Domestic Violence and Abuse

Subjects: Psychology, Biological
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Definition

Domestic violence is considered to be all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.

1. Background

Intimate Partner Violence (IPV) is one of the most common forms of family violence, along with Domestic Violence and Abuse (DVA) [1]. It includes multiple types of physical, psychological and sexual abuse, such as physical violence, threats, intimidation, isolation, emotional abuse, economic coercion, manipulation and the assertion of privilege [1]. IPV has been found to be a widespread phenomenon in every country around the world [2]. IPV occurs in almost all settings and affects people regardless of race, ethnicity, class, religious belief, age, immigration status and ability [2]. Even in developed counties such as the UK, the problem is so common and widespread that it has almost become an invisible form of crime and an everyday story in many households [2].

DVA has serious health consequences which have been the subject of numerous studies [3]. DVA is a significant risk factor for many physical and psychological health problems frequently encountered in primary care setting in the UK [4]. It has been estimated that the cost associated with DVA to NHS is GBP 1.7 billion per year, with the major cost borne by acute trusts and primary care [5].

The healthcare setting, therefore, offers a critical and unique opportunity for early identification and prevention of abuse [6]. The professionals from every aspect of our healthcare setting have daily contact with patients and are in a privileged position to help victims. These are patients whose health is damaged by domestic violence and are subsequently very likely to face extreme mental and physical injuries [3]. However, it appears that most healthcare professionals are uncertain on how to deal with domestic abuse victims [7]. While the guidelines from the National Institute for Health and Care Excellence (NICE) now recommend that there should be training around domestic violence at every level, it remains minimal or absent in most medical schools [8].

The principal objective of this study was to review the available literature and present the findings regarding a new training and support programme called the IRIS. Identification and Referral to Improve Safety (IRIS) is a training and support programme to improve the response to DVA in general practice [9]. IRIS was initially carried out as a pragmatic cluster-randomised trial, but it has now been implemented in over 35 administrative localities in the UK [10]. The trial and local evaluations of the IRIS implementation showed an increase in patient referrals from general practice to specialist domestic violence agencies [7]. In the final part of this report, an attempt will be made to conduct a feasibility study with regard to introducing IRIS to secondary care.

However, before discussing the IRIS programme and the prevention of IPV, it is important to recognize the causes of domestic violence, different forms and definitions, the background and scale of the problem, the impact on society, and the role of health care professionals.

2. Definitions

The terms such as violence against women, domestic violence, domestic abuse, intimate partner violence and gender-based violence are often used without noticing that there are in fact some subtle differences in what each term describes. It is therefore beneficial to consider a brief description of these terms.

Domestic violence: ‘Domestic violence is considered to be all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim’ [11].

Violence against women: ‘Violence against women is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’ [11].

Gender-based violence: It is recognised that gender-based violence is violence that is directed at an individual based on their biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity [12]. The United Nations Declaration on the Elimination of Violence against Women (1993) describes violence against women as: ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’ [12]. This incorporates many forms of abuse that occur throughout the life cycle, including within the family and within communities [12]. The types of gender-based violence include: rape and sexual assault; sexual harassment and intimidation at work and other settings; childhood sexual abuse; domestic abuse; stalking; harmful traditional practices such as early and forced marriage; so-called ‘honour’ based violence and female genital mutilation; sex trafficking; and commercial sexual exploitation [12].

Intimate Partner Violence (IPV): The World Health Organisation defines Intimate Partner Violence (IPV) as a ‘behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours’ [1]. The concept of physical and sexual abuse is easily defined but psychological harm has a much broader definition which includes coercive and controlling behaviour. Coercive behaviour is a type of abuse which includes threats, blackmailing, humiliation and intimidation [13]. This behaviour is intended to harm, punish or frighten the victim [13]. Controlling behaviour is a range of acts designed to make the victim subordinate and isolate them from sources of support [13]. This enables the perpetrator to exploit their resources and capacities for personal gain by depriving them of independence and escape [13].

The study presented here focuses specifically on domestic abuse against women when the perpetrator is a current or previous partner. The terms Intimate Partner Violence (IPV) and Domestic Violence Abuse (DVA) are therefore used in this context throughout this report.

3. Scale of the Problem

Numerous studies have reported IPV to be a global problem in developing and developed countries. In order to have a better understanding of the degree and severity of the problem, it is worth considering some of the published data with regards to the level of intimate partner violence recorded around the world. It is reported that:

- Globally the lifetime prevalence of physical and sexual intimate partner violence and abuse for women is around 30% [14].

- In the United States findings from the 1998 National Violence Against Women Survey showed that 1.5 million women are raped or physically assaulted by an intimate partner annually [15]. In addition, only 36% of the women injured during their most recent rape and 30% of the women injured during their most recent physical assault received some type of medical treatment [15]. Other studies found an incidence of battering from 7% to 44%, depending on the sampled population [15].

- Across Europe, an average of 22% of women report experiencing physical and/or sexual violence and that 43% have experienced psychological abuse from the age of 15 [16]. A total of 58% of women across Europe who did not feel that they had an equal say in household finances experienced

psychological abuse compared to 22% of women who believed that they had an equal say [16].

- In the UK, the reported rate of physical and/or sexual violence was 29% and psychological abuse 46% [17]. Out of the reported crimes, 25% of women had reported the most serious incident of intimate partner violence and abuse [17]. However, women are more likely to contact healthcare services about the most serious incident of abuse they had experienced [17].

- In Scotland in 2018/19, 60,641 incidents were reported to police [18]. Of these, 82% were reported as female victim and male perpetrator [18]. In contrast, male victims and female perpetrator accounted for 16% of cases [18].

- In England and Wales between 2019/2020 the crime survey estimates that 2.3 million adults aged 16–74 years experienced domestic abuse.

It is a well-established fact that IPV cuts across all levels of society, social divisions and can affect everyone [2]. Furthermore, acts of violence against women are not isolated events but rather patterns of behaviour that violate their human rights [2]. The consequence of abuse is severe, limiting female participation within society by damaging their health and well-being [2]. However, there is variation within the prevalence of violence between different cultures, communities and regions [14]. This shows domestic abuse is not an inevitable part of life or society, and it should not be treated as such [2]. Violence against women is not a minor issue that occurs on a small scale within pockets of society [2]. Instead, it is a global epidemic that is not being addressed [2]. As mentioned above global statistics show that 30% of all women who have been in a relationship will have experienced physical or sexual violence by their intimate partner [14].

However, it must be said it is not just women that are affected [8]. In the United Kingdom, as well as the 30% of women, 17.0% of men will have experienced domestic violence at some point [8]. It is therefore important to recognise that men can and do, also experience violence.

Notwithstanding this fact, it is self-evident that the degree and severity of violence, particularly sexual violence, perpetrated against women within intimate relationships is greater. It is for this reason that the primary focus of this study is on domestic abuse against women.

4. The Causes of Intimate Partner Violence and Abuse

There have been countless research articles to determine the causes of domestic violence. All of these studies point to many causes. However, all of these causes have one underlying commonality: the abuser feels the need to exert complete control over their partner [19]. There is an indication that this ‘need’ originates from a combination of both environmental and individual factors [19]. The abuser learns to use abusive tactics to control others from the influence of family members, peers, and cultural traditions, as they age from a child to an adult [19].

It has been said that intimate partner violence and abuse against women is the outcome of a dynamic interaction of risk and protective factors that range from broad social factors to individual risk factors [20]. An explanatory ecological model from the World Health Organisation may be utilised to understand this concept further [20]. It has been suggested that, globally, two factors related to gender inequality are strongly associated with intimate partner violence and abuse [20]. Firstly, the unequal position of women in relationships and society [20]. This proposition appears to correlate well with the level of violence in different societies [20]. Violence is greater in societies in which men are viewed as superior and possess economic and decision-making power [20]. Another factor relates to the social norms, which sadly states that violence is a means of resolving conflict [20].

It may be worth noting that the literature review carried out for this report indicated that the experts do not agree on the exact underlying causes of domestic violence, but they do agree that the victim never asks for or causes domestic abuse. The abuser gains control over the victim by gradually eroding their

self-esteem and sense of autonomy [19]. They often convince the victim that they deserve the abuse or provoked it in some way [19]. This represents a typical control tactic of abusers—convincing the victim that they bring it upon themselves and they are at blame for the violence [19]. However, this is not the case [19]. The victims are not at fault for the abuse and the abuser is responsible for their behaviour [19].

5. Financial Impact of DVA

DVA can result in a range of negative and harmful effects on the health, well-being and outcomes in the life of women and their family, particularly their children [3]. In this section of the report, key points regarding the consequences of domestic violence such as financial cost to the health service and impact on physical and mental health are discussed.

DVA is a significant socio-economic issue that impacts individuals, relatives of individuals and government services [3]. A multi-country study from the World Health Organisation displayed that there is a long-term detrimental impact of DVA on health and well-being [4]. Furthermore, the long-term negative health impact that victims of IPV experience remains long after the abuse has ended [3]. This leads to higher use of government services such as healthcare, criminal justice, and social services [21]. For example, a Canadian based study found that DVA victims were three times more likely to access emergency health services than women who had not previously experienced any abuse [22]. As a result, DVA is extremely expensive for the economy and the healthcare system within the United Kingdom [21]. The social and economic cost of domestic violence in the UK from 2016/17 is estimated to be GBP 66 billion [5].

6. Physical Impact of DVA

Although the physical signs of DVA may be subtle, there has been increasing evidence from research that suggests that victims of DVA are more likely to experience physical symptoms [3]. The types of symptoms experienced are associated with the type of abuse received [22]. For example, sexual abuse is strongly correlated with gynaecological problems [22]. It is difficult to accurately differentiate which branch of DVA is causing the symptoms as there is much overlap [3]. However, studies have clearly demonstrated that survivors of DVA were much more likely to experience long-term physical problems such as gastroenterological symptoms, chronic pain and gynaecological disorders [4]

Gynaecological problems are the most common and longest lasting physical health effect of domestic violence amongst women [3]. In the United Kingdom, a study showed that 21% of women attending a gynaecological outpatient clinic had previously experienced domestic violence [22]. The women with a history of domestic violence experienced more gynaecological symptoms than women with no history of DVA [22]. The gynaecological symptoms frequently experienced were lower abdominal pain, dyspareunia and dysmenorrhoea [22]. There was also an increase in smear abnormalities which could suggest an increase in cervical cancer [22]. As a result, there was a significant increase in the number of further gynaecological appointments booked by DVA victims [22].

Domestic abuse often has a major impact on pregnancy and the outcome of pregnancy [23]. The annual prevalence of IPV towards a pregnant woman in the UK is estimated to be 6.4% [3]. However, pregnancy within the past 12 months doubled the risk of physical violence [24]. IPV during pregnancy is associated with negative health behaviours, physical and mental health issues and thus a worsened neonatal health outcome [2]. Victims were more likely to smoke, drink alcohol and use illicit substances throughout the pregnancy [2]. For example, pregnant women who had experienced IPV within the last 12 months were 2.6× more likely to smoke and 2.26× more likely to drink alcohol throughout the pregnancy [2]. Studies have also shown an increase in the rate of depression, suicide rates and lack of attachment towards the child post-partum [25][26]. As a result, there were more neonatal issues in women experiencing IPV [2]. For example, the increased rates of preterm labour, intrauterine growth retardation and lower birth weight [2].

Chronic pain is defined as pain that persists or recurs for more than 3 months [27]. This may be characterized by significant emotional distress (anxiety, frustration or depression) and/or functional disability (interference in activities of daily living) [27]. Chronic pain is extremely expensive for the NHS

and the indirect cost of back pain alone is estimated to be over 10 billion pounds per annum for the UK [28]. Controlled studies have shown that chronic pain is a common clinical health consequence of IPV, and the prevalence is significantly increased in victims [29]. Women who were subject to IPV had an increase in chronic pain symptoms such as back pain, pelvic pain and headaches [29][30]. The increase was between 50–70% and was present in both the controlled studies and within the general population [29][30]. It is theorised that the psychological trauma from domestic abuse forms a complex biopsychosocial stress response that triggers chronic pain [31]. As a result, victims were more likely to develop chronic pain conditions such as chronic fatigue syndrome and fibromyalgia [31].

7. Psychological Impact of DVA

Mental health issues are multifactorial and are associated with many life events such as childhood abuse, daily stressors, martial separations, and negative life events [3]. However, there is a significant association between experiencing domestic violence abuse and developing mental health issues [32]. Within the general population, victims who have experienced domestic violence abuse are at increased risk of depression, post-traumatic stress disorder (PTSD), substance abuse and anxiety [32]. The overall cost that domestic violence has on the mental healthcare system within the UK is estimated to be GBP 176 million per year [21]. However, this is likely to be a massive underestimation as most DVA is unrecognised [7].

Depression and PTSD are the most prevalent mental health issue amongst victims [3]. PTSD is a chronic psychological disorder that occurs after exposure to traumatic events [33]. This is a potentially chronic impairing disorder characterized by re-experience and avoidance symptoms [33]. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest [34]. PTSD and depression cause lower quality of life, worse physical health outcomes and reduced productivity in the workplace [35][36]. The illness of mental health is responsible for 72 million working days lost and costs GBP 34.9 billion per year, with depression being one of the main causes [36]. A meta-analysis of multiple studies shows the prevalence of depression amongst DVA victims is 47.6% and the prevalence of PTSD is 63.8% [37].

Furthermore, an analysis of 10 different countries showed a direct correlation between experiencing domestic violence and the rate of suicide attempts [38]. The meta-review of 18 studies showed that women who have been subject to domestic violence have an average suicide rate of 18% [21]. It is suggested that the association between IPV and suicide attempts is stronger when there is physical violence involved because the physical pain acts as a precursor to future suicide attempts [38].

8. The Role of Healthcare Professionals

Intimate Partner Violence (IPV) is a public health issue, and the World Health Organisation emphasises that healthcare professionals have an important role in identifying domestic violence [6]. Women who are abused are frequently treated within healthcare systems, but they do not always present with obvious signs of trauma and are therefore undetected [3].

A healthcare professional is in a position of trust and victims of domestic abuse are more likely to contact health services than any other agency [39]. Healthcare may be a survivor's first or only point of contact with professionals [39]. Unfortunately, most clinicians fail to identify domestic violence and are uncertain about referral pathways after disclosure [7]. It should be stressed that it has been well documented that most healthcare professionals are uncertain on how to deal with domestic abuse patients [7]. The success of general practitioners in recognising cases of domestic violence in the UK has not been thoroughly investigated but is expected to be low [24]. An American study that used primary care medical records showed that fewer than 10% of women experiencing IPV were being identified by doctors [24]. It is therefore very important that healthcare professionals are provided with the required training, knowledge and skills to handle domestic violence.

9. Training Programme for Healthcare Professionals in DVA

As mentioned previously healthcare professionals are largely unaware of appropriate interventions and

have seldom received effective or, indeed, any training. Understanding the impact of domestic violence on the victim, wider society and economy can help highlight the importance of the issue of identification.

However, there is a need to present a case to show there is a link between implementing an intervention programme and reducing the economic impact of DVA. This would help to present a stronger case for the government to utilise our limited NHS budget into intervention programmes. Therefore, the Identification and Referral to Improve Safety (IRIS) programme will be discussed. IRIS is a training and support programme that was first piloted in 2007 [10]. The main goal of IRIS was to address the shortcoming and improve the response to domestic violence and abuse (DVA) in general practice [9].

10. Identification and Referral to Improve Safety (IRIS)—A Training and Support Programme

The primary objective of this report was to study the IRIS programme. Currently, the programme is implemented in primary care, in this project special attention will be given to assess the possibility of introducing IRIS to secondary care. To this end, in the following sections of this report, an attempt has been made to explore various aspects of IRIS including:

- The history and background of IRIS.
- Review of available literature associated with IRIS.
- Discussion of a randomised controlled trial of IRIS.
- Discussion of IRIS cost-effectiveness in primary care.
- Future of IRIS-Exploring the potential benefit of implementing an adapted IRIS programme into secondary care.
- Recommendation on how to adapt the programme for secondary care.
- Suggestions for future research and studies with regards to IRIS.

11. The History and Background of IRIS

In 2007 the Medical Research Council piloted a trial into primary care called the IRIS programme [10]. IRIS was the first European randomised controlled trial of an intervention to improve the healthcare response to domestic violence and abuse [39]. It aimed to determine the cost-effectiveness of a general practice-based domestic violence training and support programme and measure two outcomes: 1—the referral of women to a domestic violence agency providing advocacy, and 2—the recording of disclosure of domestic violence in the patient's medical record [39].

IRIS is an intervention that provides domestic violence training to healthcare professionals and staff within primary care [9]. The programme consists of two two-hour training sessions for clinicians and a single one-hour session for the administration team [10]. The main aim of the programme is to improve healthcare response to domestic abuse [9]. This is hoped to be achieved through two main methods; training on how to identify domestic violence and education regarding the referral pathways to appropriate domestic violence advocacy agents [9]. The sessions involve case studies and role-play to practise recognition of DVA and communication skills training [39]. They are typically delivered by an advocate educator and a clinical psychologist specialising in domestic violence or an academic general practitioner [39].

The IRIS commissioning pack states that the training model 'promotes clinical enquiry, recognition of risk indicators, safety planning and holistic care for all patients [10]. The training sessions are also followed by periodic contact with the practice in clinical meetings, where anonymised data is collected regarding referral and disclosure rates of DVA [39]. Clinicians are also provided with telephone numbers and email

exchanges for any enquiries or advice regarding DVA [39]. The one-hour training sessions with administrative staff provided IRIS information materials on the local DVA agency delivering the IRIS service [39]. In addition, there is a focus on issues of confidentiality and patient safety for victims of DVA [39]. Ongoing support is provided, and the initial training sessions are consolidated via a domestic violence advocate educator [39]. Practises will also select a 'local champion' for the project who is a clinical member of staff and typically one of the GPs working in the practice [39]. The local champion is often the practice GP safeguarding lead and helps to integrate IRIS into the work of the practice [39].

It is important to note that clinicians are specifically trained to have a low threshold for asking about domestic violence [39]. Although the IRIS intervention seeks to identify all levels of domestic abuse, the IRIS advocacy educator only deals directly with patients who are moderate risk or below [39]. Victims who are suspected to be at very high risk are referred directly to Multi-Agency Risk Assessment Conferences (MARAC) [40].

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Keywords

intimate partner violence;identification and referral to improve safety