Identifying signs of intimate partner violence

Version Accepted for Publication in *Emergency Nurse*

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Abstract

Intimate partner violence is a major public health and social problem that affects people in every community, culture and country. Nurses can play a very important role in identifying victims who present to healthcare settings domestic abuse-related health issues. Evidence suggests that the majority of women who present to emergency departments have experienced domestic abuse at some point in their life, however, only 5% are identified by healthcare professionals. To be able to effectively identify and respond to victims, emergency nurses need to understand domestic abuse and its associated complexities. This article provides an overview of the issue, including the different types of abuse, prevalence, causes and effects on health. It also explores emergency nurses' roles in identifying and managing various situations they may encounter at work.

Keywords: Domestic violence and abuse, DVA, intimate partner violence, IPV, Domestic violence in ED

Introduction

Intimate partner violence (IPV), also known as domestic violence or domestic abuse, is a major public health and social problem that affects people in all communities, cultures and countries. It refers to violence or a pattern of abusive behaviour perpetrated by an 'intimate partner' or ex-partner that results in physical, sexual or psychological harm, and includes physical aggression, sexual coercion, psychological abuse and controlling behaviours (World Health Organisation, 2014).

In the UK, the definition of IPV includes controlling and coercive behaviours. According to the home office (2012), controlling behaviour encompass 'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour.' Coercive behaviour, meanwhile, refers to 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'(Home Office, 2012).

Various other terms are used to describe IPV, including domestic violence, domestic abuse, intra-family violence, wife abuse, spousal abuse, wife battering, courtship violence, battering, violence against women and intimate partner abuse, but IPV is the most up-to-date term (Ali, Naylor, Croot, & O'Cathain, 2015; World Health Organisation, 2014). IPV can be perpetrated by men or women and there is no restriction on marital, heterosexual or homosexual relationship. Although women can be the perpetrators violence against their male partners (Anderson, 2002; Archer, 2000, 2002; Brown, 2004; Capaldi, Kim, & Shortt, 2007; Capaldi & Owen, 2001; Hamberger & Potente1994; Straus & Gelles, 1986), the number of women abused by men is far greater (Archer, 2000; Tjaden & Thoennes, 2000; Whitaker, et al.2007), and the number of women who sustain physical injuries and lose their lives is higher than men (Olive, 2007; Phelan et al., 2005).

Nurses in any healthcare setting can play a crucial role in identifying, preventing and managing domestic violence or IPV (NICE, 2014), however, nurses who work in emergency departments (ED) might regularly encounter victims of IPV, who visit frequently but present with injury or non-injury-related complaints (Houry et al., 2008). Emergency nurses are therefore in a unique position to ask patients about IPV and initiate early intervention.

Evidence suggests that at least 54% of all women who present to EDs have experienced IPV at some point in their life (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995), however only 5% of victims are identified by healthcare professionals (McGarry & Nairn, 2015) and the majority remain unnoticed (Corbally, 2001; McGarry & Nairn, 2015).

Nurses and other ED healthcare professionals must be able to distinguish between injuries resulting from IPV and other causes, and provide patient-centred, sensitive and empathetic care to such patients. However, evidence suggests that victims of IPV believe healthcare professionals often blame them for the abuse, do not show concern, and do not address the abuse (Yam, 2000), even when IPV is obvious (Bradley, Smith, Long, & O'Dowd, 2002), while other research reports that nurses and other healthcare professionals are often unprepared to deal with victims of IPV (Sundborg, Saleh-Stattin, Wandell, & Tornkvist, 2012).

There are numerous barriers to adequate detection of IPV in EDs (Hugl-Wajek, et al.,2012), including lack of time, lack of training (Gerbert et al., 2002; Gutmanis, Beynon, Tutty, WathenC, & MacMillan, 2007; Hugl-Wajek et al.,2012), and nurses' lack of confidence, knowledge and awareness about the issue (Sundborg et al., 2012). Further, this lack of knowledge about IPV and its effects can lead to feelings of inadequacy and frustration, which adds to the barriers (Husso et al., 2012). To be able to effectively identify and respond to victims of IPV nurses need to understand the problem and its associated complexities.

Types of IPV

IPV can be classified as physical, sexual and psychological. Physical IPV refers to the use of physical force to inflict pain, injury or physical suffering including slapping, beating, kicking, pinching, biting, pushing, shoving, dragging, stabbing, spanking, scratching, hitting with a fist or something else that could hurt, burning, choking, threatening or using a gun, knife or any other weapon (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005).

Sexual violence refers to 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including, but not limited to, home and work (Jewkes, Sen, & Garcia-Moreno, 2002, p. 149). In the context of IPV, sexual abuse refers to physically forcing a person to have sexual intercourse, or forcing a partner to do something that he or she finds degrading or humiliating (García-Moreno et al., 2005).

Psychological IPV describes the use of various behaviours to humiliate and control intimate partners in public or private, for example verbal abuse, name-calling, criticising, blackmailing, or embarrassing intimate partner, threatening to beat women or children, monitoring and restricting movements, restricting access to friends and family, and restricting economic independence and access to information, assistance or other resources and services such as education or health services (Follingstad & DeHart, 2000; WHO, 2002).

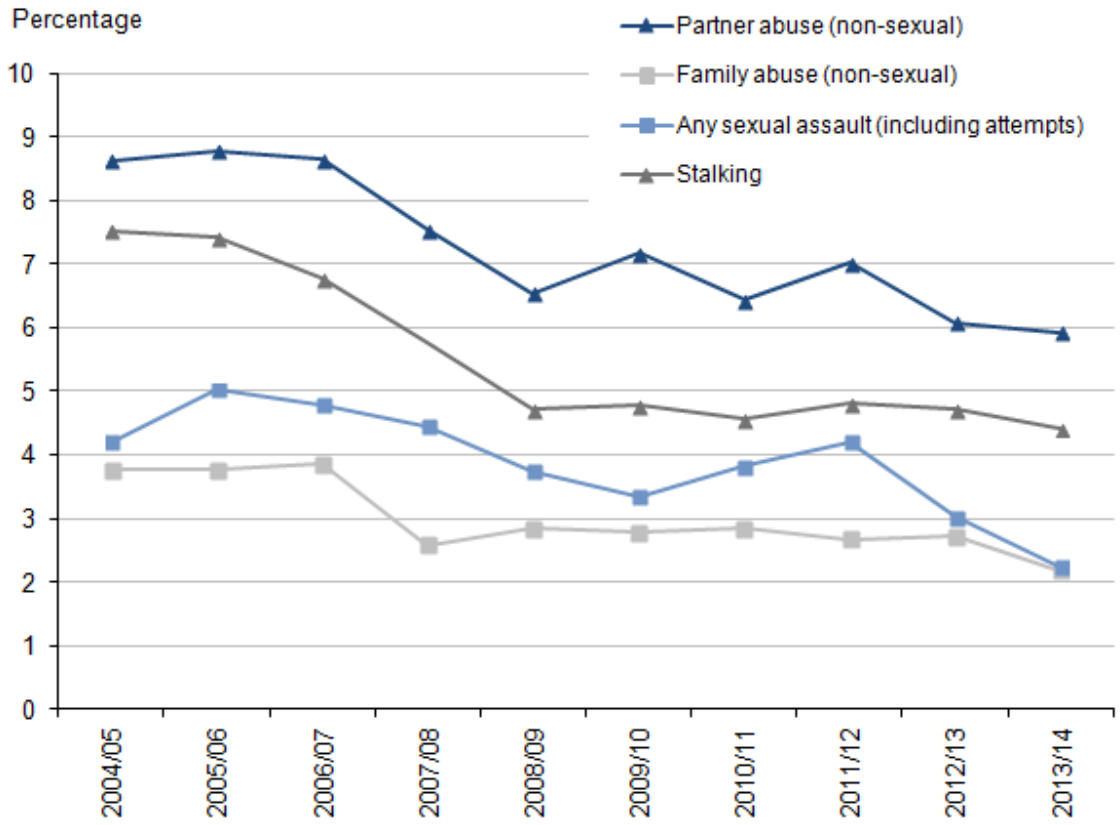
Prevalence of IPV

IPV exists in all countries, cultures and societies and, according to some authors, is becoming epidemic (van der Wath, van Wyk, & Janse van Rensburg, 2013). However, it is difficult to estimate prevalence across cultures because of inconsistencies in definition, under-reporting, and a lack of epidemiological studies (Bradley et al., 2002; Raphael, 2000). The recent crime survey conducted in England and Wales suggests that approximately 30% of women and 17% of men between the ages of 16 and 59 have experienced domestic abuse (Office for National Statistics, 2015) (Figure 1).

International evidence suggests that worldwide, approximately one in three women experience IPV at some point in their lives, and that lifetime prevalence of IPV among ever partnered women is 30% (Devries et al., 2013; Stöckl et al., 2013; World Health Organisation, 2013). Cross-sectional population surveys are considered the most accurate method for determining the prevalence of IPV (Watts & Zimmerman, 2002), and one review of 11 studies from nine European countries reported a prevalence of IPV ranging from 8% in Denmark to 45% in Finland (Hagemann-White, 2001). Another review of 48 population-based surveys from around the world revealed 10% to 50% of women have reported being battered by an intimate partner at some point in their lives (Heise, Ellsberg, & Gottemoeller, 1999).

The WHO (2002) has reported the prevalence of sexual violence by an intimate partner ranges between 10% and 30%, while a review of 35 studies from 21 countries (Krahe et al 2005) reported the prevalence of physical violence by an intimate partner ranged from 2.7% in Germany to 52% in Nicaragua, while lifetime prevalence of sexual violence ranged from 7% in Germany to 76.9% in New Zealand.

Figure 1: Percentage of women aged 16 to 59 who experienced intimate violence in the last year, by headline category 2004/05 to 2013/14 CSEW



Effects of IPV

IPV has extensive physical and psychological consequences and can be fatal. The physical effects range from cuts and bruises, punctures and bites, to more severe injuries that can lead to permanent disability, such as loss of hearing, sexually transmitted disease, including HIV/AIDS, unwanted pregnancy, miscarriage, gynecological problems, chronic pelvic pain sometimes associated with pelvic inflammatory disease, and irritable bowel syndrome (Campbell, 2002; Casique & Furegato, 2006).

The mental health effects of IPV include fear, depression, low self-esteem, anxiety disorders, headaches, obsessive-compulsive disorder, post-traumatic stress disorder, and various psychosomatic manifestations such as sexual dysfunction and eating problems (Plichta & Falik, 2001; Romito, Molzan Turan, & De Marchi, 2005). Women who experience physical and sexual violence report higher rates of poor health, decreased ability to walk, vaginal discharge, pain, loss of memory and dizziness compared to those who do not (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Vung,

Ostergren, & Krantz, 2009). Some women believe the only escape from such depressing, abusive and violent relationships is suicide (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

It is important that ED nurses are aware of the effects of female to male IPV. Male victims report being kicked, bitten, punched, choked (Archer, 2002; Mechem, Shofer, Reinhard, Hornig, & Datner, 1999), stabbed and burned (Vasquez & Falcone, 1997) by their female partners. Commonly reported effects of IPV in same sex relationships include anxiety, depression, low self-esteem, disassociation, sleep disorders, shame, guilt, self-mutilation, suicidal thoughts, drug and alcohol abuse, eating disorders, post-traumatic stress disorder, fear, displaced anger and sexual dysfunction (Sloan and Edmond 1996).

Raising awareness of IPV in practice

Emergency nurses require knowledge, understanding and confidence to identify IPV victims, and need to be able to respond appropriately to a disclosure of IPV. In the following section readers can consider some fictitious scenarios based on possible presentations of IPV that ED nurses might encounter in practice (Box 1).

Box 1: Scenarios of possible presentations of IPV

Take a few moments to consider each scenario and note your initial thoughts, for example,

- What would be your first priority?
- Who else would need to be involved?
- What action would you take in the first instance?
- Does your place of work have clearly defined policies or practice guidelines regarding the identification, reporting and management of IPV?

Scenario 1: Gemma is 21 years old and attended the ED today with a number of lacerations on her forearms that required suturing. She has disclosed previously that she has caused the injuries herself and when you ask says she's 'having a tough time'. She has attended the ED on a number of occasions over the past 12 months with similar injuries.

Scenario 2: Maggie presented to the ED today with her son Ben aged four. Maggie discloses that she had an argument with her partner and when Ben tried to stand between them, her partner pushed him out of the way.

Scenario 3: Lydia has attended the ED with her partner. She has a suspected fracture to her fingers and tells you that she trapped her hand in the car door. Lydia's partner insists on staying with her throughout the consultation.

To deal with any of the scenarios described in Box 1, and to provide holistic and patient-centred care, nurses need to be aware of their own feeling, beliefs and attitudes about IPV, and the stereotypes and prejudices attached to IPV, for example, that men are always the perpetrators or that it is a cultural issue. Self-awareness can help nurses deal with their emotions effectively while assessing and caring for victims of IPV (Natan, Ari, Bader, & Hallak, 2012; Robinson, 2010; Stinson & Robinson, 2006; Sundborg et al., 2012).

Nurses and other HCPs need to be aware of their organisation's policies related to IPV detection, management and referral to other services and organisations. It may be useful to develop appropriate clinical pathway, protocols or user friendly tools that can helps nurses and other HCPs to quickly recognise, respond and refer. Evidence suggest that appropriate organisational support, effective screening protocols, referral mechanisms and links to appropriate services and availability of initial and ongoing training can enhance practitioner's ability to provide effective services to IPV victims (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Ramsay et al., 2012). In 2014 the UK National Institute for Health and Care Excellence (NICE, 2014) published detailed guidance for all health care professionals and those they work with in terms of identification and effective management of DVA. A core component of this guidance relates to the provision of adequate preparation and training. However, it may also be argued that in addition to training clinical staff also value dedicated support and expertise especially when confronted with difficult and complex cases of IPV.

Basic principles when dealing with any of the situations described include developing a trusting relationship with the patient to try to enable them to openly share their experiences and care needs. This requires the provision of appropriately private and safe environments, where patients might feel more able to disclose information. If the patient has limited English proficiency then communication can be even more challenging, so it might be appropriate to find out if there is a bilingual nurse or other clinician available and willing to talk with the person rather than getting an interpreter. However, family members (or the accompanying person of the patient) should never be used as interpreters as this may jeopardise victim's safety and their ability to disclose abuse. In such situations, use of interpreters from an independent service is warranted.

Assessing the safety of patients' children is vitally important and nurses should explore this by asking direct, but non-judgemental questions in a non-threatening way. Referring patients to appropriate agencies and organisations that can support victims of IPV is essential. The specific steps that nurses should take when managing the scenarios in Box 1 are summarised in Table 1.

Conclusion

Nurses in any healthcare setting, but especially those in EDs, can help identify and manage victims of IPV, but to do this they need to have knowledge and understanding of its various forms, causes, prevalence, effects and manifestations. Additionally, nurses need to be clear about their own attitudes to IPV so that they are better able to provide appropriate and effective care to patients.

Remember that children are always impacted by domestic abuse. They are at risk of significant harm by direct abuse and from hearing, witnessing or intervening in incidents. This will be dealt with under multi-agency safeguarding children procedures

Table 1: Suggested actions for each scenario

Scenario 1	Scenario 2	Scenario 3
Check previous attendances for information	Check previous attendances for both Maggie and Ben	Arrange for Lydia to go to X-ray
Is Gemma on her own and is it safe to talk to her? Does the ED have a private space that you can use?	Check Maggie and Ben for injuries	See Lydia on her own in X-ray ask if anyone has hurt her and how accident happened
Ask why Gemma is having a 'tough time' and if you can help. Ask questions that are more direct, for example 'is anyone hurting you?'	Discuss with Maggie that you need to refer her to children's services and that they will inform the police	If Lydia discloses domestic abuse, offer support and complete DASH* form. Refer as required
Refer to rapid response psychiatry	Complete DASH form and involve police as a child has been assaulted as it is a child safeguarding issue	Ask if Lydia has any children – action as appropriate
Signpost to relevant services and state what these might be	Refer to relevant local domestic abuse services	
Refer to relevant services		

*DASH: Domestic Abuse, Stalking and Honour Based *Violence (DASH) checklist/ form helps practitioners including nurses to identify high risk cases. Use of this form help in identification of appropriate support needs and referral to local MARAC (Multi Agency Risk Assessment Conference) who can then use this information to make appropriate support decisions.*

Table 2: Useful websites for further information

DASH: **MARAC**	**http://www.dashriskchecklist.co.uk/** **http://www.standingtogether.org.uk/standingtogetherlocal/standingtogethermarac/**
Useful Online sites for DV training	
Independent Domestic Abuse Services **Safe Lives**	**https://www.idas.org.uk/training/** **http://www.safelives.org.uk/**

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