DOMESTIC VIOLENCE is the emotional, physical, sexual, psychological or economic abuse of power and the exercise of control by another individual, or individuals, on a family member, partner or ex-partner regardless of gender, age or sexual orientation (Kelly 1999). A more recent definition is: ‘Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’ (Hester and Westmarland 2005).

Many women who experience domestic violence go undetected in healthcare settings. Shame is one of many reasons that women give for not disclosing violence (Campbell and Soeken 1999) and fear of reprisals from their abusers is another. Women living in abusive relationships are often subject to strict controls over where they can go and who they can see, and many abusive husbands go to great lengths to keep them from getting help. Often, men will not allow their wives to visit a health centre or hospital unescorted, especially if treatment is required (McCausley et al 1998).

Men are also abused by female partners (Fiebert and Gonzalez 1997). However, domestic violence against males is not always acknowledged (Lewis and Sarantakos 2001) and little is known about the numbers of men who are abused or treated violently by their partners. Many of the effects of abuse are the same for men as for women. They are likely to feel deeply ashamed, frightened, experience a loss of self-worth and confidence, feel isolated, guilty and confused about the situation (Leonard 2003). While the idea of men being beaten by their wives or cohabitee runs contrary to many of the deeply ingrained beliefs about women and men, female violence against men is a phenomenon which is almost completely ignored by the media and society (Cook 1997).

Family violence is not confined to adults and parents may also be abused by adolescent children. As with partner abuse, it includes physical, psychological, emotional and financial abuse (Cottrell 2001). Anecdotal information suggests that adolescent violence against parents mainly occurs in one-parent families (Bobic 2004), but research on abusive adolescents, especially males, reports that parents in two-parent families are as likely to experience adolescent violence (Paterson et al 2002). Cottrell (2001) believes that the most effective way to stop parental abuse is for health professionals, including health visitors and school nurses, to raise awareness and ‘to break the silence’ that surrounds this important public health issue.

All healthcare professionals need to be aware of the risks of domestic violence and alert to possible indicators. Health staff will encounter many patients who have experienced domestic violence, yet they are often reluctant to act on their observations because they feel unprepared to ask questions and to respond to the needs of these patients (James-Hannman 1998). Some staff believe that domestic violence is a private issue and fear that patients would be upset or offended if asked about violence (Rittmayer and Roux 1999).

Women who seek help commonly turn to healthcare services. Health visitors, nurses, midwives and other professionals often lack...
knowledge about domestic abuse and what services are available for those who experience it (Taket 2004). The lack of interagency training courses and provision of support by healthcare providers mean that all health professionals and staff working in health settings will have difficulty in dealing with the problems surrounding domestic violence and so fail to identify the patterns of domestic violence and address the abuse (James-Hanman 1998) (Box 1).

Lack of awareness by staff of how common violence is in intimate relationships, and their belief that it is only people from certain social groups who are affected mean that patients are more likely to conceal abuse because of shame, self-blame, denial or fear.

Fear of breaking up the family may prevent staff from intervening in the lives of others, even in cases where intervention can save lives and prevent serious injury (Sugg and Inui 1992).

Badger and Baker (1999) believe that staff may not recognise the signs because of a lack of knowledge and understanding of abuse. If staff do not identify domestic violence they may not feel confident to give appropriate help, for example, to enable a woman to contact services that can provide the support she needs.

Mazza et al (2000) suggest that healthcare staff believe that addressing the issue of violence will expose other problems which they may not have time to deal with. However, when no action is taken, violence in intimate relationships usually increases (Laing 2003). The health and wellbeing of patients in these situations will deteriorate and the demand for health services will increase.

Female abuse

UK-based research indicates that one in four women has experienced domestic violence at some time in their adult lives (MIRRLESS-BLACK 1999). Women experience domestic violence regardless of race, class, age and disability (Peckover 2003), so all nurses and other practitioners are likely to have contact with these women at some stage during their career.

Eisenstat and Bancroft (1999) state that many women who are abused engage in behaviour that further damages their health, for example, heavy smoking or substance misuse, or have depression or eating disorders. Daniel (2003) asserts that there is increasing evidence that pregnancy and motherhood are times when women first experience domestic violence, or when existing violence and abuse escalate in frequency or severity. Women who are abused during pregnancy are more likely to have increased rates of miscarriage, premature births, fetal injury and fetal death.

The barriers to women’s disclosure of their abuse to healthcare providers are well-documented (Hegarty and Taft 2001, Ingram 2001) (Box 2).

Male abuse

The incidence of domestic violence reported by men appears to be so low that it is difficult to get reliable estimates (Leonard 2003). In Great Britain 4.2 per cent of women and men said that they had been physically assaulted by a partner during the previous 12 months (MIRRLESS-BLACK 1999).

Sarantakos (1999) states that men have remained the hidden victims of domestic violence while abused women have been the subject of extensive research and have received excellent responses from the media, support services and the justice system. Cook (1997) argues that virtually nothing has been done to encourage men to report abuse and the idea that men could experience domestic violence is so unthinkable, it is unsurprising that many men will not even attempt to report the situation.

Stitt and Macklin (1995) interviewed 20 male patients aged between 19 and 72 years who had been subjected to physical abuse. They found that all the men had endured severe forms of physical abuse, including stabbing, teeth being knocked out, scaldings and injury to their genitalia. Some men suffered verbal, emotional and psychological cruelty, for example, embarrassment and intimidation in front of others, leading to poor self-esteem and depression. Others reported threats by their partners to harm children (both born and unborn). Many of the men remained with their abusive partners because of the children (Brogden and Harkin 2000).

Healthcare professionals and the police are not always likely to believe explanations of abuse from a man. For example, when a man enters a hospital with bruises all over his body, it is assumed that he sustained those bruises while at work or while fighting with another man. It is rarely considered that these bruises could be caused by spouse abuse. Even more rarely are men asked if the bruises are the result of mistreatment. Disbelief and lack of services are factors that can compound men’s experience of abuse and may contribute to their reluctance to discuss or report domestic violence (Box 3).

Effects on children

Increased attention is being given to the effects of domestic violence on children. Children who witness domestic violence have been referred to as
the ‘silent’, ‘forgotten’, or ‘invisible victims’ of family violence (Humphreys and Mullender 1999). Children can witness or be physically assaulted during a violent incident (Edleson 1999). Children cannot help but be affected by their experiences of abuse and violence but the impact of living with domestic violence can affect children differently.

Toddlers and preschool children who are exposed to domestic violence are often at increased risk of emotional and behavioural problems (Henning et al 1996). These children may experience developmental delays and language difficulties, such as stuttering. Disruptive behaviour, such as biting, kicking and hitting other children, may also occur. There may be sleeping, eating and anxiety disorders, bed-wetting, psychosomatic symptoms, such as headache, abdominal pain and diarrhoea. In addition, Edleson (1999) suggests that children

**BOX 2**

Factors that influence female disclosure of domestic violence

- Fear and retribution – the perpetrator of the violence may have directly, or indirectly, threatened further violence if she asks for help.
- Shame and belief that the violence is her fault. Belief that the abuse is normal and common among couples. Women often assume that if something is wrong it is their responsibility to change it.
- Low self-esteem and powerlessness – a woman’s self-esteem can be eroded by a violent relationship and the belief that she does not deserve a better life.
- If the violence occurs during pregnancy belief or hope that the partner will change when the baby is born.
- Lack of information about services – many women do not know that there are sources of help and advice available or how to access them.
- Many women view the role of a health visitor as being concerned primarily with children rather than dealing with other problems.

(Adapted from Ingram 2001)

**BOX 3**

Factors that influence male reporting of domestic abuse

- Little has been done to encourage men to report abuse.
- Police are quick to believe a woman who accuses the man of being the aggressor.
- Men are conditioned not to ask for help, and because they are men, being unable to solve the problem is perceived as a sign of weakness.
- Not being able to protect themselves from their female partners causes men to feel ashamed, so they say nothing.
- Disempowerment – those in authority who respond to a man’s call for help often mistrust and disbelieve him.
- Men do not want to admit that they are being abused.

(Adapted from Cook 1997)

who witness domestic violence may become anxious or depressed, have low self-esteem and poor school performance. They are also more likely to act aggressively during school age years.

Rhea et al (1996) suggest that school-age children learn that violence is an appropriate way to resolve conflict in human relationships. They may rebel against adult instruction and authority. Teenagers, however, are faced with the unique problem of trying to fit in with their peers while keeping their home life a secret. They may deny that family violence is occurring, lie about it, or fantasise reality for themselves in which there is no violence.

Teenagers living in situations of domestic violence tend to have difficulty engaging in social interactions (Osofsky 1995). They may run away from home, misuse drugs and alcohol or engage in truancy and antisocial behaviour. In essence, living with domestic violence can have a serious negative impact on the development of children.

**Discussion**

Healthcare professionals are the first-line response for many people who experience domestic violence. Good policies and protocols for practice should be developed and implemented to identify and record domestic abuse. Awareness should be raised about the issue in practice and there should be in-depth training for health professionals. Information packs containing contact telephone numbers for women’s aid groups and helplines for men should be developed and the public need to be educated on how unacceptable violence is in the family.

The majority of people who experience domestic violence will usually attend the accident and emergency (A&E) department. However, they may present in any healthcare setting, and therefore staff working in other clinical areas need to be alert to the problem. Pahl (1995) suggests that women seeking help to cope with domestic violence are more likely to be in contact with health professionals than any other service. Health professionals have a responsibility to care for these patients and should acknowledge domestic violence as a major health problem. Staff should understand the power and control issues associated with partner abuse, accept the person’s choices non-judgementally, offer support and initiate appropriate referral procedures.

Health visitors and school nurses have widespread contact with families and young children, providing a service that is centred on promoting health and social well-being. Frost (1999) states that health visiting and school nursing are among the most accessible services for assisting abused women and men, and suggests that they should be used more often. Bacchus et al.
(2003) concluded that health visitors were more supportive than GPs and A&E staff to women who were being abused. However, it was also recognised that few women or men voluntarily discussed domestic violence because of time constraints and limited privacy or because they were disbelieved and/or ridiculed by those they approached (Frost 1999).

Hall and Elliman (2004) recommend that nurturing and developing long-term relationships with families provides health visitors and school nurses with the opportunity to identify those who may be at risk of domestic violence or undisclosed violence. The circumstances identified as likely indicators, which should prompt health professionals to ask questions are listed in Box 4.

Midwives also have an important role in raising awareness that domestic violence may begin, or increase if there is pre-existing violence in a relationship. Screening and assessment for domestic violence are essential to aid women and men in disclosing abuse. Hegarty and Taft (2001) suggested that women will disclose information about abuse more readily if health professionals ask them to. It is important, therefore, that health professionals create a private environment where it is safe to talk about violence.

To raise the issue of domestic violence, health professionals need to have a good understanding of the issues facing the patient who is being abused and incorporate this into a general conversation. Ask questions that will allow the patient to talk about his or her experiences of violence. James-Hanman (1998) maintains that simple, direct, non-judgemental questions are effective to elicit appropriate information. Campbell Bliss et al (2000) suggest that health professionals should develop awareness and sensitivity to the barriers that inhibit effective interaction between patients who have been abused and healthcare providers. It may be appropriate sometimes to offer the patient a choice of who he or she would feel more comfortable talking to, to help him or her disclose the abuse that has taken place. Questions intended as prompts in such a situation are listed in Box 5 – it will not always be necessary, or appropriate, to ask all of them.

Health professionals, whether in acute or community settings, should provide follow-up care and advocacy for those who have experienced violence. They can convey their awareness of domestic violence to all those accessing the service by displaying information leaflets and posters in GP surgeries, health centres and hospitals.

Developing good multi-agency relationships and referral systems are essential to enable safe disclosure of information. Staff require appropriate training and supervision to increase awareness and knowledge of how to recognise and deal with domestic violence. Hague (1997) believes that all relevant statutory and voluntary sector agencies should develop a co-ordinated approach (Frost 1999).

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Domestic violence is a key public health issue, which affects the health and welfare of men, women and children. It is not restricted to any one group in society. Violence against another person is a crime and for many women abuse and violence start early in a relationship. For others it may start later, often during pregnancy (Salmon et al 2004).

It is important to educate the public about the cycle of violence and the serious and long-lasting effect this has on children and also to acknowledge that domestic violence against men is an increasing health issue. While the media, health professionals, support services and the justice system responds positively to female abuse, they can be criticised for ignoring male victims, who therefore remain hidden and do not report their abuse. Children may develop emotional and behaviour problems. All health professionals should become actively involved in breaking the silence surrounding violence, so that they can provide an appropriate and effective service.

**Conclusion**

**References continued**


