health visitors as 'social actors' may be unable to explain objectively and to account fully for their actions in the situations they describe. For instance, as social actors they are constrained and bound by social structures, and the conceptual tools and discursive resources available to them in their culture which provide them with ways of interpreting their circumstances (Sayer, 1992). These structures are not things with material existence, nevertheless are 'real' in that they possess causal powers. Again, the issue of context is important here.

The most common harm reduction intervention that appears to be consistently applied by health visitors in this study is *Repeated Enquiry*. This means the practitioner asking recurrent direct questions to women about domestic violence. Ensuring that relevant healthcare practitioners carry out routine enquiry about domestic violence is not a new concept. It has been part of clinical policy in many healthcare organisations for the last decade (Peckover, 2014), and is advocated in current Department of Health and NICE guidance (Department of Health, 2013a; NICE, 2014). The perceived protective factors of routine enquiry are that it allows all women to be given information, and provides an opportunity for health visitors to assess risk, offer appropriate support and make a referral if required (Department of Health, 2005). Routinely asking women has also been said to be de-stigmatising in that it gives the message that no-one is being specifically targeted for enquiry (Hester & Pearson, 1998). Although insufficient evidence has been

found to recommend screening or routine enquiry within all healthcare settings, routine enquiry is viewed as best practice by some professionals (Public Health England, 2015). Unlike screening however, little appears known about outcomes for victims following routine enquiry, other than referral to specialist services. Further research which measures levels of violence following routine enquiry would, perhaps provide better evidence of its usefulness and is another suggested recommendation from this research.

Significantly, in this study health visitors appear to feel that asking the question in this population group is often of equal value to the outcome of the question in that it raises awareness. Again, the justification for this view appears to be due in part to frequent non-disclosure of the abuse, but is also partly due to the health visitors' perception that some Pakistani women do not always see their situation as being abusive in the same way that they themselves might do. The perceived benefit of *Repeated Enquiry* was stressed by those interviewed because it is felt to raise awareness in the woman that help is available should she choose to at some point acknowledge the abuse and accept further support. This suggestion was also made by Salmon et al. (2015) in their study of routine enquiry in the antenatal setting. The literature suggests however that within collectivist and honour based cultures, similar to those seen in most Pakistani communities in Britain, concentrated efforts are made by abused women to refrain from exposing the violence outside of the family so that the reputation of the 'collective' is preserved. Disclosure of the 'family secret' to a practitioner can, it is suggested, arouse intense anger in the husband, the woman's family of origin and the collective and lead to intense pressure placed on the woman to sever contact with the practitioner (Haj-Yahia, 2011; Haj-Yahia & Sadan, 2008).

Lack of a confidential environment was cited by the health visitors as a frequent barrier to asking about abuse in Pakistani households suggesting that the question is therefore often difficult to ask. In these circumstances the issue however is not one of denial, rather than difficulty in speaking safely. This notion has been linked in the study to the concept of the *Elephant in the Room*, a metaphorical idiom for an obvious truth that is going unaddressed. In other words, the health visitor senses a troubling problem but for differing reasons neither they nor the woman want to talk about it. These findings concur with two studies carried out among midwives in London which found the lack of a confidential environment within which to ask the question caused difficulties conducting routine enquiry, and that this problem frequently occurs in both the hospital and home setting (Bacchus et al., 2010; Mezey et al., 2003). The presence of the main partner was also found to be a key barrier to routine enquiry in one antenatal unit in the south west of England (Salmon et al., 2006). All cited studies were carried out within mixed ethnicity populations suggesting this problem is not unique to Pakistani women.

*Repeated Enquiry* however, requires *Presence* of some kind. In other words the practitioner needs to see or be with the woman to ask the question. The concept of, and value of nursing presence is well documented in the nursing literature (Doona, Chase, & Haggerty, 1999; Zyblock, 2010) and has been linked to the 'art' of nursing as described in Carper's Patterns of Knowing (Carper, 1978). One of the earliest nurse scholars who attempted to describe the concept of nursing presence was Peplau (1952) who studied the nurse-patient relationship and its implications for patient welfare. Over the subsequent decades presence became a component of several nursing frameworks (Finfgeld-Connett, 2006). Presence has been described by Benner (1984) as a nursing intervention associated with the concept of the expert nurse, and by Finfgeld-Connett (2006) as an interpersonal process requiring professional and personal maturity. Many more definitions of the term presence are advocated within the literature suggesting differing defining characteristics for the phenomenon (see e.g. Zyblock, 2010). In this study however *Presence* is characterised by the features first identified by Doona et al. (1999) which are sensing, going beyond the scientific data, knowing and being with the patient, because these attributes are felt to more accurately reflect the specific observations noted within the research data. *Presence* is linked to harm minimisation because it is a component of risk assessment. A major area of concern raised by the health visitors working with Pakistani women however is that whilst they believe maintaining *Presence* with the victim can contribute towards keeping her safe, it might also, under certain circumstances, put her at more risk.

The fear of 'doing more harm than good' is a moral dilemma frequently voiced by participants in the study and is loosely linked in the thesis to the concept of *Moral Distress*. The term 'moral distress' has been used in other healthcare situations to describe negative stress symptoms experienced by clinicians that occur in circumstances involving ethically challenging events (Burston & Tuckett, 2013). In this context it is used to depict how health visitors are at times seemingly walking a tightrope that balances potential benefits to the woman with risk of even greater harm. One of the contributing factors is the further harm that may be indirectly caused to the woman by introducing outside agencies into the situation, for example Social Services or the GP. Again, looking towards the domestic violence literature which discusses behaviours more associated with collectivist and honour based cultures (e.g. Haj-Yahia, 2011; Haj-Yahia & Sadan, 2008; Triandis, 2001) it is suggested that in such families abused women can pay a high price for their involvement with healthcare professionals.

The potential for harm and examples of actual harm to women following routine enquiry were identified in another UK study carried out within maternity and sexual health

services (Bacchus et al., 2010), and there are many references in the literature to the suggestion that health practitioners may occasionally do harm in their professional work (e.g. Hammersley, 2005). Florence Nightingale identified more than 150 years ago that hospitals should do no harm to the sick (Nightingale, 1860, cited in Tucker, Unsworth, & Hindmarsh, 2015). Indeed some of the rationale and debate around the evidence-based practice movement has included discussion on harm minimisation to patients (Chalmers, 2003; Hammersley, 2005). Doona et al. (1999) however link sensing, subjectivity and the judgement of the expert nurse to *Presence* as a way of sensitively balancing the tightrope of patient safety. They suggest that *Presence* is "going beyond the scientific data" (p. 60), again raising the issue of what constitutes robust clinical evidence. In their study Doona et al. (1999) also talk about "knowing the patient" and "knowing when to act" as being important components of *Presence*, particularly during situations of clinical uncertainty (p.62), and Finfgeld-Connett (2006) describe how trusting relationships enabled by *Presence* can allow risk taking to take place in the clinical situation. These findings appear to resonate with certain elements of the present study whereby *Building Trusting Relationships*, and time, are perceived by the health visitors as important contributing factors in helping keep Pakistani women safe.

It seems therefore that harm minimisation as an approach to health visiting interventions in the context of abused Pakistani women involves seeing the situation as a whole and gaining a deep understanding of the full range of risks and benefits. With this population group *Presence* has been found to be seen as one of the important components of harm minimisation. In this context *Presence* is seemingly more of an enabler, rather than an exclusive part of this phenomenon. The findings also indicate that in certain circumstances maintaining *Presence* in the household is perceived to have a powerful direct effect on outcomes for women. It has also been suggested however that the outcome may not always be a positive one.

The last section of this discussion further explores the concepts of *Presence* and harm in the specific context of the health visitor's role and obligations to safeguard children in Pakistani households where domestic violence is suspected or confirmed. How this appears to impact on the way health visitors feel able to support abused women is discussed. This final section of the discussion links predominantly to the sub-theme described in the findings as *Surveillance*, which is a component of *Covert Actions*.

#### **6.4 Surveillance versus support**

Kostovich (2012) describes surveillance as one of the antecedents of presence. Though not a term used by participants in this study with reference to their role with mothers,

the concept of *Surveillance* is adopted within the thesis to describe those aspects of 'being with' a woman more associated by the health visitors with a 'monitoring' or 'policing' approach to their interventions. *Surveillance* contrasts with other more passive and supportive elements of *Presence* noted in the findings, for example 'observing' or *Watchful Waiting*. *Surveillance* as used in the context of this study appears to form part of the health visitors' response to non-disclosure. In a similar way to the notion of *Contrived Interventions*, *Surveillance* seems to be an activity sometimes carried out covertly by the health visitors under the guise of other interventions. The findings suggest however that the overall purpose of the *Surveillance* of Pakistani women by the health visitors is primarily safeguarding children, rather than protecting the woman.

The effects of domestic violence on children have been well documented (e.g. Humphreys & Bradbury-Jones, 2015; Sousa et al., 2011). Health professionals, including health visitors are required to determine the risks and effect of behaviours which are perpetrated between adults, but which impact upon children and young people (Devaney, 2008; Humphreys, 2007). There appears little evidence to suggest that children from Pakistani households are at any more or less risk from the emotional effects of domestic violence than those from other ethnic groups, though the UK literature on referral patterns to social services from different ethnicity minority groups is said to be small (Chand & Thoburn, 2006). There are suggestions however made within this, and other study findings (e.g. Jeevan, 2009), that for a number of reasons Pakistani women in the UK infrequently leave the abusive situation. Reasons for this include fear of deportation, fear of losing her children and fear of reprisals from the wider family (Patel, 2008). *Surveillance* of the household by health visitors therefore seems also to be a response following disclosure of abuse in circumstances where the woman continues to live with her children in what is perceived as a violent household. Findings suggest that these actions are perhaps more necessitous in Pakistani households due to the issues seen within the literature (Chantler, 2012; Gill, 2004) associated with barriers Pakistani women face to seeking help.

*Surveillance* as an intervention in health visiting is more frequently associated with child health, in particular immunisation, screening and developmental assessments (Department of Health, 2009). More recently however, several references to the surveillance of families by health visitors have been made within the health visiting literature, particularly referring to the seemingly conflicting elements of the role, namely support and surveillance (e.g. Peckover, 2013). These views are also evident within the finding of this study and we have seen how *Surveillance* is frequently an activity 'done to' the woman as opposed to with fully informed consent. In critical realist terms these actions are influenced at both a 'real' and 'actual' level by the structures surrounding

health visiting practice. The findings suggest these structures include fear of 'missing something', child protection legislation, professional isolation and a perceived duty of care.

Some scholars have adopted a Foucauldian (1926-1984) theoretical lens from which to analyse the so called regulation of the population via the surveillance of health visitors (Peckover, 2002b). One such text (Bloor & McIntosh, 1990) discusses the issues of disciplinary power in therapeutic relationships from a Foucauldian viewpoint and focuses on how power is exercised and resisted (Foucault, 1979). Peckover (2002b) suggests that the private nature of domestic abuse provides opportunities for both surveillance by health visitors and resistance by parents. Bloor and McIntosh (1990) see surveillance as being an essential component of the preventative activities carried out by health visitors around monitoring abuse and neglect in children, and suggest advice given in this and other areas of their work with families is more likely to be instructional rather than non-directive. McIntosh (1986) has argued that the health visitor's role of monitoring families greatly reduces their acceptability by mothers and subsequently the effectiveness of health visiting interventions because of ensuing resistance. Similarly, work by Mayall and Foster (1989) suggests mothers accept surveillance as a necessary but not always welcome function of the health visitor's role. Little of this work however focuses on families living within collectivist cultures, for example many Pakistani families in the north of Britain, where responsibility for childcare is often that of the wider family rather than the biological mother. The latter phenomenon was however noted in another, albeit dated, study of health visitors' work with Pakistani families living in the UK (Bowes & Meehan Domokos, 1998).

The findings from the current study do however go some way to support Bloor and McIntosh's (1990) extension to this line of reasoning which examines concepts such as concealment by parents as a form of resistance, and suggests why sometimes more covert methods of surveillance are subsequently adopted by health visitors as a way of monitoring families. We have seen evidence of similar behaviour in this study and observed how many of the health visitors justify their actions believing that they are contributing towards keeping women and children safe. Other practitioners however articulated opinions more sympathetic to those of Machen (1996) and Cowley (1995) who prefer to emphasise client empowerment and non-hierarchical approaches to health visiting practice, or Peter and Morgan (2001) who claim that caring relationships with an imbalance of power are at risk of being exploitative.

For some health visitors in the study supporting the woman is also seen as a means of protecting the child. The findings suggest however that at times there is tension between what might seem to be two aspects of the same function. Appleton (1996) has described other health visitors in similar circumstances as being the “the reluctant monitor” of mothers (p.913). The dilemma health visitors working with Pakistani women describe facing appears to focus on potentially losing the trust of the woman if a referral to social services is made, and the consequence of that broken relationship in terms of further harm she might suffer from the wider family. Again, there appears to be a balance of risk and this is perhaps another example of *Moral Distress*. These conclusions are similar to those of Oberle and Tenove (2000) who found public health nurses in Canada expressed moral distress about being placed in the position of trying to establish and maintain trusting relationships with families while simultaneously having responsibility for surveillance of parenting practices and children’s well-being. The client group in that study was not from any one specific ethnic group which suggests that these tensions are not necessarily unique to health visitors working with Pakistani mothers. Nevertheless, as Marcellus (2005) asks, can public health nurses practise moral and ethical care involving trusting relationships with families within the constraints of a legal system which also requires a policing role from them in regard to the best interest of the children? This present study does not provide any answers to that question, however it may go some way to illuminating why certain health visitors facing such complex dilemmas, whilst at the same time believing they are ill-equipped to do so, may experience *Role Strain* and consequent feelings of anxiety and vulnerability.

## **6.5 Conclusion**

For the health visitors interviewed for this study, working with Pakistani mothers experiencing domestic abuse is a challenging area of practice compounded by the seemingly hidden nature of the problem and often complex family relationships. In this chapter we have seen how, in endeavouring to meet the perceived needs of the women, health visitors appear to be integrating a complex hybrid of both theoretical and practical knowledge to inform their practice. For many this includes using more tacit and unattributed evidence as methods of assessment. A significant factor of note is that many of the subsequent responses carried out, for example certain covert activities undertaken as a way of maintaining proximity to the woman, are not always consonant with more accepted mainstream health visiting practice.

As health professionals with responsibility for the health and welfare of mothers, fathers and pre-school children, participants in the study appear to display high levels of awareness and recognition of the impact domestic abuse has on children as well as

mothers, and of their own statutory responsibilities regarding child protection. As a consequence of these obligations some health visitors speak of undertaking behaviours which act as a form of surveillance on families where the mother continues living with the perpetrator/s. This appears to be particularly necessitated in Pakistani households where women rarely leave or seek help.

In the next and concluding chapter in this thesis the main areas covered in this study are revisited, the significance of the research findings for contemporary health visiting practice are examined and recommendations are made for further enquiry. A reflective look at the process of developing the study is taken together with an assessment of what the application of taking a reflexive approach has added.



## **Chapter 7**

### **Conclusion, Reflections and Recommendations**

The purpose of this chapter is to bring together the main areas covered in this thesis, draw conclusions about the significance of the findings and look at the subsequent implications for health visiting practice. Potential limitations or weaknesses in the work are identified and the relative importance of any shortcomings is discussed in terms of how this may affect the validity of the study. Recommendations for future research are made.

#### ***7.1 Introduction***

The aim of this study was to better understand the challenges health visitors encounter when working with Pakistani mothers experiencing domestic abuse and to learn what actions they take to help keep such women safe. The philosophical principles of critical realism were applied to the research methodology. The review of the literature concluded that in light of current gaps in knowledge, it would also be useful to investigate health visitors' perceptions of the effectiveness of routine enquiry into domestic abuse among Pakistani mothers. The final objective was to understand what skills and knowledge health visitors draw from when working with this population group.

#### ***7.2 Summarising the research findings***

Domestic abuse is widely considered a public health issue with long term health and social consequences for its victims (Bradbury-Jones & Taylor, 2013; Ellsberg et al., 2008; Evanson, 2006). The prevalence of domestic violence among women seeking healthcare is higher than in the general population (Gregory et al., 2009) and often begins or worsens in pregnancy. Postnatal women appear to be at even greater risk (Dennis, 2014a). Health visitors, because of their role with pregnant women, mothers, fathers and pre-school children are ideally placed to identify abuse and offer supportive interventions (Litherland, 2012).

Drawing on first-hand accounts from health visitors, this study set in the north of Britain has shown working with domestic abuse perpetrated against Pakistani mothers to be a complex aspect of health visiting practice often compounded by an inconsistent approach to the issue. The findings have confirmed the prior assumptions that the nature of the

violence suffered by many Pakistani women in the north of Britain often differs from that seen in other ethnic groups and that that perpetrators of violence and abuse can be other family members as well as intimate partners. Health visitors describe how issues of shame and a desire to maintain family honour appear to influence the woman's ability to disclose the abuse, even after repeated enquiry by practitioners. There is evidence that health visiting interventions are further impacted by factors such as extended family living arrangements and deep rooted cultural and social practices such as chaperoning, which mean women are rarely seen alone. Despite this many health visitors speak of often sensing or knowing by intuitive means that a woman is being abused. A wide range of measures are subsequently deployed by health visitors, often covertly, in efforts to keep the woman safe. Health visitors also perceive there to be a failure by many Pakistani women to recognise certain behaviours as abusive leading to a view by some practitioners that raising awareness of the issue is part of their duty of care to women.

The study has shown how health visitors perceive that it is the hidden nature of abuse within such households and the apparent silencing of Pakistani women that is often the key barrier to women seeking or receiving help, rather than a lack of specialist support available. This is contrary to the prior assumptions of this research and the findings of some other studies (e.g. Batsleer et al., 2002; Chantler, Burman, & Batsleer, 2003). Many of the health visitors view that their repeated presence in the household can have positive benefits for a woman in that the family become heightened to the fact that her welfare is being monitored and will subsequently modify their behaviour. At the same time however the health visitors also fear that their presence in the household or their actions may sometimes put women at even greater risk of harm as the woman is then blamed further for bringing shame to the family. The introduction of other healthcare professionals, for example GPs, can be perceived by health visitors as increasing the risk to the woman. Likewise, referral to Social Services, though often necessitated by judgements that significant harm to a child/children exist, are also tempered with balancing the benefits such agencies can offer with the perceived risk of jeopardising the health visitor/mother relationship. Consequently, subsequent feelings of professional isolation appear to add to the health visitors' sense of vulnerability and anxiety. The major focus of their work therefore appears to be underpinned by a risk management approach which is ultimately aimed at minimising harm.

### ***7.3 Drawing conclusions, significance and implications for practice***

This section of chapter presents the conclusions drawn from the study. It focuses on those findings that relate specifically to the objectives of the research and looks at the significance and implications of the conclusions for contemporary health visiting practice.

### **7.3.1 The health visitors' role with abused Pakistani mothers**

The study revealed a wide range of perceptions among participants about the nature and remit of the health visitors' role with abused women. Such findings are however consistent with claims made within the literature which suggest elements of health visiting practice can lack clarity (e.g. Pritchard, 2005). For health visitors participating in this study, the major contradictions in practice appear to be relating to the boundaries of their responsibilities to Pakistani women living with violence. Whilst most participants felt that offering 'support' was a key aspect of the role, the nature and extent of the support they thought should be provided divided participants. The significance of this for practice is that this may cause confusion or raised expectations with mothers as to what can be expected from the health visiting service, particularly among immigrant women with no previous knowledge of primary healthcare. Differing levels of intervention may also give mixed messages to perpetrators as to how certain behaviours are tolerated by statutory services. The implication of this is that further work needs to be undertaken to define and articulate the key components of health visitors' work with abused women so that the boundaries are clearer for both practitioners and victims.

Where there was consensus among health visitors about the role, it was that the safety and welfare of children are paramount. Balancing the requirement to protect children, whilst at the same time trying to maintain a trusting relationship with the mother, is however a difficult area of practice for some. The literature concurs that the challenge of successfully achieving this balance is not unique to health visitors working with Pakistani mothers (e.g. Peckover & Trotter, 2015). It could be argued nevertheless that the significance of this issue is particularly compounded if those practitioners are working among a population group that is already confused about the remit of the health visiting service. Further clarity about the boundaries of the health visiting role with abused women, as described above, could however contribute towards achieving that balance.

A fundamental, yet major challenge for health visiting practice is how to engage with hard to reach groups and work towards addressing inequalities in health. A fairer distribution of healthcare however means providing services in ways relevant to the individuals and the populations served, and women from some Pakistani communities in the UK appear to live very isolated lives (Thiara & Gill, 2010b). This study has highlighted a necessity for health visiting practice to look again at how the specific needs of those from honour-based and collectivist populations living in Britain are assessed and met. With particular reference to domestic abuse, the study has provided further understanding of how the life circumstances of individuals living in collectivist groups are largely influenced by the characteristics of the collective. Points for consideration and

recommendations for future practice include a re-evaluation of how some of the philosophical assumptions associated with Western models of healthcare, such as health visiting, occasionally sit uneasily alongside the ideologies of some minority ethnic groups living in Britain, for example Pakistani families. A paradigm shift of focus from working with the individual to the collective should therefore be considered by health visitors when working with such population groups. Future practitioners should deliberate how engagement with significant figures from the collective could further contribute towards the protection of the woman and her children, and perhaps serve as a powerful source of instrumental and emotional support for them.

This proposed change in focus is consistent with the philosophy underpinning the Community Level of service delivery described within the Health Visitor Implementation Plan (Department of Health, 2011c) which aims to promote community capacity building in order to enable families and communities build on their strengths to improve health outcomes. The Plan also stresses the need for health visitors to “regain professional autonomy in working with families and communities in determining local approaches to health and wellbeing” (p.12). This statement further supports the findings from this study which suggests some health visitors are currently experiencing feelings of diminishing autonomy.

Another important practice issue for health visitors working to address inequalities is the issue of intersectionality. That is to say, looking at women just in terms of ethnicity or as a victim of domestic violence can often fail to recognise the multiple oppressions that many such women may experience. These oppressions can, as this study and other commentary have suggested (see e.g. Strid et al., 2013), create a unique set of experiences that are perhaps more significant than the sum of their parts. For many Pakistani women living in the north of Britain it could be argued that they are disadvantaged by the multiple oppressions of race, gender and possibly class and immigration status. Their experience, and consequently their health needs, are therefore likely to be complex and cannot necessarily be met by taking a unidimensional approach to health visiting interventions. Hence it is advocated that a more nuanced and sophisticated understanding of the issue and how it can differentially affect those who experience and survive abuse would benefit health visitors working within some Pakistani communities. These conclusions suggest therefore that comprehensive assessment both at an individual and population level should take account of the impact of the multiple oppressions some women encounter for example, poverty, immigration status and ethnicity. They also provide further weight to the afore mentioned requirement, which is supported by policy documents such as the Health Visitor

Implementation Plan (Department of Health, 2011c), for health visitors to be enabled to regain professional autonomy when working with families and communities in order to provide a more flexible, needs led service.

Developing this conclusion further, another important practical implication this study has highlighted concerns the use of rigid assessment tools. These research findings strengthen the idea that health visiting assessments which include subjective elements of evidence gathering, may allow clinical judgement to be better informed - for instance make visible, the invisible. Such an approach would also legitimise the more tacit aspects of assessment allowing subsequent care planning and interventions to be more candid. This recommendation takes on an even greater significance in clinical situations whereby the evidence-base is scant or absent. Again, the issue of health visitors being enabled to work more autonomously and responsively is central to this debate. It must be stressed however that any such assessment tools would need not only to be validated, but dynamic enough to capture the silent escalation of risk that the literature tells us can be evident in families where abuse is hidden and denied (e.g. Harlow & Smith, 2012).

### **7.3.2 Routine enquiry into domestic abuse among Pakistani mothers**

This study has indicated that much of the activity carried out by health visitors appears to be aimed at bringing about disclosure by repeated enquiry into the presence of abuse. Routine enquiry of all pregnant and postnatal women about domestic violence by health visitors was established practice within the healthcare organisation at the time of this study. Since the publication of NICE Public Health Guidance 50 in 2014 all trained staff working in certain health services should ask about service users' experience of domestic abuse as part of good clinical practice, even where there are no indicators of such violence and abuse. This study has shown however that disclosure among this population group is rare and concurs with the literature (e.g. Critelli, 2012) which claims that Pakistani women seldom leave an abusive household or relationship, often preferring to find other ways of coping with their circumstances (Chaudhuri et al., 2014). Indeed Idriss and Abbas (2011) suggest disclosure to health professionals is the least productive method of identification of 'honour' related violence. Despite this, health visitors participating in this study, whilst acknowledging that the question is often difficult to ask, appear to value routine or repeated enquiry as an intervention. Many perceive it may enable women who have not already recognised that they are experiencing domestic violence to see this is the case and perhaps access support at a later time. Raising

awareness and signposting to other agencies are therefore also seen to be common features of how the health visiting role with abused Pakistani women is perceived by practitioners. The significance of this finding however is that much of the health visiting activity described with Pakistani women is therefore centred on the perception of the presence of abuse rather than any spoken reference to it. Similarly, the empirical evidence (Public Health England, 2015) and the findings of this study suggest that increased identification does not necessarily lead to increased referrals to specialist services. These factors both suggest that measuring or demonstrating successful outcomes from their interventions with abused Pakistani mothers can be difficult for health visitors. One possible explanation for this is that current mainstream service responses to domestic violence privilege an assumed common gendered experience of abuse that fails to recognise how abuse is experienced and contextualised differently by many Pakistani women.

Implications for practice therefore include helping those health visitors working with Pakistani communities to take a broader view of violence against women which, whilst guarding against cultural determinism, truly recognises and responds to 'difference'. Likewise, health visiting service providers should be aware that provision to Pakistani populations need to be flexible enough to allow practitioners to openly serve those populations in different and innovative ways.

### **7.3.3 Helping keep women safe**

The findings of this research are consistent with previous studies (e.g. Cowley et al., 2015b; Seal, 2013) which have shown that developing the health visitor/client relationship is considered a central part of the health visiting role, thought to aid the facilitation of a robust needs assessment. Many health visitors in this study perceive that repeated contacts with an abused Pakistani mother are necessary in order for them to develop a deep understanding of her situation and see building a trusting relationship with the woman as an essential component of this process. The findings also suggest that building a trusting relationship is considered part of helping the woman feel safer, and for practitioners appears to contribute towards problem solving in complex situations. It could be argued however that the pursuit of this 'relationship' at times appears incompatible with a client group whose behaviours, in the way they are described by the participants of this study, seem more associated with those of a collectivist orientation. We know from the literature that those from collectivist cultures, such as many south Asian population groups, even in diaspora, would view violence against women as a personal and family problem rather than a social or criminal problem

(see e.g. Haj-Yahia, 2011). The Western, individualist model of health visiting with its focus on one-to-one relationships may at times therefore be inconsistent with certain cultural patterns where the practitioner's desire to intervene may be viewed with suspicion and as an attempt to undermine the 'harmony' of the family. Intervention could also arouse further anger against the victim (Haj-Yahia & Sadan, 2008). These conclusions therefore have significance for health visitors working with Pakistani women where main-stream, individualist interventions may be less suitable for implementation for those living within honour based and collectivist communities. The implication associated with this conclusion is for practitioners who work among such population groups to consider issues like: Who is the client, the individual or her collective? Recommendations for practice echo those in section 7.3.1 in terms of exploring how, in accordance with the Health Visitor Implementation Plan (Department of Health, 2011c), health visitors can help build community strengths and capacity to generate local responses from local people to the health issues that matter to them.

Actions aimed at responding to risk to children in the home were also found to be a major feature of the health visitors' work with Pakistani women living in violent households. The findings of the study suggest that attempts to safeguard women are frequently seen as a means of protecting children; indeed child protection appears to be the primary intervention objective for certain practitioners. Monitoring, observing, checking and watchful waiting were therefore all found to be activities described by health visitors that, for some, were on the continuum of surveillance interventions being carried out with the ultimate aim of safeguarding children. There are suggestions in the study however, also stated elsewhere within the literature (e.g. McIntosh, 1986), that surveillance of families can result in the active concealment of issues, for example violence, which mothers fear could lead to their children being removed (Batsleer et al., 2002). Paradoxically therefore, increased surveillance seen by some practitioners as a justifiable way of providing greater support to women could, in certain circumstances, be counterproductive and foster non-disclosure of abuse increasing risk to both mother and child. This conclusion provides further evidence of the importance of health visitors being able to read, interpret and promptly act on non-verbal and other cues - a point which also links to previous recommendations suggesting assessment tools should include subjective elements of evidence gathering.

Finally, harm minimisation has been found to be the main approach used by health visitors during their encounters with Pakistani women thought to be experiencing violence and abuse. Minimising an effect or preventing events from occurring can however be hard to demonstrate or measure. Nevertheless there is now an increasing

emphasis to improve efficiency and provide value for money within all NHS funded services which puts additional pressure on professions such as health visiting to identify ways of demonstrating the effectiveness of their interventions. In addition, academics such as Robinson (2012) and Murphy (2012) make expedient arguments when stating that when a practitioner intervenes in a client's life the outcome should be that the client is significantly advantaged. The findings of this study therefore have implications for practitioners to find further and more compelling ways of evaluating and measuring the impact or outcome of their work in ways sensitive enough to reflect harm reduction.

In conclusion to this section, suggestions that the health visitors face a range of concerns associated with working with women from an honour based and collectivist culture has raised complex and significant issues for practice. The literature (e.g. Haj-Yahia, 2011; Haj-Yahia & Sadan, 2008; Triandis, 2001) and findings from this study have suggested that if the cultural and socio-political contexts of the lives of such women are ignored, the risks posed to them may be increased. Nevertheless, it is argued that such sensitivity should not be emphasised at the expense of a woman's safety and well-being. Rather, the implications for practice are that mainstream domestic abuse interventions should be used with sensitivity to the different cultural contexts in which many Pakistani mothers live, and attempts should be made to develop appropriate interventions that derive from those contexts. Many of the recommendations made in this section are consistent with the Service Vision for Health Visiting in England (Department of Health, 2010b) and the Health Visiting Implementation Plan (Department of Health, 2011c) and should therefore have relevance for commissioners and service managers, as well as practitioners.

### **7.3.4 Skills and knowledge**

This research has also raised important questions about how individual practitioners cope and respond in a safe and therapeutic way to seemingly ill-defined and changing health needs. The study has elucidated how, though their actions might prove to the contrary, many health visitors feel ill-equipped for working with abused Pakistani women and to know how to recognise and respond to the associated complex and potentially risk-filled situations they themselves encounter.

Exploring the skills and knowledge that health visitors subsequently draw from to inform their practice with this population group has however illuminated one of the most significant findings to arise from this study, which is the key role intuitive practice appears to play in these processes. Intuitive practice has been described within the academic literature as part of the 'art' and the 'personal knowing' of the nurse (Carper,



1978), and though highly valued by the participants in this study intuition appears to be associated by the health visitors with more non-legitimate forms of practice. Assessment and clinical decisions based on intuition are therefore often concealed by health visitors under the guise of interventions perceived by them to have higher authority. Indeed judgements based on intuition do not appear to be recognised within more formal, prescribed assessment processes that the health visitors describe as being required to use, nor legitimised within current educational models (Pritchard, 2005). We have seen how the emphasis within the evidence-based practice movement on more technical aspects of clinical practice and the dominance of the biomedical model in contemporary healthcare appear to partially account for these perceptions (Risjord, 2010). An increasingly target driven health economy and conventional understandings of professionalism are perhaps other contributory factors (Appleton, 2011; Traynor et al., 2010b). This study has shown however that in practice, judgements the health visitors make based on intuition are generally thought to be reliable and are said to be frequently later validated by their outcome. Intuition appears therefore to be perceived as an important but unaccredited component of the health visitors' practice with this population group.

In addition to using intuition as a form of knowledge, the health visitors appear to be drawing from an eclectic range of skills and competencies on which to base their interventions. Many of the aptitudes described are however perhaps less associated with those formally acquired through more didactic forms of education rather are more connected with experiential types of learning as well as personal or private knowledge. Whilst most of the health visitors in the study were seen to be integrating a complex hybrid of theoretical, practical and tacit knowledge into their practice, feelings of being ill-equipped to work with this client group were evident in many of their accounts. These judgements however seem to arise as a result of systems that fail to recognise or validate knowledge not captured within formal analytical tools, or, perhaps tools that do not capture more tacit knowledge types. In essence this knowledge and the application of it, is therefore invisible. These final conclusions drawn from the study therefore link back to previous implications and suggestions made that health visiting assessments which include subjective elements of evidence gathering, may allow clinical judgement to be better informed and practitioners to be more confident in their decisions.

Similarly, whilst the narratives imply current support in the form of clinical supervision is highly valued by the health visitors when working with abused Pakistani mothers (see section 4.12.5) residual feelings of uncertainty were evident in their accounts. Some of this apparent anxiety and vulnerability could, it is suggested, be perhaps lessened for them and other practitioners working in such complex caseloads, by further

strengthening supervision arrangements. The implications for practice therefore are that structured clinical supervision, such as that recommended by the Care Quality Commission (2013), would provide further opportunity for health visitors working with Pakistani families to:

- Reflect on and review their practice
- Discuss individual cases in depth
- Change or modify their practice
- Identify training and continuing development needs

(CQC, 2013, p. 4)

Stated benefits being that clinical supervision can help practitioners manage the personal and professional demands created by the nature of such work and allow them to reflect on and challenge their own practice in a safe and confidential environment. Cultural awareness training opportunities should include helping practitioners explore and understand how domestic violence interventions developed and implemented in individualist western societies must be delivered with sensitivity to the context of the way in which many Pakistani mothers in Britain live.

#### ***7.4 Summary of recommendations***

Whilst acknowledging that absolute knowledge of reality is impossible and critical realism does not expect to find successful generalisations at the concrete level, by the application of methodological rigour this thesis has sought to provide explanatory accounts of the 'real' world on which credible, authoritative pronouncements can be made. These, in turn, can seek to influence the future direction of health visiting policy and practice. Based on the research conclusions outlined above and stated implications for health visiting practice, the following is therefore a summary of recommendations arising from this study. Whilst certain of the recommendations are specifically focused towards those practitioners working among domestic violence victims from Pakistani communities, most of the recommendations have more general relevance to mainstream health visiting practice and particularly those health visitors who work generally among other collectivist or honour-based population groups.

##### *Short/medium term actions*

- Further work needs to be undertaken to define and articulate the key components of health visiting interventions with abused women and to clarify the boundaries and scope of the health visitor's role within domestic violence

- Practitioners should have access to regular structured clinical supervision such as that recommended by the Care Quality Commission
- Cultural awareness training should include helping practitioners explore and understand how those domestic violence interventions developed and implemented in individualist Western societies must be delivered with sensitivity to the context of the way in which many women from collectivist and honour-based communities live
- Holistic assessment tools used by health visitors should be flexible enough to allow clinical judgements to be informed by the more subjective elements of evidence gathering. Such tools however must be validated and be dynamic enough to capture the covert escalation of risk. Comprehensive assessment should also take into consideration the impact of multiple oppression

*Longer term actions*

- Health visiting services need to look for more innovative ways of evaluating and measuring impact/outcome in ways that are sensitive enough to reflect harm reduction
- Those commissioning and providing health services within areas of mixed ethnicity should re-evaluate some of the philosophical assumptions associated with Western models of healthcare. Consideration should be given to the provision of more community based interventions when local intelligence suggests certain population groups are of a collectivist and/or honour-based culture
- Service providers should take a broader view of domestic violence that recognises 'difference' and therefore enables health visiting interventions to be flexible and responsive to differing need

***A final note:***

Lastly, it is added, parenthetically, that the irony within the findings of this study has not been missed. Whilst much emphasis has been placed on the implications for health visiting practice of the hidden nature of domestic abuse in some Pakistani households and the silencing of many abused women, health visitors themselves have also been seen to work in a covert manner in response to this phenomenon. Indeed there are a plethora of references within the professional literature, some of which are cited in this study, about the 'invisibility' of health visiting work. We have also seen how intuitive practice has been referred to by others as the 'silent alarm' of health visiting practice (Ling & Luker, 2000). Not only is this therefore a seemingly gendered crime

encountered by a gendered profession, this study has also shed a somewhat unique light on a workforce often imperceptibly shadowing a silenced population.

### ***7.5 Contribution of the study***

A detailed review of the academic literature on the related topics has revealed that although there is a large body of work pertaining to domestic violence prevalence, prevention and interventions, little is known empirically about health visitors' work with Pakistani mothers who are living with abuse. This study therefore offers insight into an area of practice not previously studied and as such represents an original contribution to the existing knowledge base of health visiting. Moreover, certain aspects of the findings are transferable to those practitioners working among other population groups where a collectivist and, or, honour-based culture is evident. The study has also raised further issues that will contribute towards the debate about how knowledge in nursing and health visiting is managed and valued, particularly in terms of looking at what constitutes valid evidence.

### ***7.6 Limitations of the study***

The findings of this study are tempered by certain limitations. Firstly, the research was undertaken within a specific geographical region in the north of Britain which has witnessed a predominance of immigration from the Mirpur and Faisalabad regions of Pakistan over many decades. This area was deliberately chosen because of its characteristics which it is felt make this study unique. At the same time however it inevitably means that certain findings are not automatically generalisable to Pakistani subgroups elsewhere in Britain. For example some of the cultural behaviours described, like chaperoning, which appear to have bearing on disclosure might not necessarily be as prevalent in other Pakistani population groups living the UK. Similarly, the role of honour on women's ability to disclose violence does not affect all Pakistani women equally (Latif, 2011). Whilst acknowledging that Pakistani mothers are not one homogenous group, the literature suggests however that even in diaspora many practices associated with collectivist and honour based cultures persist among immigrant south Asian and certain other population groups in the UK (Azam, 2006; Harriss & Shaw, 2009). Therefore, whilst the study focuses on one particular community and their experience is unique, the research findings and their implications may be seen as an exemplar of the many challenges other health visitors face when working more generally with collectivist communities. It is anticipated therefore that insight gained from many of the issues

explored in this study will have relevance and be transferable to health visitors working in wider parts of the UK and subsequently add to the broader knowledge base of health visiting practice.

The second issue which may have influenced the findings of the study is that whilst the decision to adopt a purposive sample of health visitors was a deliberate methodological strategy, it is possible that because the participants were all self-selecting they are likely to have volunteered to participate due to a particular interest in, or having had specific experiences around this area of practice. Whilst this has enabled the gathering of rich and varied data, it will inevitably have affected the perception of the participants about the issues discussed and their views may not be representative of all health visitors working in the area. Expressing interest in the research topic may also be an indication of knowledge and skill that may not be typical of other colleagues. Indeed confusion about the remit of the role with abused Pakistani mothers, as has been identified within this study, may be even more profound if less experienced health visitors were consulted. In taking a qualitative approach and a critical realist perspective to this study however there was no prior assumption that one correct, objective understanding of the issues being explored would emerge, rather the intention was to deepen and broaden awareness and existing knowledge. It could be argued therefore that whilst the stated issues affect generalisability, access to valuable and meaningful information about the perceptions of a group of practitioners was gained that will nevertheless provide greater insight into an under-researched area of practice.

Lastly, the interviewer being a senior manager in the same organisation as the participants were working may have influenced their responses. Some health visitors may have been unwilling to share perceived limitations in their knowledge or areas of practice where they feel less confident. They could also have answered the questions by telling the interviewer what they felt she wanted to hear. Many other possible areas of weakness may be present as a consequence of this issue. The Methods chapter of this thesis however describes how every attempt to mitigate against this possibility was made and how some of these challenges were addressed at the time. Some of the stated limitations however, will inevitably remain.

### ***7.7 Recommendations for future research work***

The findings of the study have raised new questions as well as revisiting and adding to the existing knowledge base of health visiting and domestic violence. Gaps in the current literature and recommendations for further examination have however been noted in the previous chapter and are summarised here, namely:

- What is the nature of the presence of an interpreter during health visitor/client interactions, and what impact does that have on the outcome?
- How effective is routine enquiry into domestic abuse in reducing levels of violence and abuse?
- How are childless or older Pakistani women victims of domestic violence with no access to health visiting or midwifery services detected and supported?

### ***7.8 Reflecting and being reflexive***

I wish to finish this thesis by taking a reflexive turn. I feel this makes an important finishing point because, as Mauthner and Doucet (2003) remind us, it is often only with the benefit of hindsight that we become aware of some of the factors that may have influenced our research.

For me as a clinician it has been helpful and rewarding to be able to explore an area of practice that was troubling me for many years. Reflecting, and reading my reflexive diary however I now believe that despite me approaching this work as a 'researcher', the study was heavily influenced by the fact that I am a health visitor. Some of my initial interpretations of the data appear, in hindsight, clinically led rather than data led. In other words my approach to analysis was often to 'diagnose' the issues as opposed to letting the data speak for themselves. In the end however, after revisiting the literature and attempting to be more self-aware, I do believe I managed to achieve a reasonable balance of 'top-down/bottom up' interpretation. On reflection I also think that at times during the interviews in order to encourage participants to reveal their thoughts and perceptions, I shared too many of my own clinical experiences in the field, which could then have influenced how they subsequently responded. I also now believe that I was perhaps, years later, searching for some justification as to why as a practitioner I had found this area of practice so challenging.

During the interviews I was particularly aware of the power imbalance between me and the research participants and the privileged position I was in being allowed the time and resources to complete a major piece of academic work as part of my substantive role. Indeed I now look back and wonder if, in almost colluding with the participants on certain issues discussed, I was trying in some way to atone for this privilege by over-identifying with the health visitors during the interviews.

Undoubtedly the participants' responses and my interpretation of them will have also been affected by issues such as their and my ethnicity, gender, age, life experiences and other factors. I am also aware that, as Mauthner and Doucet (2003) assert, rather than

arguing that the voices of the respondents speak on their own, I as the researcher have made choices as to how those voices are constructed and which elements of the transcriptions were used as evidence. Applying a reflexive approach however has, I hope, provided transparency on all of these issues, and the robustness of the research processes undertaken I feel has nonetheless furnished a high degree of rigour to the work undertaken that will be capable of further advancing health visiting knowledge.

## **8. Appendices**

### **Appendix A**

Reflexive diary

### **Appendix B1/2/3/4**

Organisational approvals

### **Appendix C**

Topics discussed and key issues arising from the scoping exercises

### **Appendix D**

Key issues arising from the district nurse interviews

### **Appendix E**

Search for survivors

### **Appendix F**

Interview schedule

### **Appendix G**

Consent form

### **Appendix H**

Participant information sheet

### **Appendix I 1/2/3**

Ethics application and approval documents

### **Appendix J**

Consideration of different research approaches

### **Appendix K 1/2**

Node summary and example coding summary reports

### **Appendix L 1/2**

Thematic 'mind-map' of initial data categories / candidate themes

### **Appendix M 1/2/3/4/5/6**

Associated publication, conference presentations and awards



## Appendix A Reflexive Diary Excerpts

Below are excerpts from the reflexive diary that was kept throughout the research process. In it are recorded thoughts, feelings and ideas along the 'journey'. The rationale behind certain research decisions is evidenced.

Date	Event	Diary entry
22 June 2012	Attended the Feminist Narrative Symposium	" <i>You can't narrate the chaos when you are in it</i> ". Excellent quote by one of the speakers, taken from Arthur Franks. Maybe I'm mistaken in trying to speak to women experiencing domestic abuse. Perhaps they are too close to the issue. However, do survivors have a different perspective – after all they are no longer in the situation, and, not everybody 'survives'. Is it possible to speak to silenced people anyway? Is it even ethical to use people's stories if you can't help them? Or, is it vitally important that you become a voice for silent lives otherwise, how will people know? At the end of the day it may be the practicalities that decide the approach.
27 August 2012	Begun reading the Koran	Found an English translation, the first by a woman. The opening chapter is very enlightening on the role of women, domestic violence, and feminism. Chapter 4 covers this in depth. I'm realising the power of translation, interpretation and words
12 October 2012	Supervision – discussed my research participants	Am I looking at south Asian women, Pakistani women, immigrant women, Muslim women? Is this a cultural phenomenon or a class issue? I'm in danger of sounding racist if I don't choose the right approach or use the correct language. Discussed the insider / outsider perspective (I need to read about this). My previous role as a HV might mean women feel they can trust me. It will definitely influence how I see and interpret things. Lots to ponder on.
11 January 2013	Contacted IMKAAN and Karma Nirvana	The search for 'survivors' has gone on for months now. I'm beginning to feel like a nuisance to these support groups. I'm not sure I'm even on the right track any more. This is a professional doctorate in nursing; I think I'm getting drawn away from that important point. I need to refocus and think how I'm going to make a unique contribution to <i>nursing</i> . Plan – do some more reading of the nursing literature, where are the gaps in knowledge around this subject?
12 March 2013	Spent the day with the Freedom Project	This has been a revelation. I hadn't considered that living WITH violence is an option/choice for some women. I learned a lot about how they teach harm minimisation techniques. Until this point I'd presumed the approach was always zero tolerance.
10 & 11 July 2013	Attended Women's Aid Conference	Useful speakers, particularly Amrit Wilson., I must read her work. Made me think about my perspective. Am I taking a feminist perspective? How does this fit with nursing / health visiting / a clinical approach? Should I be looking at theories of violence?
1 September 2013	Supervision – discussed theory	Am reading a lot about nursing knowledge, where does it come from? Struggling to understand my epistemology. Lots of the texts are very philosophical. It suddenly feels too hard. Carper / White framework makes sense, but it's very dated. I will read other studies to look at how this framework is applied to research.

1 November 2013	Difficult supervision	Supervisors don't seem to agree. There is a lot of tension and it's not helpful. I think I need to decide what I want to do, things seem to be drifting. I'm thinking about just focusing on health visitors and let them tell THEIR story of working with women. Look at the intervention and not focus on the 'problem'. That way it will be more 'nursing'. Plan – gain permission to do 1-1 interviews with HVs. Not sure about the methodology – is it story telling? Narrative analysis? There is a small study group at the university looking at these methodologies, I will go along.
2 June 2014	Reflections following progression review	I need to pin this down to Pakistani women (rather than south Asian) but need to justify why. Plan to go back to the literature. I will also need to incorporate a clarification question into my interview schedule. There is a lot I'm bringing to this that are my assumptions (based on my experience I think), however I need to test these out somehow.
15 July 2014	Interview	Great comment came up during an interview today about human rights. I hadn't thought about that before, I was focusing on 'culture'. This seems to add a new dimension. Not sure how yet though. It certainly has made me realise that even I am finding cultural 'excuses' for some of the behaviour I'm hearing about in these interviews.
8 August 2014	Interview	Lots coming through during interviews, things I didn't expect - for instance lots on intuition/gut feeling etc. Most of the HVs want to tell me about the 'cases', if I'm not careful it's more like clinical supervision than interviewing. I need to ask more questions about how they feel, not just what they did.
7 September 2014	Interview	I'm realising how vulnerable the health visitors are feeling. They do a lot of 'covering themselves' on these visits. I'm amazed at how they refuse to give up on the women, even when they have no real reason to keep going back and they are obviously very busy.
11 September 2014	Presented a paper on my research to the FWSA conference	One of the questions asked made me think that I must put more emphasis on this being a study about health visiting rather than domestic violence or Pakistani women. I think possibly I don't stress that enough. This is about clinical practice. Possibly I do that to make it sound more interesting!! What does that say?
22 December 2014	Noticings so far from conducting the analysis	<p>- There is an <b>inconsistency of approach</b> to DV across the HVs which seems to be associated with the number of years qualified. Most HVs however see safeguarding children as their priority. HVs are not receiving referrals from childless (other than pregnant) or older women</p> <p>- Many HVs are using <b>intuition &amp; 'gut feeling'</b> to identify DV in addition to formal screening tools. Interpreters also speak of using this approach. ISSUES are: access (family present), shame (of the woman, not wanting to bring dishonour on the family), communication barrier, lack of awareness of the concept of DV among some immigrant Pakistani women</p> <p>- HVs are resorting to <b>'surreptitious behaviour'</b> to maintain contact with women by fabricating reasons to visit or see the woman.</p> <p>- DNs do not see addressing DV in homes as part of their role beyond any abuse perpetrated towards the patient</p>

		<p>they are caring for</p> <ul style="list-style-type: none"> <li>- <b>Fear of appearing racist and or judgemental</b> towards the Pakistani community is an issue for some community nurses and this may be impacting on how they approach women being abused by the wider family</li> <li>- <b>Routine and repeated enquiry</b> about DV &amp; A appears to make a difference</li> <li>- <b>Trust</b> is an important factor for the women experiencing abuse. Some health visitors feel many South Asian GPs collude with the family and breach confidentiality</li> <li>- There is a <b>lack of both pre and post qualification training</b> on domestic abuse within South Asian communities which is making some newly qualified health visitors feel ill-prepared when they are confronted with this issue in practice</li> </ul>
27 March 2015	Conducting the analysis	I'm realising I keep slipping into clinical analysis of the issues (i.e. looking for causes rather than concepts). This is hard. Not my natural way of thinking. I'm really having to think 'out of the box' and it's uncomfortable. Long walks on my own are helping me think!
3 November 2015	Reading another thesis on domestic violence found on EThoS	This has reminded me that several theories of violence exist and I seem to have drifted into thinking almost predominantly from a feminist perspective. Not sure how this has happened, but I think I have been heavily influenced by a couple of feminist conferences I've attended over the last year or so and some of the literature I'm reading. I need to be more balanced – either that or decide to take a full on feminist perspective. I'll think about that!
23 November 2015	Reflections following Progression review	So far I've been using the word 'women', and really from what the health visitors have told me, they only see women with children under 5. I probably need to be clear that this study is about mothers, and say that in the thesis.
5 January 2016	Reading through completed findings chapter, thinking about the discussion chapter, particularly covert practice	Looking at the literature on covert practice it made me think whether I am looking for reasons to justify some of the health visitors' views and actions. It's a grey area, and while I hold my own views I need to let the data speak for themselves and base my interpretation on the literature. I feel I may be in danger of colluding with the health visitors!

## Appendix B1 Organisational Approval

*(Organisational header removed to maintain anonymity)*

11 February 2013

Study Title: **What are the barriers South Asian women living with violence experience in seeking help from Community Health Services?**

Thank you for submitting the above project for approval by XXX. The project has been considered by the Integrated Governance team and I am pleased to confirm that we have agreed to approve the project.

It is required that you make yourself familiar with, observe and comply with:

- XXX Health and Safety policies
- Our procedures for the recording and reporting of adverse incidents. In the event of an adverse incident, the Integrated Governance team must also be notified.
- XXX Equal Opportunities policy
- XXX Information Security and Confidentiality policies

You must also:

- Immediately notify the Integrated Governance team of any changes in protocol or new information that would raise questions about the continued conduct of the research
- Ensure that all data and documentation is available for auditing purposes

Basic information on the project will be entered into the organisation's research database and may be submitted to the Department of Health. The Integrated Governance team may seek further information from time to time in order to fulfil the information requirements of the organisation and NHS Commissioning Board.

I would be grateful if you could provide a brief annual report on the progress of this research to the Integrated Governance team including reference to any publications that have arisen from the research. This report should be submitted during March each year, so that pertinent information can be included in the organisation's annual report.

Yours sincerely

Head of Integrated Governance & Quality

## Appendix B2 Organisational Approval

**From:** XXXX  
**Sent:** 22 April 2014 10:25  
**To:** Smyth, Catherine  
**Subject:** RE: Permission to undertake research

Hi Cath

I am very happy to support your research project as part of achieving your Professional Doctorate in Nursing,

Wishing you all the best and if there is anything I can do to help and support the process please give me a call.

Many thanks

**XXXXX | Operational Manager**

**From:** Smyth, Catherine  
**Sent:** 22 April 2014 09:09  
**To:** XXX  
**Subject:** Permission to undertake research

Hi XXX, attached letter from me. Sorry about the formal tone, but I have to provide evidence of going through all the correct approval processes. It would be helpful if you would drop me a reply saying you have no objections. Thanks, Cath

**Regards, Catherine**

## Appendix B3 Organisational Approval

21 June 2014

(Organisational headings and addresses removed to maintain anonymity)

Dear XXX,

### Regarding: Professional Doctorate in Nursing – Catherine Smyth

With reference to the attached letter from XXX dated 11 February 2013, please can I provide you with the following update:

- **Study title** – in light the publication of the 2014 NICE Public Health Guidance 50, the focus of the study has changed slightly. The title is now:

*Using the experiences and knowledge of community nurses from the north of England working with South Asian women experiencing violence, to influence future domestic abuse clinical practice and nurse education*

- **Research participants** – due to difficulty in recruiting South Asian women survivors of domestic abuse, I intend to focus totally on interviewing community nurses. I have revised ethics permission to do so (*Revision Approved: 07-Apr-14 (SREP/2013/34\_Rev\_1\_050414)*). I have also received written permission from relevant operational managers to conduct one-to-one interviews with those XXX nurses who have volunteered to be interviewed.
- **Publications** – I have recently successfully published the following manuscript:

*Smyth, C. (2013). Alcohol and violence – exploring the relationship. Drugs and Alcohol Today, 13(4), 258-266.*

As R&D lead, please can you let me know if I have your approval of the changes described above and permission to continue with the study.

Thank you,

Regards,

*Catherine J Smyth*

## Appendix B4 Organisational Approval

23 June 2014

*(Organisational header and addresses removed to maintain anonymity)*

Dear Catherine

### **Regarding: Professional Doctorate in Nursing – Catherine Smyth**

Thank you for your letter dated 21 June 2014 outlining the proposed changes to your study which are:

- Revised title, which is now:

*Using the experiences and knowledge of community nurses from the north of England working with South Asian women experiencing violence, to influence future domestic abuse clinical practice and nurse education*

- Research participants – carrying out one-to-one interviews with consenting XXX employed community nurses

As R&D lead for XXX, I am pleased to confirm that you have received approval to continue your study in the way you have outlined in your revised proposal. May I wish you continued success with your project and look forward to reading the final report.

Regards,

Director of Clinical and Operational Services

## Appendix C Key Issues From the Scoping Exercise

*Focus group questions were:*

1. What types of violence do you come across when working with women from south Asian<sup>19</sup> communities?
2. How is this different from that experienced by other women?
3. What is the current provision for south Asian women in terms of help and support?
4. What tends to be the outcome for these women?
5. Does your team ever get referrals about older or childless women subject to domestic violence?

*Key points arising from the discussion (based on group consensus reached on the issues)*

### Perpetrators

- The difference between the violence experienced by south Asian women and other (white) women is that's the violence is not just between intimate partners but is perpetrated by other family members e.g. in-laws, other women in the house, their own parents sometimes

### Types of violence

- The violence isn't just physical but is often more about control / isolation / not being allowed to go out / loss of autonomy & freedom / needing permission to do things. Bullying by other family members is common. Economic dependence appears a big issue, the women are not secure, and money is often with-held from them. There seems to be a fear from the family that if the woman does have access to money that she will send it back to her own family in Pakistan
- School nurses are aware of forced marriage. Usually the girl goes on 'holiday' and doesn't return. Often it is mid-term in year 10 or 11 (before GCSEs). The school ring the police but the girls go missing in Pakistan. They seem to fear confiding in anybody about what's going to happen to them. School nurses are not allowed in the Islamic Schools
- Marital rape is an issue. Women do not seem to understand the concept of rape. It is instilled in the men that once they are married they have a right to have sex with their wives whenever they want. It is the wife's duty, she must not refuse. Wives are told it is sinful to do so. There are cases of the men bringing white women back to the house. The wives tend to sleep with the children and the men have their own rooms

### Immigration

- There is a difference between what the women in the family who are born in this country experience and those coming in to the family from abroad. Those born here find it easier to 'fight back', those coming in accept it. Those coming in can be

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<sup>19</sup> This overarching term is also more commonly used among practitioners. The majority of south Asian families living in the area the research was undertaken are however Pakistani.



ostracised and controlled by the rest of the family (including other women) and have to do the cleaning and the cooking whilst the British born girls are given more freedom, like being allowed to have mobile phones

- The right to stay / leave to remain can be a factor. Women with no 'legal status' can't get benefits and have no-where else to go. There is a fear of being deported. They often have no family of their own in the country and even if they were to tell the family in Pakistan they would be encouraged to stay and stick it out
- It seems harder for those moving into the household (i.e. marrying one of the sons) they are often treated like slaves. Not included in the family. Their own family is abroad and the woman is isolated, often with no legal visa or bank account. Younger family members (e.g. the children of the other women) are encouraged to treat her with disrespect. They are also watched by the local community

#### Household behaviour

- Boys are often encouraged by fathers to be aggressive towards their mother and younger siblings – they are brought up to think of themselves as superior. Many families watch Asian TV which re-enforces these gender stereotypes (i.e. submissive woman, the man as the master of the house)
- Talking to the women alone is hard to do as the wider family often won't leave the room when nurses are visiting. Often the women are not allowed to leave to house to attend clinic / Sure Start etc.
- At Core Group (Child Protection) meetings you see that the mother often can't talk freely. They are always accompanied and not allowed to say anything.

#### Acceptability

- There are different levels of acceptability (compared with 'white' women) as to what the women see as violence (i.e. rape within marriage would be seen as acceptable)
- Whilst there may be similar incidence of violence between white and south Asian communities, less is reported by the Asian women (evidence from domestic violence referrals from the police). Reasons for not reporting seem to be to do with not wanting to bring dishonour or shame to the family. There is a feeling that family issues should not be discussed outside of the family. Particularly for women who have married into the family, there is a sense of obligation to the wider family.

#### Barriers to help-seeking

- Language is a barrier to seeking help and although English classes are available they are not encouraged. Even more educated women who can speak English are prevented from doing so

- GPs from the same community (usually the norm) can be a barrier to help-seeking as women often don't trust the GP (there is lots of evidence that confidentiality is frequently breached). GPs tend to encourage the women to keep quiet and be obedient to their husband. They appear to collude with the patriarchal culture and little action is taken
- White women tend to stay of their own choice rather than family members making them. They seem more willing to talk about their situation and are generally encouraged by their own families to leave the perpetrator
- The alternative for south Asian women appears to be a life of loneliness. Husbands have to agree to a divorce and the Islamic Courts decide if there are 'grounds' (there is a court in the local town)

### Provision

- KABWR (Asian speaking workers who can arrange refuge provision)
- Freedom Project (a drop in centre for all women, offer a 10 week course)
- Safer Communities Project (a counselling service with Asian workers)
- Local health service worker – named nurse for domestic violence
- Women's Refuge – however the local Pakistani taxi drivers all seem to know where the women's refuge is. The women in the refuge are often targeted by local shop-keepers for sex/relationships

### Outcomes

- Usually poor, often go back due to lack of support. There is a local difference between the different south Asian sub-groups (i.e. Pakistani & Indian). It can depend where the immigrants come from. This area it is where Pakistan was 40 years ago when the first immigrants came. The values and behaviour have remained the same
- Some do manage to escape and go to a refuge, most do not formally report it as they fear divorce (it's easy for men to divorce women in Islam). They are afraid of losing their children. Those living away from the husband get harassed by the family or by the husband. The 'community' reaction is a big issue for such women. There is cultural shame. Generally speaking they just stay – they don't want to go to the support groups and most of the groups are known to the local community. They think they would be watched. Usually the women have no money or no transport so they can't leave. Many do not speak English

### Referrals

- School nurses get notifications via the Domestic Violence Unit of any household violence reported to the police where there are school age children living. Health visitors are notified by the DVU when children under 5 are living in the household. Neither group get referrals about childless or older women

## Appendix D District Nurse Interviews

The purpose of interviewing the three district nurses was to ascertain their understanding of the role they have within domestic violence and abuse. Three main questions were therefore asked:

1. *Do district nurses encounter domestic abuse?*
2. *What is the district nurses role within domestic abuse?*
3. *What training do district nurses have on recognising and responding to domestic abuse?*

The following is a summary of the responses received:

### Observed household behaviour

- Behaviour is sometimes observed that district nurses consider abusive for example husbands openly bragging to them about affairs with ‘white’ women. The family are said to “turn a blind eye” to certain things. All the nurses were aware that there is often cruelty towards younger, usually immigrant women in the household. “*The younger ones that have come into the extended family, they’re just like slaves*” said Nurse C. Examples given were not being allowed out, being locked in the bedroom during the day, not being given any money, the phone being monitored. One case was shared where a patient revealed to the nurse that she was forced by the family to have sex with her severely disabled husband against her wishes so that she would become pregnant.
- Caring responsibilities for the sick and elderly almost always fall on the women (daughters-in-law).
- During the nurses’ visit, other family members often speak for the patient, even if they can speak English.

### Training

One district nurse of 26 years’ experience (Nurse A) didn’t recall getting any training on domestic abuse specifically although she had been trained in Safeguarding Vulnerable Adults. When asked, she said that this was fairly typical of other nurses in her team.

Another, (Nurse B) was aware of local training on domestic abuse and forced marriage, but cited “capacity” among the team as a barrier to them attending.

Nurse C said the only training relating to abuse she had received was “Safeguarding”.

All three nurses felt there to be a need for more “cultural awareness” training for district nurses. One suggested that training in “human rights” would be helpful.

### Perceived level of responsibility

The nurses felt that as district nurses they are only clinically responsible for their named patient or whoever is on their “caseload”. However if a child in the home were at risk they would inform the Safeguarding Team. Nurse A said if she did witness anything during the course of her work regarding an adult in the house who was being harmed she would tell her manager, other than that she is unsure what the process is. If the adult was “competent”<sup>20</sup>

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<sup>20</sup> Someone 18 years or older who is deemed to have full mental capacity

she feels she wouldn't get involved. *"I don't know whether you'd want to get involved because you don't want to make their life any worse"* said Nurse C.

Nurse B feels that their main safeguarding function is around any children in the home. If they suspected a child was at risk they would "refer". She also believes that the health visitors in her team are very "child focused" as opposed to considering the needs of the woman (mother). She added however that adults are able to make *"unwise decisions and choices"* and therefore often remain in the household where they are being victimised. She believes the GP has a responsibility for protecting abused women but recognises the woman would need to feel comfortable enough to tell the doctor. Two of the nurses gave examples of breach of confidentiality among local south Asian GPs. Nurse C felt that children are *"a different kettle of fish"* and if concerned about a child she would speak to the health visitor, but not if the concern was just about the woman.

Nurse B commented that *"if the woman hasn't got a child then she isn't protected by any of our systems and processes"*. She believed most of her district nurse colleagues would think domestic violence is not part of their role. *"We are more task orientated than risk assessment, we are contract driven"*. Nurse C also talked about being "task orientated", she went on to say *"We don't have that long to be able to spend time having lengthy conversations. We do what we've gone to do and then we leave, we're blinkered"*.

## **Culture**

Nurse A felt that forced marriage is part of the "culture" of the Pakistani population and both Nurse B and Nurse C attributed certain abusive behaviours as "cultural".

*"I think it's cultural. It's not acceptable is any type of abuse to me, for us. And it shouldn't be acceptable for a Pakistani family, but from the people that I've spoken to, it's acceptable to them"* said Nurse C, however later went on to say *"you can say it's cultural but if you asked me what their beliefs are I would probably go 'I don't really know' "*.

All three nurses expressed views that suggested they were fearful of being branded as racist if they were to be openly critical of certain activities *"how do we determine that it is not racist, that we are not going against their culture?"* said Nurse B for example. Nurse C felt that if she did come across some behaviour towards an adult she was uncomfortable with she would *"just try and ignore it"*. She did feel however that *"I suppose if we understood the cultures more we would then know what was acceptable to talk about to them"*.

## Appendix E Searching for Survivors

After careful deliberation it was decided that the approach to this study would be to target Pakistani women who were, at that point, safe and living apart from their abuser/s. The initial Ethics application which was approved in July 2013 therefore carefully addressed all of the issues to be considered when undertaking sensitive research - which include managing boundaries and mitigating risk to both research subject and researcher. The approach at that point also included interviewing health visitors about their professional experience of working with Pakistani women living in violent situations. The health visitors would not however be used as a way of targeting women as potential research participants, as health visitors would only ever be in formal contact with women in high risk situations.

The search for women survivors lasted for a year. In all of that time only four women expressed interest and two of them subsequently withdrew. The following is a brief summary of efforts made to engage with the women and the rationale for the decision in April 2014 to shift the focus away from women survivors, to look solely at the first-hand accounts of health visitors.

Initially, both women's refuges within the geographical location of the study were contacted. Refuge staff however appeared guarded. The general and understandable consensus was that women currently living within such safe houses are often at that point, still very traumatised by their experiences. One worker described how women living within shelters frequently "struggle to open up to trained counsellors" therefore it would seem inappropriate to suggest they might talk to a researcher. When asked if refuges remain in contact with women who had moved on and who may be more ready to reflect on their experiences, the answer was no. A helpful suggestion was made however, to contact local and national pressure groups. Three were recommended as being keen to add to their research base. A tour of those organisations' web sites revealed a large body of research papers that supported this view. Systematically each one was contacted.

Responses from the pressure groups were disappointing. Only one was willing to engage in any kind of dialogue and for a while it seemed likely that someone might at least talk face-to-face with me. Sadly no volunteers came forward. Throughout the following months many other women's groups and campaigning organisations were contacted, initially local to the study, then widened to national or London based groups. Several were subscribed to. When approached regarding contributing to this study responses varied from no response, to stating that they were supportive of the work but didn't

have the capacity to get involved. Scouring the organisations' newsletters, a two day attendance at the Women's Aid annual conference and a full day spent with a domestic violence project in the north of England all failed to lead to any actual interview opportunities with women survivors.

An opening arose to meet with a PhD student undertaking research with women refugees and asylum seekers, and who also worked as a volunteer at a women's centre in the north of England. The centre provides drop-in facilities, counselling and advice for women experiencing domestic violence. The student offered to distribute information about this study among women workers at the centre, some of whom are themselves survivors of abuse. This led to a series of telephone conversations and email exchange with one woman in particular, but this never progressed to the point of her feeling comfortable enough to be formally interviewed.

Attendance at the Women's Aid conference in June 2013 was an opportunity to hear first-hand from prolific commentators and, or, authors on the subject of violence against south Asian women. Two major national figures who contributed were contacted following the event and asked if they would know of any women survivors who would be willing to be interviewed. Brief details of the study were sent with emphasis on the potential of the findings to influence local specialist provision – underfunding of such provision is a key issue according to the work of both writers. One of the authors never replied, the second was unable to help due to the pressure of work.

Social media was considered. There appears a lot of debate in the literature amongst academics and researchers about the opportunities and challenges of online and social media research and the approach is said to be wrought with ethical dilemmas. Tentatively, however this was explored to find out if either 'blogging' or 'tweeting' would work as a method of reaching women. Certainly there are very many established social networking groups for women experiencing domestic violence, some specifically targeted at south Asian Women. Most however are American, all are unregulated, and I felt social media users were probably not representative of the women I wanted to speak to. It was eventually felt that there are too many methodological problems with using this approach, and social media was therefore discounted as a method.

The next approach was to contact those Members of Parliament with either a stated specialist interest in women and violence, or who hold a more formal portfolio for 'women's issues'. Three were identified who met those criteria and who hold constituencies in the north of England. A participant's information sheet with brief details of the study and its potential benefits was sent, and each was asked to forward it on to

any women constituents who may wish to contribute to the study. Nothing was heard from any of the politicians or any woman victim or survivor of domestic violence.

Another potential opportunity arose from a colleague with a Pakistani female friend who recently left a very abusive relationship. The woman, it was suggested, would be willing to tell the story of her experiences. Tentative arrangements were made to meet to discuss a possible interview; however the woman decided to return to her abuser and felt therefore unable to proceed any further. Two further women contacted me some time later after hearing about my research via my professional networks. The point had come however when I had decided to change my approach.

The literature provides some clues as to why access to women survivors has proved so difficult and suggests the issue of violence within some south Asian households is often shrouded with secrecy. Reasons for this seem to be associated with social stigma and expected silence from the community (Ahmad, Driver, McNally, & Stewart, 2009; Ahmad, Rai, Petrovic, Erickson, & Stewart, 2013), the role of honour on women's ability to disclose violence (Latif, 2011; Liang, Goodman, Tummala-Narra, & Weintraub, 2005), shame (Ammar, Couture-Carron, Alvi & Antonio, 2013; Anitha & Gill, 2009) and fear of retaliation (Lee & Hadeed, 2009). The literature frequently refers to south Asian women as being 'hidden' victims of abuse (Chakraborti, Spalek & Garland, 2006; Gangoli, McCarry, & Razak, 2008; Natarajan, 2002). All of these issues are explored in more detail elsewhere in this thesis but are noted here in order to suggest why some Pakistani women might be reluctant to engage with research of this nature.

### Summary of the organisations<sup>21</sup> approached in the search for survivor stories

Description of organisation N=national L=local to study (or local branch of national organisation)		Response
Key national charity working to end domestic violence against women and children. They support a network of over 300 dedicated specialist domestic violence services across the UK	L	No response received.
Women's refuge x 2 (one of which is a shelter for BMER women)	L	Informed that it is not appropriate to interview women at this point in their escape from violence. Said to be too close to the event.
Black feminist organisation dedicated to addressing violence against women and girls	N	No response received.
Organisation supporting victims of honour crimes and forced marriage	L	Initially agreed to be involved, asked for more information but never responded. Contacted three times. Similar pattern.
Women's organisation that assists women affected	N	No response received.

<sup>21</sup> Anonymised due to the fact that some of these are Safe Houses

by physical as well as mental, financial, sexual and emotional domestic abuse		
Women's support service which provides information, practical and emotional support, and safety planning advice	L	Contact made and one woman agreed to be interviewed, but later withdrew
Charity which aims to engage the public, and especially the minority Muslim communities, to become aware and take action against domestic violence	N	After initial contact made and encouraging email communication, no further contact received other than promotional material
A not-for-profit organisation set up to meet the needs of black (Asian and African-Caribbean) and minority ethnic women	N	Appeared supportive of the research but stated that due to work pressure they were unable to be involved
Organisation for women facing domestic violence - which provides legal advice, safety planning and re-settlement support	N	Informed they do not have the resources to support students doing project work
Domestic Violence Project dealing with male violence to women and children	L	Informed by staff that they are very rarely contacted by South Asian women

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## Appendix F Interview Schedule

- **Introduction** – thanks for coming, revisit the purpose of the study, length of the interview
- **Ground rules** – the right to withdraw, the right to not answer any of the questions, the interview will be taped, notes may be taken by the researcher, anonymity, confidentiality
- **Information leaflets/consent** – go through together, ensure informed consent

### Semi-structured questions

1. How do you see your role in the context of domestic violence? Do you approach it any different in Pakistani households?
2. In your experience, what kinds of violence and abuse do Pakistani women experience?
3. How does it differ from the types of violence you see other women experiencing? *Why* is it different do you think? Is there any difference between Indian & Pakistani women's experience (*check the cultural origin of the client group the nurse has experience of working with*)?
4. Who are the perpetrators in Pakistani households?
5. How do the women seem to view their situation? What do they expect from you?
6. In terms of the Pakistani women you have supported in the past what do you think helps and what doesn't help? *Why*?
7. What would be a good outcome? / What does good look like for Pakistani women experiencing violence?
8. What sort of training have you had? Did this prepare you adequately for working with Pakistani families?
9. Are you aware of any local policy / approach / pathways in relation to domestic abuse? How helpful is it? Can you give some examples? Do you follow it in the same way with *all* women? *Why/why not*?
10. Do you think that there should be a zero tolerance approach to domestic abuse? Could risk management strategies work better for some women? Is it acceptable to have different approaches/models of intervention for different cultural groups? *Why/why not*?
11. Are you a CPT? If so, how do you prepare your students for visiting Pakistani women victims of domestic abuse?
12. From your experience, if you could, how would you influence domestic violence training for nurses working with Pakistani communities?
13. Is there anything else from your experience you think I need to know that would contribute towards me understanding this issue more? If so, what?

### End of the interview – to consider:

Is any further help or support required for the participant?

## Appendix G Consent Form

### CONSENT FORM

*It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.*

	Initials
I have been fully informed of the nature and aims of this research	
I consent to taking part in it and having my interview audiotaped	
I understand that I have the right to withdraw from the research at any time without giving any reason - up to the point that the study is written up	
I give permission for some of my words to be quoted (by use of pseudonym) within the study	
I understand that the information collected will be kept in secure conditions, for a period of five years at the University of Huddersfield (audio tapes will be destroyed once transcribed into a written format). This will be in an anonymised format	
I understand that no person other than the researcher will have access to the actual information I provide	
I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report	
I understand that if I identify during the course of my interview anything that suggests either me or someone else is at risk of significant harm, the researcher may be required to report this to an appropriate authority	
I understand that should any negligent clinical practice become apparent during the course of the interviews with either group, the appropriate line manager will be informed	

Signature of Participant:  _____	Signature of Researcher:  _____
Print:  _____	Print:  _____
Date:	Date:

(one copy to be retained by participant / one copy to be retained by researcher)

# **Appendix H Information Sheet for Research Participants**

## **Research into Working with Pakistani Women Experiencing Violence**

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### **INFORMATION FOR INTERVIEW PARTICIPANTS**

You are being invited to take part in this study looking at working with Pakistani women experiencing violence. Before you decide to take part in the interview it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the study about?**

The study aims to further advance clinical knowledge about the specific nature of violence perpetrated against some women living in Pakistani households and to understand why these women appear not to benefit from existing community nursing domestic violence policy and interventions.

#### **Why I have been approached?**

You have been asked to participate because you currently work or have recently worked predominantly with a population of south Asian individuals and families and may have experience of supporting women from that community who are experiencing abuse.

#### **Do I have to take part?**

It is your decision whether or not you take part. If you decide to participate you will be asked to sign a consent form, and you will be free to withdraw at any time and without giving a reason - however once the material has been written up it cannot be retracted. Approval for your inclusion into the study has been agreed by XXX R & D Lead and Huddersfield University Research & Ethics Panel. Should you consent to take part I will gain further permission from your line manager.

#### **What will I need to do?**

If you agree to contribute your knowledge to the research we will meet at a time and venue of your choice. I hope to carry out the interviews during Spring/Summer 2014. I will ask you a series of questions based on your experiences and with permission record your responses on an audiotape. I may also make some written notes which will be my personal reflections at the time. If you prefer not to answer any of the questions please let me know immediately. Once the interview has begun I will ask you not to identify yourself, anyone else or the name of any support group or refuge you may have had contact with. The interview will last approximately an hour.

#### **Will my identity be disclosed?**

All information disclosed will be kept confidential, except where legal obligations would necessitate disclosure by me to appropriate personnel (for instance if you or another person was at risk of significant harm). Likewise, should any negligent clinical practice become apparent during the course of the interview, your line manager will be informed.

**What will happen to the information?**

All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report, however, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings. Your permission for this is included in the consent form.

**Who can I contact for further information?**

If you require any further information about the research, please contact me: *(details provided)*

# Appendix I 1 Ethics Application

THE UNIVERSITY OF HUDDERSFIELD

School of Human and Health Sciences – School Research Ethics Panel

## OUTLINE OF PROPOSAL

Please complete and return via email to:

**Kirsty Thomson SREP Administrator: [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)**

Name of applicant: Catherine Smyth

Title of study: ***What are the barriers South Asian women living with violence experience in seeking help from Community Health Services?***

Department: School of Human and Health Sciences

Date sent: May 2013

Issue	<p>This study aims to further advance the knowledge of community nurses about the nature of violence perpetrated against women living in South Asian households in the north of England. By doing so it is hoped that the perceived barriers such women appear to experience in being able to remain free from harm can be better understood.</p> <p>Violence against women has received attention at both international and national level since the mid -1990s. Whilst recognising definitions of violence are complex and varied and cannot be universally applied without qualification to all women, domestic violence is often a gendered crime most frequently perpetrated by men on women. Indeed much of the statutory and non-statutory support for victims of domestic abuse is funded to aid women in this specific situation. For some however, including South Asian women, abuse is also perpetrated by wider family or household members. For these women support provision appears extremely restricted, and community nurses working with South Asian women often find that the options available to such a woman to remain safe or to flee a violent home situation, for many reasons, are very limited. These options are further curtailed by the absence of wider birth family support, inadequate command of the English language, economic dependence and uncertain legal status in cases where the woman is a recent settler in the UK. Initial scoping of the issue of violence against South Asian women for this proposed study, also reveal that the types of violence towards some South Asian immigrant women differs from that experienced by British born women, including those from Indian and Pakistani origin.</p> <p>The aim of the study is to improved appreciation of the issues so that is may lead to change in clinical practice in order that community nurses can contribute to better and safer outcomes for South Asian women experiencing domestic abuse. Raising awareness could also increase the range and appropriateness of other available NHS support provision. This study hopes to provide a voice for those who by nature of their circumstances, cannot always speak for themselves.</p> <p>During the course of the study information will be sought from health visitors, general practice nurses and other community nurses working in geographical areas of high South Asian population across XXX. This will contribute towards increasing the pool of knowledge and understanding from the practitioner’s perspective and experience of working among South Asian families and communities. In addition to this, participant women volunteers will be sought from the South Asian community who have experienced domestic and family violence and might describe themselves as ‘survivors’. These will be recruited from Support Groups across XXX and by word of mouth. It is anticipated that these will be women who have, by some means, managed to escape</p>
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	<p>the violence. The literature will be used to triangulate this data.</p> <p>The ethics associated with researching vulnerable groups had been considered throughout the planning process for this study and it is acknowledged that during the course of the research several topics traditionally thought of as ‘taboo’ or private areas of people’s lives will be investigated. It is therefore anticipated that there are specific ethical issues to consider in carrying out this study including giving careful consideration as to whether the research findings might further stigmatize or marginalize the population under study. The decision to avoid research on sensitive topics has however been described as an evasion of responsibility (Dickson-Swift et al. 2008) and the act of conducting research with vulnerable people as “good in the moral sense”(Morse, 1995). Methodological design is therefore particularly crucial in such studies and the specific issues that will be considered during the design of this proposed study are highlighted below (see ‘Other Issues’ section).</p> <p>At all times the World Health Organisation Ethical and Safety Guidance for Research on Domestic Violence against Women (WHO, 2001) and the University of Huddersfield (2011) Ethical Guidelines for Good Practice in Teaching and Research will be considered and adhered to.</p>
Researcher(s) details	<p>Catherine Smyth. Student Number U9002118 undertaking a Professional Doctorate in Nursing.</p> <p>I am a registered nurse and health visitor and am currently working for a local community healthcare provider organisation XXX</p>
Supervisor details	<p>Dr Rachel Armitage</p> <p>Dr Stephen Parkin</p> <p>Dr Dawn Leeming</p>
Aim / objectives	<p>Aim:</p> <p>To advance knowledge among community nurses as to the specific context of violence for South Asian women living in the north of Britain and the barriers experienced by them in seeking help from Community Health Services</p> <p>Objectives:</p> <ul style="list-style-type: none"> <li>• To improve understanding of the issues associated with violence towards South Asian Women living in the north of Britain</li> <li>• To provide knowledge that can be used to advance clinical effectiveness within community nursing with respect to reducing the risk of harm to South Asian Women</li> <li>• To contribute to better outcomes for South Asian women experiencing violence</li> </ul>
Brief overview of research methodology	<p>A 2 layer approach will be used, using both the experience of South Asian women survivors of domestic violence as well as that of those nurses working in the community within which the women are living. This strategy will provide multiple sources of data allowing for the development of a broader understanding of the issues.</p> <p>No direct attempt to access women currently experiencing violence will be taken for reasons of:</p> <ul style="list-style-type: none"> <li>- lack of access (the planning and scoping exercise carried out thus far indicated many such women are not able to leave their home un-chaperoned)</li> <li>- safety (possibly putting the women in greater danger) or</li> <li>- language (many of the women are new immigrants and do not speak English)</li> </ul> <p>It is acknowledged that the women ‘survivors’ interviewed may not fully represent the women under study due to the fact that they have been able to access the necessary</p>

resources to escape their previous situation, however they may be aware of such women. This will be therefore in essence, a 360° perspective of the issue.

#### Sampling strategy

Approximately 8 community nurses will be recruited to the study from the existing workforce under the same employ as the researcher using a purposive sampling strategy. Nurses will be targeted who work predominantly with South Asian caseloads or within South Asian population groups in XXX - over 1 in 8 people living in XXX are of South Asian origin (JSNA, 2010). Nurses will be recruited through team meetings, professional forums and via organisational email circulation. Where possible, those with extensive experience of working with South Asian women will be selected.

Women 'survivors' will be recruited from local Domestic Violence Support Groups. It is hoped that a 'snowball sample' can be achieved. Several such organisations run across XXX as part of the current provision for women living with, or fleeing from violence (e.g. XXX).

#### Data collection

Data will be collected from the community nurses group by using standard focus group methodology (Morgan and Krueger, 1997). This will provide a range of views and opinions based on each participant's own professional experience of working with local South Asian women. It is felt that the group approach will provide an efficient and effective means of gathering sensitive data. The focus groups will be audio-recorded, and personal reflections will be recorded by the researcher during the discussions. Semi-structured questions will be developed to drive the study and to ensure consistency. No recordings will be made without the permission of those involved (agreement to be recorded will be a pre-requisite for taking part) and notes made from the discussions and transcripts from audio-recordings will be checked for accuracy with participants. Audio-tapes will be erased following transcription.

Data from the women 'survivors' will be gathered by carrying out in-depth 1-1 interviews at a mutually agreed venue. The purpose is to elicit from them what their definition of violence is, to understand the types of violence they themselves and other women they know of have experienced, and to understand from their perspective what aspect of the community nursing support available was helpful or could have been of more help to them. Questions using loaded terms will be carefully avoided and every attempt will be made to ask all questions in a supportive, non-judgemental, non-stigmatising manner.

Each woman will be contacted by telephone prior to the interview so that the detail of the interviews can be explained and background to the study provided. Further written information can be sent if the woman requires this and has a safe address to send it to. If not, the information sheet will be provided on the day of the interview. At each stage of the study the participants will be offered information about support agencies should they require it (e.g. XXX, Health Visiting Service) and the right of the participant to withdraw at any point of the process – up to the point of 'write up' - will be reiterated throughout.

Ensuring researcher safety is an essential component of this study. Identifying, managing, minimising and mitigating any potential risks around personal security and safety is a fundamental part of the planning of the methodology for this research project, and the detail of how this will be done is covered extensively in Appendix D. This includes providing the supervisor (or other 'competent person') with a schedule of interviews which contains time / location and an agreed process for reporting back when completed, also practical steps - for example carrying a mobile phone which has pre-programmed numbers for accessing help if required.

Only women with a good command of the English language will be interviewed and






	<p>any professional concerns freely and signposted to local Clinical Supervision processes for professional or clinical support if required. The focus groups will not include any Operational Managers.</p> <p>Women 'survivors' will be targeted via the Support Groups and by word of mouth ('snowballing' technique). Several local organisations have already been contacted and some are showing interest in the proposed study (e.g. XXX). Individual women and volunteers will be approached via the organisation's Support Team and not directly unless they subsequently give permission for this to happen. It is acknowledged that Support Groups beyond the local geographical area may also need to be contacted if the pool of local volunteer participants is very small.</p> <p>At no time at all will any pressure be placed on any organisation or individual to take part in this study. All participants will be volunteers and free to leave at any time up to the point of 'write up'. This will be made clear to them throughout.</p>
Confidentiality	<p>The NMC Code: Standard of Conduct, Performance and Ethics (2008) will be adhered to at all times.</p> <p>At each stage of the research process every effort to maintain confidentiality will be taken and this will be stated on the consent forms and discussed with the participants. However it will also be made clear within the discussion and in the supporting information that confidentiality is not absolute and may be breached where there is an urgent risk to safety or the life of the participant or another person. Likewise, should any negligent clinical practice become apparent during the course of the interviews with either group, the appropriate line manager will be informed.</p> <p>XXX Multi-agency Safeguarding policies will be followed where necessary.</p> <p><u>Personal information:</u></p> <p>All materials when not in use (e.g. written, audio-tapes) concerning the project will be kept in a locked drawer in a secure office on XXX premises. Any identifying information (e.g. names, contact details) will be stored separately from other information (in a different locked drawer). Electronic data will be encrypted and password protected. Academic Supervisors will only have access to the data analysis and not the full transcripts.</p> <p>Any Support Group contacted as part of either the scoping exercise or during the data collection process will be informed of and assured of the confidentiality issues and measures described above.</p>
Anonymity	<p>Any report or transcription relating to the interviews or the study in general will be written in such a way as to preserve the anonymity of the participants by the use of a pseudonym. The anonymity of third persons referred to will also be maintained as will the name or details of any support group or refuge alluded to.</p> <p>Every effort will be made to ensure that other people within the community cannot be identified by the research findings by avoiding naming the exact geographical areas in the north of Britain where the research participants are from.</p>
Psychological support for participants	<p>It is acknowledged that taking part in the research may cause emotional distress to some participants. Painful memories may return during the course of the interview with the survivors and practitioners may be reminded of their feelings of helplessness in being unable to help some women victims in the past. The researcher is aware that there might be times when the interests of the research question will need to be balanced against the best interest and sensitivities of the research participants. Clinical judgement as to cease further questioning will be used should this situation arise (the researcher is an experienced health visitor and nurse). There will be opportunities for breaks. Consent can be rechecked at any point - the participants will be clearly</p>

	<p>informed that they have the right to withdraw from the research at any stage - up to the point of write up (see Information Sheets and Consent Form – Appendices E,F,G).</p> <p>The researcher will hold a de-brief session after each interview in order to assist the participants in having the opportunity to talk about the situation or feelings that might have triggered an emotional reaction. Where necessary counselling can be arranged via the Occupational Health Department (for community nurses) or local Psychological Services as appropriate (via XXX NHS Trust referral processes) for the women interviewed.</p>
<p>Researcher safety / support</p> <p>(attach complete University Risk Analysis and Management form)</p>	<p>Risk assessment attached (Appendix D)</p>
<p>Identify any potential conflicts of interest</p>	<p>This research is not funded by an external agency.</p> <p>As XXX from 1<sup>st</sup> April 2013 Research Governance comes into my portfolio causing some potential conflict of interest. Initial permission to undertake the study and to approach members of the community nursing service was obtained from the Head of Integrated Governance before my appointment was made. From herein, any subsequent necessary organisational permission or authorisation required will be referred to the Director of Operations at XXX.</p> <p>Whilst some of the staff participants are likely to be known by me, no lines of responsibility or accountability will exist. My request for participation from the staff group will be as a researcher rather than as a Senior Manager – letters will go out on Huddersfield University headed paper rather than XXX s so that my 2 roles are clearly separated. There will be no obligation on any XXX staff member to take part.</p> <p>No women ‘survivors’ will be accepted into the study if known personally to me prior to its commencement.</p>
<p><b>Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy</b></p>	
<p>Information sheet</p>	<p>Appendix E1 is a copy of the information sheet already sent to a local women’s support group via one of its volunteer Support Team Members as part of the initial scoping process undertaken in April 2013.</p> <p>More specific detail regarding confidentiality and anonymity (as outlined above and below) and the proposed interview processes involved are in the information sheet for women ‘survivors’ participants (Appendix E2).</p> <p>Appendix F is the initial information sheet that will be sent out to the community nurses</p>
<p>Consent form</p>	<p>Each person participating in the research will be provided with adequate written information about what is being asked of them, the rationale and purpose of the research and how their information will be used, managed, stored and destroyed. This will include obtaining specific permission to audio-tape the interviews.</p> <p>The women ‘survivors’ will be fully informed about the nature of the questions they will be asked and that they will have the opportunity to stop the interview at any point or not answer any particular question (example consent forms - Appendix G). The practitioners consent form (Appendix G1) contains an additional question that confirms they understand what would be the consequences of unsafe or unethical clinical practice being disclosed.</p> <p>It is acknowledged however that consent is often a process and should be revisited and</p>

	re-affirmed throughout the data collection stage particularly if unforeseen situations arise.
Letters	Letter sent to Head of Integrated Governance at XXX – Appendix A Letter received from Head of Integrated Governance – Appendix B Proposed letter for individual line managers of the staff group members – Appendix C
Questionnaire	N/A
Interview guide	Attached (Appendix H)
Dissemination of results	The World Health Organisation Ethical and Safety Guidance for Research on Domestic Violence against Women (WHO, 2001) state that there is an ethical obligation to ensure that findings in domestic violence research are properly interpreted and used to advance policy and intervention development.  This completed study will be presented as a Doctoral Thesis. Elements of it may be subsequently used for journal publication or conference presentation papers. XXX Director of Operations will receive a copy of the final report.
Other issues	<ul style="list-style-type: none"> <li>• <b>Ensuring the physical safety of the research participants</b> It is not anticipated that participation in this study will pose any physical risk to any member of the community nursing group. Interviews will all be carried out on organisational premises, during working hours at a mutually agreed time.  The women in the ‘survivors’ group will always be approached via the contact method of their choice and in the manner determined by them. Initial contact will be by telephone directly through the relevant Support Group.  Risk assessment and preparation including careful attention to maintaining the anonymity of the participants are intended to mitigate any potential risk during the interview phase of the study. This will include conducting the interviews in a private space within a local health centre that is easily accessed by public transport.</li> <li>• <b>Managing emotional labour</b> There is a growing awareness that researchers undertaking qualitative research on sensitive topics may be emotionally affected by the work that they do – to the point of experiencing emotional exhaustion (Dickson-Swift et al, 2008). In this study steps will be taken in advance to mitigate this effect by establishing a system of Clinical Supervision so that debriefing and support can be available to the researcher. Keeping a reflexive journal throughout the process can be another practical strategy to work with any emerging emotional responses to the subject matter.</li> <li>• <b>Maintaining boundaries</b> Management of the relationship with the participants is also part of effectively managing emotional labour during the researching of sensitive topics. This includes the management of ‘self’ during the interview process. It is anticipated that the researcher’s considerable experience as a healthcare professional will contribute towards successfully maintaining a sense of ‘professional detachment’ enabling clear boundaries to be established between self and research participant. This includes the prior planning of strategies for leaving the research relationship.</li> <li>• <b>Respect and dignity</b> At all times each participant will be treated with respect and with an awareness of any potential cultural, religious or racial divisions that may be present and the researcher is aware of the responsibility to act with integrity throughout the research process. This includes accepting that diverse perspectives on the subject matter may exist and</li> </ul>

	<p>understanding that ensuring democratic participation throughout is important.</p> <p>It is acknowledged that some of the participants may have had to deal with stigma and discrimination at times in their lives and it is not the intention of the researcher to further exploit any woman interviewed. The principles of beneficence and non-maleficence will be applied at all times via the practice of reflexivity - which is intended to be carried out throughout the research process.</p>
Where application is to be made to NHS Research Ethics Committee / External Agencies	<p>As stated above, University ethics approval (SREP) is required <u>before</u> research governance approval will be considered by the local R&amp;D Committee.</p> <p>IRAS application is not considered as being required.</p>
All documentation has been read by supervisor (where applicable)	<p>Read by Supervisor:</p>  <p>Date –29/04/2013</p> <p>Name of Supervisor – Dr Rachel Armitage</p>

**All documentation must be submitted to the SREP administrator. All proposals will be reviewed by two members of SREP.**

**If you have any queries relating to the completion of this form or any other queries relating to SREP's consideration of this proposal, please contact the SREP administrator (Kirsty Thomson) in the first instance – [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)**

**Appendices:**

**Appendix A** – Letter requesting organisational approval to undertake the study

**Appendix B** – Letter from Integrated Governance Lead XXX

**Appendix C** – Managers letter

**Appendix D** – Researcher Safety Risk Analysis and Management form

**Appendix E** – Information sheet for the Support Group volunteers

**Appendix F** – Information sheet for community nurses

**Appendix G** – Consent form

**Appendix H** – Interview guide

## **References:**

Dickson-Swift, V., James, E.L., Liamputtong, P. (2008) *Undertaking Sensitive Research in the Health and Social Sciences*. Cambridge UK. Cambridge University Press.

XXXXX Joint Strategic Needs Assessment for XXXX (2010) *Health and Wellbeing: key issues for the people of XXX*. JSNA, 2010

Liamputtong, P. (2007) *Researching the Vulnerable*. London: Sage.

Morgan, D.L., Krueger, R. A. (1997) *Focus Groups as Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Morse, J.M., Field, P. (1995) *Qualitative Research Methods for Health Professionals*. Thousand Oaks, CA: Sage Publications.

Nursing and Midwifery Council (2008) *Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.

World Health Organisation (2001) *Putting Women First: Ethical and safety recommendations for research on domestic violence against women*. Switzerland: WHO.

University of Huddersfield (2011) *Ethical Guidelines for Good Practice in Teaching and Research*.

Your SREP Application - Catherine Smyth (Prof Doc Student) - APPROVED - What are the barriers South Asian women living with violence experience in seeking help from Community Health Services? (Ref: SREP/2013/34)

Kirsty Thomson

To: Catherine Smyth U9002118  
Cc: Rachel Armitage; Karen Ousey; Nigel King

03 July 2013 09:31

- You replied on 12/07/2013 07:31.

Dear Catherine,

Dr Karen Ousey, Deputy Chair of SREP, has asked me to confirm that you have addressed the issues raised to her satisfaction and full ethical approval has now been granted.

With best wishes for the success of your research project.

Regards,

Kirsty  
(on behalf of Dr Karen Ousey, Deputy Chair of SREP)

Kirsty Thomson  
School of Human and Health Sciences Research Office (HHRG/01)  
University of Huddersfield  
Queensgate  
Huddersfield  
HD1 3DH  
Direct Tel: +44(0)1484 471156  
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## Appendix I 2 Ethics Application (amendments)

### THE UNIVERSITY OF HUDDERSFIELD

#### School of Human and Health Sciences – School Research Ethics Panel

#### AMENDMENT(S) TO PREVIOUSLY APPROVED APPLICATION

(Attach separate sheets as necessary)

Applicant Name: Catherine Smyth

Title of previously approved study: ***What are the barriers South Asian women living with violence experience in seeking help from Community Health Services?***

Date approved: July 2013 (SREP/2013/34)

(please also give details here if the title is to be revised):

***Using the experiences and knowledge of health visitors from the north of England working with South Asian women who are living with violence to influence future domestic abuse policy and practice***

Issue	Please clearly identify below revisions made to previously approved SREP application.
Researcher(s) details	No change
Supervisor details	No change
Aim / objectives	<p><b>Aim:</b></p> <p>By exploring the knowledge and experience of health visitors who work with South Asian Women living with violence, this study aims to find out what it is that health visitors feel is different from working with other groups of abused women and what specific challenges to practice that difference brings. The study will elicit the health visitors' views on existing domestic violence policy and interventions and how they impact both positively and negatively on outcomes for South Asian women. It is intended that the findings of the study will influence better and more effective ways of preparing community nurses for working with this particular population group.</p> <p><b>Objectives:</b></p> <ol style="list-style-type: none"> <li>1. To improve understanding of the specific nature of violence experienced by South Asian women living in Britain by considering issues such as gender, diaspora, the concepts of shame and honour, and collectivist culture</li> <li>2. To explore the suggestions made within the literature that current domestic violence policy and provision in Britain does not meet the needs of many South</li> </ol>

	<p>Asian women</p> <p>3. To provide both an applied and a theoretical value to any emergent themes regarding domestic violence interventions, that can be used to advance clinical effectiveness in relation to this population group</p> <p>4. To suggest how safer outcomes for South Asian women experiencing violence can be achieved and thus inform Health Visiting practice</p> <p>5. To influence better ways of preparing Health Visitors for working with women and families from South Asian communities</p>
Methodology	<p>Data will be collected by <b>semi-structured interview</b>.</p> <p><u>Note:</u> The intention within the first ethics submission was to undertake a focus group interview, after discussion with Supervisors each health visitor will now be interviewed separately.</p> <p>Purposive sampling has already been carried out in order to target those health visitors with the necessary knowledge and experience. A community healthcare provider from West Yorkshire has agreed to participate in the research. The aim is to undertake in depth one-to-one interviews with approximately 12 individuals. Health visitors have been selected who work with predominantly South Asian 'caseloads'.</p> <p>All participants will be asked to read and sign a consent form. Interviews will be audiotaped and are expected to last an hour to 90 minutes. Open ended semi-structured questions will be used. The personal reflections of the researcher (who is also the interviewer) will also be made. Data protection and confidentiality measures that will be taken have been outlined in detail within the original ethics submission for this study.</p> <p>The approach to data analysis will be <b>thematic analysis</b>. Thematic analysis is a widely used qualitative analytical method, often not seen as a specific method but as a tool to use across different methods. . Academically applied however, it is able to provide a flexible and useful research tool which can potentially provide a rich and detailed yet complex account of data that is theoretically and methodologically sound.</p>
Permissions for study	No revisions required – all permissions previously gained. The letters to line managers have however been slightly amended as outlined below.
Access to participants	<p>Women domestic violence 'survivors' will no longer be sought to interview. I will only be interviewing health visitors (previous ethics approval was for both groups of participants).</p> <p>Each health visitor participant has been contacted and has verbally agreed to be interviewed individually (previously initial consent was to participate in a focus group interview)</p>
Confidentiality	No revisions required
Anonymity	No revisions required
Psychological support for	No revisions required

participants	
Researcher safety / support  (attach complete University Risk Analysis and Management form)	The revised methods <i>reduce</i> risks to researcher (updated Risk Analysis form attached)
Information sheet	Revised information sheet for participants attached (very minimal changes)
Consent form	No revisions required other than a change to the title of the research (attached)
Letters	Letter to managers changed slightly to state 'interview' as opposed to 'focus group' (attached)
Questionnaire	N/A
Interview schedule	Revised (attached)
Dissemination of results	No revisions
Other issues	None
Where application is to be made to NHS Research Ethics Committee	N/A
All documentation has been read by supervisor (where applicable)	Read and discussed at supervision on 25 March 2014

Signed:

*Catherine J Smyth*

---

(SREP Applicant – electronic signature acceptable)

Date: 5 April 2014



Catherine Smyth - Revision to previously approved SREP Application - APPROVED - Using the experiences and knowledge of health visitors from the north of England working with South Asian women..... - SREP/2013/34\_Rev\_1\_050414

Kirsty Thomson

To: [Catherine Smyth U9002118](#)

Cc: [Dawn Leeming](#); [Rachel Armitage](#); [Karen Ousey](#); [Jane Tobbell](#)

07 April 201

Dear Catherine,

**Revision to previously approved SREP Application**

**Previous Research Title:** What are the barriers South Asian women living with violence experience in seeking help from Community Health Services?

**Approved:** 03-Jul-13 (SREP/2013/34)

**Revised Research Title:** *Using the experiences and knowledge of health visitors from the north of England working with South Asian women who are living with violence to influence future domestic abuse policy and practice*

**Revision Approved:** 07-Apr-14 (SREP/2013/34\_Rev\_1\_050414)

Dr Karen Ousey, Chair of SREP, has asked me to contact you with regard to your proposed revisions submitted on 05-Apr-14 in connection with your previously approved SREP application (approved 03-Jul-13).

I confirm that the revisions to your SREP application as detailed above have received full ethical approval.

With best wishes for the success of your research project.

Regards,

Kirsty  
(on behalf of Dr Karen Ousey, Chair of SREP)

**Kirsty Thomson**

Research Administrator

☎: 01484 471156

✉: [K.Thomson@hud.ac.uk](mailto:K.Thomson@hud.ac.uk)

🌐: [www.hud.ac.uk](http://www.hud.ac.uk)

School of Human and Health Sciences Research Office (HHRG/01)  
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

**Sent:** 23 June 2014 15:02  
**To:** Catherine Smyth U9002118; Kirsty Thomson  
**Subject:** Re: Changes to Ethics Application 2013/34 Rev 1 050414

Hi Catherine,  
Yes that is fine

Kirsty please see below I am happy to take chairs action for the changes  
Best wishes, Karen

Sent from my iPhone  
On 23 Jun 2014, at 15:00, "Catherine Smyth U9002118" <[U9002118@hud.ac.uk](mailto:U9002118@hud.ac.uk)> wrote:

Hi Karen, regarding my (very recent) email. Dawn Leeming has suggested I briefly explain the proposed changes to save you time reading through all the attachments (see email below).

My Ethics approval was previously to interview health visitors from XXX. I have since decided it would be better to open up the study to include other community nurses as well, not just health visitors (e.g. district nurses & school nurses) - from the same organisation. I have R&D approval from XXX to do that.

Hope this makes it a bit clearer. Thank you.

Regards, Catherine Smyth

---

**From:** Dawn Leeming  
**Sent:** 23 June 2014 14:49  
**To:** Catherine Smyth U9002118  
**Subject:** RE: Changes to Ethics Application 2013/34 Rev 1 050414

Hi Cath,

Might be worth a further email clarifying that the only change is that you are expanding from just HVs to all community nurses & that when you say 'community nurses' this includes HVs (just means Karen doesn't have to hunt through everything to check what you're changing & that you'll be less likely to be asked to redo your form)

Best, Dawn

---

**From:** Catherine Smyth U9002118  
**Sent:** 23 June 2014 14:44  
**To:** Karen Ousey  
**Cc:** Dawn Leeming; Rachel Armitage  
**Subject:** Changes to Ethics Application 2013/34 Rev 1 050414

Hi Karen, following Supervision last week I have made some small changes to my study. In light of this I have received updated R&D approval from the organisation I'm working with, which I have attached - along with the completed amendments form. I have also attached those documents I'm using where there have been some slight changes to the wording. There are no significant changes or new ethical considerations. Please can you let me know when I have your approval to make these changes and continue. Thank you.

Regards, Catherine Smyth

## Appendix I 3 Ethics Application Risk Assessment

### THE UNIVERSITY OF HUDDERSFIELD: RISK ANALYSIS & MANAGEMENT

<b>ACTIVITY: Research</b>			Name: Catherine Smyth (U9002118)	
LOCATION: XXX Health Centre Premises			Date of original submission: July 2013	Date Reviewed: April 2014
<b>Hazard(s) Identified</b>	<b>Details of Risk(s)</b>	<b>People at Risk</b>	<b>Risk management measures</b>	<b>Other comments</b>
Lone worker/researcher	Personal safety	Researcher	All interviews with health visitors to take place on XXX premises. Consent for this has been obtained. Consulting rooms have 'panic' measures in place for gaining help if necessary. At the request of the participants some interviews may take place elsewhere in which case this will be clearly stated within electronic diaries, to which all managers have access to view. Provide an interview itinerary to a competent person and report back when finished (giving a pre-agreed approximate time). Have a back-up plan for if the researcher does not report back.	All XXX Health and Safety and Lone Worker Guidelines will be adhered to throughout
Risk of intimidation or abuse	Threats from the local community if the nature of the research is known	Researcher	Report any threats or intimidation to the police. Keep academic supervisors informed of untoward occurrences. Complete and submit to XXX Risk Manager Incident Forms where indicated. Anonymity of all aspects of the research to be maintained throughout	
Emotional risk	Coping with disclosure  Emotional overload	Researcher	Clinical Supervision processes in place. De-briefing / peer support available. Planning for dealing with significant emotional reaction from the	

	<p>Vicarious traumatization</p> <p>Dealing with personal unresolved issues</p>		<p>research participants/managing distress. Spacing of the interviews to reduce the risk of emotional exhaustion. Consider strategies for 'emotional distancing' and how to end the relationship. Become familiar with signs of 'burn-out'</p>	
Loss of / theft of data	<p>Security</p> <p>Information Governance</p>	Interviewee	<p>Electronic data to be stored on a password protected computer or encrypted USB stick that was not transported between places (would be kept in a locked office drawer). Dictaphones with audio recordings to be transported in a lockable case. No personal identifiable data to be kept with either of the above. Laptop and any other data storage device to be transported in the boot of the car. All equipment used to be transported as little as possible (i.e. only when necessary for use during the interview). When not in use, kept in a locked office on XXX premises</p>	
Physical health and well-being	<p>Musculoskeletal problems from poor posture whilst using computer/laptop.</p> <p>Visual problems from extensive periods of time looking at the screen</p>	Researcher	<p>Adhere to all Moving and Handling principles in terms of posture, rest, use of equipment. Complete XXX Moving and Handling in-house training programme as mandated. Attend for routine vision testing as recommended</p>	

## Appendix J Consideration of Different Research Approaches

Research strategy	Rationale for how this fits or doesn't fit with this study
Narrative	More useful for telling the story of a single individual and I want to get at the essence of the experience and acquired knowledge of a group of individuals.
Grounded Theory (both Strauss & Corbin and Charmaz)	I can see how Charmaz's approach particularly might work for this study as I am looking for a theoretical explanation of why something (i.e. an intervention) doesn't currently seem to work for a particular population group. I'm not sure however that practically I can keep going back to the participants and testing out the emerging theory, as appears to be suggested with this iterative approach. The numbers of interview suggested as being required i.e. 20-60 would also be prohibitive However, I see my study more as knowledge building rather than theory building. Also, grounded theory avoids engagement with existing theory during the analysis process therefore could be incompatible with a critical realist approach to data analysis
Case Study	I am not exploring a life/lives.
Ethnography	I am not attempting to describe the behaviour of a cultural group by immersing myself within that group or by direct observation.
Phenomenology	I want to look at both knowledge and experience. Experience in this study is more about professional experience rather than the 'lived experience' of individuals. I'm more interested in how the health visitors currently apply their experience in clinical practice and how this works or doesn't work for this population group. What experience and knowledge have they gained, and how can that influence future policy/training etc. How do such things as intuition, interpretation and perception which come from experience, fit with the more traditional forms of empirical evidence currently encouraged. This study focuses to a great extent on <i>other people's</i> experience; I'm not convinced therefore it is the natural fit for this study.
Thematic analysis	Accessible and theoretically flexible approach. Methodologically sound as long as my own theoretical position and assumptions are clearly stated. Fits within a realist or constructionist paradigm and would appear to fit with the theory of critical realism which I'm considering for the approach. I think this would work well if academically applied in the way suggested by Braun & Clarke and the stated pitfalls avoided.

## Appendix K 1

# Node Summary<sup>22</sup>

## Thesis

Source Type	Number of Sources <sup>23</sup>	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded
-------------	---------------------------------	-----------------------------	-----------------------	----------------------------

### Node

**Nickname:** Nodes\\Behaviour in household

**Classification:**

**Aggregated:** No

Document	19	190	9,594	303
----------	----	-----	-------	-----

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**Nickname:** Nodes\\Behaviour in household\Family violence

**Classification:**

**Aggregated:** No

Document	17	91	4,928	156
----------	----	----	-------	-----

---

**Nickname:** Nodes\\Behaviour in household\Honour, Shame

**Classification:**

**Aggregated:** No

Document	11	29	1,232	42
----------	----	----	-------	----

---

**Nickname:** Nodes\\Behaviour in household\IPV

**Classification:**

---

<sup>22</sup> This report is intended to provide the reader with an overview of the coding and grouping process. Several nodes were created to hold peripheral data. These do not feature in this report

<sup>23</sup> This number includes ALL sources of data gathered during this project. Some (e.g. District nurses) were excluded from the final analysis however brief notes are included in the appendices for information.

**Aggregated: No**

Document 10 34 1,766 56

Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded
-------------	-------------------	-----------------------------	-----------------------	----------------------------

**Nickname: Nodes\\Covert practice**

**Classification:**

**Aggregated: No**

Document 14 44 2,910 75

**Nickname: Nodes\\Difference in violence**

**Classification:**

**Aggregated: No**

Document 13 56 2,887 95

**Nickname: Nodes\\DV general**

**Classification:**

**Aggregated: No**

Document 12 23 1,017 29

**Nickname: Nodes\\Gender issues**

**Classification:**

**Aggregated: No**

Document 12 26 1,136 32

**Nickname: Nodes\\Health Visitors knowledge**

**Classification:**

**Aggregated: No**

Document 16 163 8,648 332

Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded
-------------	-------------------	-----------------------------	-----------------------	----------------------------

**Nickname:** Nodes\\HV role in DV

**Classification:**

**Aggregated:** No

Document	14	199	10,804	302
----------	----	-----	--------	-----

**Nickname:** Nodes\\HV role in DV\How it feels

**Classification:**

**Aggregated:** No

Document	16	119	5,810	219
----------	----	-----	-------	-----

**Nickname:** Nodes\\HV role in DV\Professional issues

**Classification:**

**Aggregated:** No

Document	13	43	2,124	71
----------	----	----	-------	----

**Nickname:** Nodes\\HV role in DV\Safeguarding

**Classification:**

**Aggregated:** No

Document	14	61	3,254	79
----------	----	----	-------	----



**Nickname:** Nodes\\HV role in DV\what women expect

**Classification:**

**Aggregated:** No

Document	15	45	2,321	55
----------	----	----	-------	----

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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded
-------------	-------------------	-----------------------------	-----------------------	----------------------------

**Nickname:** Nodes\\HV role in DV\What works doesn't work

**Classification:**

**Aggregated:** No

Document	16	201	12,322	311
----------	----	-----	--------	-----

---

**Nickname:** Nodes\\Interpreters contribution (HV view of)

**Classification:**

**Aggregated:** No

Document	16	88	5,194	188
----------	----	----	-------	-----

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**Nickname:** Nodes\\Intuition

**Classification:**

**Aggregated:** No

Document	14	62	3,880	119
----------	----	----	-------	-----

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**Nickname:** Nodes\\Provision (stat & vol)

**Classification:**

**Aggregated: No**

Document	15	130	7,587	263
----------	----	-----	-------	-----

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**Nickname: Nodes\\Trust**

**Classification:**

**Aggregated: No**

Document	13	39	2,237	72
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## Appendix K 2 Example Coding Summary 'Vanessa' – Data coded at node named Behaviour in Household

### Coding Summary By Source

#### Thesis

Classification	Aggregate	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
----------------	-----------	----------	-----------------------------	------------------	-------------------	-------------

#### Document

Internals\\Interviews\\HVs\\Interview 2 - Vanessa

#### Node

Nodes\\Behaviour in household

No	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On	
	0.1503	28				
			1	CS	13/12/2014 10:24	
<p>I think the women that are in there see the physical abuse as abuse, whereas the controlling and the stopping them from going out just becomes part of their norm, so they don't actually see that as abuse. So it's when it becomes physical that they...</p> <p>Interviewer – So they differentiate in their minds between different types of abuse?</p> <p>Interviewee – Yes. Well to them abuse is just punching, kicking – physical. Verbal and anything else isn't necessarily abuse to them, its normal</p> <p>Interviewer – They just see it as part of normal life?</p>						
			2	CS	13/12/2014 10:25	
<p>I think some of them, how they have grown up, their father figure has been the controlling factor in their life so it's automatic that the husband would be a controlling factor. So they are brought up from a very early age with the male being the controlling factor really so they see it as normal</p>						
			3	CS	13/12/2014 10:26	
<p>a lot of the women are sort of new to the country. I don't know what is said to them before they come over, that they must behave themselves.</p>						
			4	CS	13/12/2014 10:26	
<p>they are told that they can't bring shame upon the family so they must do as their new family tells them to</p>						
			5	CS	13/12/2014 10:26	
<p>quite often they have very limited contact with their own family and the mother-in-law becomes the main person, and the person that the mother spends more time with really, in the house</p>						

6	CS	13/12/2014 10:30
the younger woman spends time with the mother-in-law		
10/04/2016 07:37		
7	CS	03/01/2015 07:39
it is very very difficult to get a contact with the mum on her own. You will find that you go into the house and generally its father-in-law that will sit in, or another male extended family member, that will sit in on the visit and listen to everything and it is very difficult to ask them to leave. I have had people refuse to leave so you do sort of skirt around the issue a little but because you know that mum is not going to answer.		
8	CS	13/12/2014 11:03
what we try and arrange is for them to come to clinic, but again, when they come out to clinic they will come with somebody else which then tends to be mother-in-law when they come to a clinic setting. So it is very difficult to actually speak to them on their own		
9	CS	03/01/2015 07:43
But quite often their mobile phones are monitored as well, or they don't have access to their own mobile phone so it is very difficult.		
10	CS	03/01/2015 07:45
Interviewer – So there doesn't tend to be any natural triggers?		
Interviewee – No, no it's just the norm		
11	CS	03/01/2015 07:46
Interviewer – So it seems to be that that's the expected way of behaving to each other?		
Interviewee – Yes it's an expectation		
12	CS	03/01/2015 07:52
The men in these families and the mother-in-laws in these families are very sort of clever knowing what the core visits are and when we should be going, so they are quite clever at working out that "this isn't a planned visit so what are you coming for?" So you do need to go with a really good excuse.		
13	CS	03/01/2015 07:53
quite often the families will let the young women use the Children's Centre as well so that is another good support and they can build up relationships there.		
14	CS	03/01/2015 07:58
And quite often they are allowed to go to the English classes		
Interviewer – On their own?		
Interviewee – Yes. Yes. Because it's run by the Children's Centre it is seen as acceptable so the Children's Centre really does have quite a lot of authority in the area		
15	CS	03/01/2015 07:58
Very rarely I am refused entry into the home. You're always made to feel very welcome and taken into them so they do offer us a lot of respect.		

16	CS	03/01/2015 07:59
<p>baby clinic they are allowed to come to but they come with the mother. If they are going to the English classes I suppose – something that I have only just thought about – they are coming on their own, they are not bringing their child with them so they have got that tie that they have to go back, they wouldn't run off at that point. So I suppose in a way that that's controlling as well because they know that they've got a hold on that mother haven't they because she will be going back for her baby</p>		
17	CS	03/01/2015 15:46
<p>some of the families that I have worked with, they have told their own parents, and quite often it's "well you'll do as they say now. They're your family. Respect what they want".</p>		
18	CS	13/12/2014 11:24
<p>I still think that the communities all still sort of stay together and adopt a location/a village and then it becomes sort of their area. And then you will get one or two sort of families, sort of moving out. And it tends to be the Indian families that sort of move out and live with different groups of communities</p>		
19	CS	03/01/2015 15:48
<p>Is it still the case that young men are bringing wives in from abroad to live in their family. Its still that way isn't it?</p> <p>Interviewee – Yes. They tend to sort of go over. They go over and meet them and they might spend a couple of months over there and then probably get married at the end of those couple of months and then the man will come back and start arranging the visa and the bits and bats. And then quite often when they go back to pick them up they come back with a baby or they're pregnant so it must take quite a few months to come back. And then they're over here, that's it, they're stuck here.</p>		
20	CS	03/01/2015 15:51
<p>Quite often it's the daughters in the house will be treated as an equal, they're not bullied into anything – I'm just thinking of specific families now – they're not there to do the work, there just sort of treated as an equal. And quite often in some of these cases now the daughters have been brought up in England and so they've got the English language, they've been through the education systems. Quite often they've got jobs and they go out. It's the girls that are brought over</p> <p>Interviewer – So immigration is a big thing isn't it in all of this</p> <p>Interviewee – Yes it is the girls that are brought over with no, or very limited, little education and this threat of deportation, yes. And I suppose they do see there sister-in-law getting a lot more freedom so they are kind of classed as second class citizens really</p>		
21	CS	03/01/2015 15:52
<p>I was trying to get to that really, that they see there is a different life because they see their sister-in-law having a different life</p> <p>Interviewee – Yes they do. And I suppose if they have been brought up here as well then they are going out with their friends on a night-time, they are doing everything that sort of English girls do</p>		
22	CS	03/01/2015 15:53
<p>Obviously the difficulty is that they're in their in-law's home and obviously they still have to be very respectful to the in-laws. The in-laws are the boss.</p>		
23	CS	03/01/2015 15:53
<p>I think little things, bills and things like that, a lot of the bills are sort of left to the in-laws to pay</p>		
24	CS	03/01/2015 15:54
<p>Mother-in-laws top of the pile with regards to the daughter-in-law, whereas father-in-law is the boss of everything</p>		

25	CS	13/12/2014 11:29
<p>he knows what's going on but it's mother-in-law that deals with it. I don't know what involvement he's got in it but he knows what's going on. He doesn't stop it, but he doesn't get involved in it. Very rarely have I ever heard it's father-in-law that is doing any violence. I don't think I have ever heard... I don't think I have ever been in that situation where it's the father-in-law has been the perpetrator</p>		
26	CS	03/01/2015 15:57
<p>It's not a general rule that the whole family treat the sister-in-law as bad but what I would say is that the daughters just don't get involved. Again, they know what's going on, they don't try to stop it or anything</p>		
27	CS	03/01/2015 15:57
<p>So it's like everybody knows their place, and each others?</p> <p>Interviewee – Yes. Yes. And whilst they might not agree with it, they wouldn't actually step in and sort of say “no stop this isn't right”, they kind of pretend its not happening</p>		
28	CS	03/01/2015 16:14
<p>I think they are very family orientated and my own opinion is they probably put family first, whereas we would have the judgment of a doctor first</p>		

## Nodes\\Behaviour in household\\Family violence

No	0.0816	15
1	CS	13/12/2014 10:22
<p>I do work quite closely with a refuge for south Asian women and a lot of the ladies that are in there it is physical abuse that they've been subjected to and with the controlling behaviour as well. And also from mother-in-laws and extended family members. Quite often with mother-in-laws again it's controlling and verbal behaviour. There is one family that I have worked with recently and the prime person that is doing the domestic violence is the mother-in-law and is controlling the mum of the child by saying that they will send her back to Pakistan if she doesn't do what she is supposed to be doing, but they will keep the child</p>		
2	CS	13/12/2014 10:22
<p>So is the woman an immigrant?</p> <p>Interviewee – She is yes. And I think a lot of them they apply for the status but the partner and the mother-in-law tend to sort of take control of that so a lot of the women don't know whether they have got the status or not</p> <p>Interviewer – So that's the permission to remain in the country?</p> <p>Interviewee – Yes. So they don't know whether they have got that or not because that information is withheld from them</p>		
3	CS	13/12/2014 10:23
<p>They're holding the threat over their head, yes, that “if you don't do this then we can send you back” and they don't know any different so they continue to do what they think they have to do and live in that way</p>		
4	CS	13/12/2014 10:25
<p>I think some of them, how they have grown up, their father figure has been the controlling factor in their life so it's automatic that the husband would be a controlling factor. So they are brought up from a very early age with the male being the controlling factor really so they see it as normal</p>		

5	CS	13/12/2014 10:31
visiting somebody and it was a young girl who had fled her arranged marriage and was in hiding basically, pregnant, and was in hiding. And I remember her telling me that if her parents got a hold of her they would, she actually said they would kill her, and she did feel that you know, that was a real possibility		
6	CS	13/12/2014 10:32
She left her husband because it did get physical – and the mother-in-law was also involved		
7	CS	03/01/2015 07:43
But quite often their mobile phones are monitored as well, or they don't have access to their own mobile phone so it is very difficult.		
8	CS	03/01/2015 07:46
Interviewer – So it seems to be that that's the expected way of behaving to each other?		
Interviewee – Yes it's an expectation		
9	CS	13/12/2014 11:12
The men in these families and the mother-in-laws in these families are very sort of clever knowing what the core visits are and when we should be going, so they are quite clever at working out that "this isn't a planned visit so what are you coming for?" So you do need to go with a really good excuse.		
10	CS	03/01/2015 08:00
If they are going to the English classes I suppose – something that I have only just thought about – they are coming on their own, they are not bringing their child with them so they have got that tie that they have to go back, they wouldn't run off at that point. So I suppose in a way that that's controlling as well because they know that they've got a hold on that mother haven't they because she will be going back for her baby		
11	CS	13/12/2014 11:22
from my experience that's very few that sort of take into account the woman's needs		
12	CS	03/01/2015 15:51
the girls that are brought over with no, or very limited, little education and this threat of deportation		
13	CS	13/12/2014 11:29
he knows what's going on but it's mother-in-law that deals with it. I don't know what involvement he's got in it but he knows what's going on. He doesn't stop it, but he doesn't get involved in it. Very rarely have I ever heard it's father-in-law that is doing any violence. I don't think I have ever heard... I don't think I have ever been in that situation where it's the father-in-law has been the perpetrator		
14	CS	03/01/2015 15:57
It's not a general rule that the whole family treat the sister-in-law as bad but what I would say is that the daughters just don't get involved. Again, they know what's going on, they don't try to stop it or anything		
15	CS	03/01/2015 15:57

So it's like everybody knows their place, and each others?

Interviewee – Yes. Yes. And whilst they might not agree with it, they wouldn't actually step in and sort of say "no stop this isn't right", they kind of pretend its not happening

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### Nodes\\Behaviour in household\\Honour, Shame

No	0.0331	7			
			1	CS	13/12/2014 10:26
			they are told that they can't bring shame upon the family so they must do as their new family tells them to		
			2	CS	13/12/2014 10:30
			Do you think this issue of shame is a big... is of importance in the family? Bringing shame on the family?		
			Interviewee – Yes, yes, a big one		
			3	CS	13/12/2014 10:31
			visiting somebody and it was a young girl who had fled her arranged marriage and was in hiding basically, pregnant, and was in hiding. And I remember her telling me that if her parents got a hold of her they would, she actually said they would kill her, and she did feel that you know, that was a real possibility		
			4	CS	13/12/2014 10:31
			So is there an issue of bringing shame on the birth family as well as the in-laws?		
			Interviewee – Yes		
			5	CS	13/12/2014 10:32
			her parents came round to see her and said "look you have got to make a go of this. You must go back otherwise it will bring shame on the family", so she actually had to go beg her mother-in-law and her husband to let her go back into the house. The mother-in-law wouldn't... so her family are disowning her now because she has brought that shame of divorce upon the family. So yes I think a divorce or talking about their experiences in the wider community will bring the shame on both families		
			6	CS	03/01/2015 15:46
			haven't got the opportunity to go back and go back home to their mum and dad like we probably would because it does bring shame upon them – embarrassment – that you know, they're not able to keep their husband or..... And I think some of the families that I have worked with, they have told their own parents, and quite often it's "well you'll do as they say now. They're your family. Respect what they want".		

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### Nodes\\Behaviour in household\\IPV

No	0.0158	2			
			1	CS	13/12/2014 10:21
			violence from husband which can be physical. A lot of it I would say is more verbal than the physical, such as not letting them out of the house. Controlling behaviour. Controlling their finances. Controlling where they go.		
			2	CS	13/12/2014 10:24



I think the women that are in there see the physical abuse as abuse, whereas the controlling and the stopping them from going out just becomes part of their norm, so they don't actually see that as abuse. So it's when it becomes physical that they...

Interviewer – So they differentiate in their minds between different types of abuse?

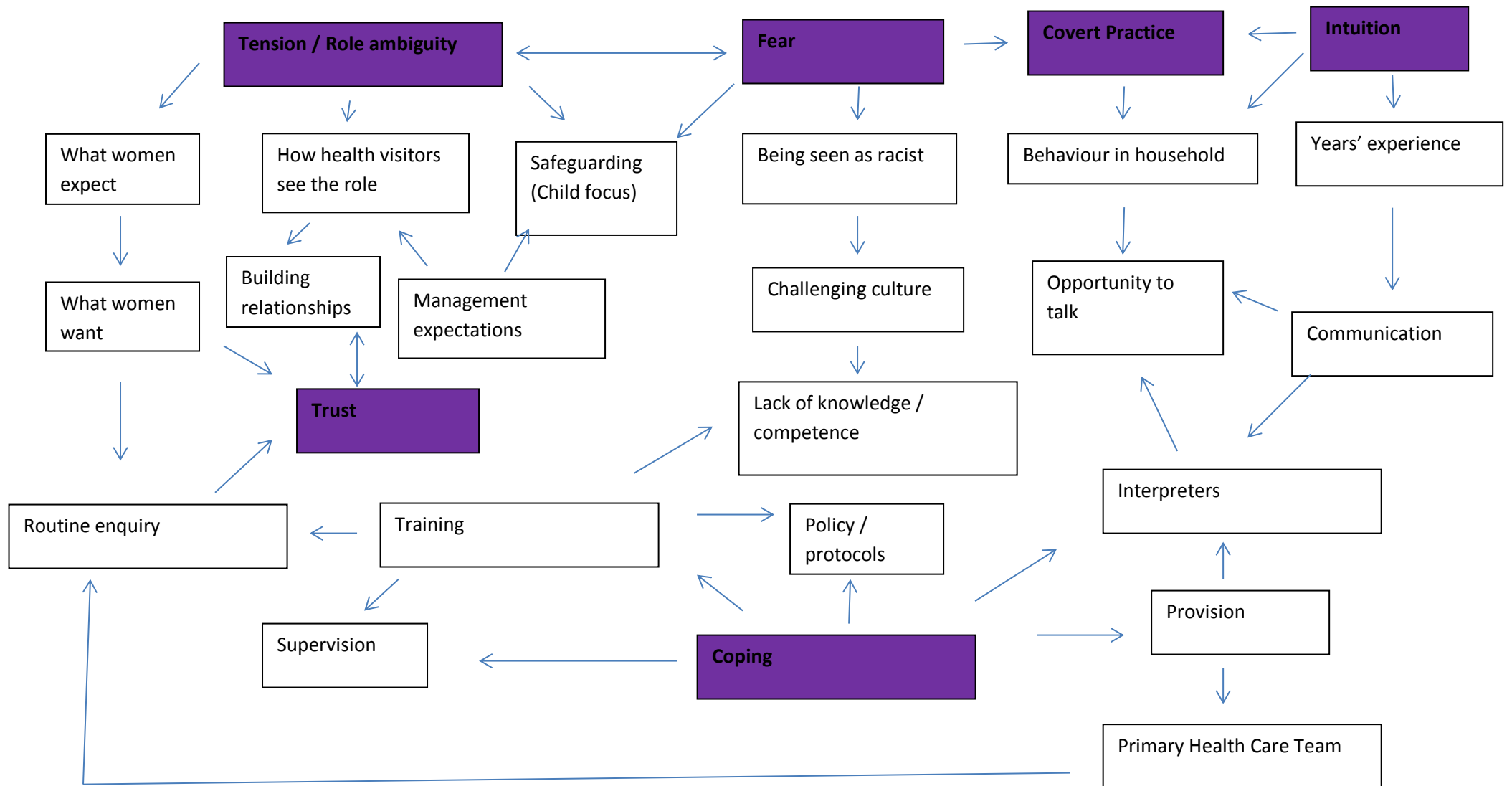
Interviewee – Yes. Well to them abuse is just punching, kicking – physical. Verbal and anything else isn't necessarily abuse to them, its normal

Interviewer – They just see it as part of normal life?

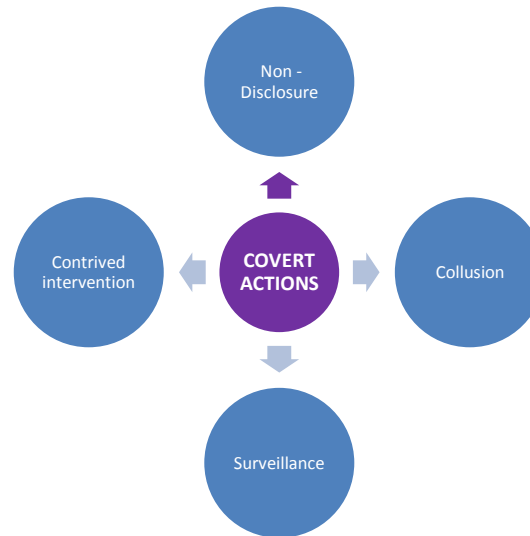
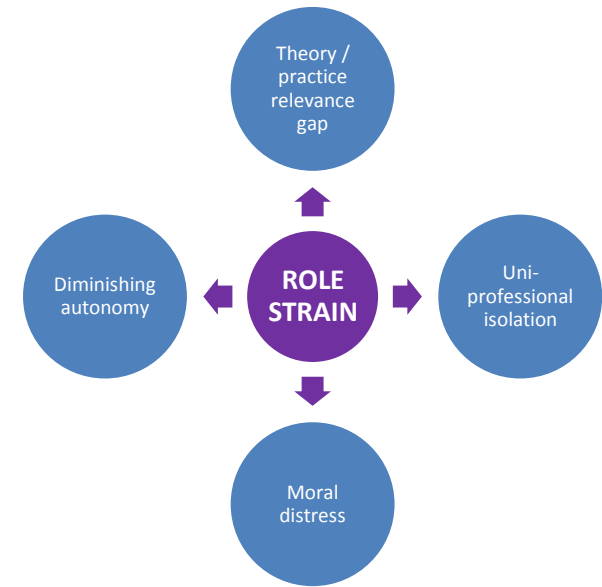
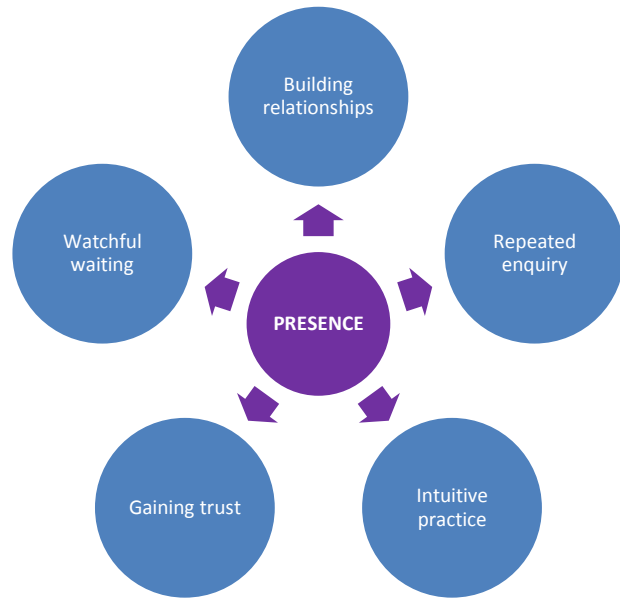
Interviewee – Yes.

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## Appendix L Thematic Mind Map (Initial Data Categories and Sub-categories)



## Appendix L2 Candidate Themes





## Drugs and Alcohol Today

Alcohol and violence - exploring the relationship  
Catherine Smyth

### Article information:

To cite this document:

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(2012), "Controlling pre-loaders: alcohol related violence in an English night time economy", *Drugs and Alcohol Today*, Vol. 1 Iss 2 pp. 89-97 <http://dx.doi.org/10.1108/17459261211235119>

(2013), "Co-producing addiction aftercare", *Drugs and Alcohol Today*, Vol. 13 Iss 4 pp. 225-233 <http://dx.doi.org/10.1108/DAT-05-2013-0024>

# Alcohol and violence – exploring the relationship

Catherine Smyth

Catherine Smyth is the Head of Quality, based at Locala Community Partnerships West Yorkshire and is undertaking Doctorate studies at the University of Huddersfield, Huddersfield, UK.

### Abstract

**Purpose** – Concerns about the alcohol – violence correlation are increasing and impacting on social policy in the UK and throughout the world. It is not certain, however, how much, or if at all, violence is linked to alcohol consumption. The purpose of this paper is to contest often widely held notions and accepted views about alcohol-related violence and to highlight a belief that the link between the two is much more complex than it is sometimes portrayed.

**Design/methodology/approach** – Review and analysis of the recent literature.

**Findings** – Many studies throughout the literature claim to evidence a biological or pharmacological explanation for the relationship between alcohol and violence in terms of the effect alcohol has on the central nervous system and ensuing behaviour. Other authors who focused on the fact that the relationship may be mediated by all kinds of other personal, social, environmental and cultural factors argue that the effects of alcohol depend upon the social context in which the drinking occurs. From this analysis, four main perspectives and subsequent theories emerge which appear to define the concept.

**Originality/value** – By challenging what is often seen by some as a mechanistic causal link between alcohol and violence, clinicians and other professionals working with those individuals affected by alcohol dependence can suggest interventions that help perpetrators of violence work towards addressing their aggression that are not necessarily dependent upon how successful they are in reducing their alcohol consumption.

**Keywords** Violence, Alcohol, Aggression, "Excessive drinking", "Heavy drinking"

**Paper type** Conceptual paper

## Appendix M2

### Letter from Professional Doctorate Exam Board



25 March 2013

Mrs Catherine Smyth  
39 Bradford Road  
WAKEFIELD  
WF1 2RF

Dear Catherine

As Chair of the Professional Doctorate Examination Board I have the privilege of writing to congratulate you on your outstanding performance.

Marks presented to the board on 5 February 2013 indicate that you have worked to a consistently high standard. The Examination Board Members have requested that I write to you in recognition of your hard work and achievements.

Congratulations from the Professional Doctorate Examination Board Members.

Yours sincerely



**Nichola Barlow**

Chair of the Professional Doctorate Examination Board / Senior Lecturer

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## Appendix M 3

### Engaging with Methodology: Diversity Questions and Challenges

31 May 2013 University of Brighton

<b>Name of presenter</b>
Catherine Smyth
<b>Presentation type</b>
Round table discussion – Chair
<b>Institute</b>
University of Huddersfield. West Yorkshire
<b>Programme of work being undertaken</b>
Professional Doctorate (Nursing)
<b>Title</b>
Managing Personal Risk when Undertaking Sensitive Research
<b>Abstract</b>
<p>Many areas of research have the potential to be threatening to those taking part, and this is particularly true for researchers exploring issues sometimes labelled as taboo subjects. Examples of such may be drug abuse, deviance and violence. Topics that invade the private sphere of people's lives and certain cultures can be particularly sensitive and are often 'gate-kept' quite fiercely by professionals working in the field, by ethics committees or by the community themselves - though inevitably different groups of people will have differing perceptions of risk. Quite often managing, minimising and mitigating those risks to potential participants needs to be a fundamental part of research methodology and planning.</p> <p>Sensitive research though, can sometimes also prove to pose a risk to the researcher in cases where the research process itself evokes emotional distress or at times even threatens personal security or safety. Much of the literature regarding vulnerability in research however appears to focus on the vulnerable nature of the research subject as opposed to the researcher's own physical and emotional susceptibility.</p> <p>This round table discussion aims to provoke debate about the potential dangers faced by researchers investigating sensitive topics and how to mitigate against them during the research planning process. Issues such as managing boundaries, emotional labour and self-disclosure will be explored as well as ways to lessen the possible physical risks and dangers researchers may sometimes face. The presenter's own current area of research into family violence as it is experienced by South Asian women will be used as an example of research into a sensitive area of life. The methodological challenges it is raising will be shared and opened up for round table discussion in order to stimulate interesting debate and foster learning.</p>

## Appendix M 4

North West Gender Conference 2015

Abstract and Biography

<b>Name of presenter</b>
Catherine Smyth
<b>Institute</b>
University of Huddersfield. West Yorkshire
<b>Title</b>
Health Visitors' accounts of failing to meet the needs of Pakistani women suffering gendered violence and abuse
<b>Abstract</b>
<p>The aim of this research is to use the knowledge and experience of community nurses to explore suggestions made within the academic literature that current domestic violence policy and provision does not meet the specific needs of many South Asian women suffering gendered violence and abuse.</p> <p>Using qualitative methodology and writing from a clinical perspective influenced by feminist theory, the author has interviewed 14 community nurses working within a Pakistani population in the north of England. The semi-structured interviews reveal how training fails to equip community nurses with the skills and knowledge to ease the suffering of this population group. Current clinical policy focuses largely on safeguarding children, and interventions intended to protect adults neglect to address the role of the wider family in gendered violence and abuse. The childless woman appears particularly vulnerable.</p> <p>The study is raising issues of human rights and how state intervention can have a detrimental impact on Pakistani women's struggle for greater freedom. It reveals how nurses negotiate their way through a patriarchal and sometimes hostile family system. Nurses speak of frequently 'bending the rules' and adapting their clinical practice in an attempt to reach out to these women. This is the nurses' account of feelings of inadequacy, a seemingly inconsistent approach to clinical practice, personal worries of challenging what is believed to be 'cultural', and a fear that not tolerating 'difference' could be viewed as racist.</p>
<b>Biography</b>
<p>Catherine Smyth is presently undertaking a Professional Doctorate in Nursing at the University of Huddersfield. Many years of professional experience working among women living with domestic abuse and academic interests in gender and women's health issues has led to this study of family violence within Pakistani households. Her only publication to date has been a review and analysis of the recent literature on alcohol related violence (Smyth, 2013).</p> <p>Smyth, C. (2013). Alcohol and violence – exploring the relationship. <i>Drugs and Alcohol Today</i>, 13(4), 258-266. doi: 10.1108/DAT-04-2013-0019</p>

## Appendix M 5

### Presentation to Feminist and Women's Studies Association Biennial Conference 2015

   
UNIVERSITY OF LEEDS

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Feminist and Women's Studies Association (FWSA)  
Biennial Conference 2015:  
Everyday Encounters with Violence:  
Critical Feminist Perspectives

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Wednesday 9 September – Friday 11 September 2015

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Stage@Leeds  
University of Leeds, UK

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**Thursday 10 September**

**14:00-15:30 - Parallel Session 5: Neoliberalism and Feminist Resistance**  
Location: Alec Clegg Studio    Chairs: Laura Clancy, Emily Falconer

- **Feminist Resistance and the Importance of Coalitional Opposition in Neoliberal Times: The Cross Sectoral Violence Against Women Strategy Group**  
Gillian Anderson, Vancouver Island University, Canada
- **Violence Against Women in the Context of Neoliberal Globalization: Austericide in South Europe**  
Iratxe Perea Ozerin, University of the Basque Country, Spain
- **'Strong Russian Women' as National Characteristic, and Hair as a Site of Resistance. How Do Signs and Signifiers Manifested Through Post-Soviet Hairstyles Liberate and Reinforce Tropes of Female and Other?**  
Kitty Brandon-James, The British Higher School of Art and Design, Russia
- **Encountering the Structural Violence of Neoliberal Nationalism: Beauty Queens and Hindu Militants in India**  
Nazia Hussein and Saba Hussain, University of Warwick, UK
- **Questions and Answers**

**14:00-15:30 - Parallel Session 5: Domestic Violence**  
Location: Dance Studio    Chairs: Helen Snailth, Finn Mackay

- **When There's Nowhere to Run: Experiences and Constructions of Rural Domestic Violence in SW England**  
Jo Little, University of Exeter, UK
- **Community Nurses' Accounts of Failing to Meet the Needs of Many Pakistani Women Experiencing Abuse**  
Catherine Smyth, The University of Huddersfield, UK
- **Locating 'Gender' in the Gender-Based Violence, Domestic Abuse and Sexual Violence (Wales) Bill**  
Natalie Davies, Bangor University, UK
- **Towards Intimate Geographies of Peace? Local Reconciliation of Domestic Violence in Cambodia**  
Katherine Brickell, Royal Holloway, University of London, UK
- **Questions and Answers**



## Appendix M 6

Best Abstract award winner at the Huddersfield University PGR Conference 2015



Room: BSG/22 - Medical & Psychological Science & Theory			Room: BSG/23 - Business, Innovation & Technology		
<b>Session 1C</b>			<b>Session 1D</b>		
10:00	Yeshtwanth Pulijala	Learn through surgeon's eyes: Application of immersive virtual reality experience to improve the training methods of Oral and maxillofacial surgery	10:00	Moamar Hamed	Frequency Response Function (FRF) Technique for the Diagnosis of Dynamic Characteristics of Suspension System
10:15	Michelle McHugh	Enhancing complex wound prognosis using advanced metrology techniques	10:15	Danilo Fernando de Oliveira Gomes	The relevance of working on cognitive aspects of design thinking for BIM adoption
10:30	Catherine Smyth	How health visitors in Kirklees endeavour to meet the perceived needs of Pakistani women living with violence and abuse, and the challenges they face in keeping such women safe	10:30	Fathalla Eibargharhi	Dynamic Modelling of Two-Stage Helical Gearbox and Application to Gear Fault Diagnosis
10:45	Becky Scott	'A Discursive Study of People's Representations of Mental Health and Distress in Relation to Austerity and Benefits Culture	10:45	Awis Alhares	A Cross-Country Study of the Effects of Corporate Governance Mechanisms on Risk-Taking, Credit Rating and Cost of Capital
<b>Session 2C</b>			<b>Session 2D</b>		
14:00	Nicola Carroll	Lone Motherhood in Context: Exploring Experiences of Stigma using a Comparative Approach.	14:00	Khaldoon F. Brethee	Analysis of Frictional Effects on the Dynamic Response of Two-Stage Helical Gearbox with Tooth damage and the Implications for Diagnostics
14:15	Dieudonné J. van der Meer	A single test for body fluid identification of criminal case samples using microRNAs	14:15	Saeed Talebi	Tolerance Management in Construction and New Technologies
14:30	Michael Young	A Hidden Agenda: attempts to determine the contribution of nurses to the care of distressed British Imperial minds in Colonial India, 1914- 1947.	14:30	Phillip Clegg	Establishing a best-practice model for effective early-stage Social Enterprise Business Support interventions; the case for CASE
14:45	Ryan Handley	Informal Caregiving and its Effects on Bridge Employees' Wellbeing	14:45	Rabia Jilani	Learning Static Constraints for Domain Modeling from Training Plans
<b>Session 3C</b>			<b>Session 3D</b>		
15:35	David Bruton	A compact FFAG for Radioisotope production	15:35	Andrew Townsend	Surface topography solutions for Additive Manufacturing
15:50	Ashok Patnak	A Comparison of Organizational Cultures around Promoting Equity in Public and Hybrid Healthcare Organizations	15:50	Patsorn Sawatasuk	The Motivation Behind Open Innovation Access in the Support of New Product Development: the Case of Thai Dessert SMEs
16:05	Claire Newton	Studying the long-term psychological effects of emotional abuse experienced in childhood – Abstract.	16:05	Darshil Kapadia	Measurement of Edge Wear in Ceramic-on-Ceramic Acetabular Component of Total Hip Replacement Devices
16:20	Samantha Shepherd	Pre-clinical evaluation of novel inorganic compounds as potential anticancer therapies	16:20	Saad Zighan	An investigation into servitization strategy in the real estate development sector

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