Researching risk, abuse and violence in the context of health

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RAV Research: Pushing the boundaries

- Empirically
- Philosophically
- Methodologically
- Theoretically
- Conceptually
Health professionals’ beliefs about domestic abuse and the issue of disclosure: a critical incident technique study

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Abstract
Domestic abuse is increasingly recognized as a serious, worldwide public health concern. There is a significant body of literature regarding domestic abuse, but little is known about health professionals’ beliefs about domestic abuse disclosure. In addition, the interaction between health professionals’ beliefs and abused women’s views remains uninvestigated. We report on a two-phase, qualitative study using Critical Incident Technique (CIT) that aimed to explore community health professionals’ beliefs about domestic abuse and the issue of disclosure. We investigated this from the perspective of both health professionals and abused women.

What is known about this topic
- Domestic abuse is a serious public health issue.
- Women who experience domestic abuse often conceal their experiences.
- Health professionals’ responses to domestic abuse are sometimes inadequate.

What this paper adds
- Health professionals and abused women do not always share the same beliefs about domestic abuse.
- Discussing abuse with women is something that health professionals find difficult, but women want to be asked.
- Several practices can be adopted by health professionals to keep women safe post-disclosure, including ‘safe talk’.

Domestic abuse is a common cause of: physical injury (Campbell 2002), depression and alcohol/drug misuse (Lashante et al. 2009); and suicide (World Health Organization 2005). In its most extreme form, violence kills women. In the United Kingdom, two women are killed every week by a current or former partner (Hester 2009). We acknowledge that domestic abuse can take place against men by men (Finch...
Leventhal’s Common Sense Model

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Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation

Caroline Bradbury-Jones, Julie Taylor, Thilo Kroll and Fiona Duncan

Aims and objectives. To investigate the dynamics of domestic abuse awareness and recognition among primary healthcare professionals and abused women.

Background. Domestic abuse is a serious, public health issue that crosses geographical and demographic boundaries. Health professionals are well placed to recognize and respond to domestic abuse, but empirical evidence suggests that they are reluctant to breach the issue. Moreover, research has shown that women are reluctant to disclose abuse.

Design. A two-phase, qualitative study was conducted in Scotland.

Methods. Twenty-nine primary health professionals (midwives, health visitors and general practitioners) participated in the first phase of the study, and 14 abused women took part in phase two. Data were collected in 2011. Semi-structured, individual interviews were conducted with the health professionals, and three focus groups were facilitated with the abused women. Data were analysed using a framework analysis approach.

Findings. Differing levels of awareness of the nature and existence of abuse are held by abused women and primary healthcare professionals. Specifically, many women do not identify their experiences as abusive. A conceptual representation of domestic abuse – the ‘Abused Women, Awareness, Recognition and Empowerment’ (AWARE) framework – arising from the study – presents a new way of capturing the complexity of the disclosure process.

Conclusions. Further research is necessary to test and empirically validate the framework, but it has potential pedagogical use for the training and education of health professionals and clinical work with abused women.

Relevance to clinical practice. The framework may be used in clinical practice by nurses and other health professionals to facilitate open discussion between professionals and women. In turn, this may empower women to make choices regarding disclosure and safety planning.

Keywords: awareness, disclosure, domestic abuse, domestic violence, empowerment, health visitors, interprofessional violence,Jakari window, midwives, nurses, recognition

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The Johari Window

- **Open Area**: Both woman and health professional recognise DA
  - #1

- **Blind Area**: Health professional recognises DA but woman doesn’t
  - #2

- **Hidden Area**: Woman recognises DA, but health professional does not
  - #3

- **Unknown Area**: Neither woman nor health professional recognise DA
  - #4
Domestic abuse as a transgressive practice: understanding nurses’ responses through the lens of abjection

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Abstract

Domestic abuse is a worldwide public health issue with long-term health and social consequences. Nurses play a key role in recognizing and responding to domestic abuse. Yet, there is considerable evidence that their responses are often inappropriate and unhelpful, such as trivializing or ignoring the abuse. Empirical studies have identified several reasons why nurses’ responses are sometimes wanting. These include organizational constraints, e.g., lack of time and privacy, and interpersonal factors such as fear of offending women and lack of confidence. We propose, however, that these factors present only a partial explanation. Drawing on the work of Julia Kristeva, we suggest that alternative understandings may be derived through applying the concept of abjection. Abjection is a psychological defence against any threat (the abject) to the clean and proper self that results in rejection of the abject. Using examples from our own domestic abuse research, we contend that exposure of nurses to the horror of domestic abuse evokes a state of abjection. Domestic abuse (the abject) transgresses established social boundaries of clean and proper. Thus, when exposed to patients’ and clients’ experiences of it, some nurses subconsciously reject domestic abuse as a possibility (abjection). They do this to protect themselves from the horror of the act, but in so doing, render themselves unable to formulate appropriate responses. Rather than understanding the practice of some nurses as wilfully neglectful or ignorant, we argue that through a state of abjection, they are powerless to act. This does not refute existing evidence about nurses’ responses to domestic abuse. Rather, as a relatively unknown concept in nursing, abjection provides an additional explanatory layer that accounts for why some nurses respond the way they do. Crucially, it elucidates the need for nurses to be supported emotionally when faced with the transgressive practice of abuse.

Keywords: abjection, disgust, domestic abuse, horror, nursing, responses.

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Julia Kristeva’s Abjection
Access and utilisation of maternity care for disabled women who experience domestic abuse: a systematic review

Jenna P Brecklidge1, John Devaney2, Thilo Voil3, Anne Lazenbatt3, Julie Taylor3 and Caroline Bradbury-Jones2

Abstract

Background: Although disabled women are significantly more likely to experience domestic abuse during pregnancy than non-disabled women, very little is known about how maternity care access and utilisation is affected by the co-existence of disability and domestic abuse. This systematic review of the literature explored how domestic abuse impacts upon disabled women’s access to maternity services.

Methods: Eleven articles were identified through a search of six electronic databases and data were analysed to identify the factors that facilitate or compromise access to care the consequences of inadequate care for pregnant women’s health and well-being, and the effectiveness of existing strategies for improvement.

Results: Findings indicate that a mental health diagnosis, poor relationships with health professionals and environmental barriers can compromise women’s utilisation of maternity services. Domestic abuse can both compromise, and enhance, access to services and social support (e.g. in a positive factor when accessing care). Delayed and inadequate care has a negative effect on women’s physical and psychological health; however further research is required to fully explore the nature and extent of these consequences. Only one study identified strategies currently being used to improve access to services for disabled women experiencing abuse.

Conclusions: Based upon the barriers and facilitators identified within the review, we suggest that future strategies for improvement should focus on: understanding women’s reasons for accessing care; fostering positive relationships; being woman-centred; promoting environmental accessibility; and improving the strength of the evidence base.

Keywords: Disability, Domestic abuse, Pregnancy, Maternity, Access, Utilisation, Review

Background

Domestic abuse during pregnancy has such negative consequences for maternal and infant health that the World Health Organization (WHO) has declared it a significant global concern [1]. More than 30% of domestic abuse begins during pregnancy [2,3] and evidence suggests that pre-existing abuse may escalate during the prenatal period [4,5]. Although 10% of women giving birth in the United Kingdom (UK) are expected to have some degree of disability, there is little understanding of disabled women’s experiences of domestic abuse during pregnancy. Disabled women are two times more likely to suffer physical abuse from an intimate partner than non-disabled women [7], and it is therefore likely that disabled women may be particularly vulnerable to pregnancy-related abuse. Nicom [8] has suggested that disabled women who experience domestic abuse face compound oppression. Several studies have linked domestic abuse with adverse maternal and infant outcomes [9,31]. Potentially comprising these negative consequences, certain disabled women may be more susceptible to pregnancy complications than non-disabled women [14,35]. Moreover, studies have suggested that abused women delay accessing maternity services until the third trimester [16-18] and that disabled women are also likely to have delayed or additional access to healthcare [14,19,20].
Andersen’s Model of Health Care Utilisation
Development of a practice framework for improving nurses’ responses to intimate partner violence

Caroline Bradbury-Jones, Maria T Clark, Jayne Parry and Julie Taylor

Aims and objectives. The aim of this article is to discuss critically the theoretical concepts of awareness, recognition and empowerment as essential in intimate partner violence and to show how these can be translated into a practice framework for improving nurses’ responses.

Background. Intimate partner violence is a universal problem and is considered a significant public health issue. Nurses are in an ideal position to recognize and respond to intimate partner violence, but many lack confidence in this area of practice. In our previous empirical work, we identified three concepts through which nurses’ responses to intimate partner violence can be understood: awareness, recognition and empowerment. In this article, we advance nursing knowledge by showing how these concepts can form a practice framework to improve nurses’ responses to intimate partner violence.

Design. A discussion paper and development of a practice framework to improve nurses’ responses to intimate partner violence.

Discussion. The framework comprises three principal needs of women and three related key requirements for nurses to meet these needs. Arising from these are a range of practice outcomes: enhanced understanding of intimate partner violence, increased confidence in recognizing intimate partner violence, establishment of trusting relationships, increased likelihood of disclosure and optimized safety.

Conclusion. Nurses sometimes lack confidence in recognizing and responding to intimate partner violence. Awareness, recognition and empowerment are important concepts that can form the basis of a framework to support them. When nurses feel empowered to respond to intimate partner violence, they can work together with women to optimize their safety.

Relevance to clinical practice. Access to adequate and timely intimate partner violence education and training is important in improving nurses’ responses to intimate partner violence. Getting this right can lead to enhanced safety planning and better health outcomes for women who experience intimate partner violence.

Although difficult to measure as an outcome, nurses’ improved responses can contribute to higher rates of referral for help and reduction in intimate partner violence rates.

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## Developing a Theory of Change

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Child maltreatment: pathway to chronic and long-term conditions?

Julie Taylor¹, Caroline Bradbury-Jones², Anne Lazenbatt¹, Francesca Solman¹

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Abstract

The new UK government’s draft White Paper, One Better: the UK Faculty of Public Health (2015) sets out compelling research for the implementation of a public health strategy to target a wide-ranging set of challenges to public health. This article explores the long-term negative consequences of child maltreatment and its impact on long-term health outcomes. We suggest that applying child maltreatment and long-term conditions frameworks could have significant health and wellbeing implications for practice and policy.

Introduction

In 2014, the UK Faculty of Public Health (2015) identified 12 compelling priorities for the protection of people’s health. The priority areas fall under four broad categories: every child a good start; lead a healthy life; good care; and protect health and well-being. These four areas provide opportunities to address public health challenges beyond the traditional targets of smoking, alcohol, obesity, and mental health. The focus of this article is on the protection of children, calling for a comprehensive strategy to target a wide-ranging set of challenges to public health, such as addressing the growing epidemic of obesity and alcohol consumption, and addressing targeted outcomes such as securing the monitoring and evaluation of tobacco, alcohol and unhealthy foods (Table 1).

While some priority areas focus specifically on children, the focus is on the prevention and management of child abuse and neglect, and their long-term negative impact on long-term health outcomes. According to the manifestos, “family and community change are two of our biggest public health challenges” (p. 12). We argue, therefore, that child maltreatment also constitutes a significant threat to public health. Child maltreatment is a public health issue that is not a disease process, but its consequences may create pathways to disease; these are overlapping and include determinants which significantly impact the physical, social, emotional, and mental health of children. This article explores the long-term consequences of child maltreatment and how these might be conceptually aligned with the characteristics of long-term health conditions. By looking at maltreatment through a public health lens, we can better understand and manage its impact on public health, but also devote more efficient and comprehensive public health strategy.
Applying a long term conditions framework
Young People’s Experiences of Going Missing From Care: A Qualitative Investigation using Peer Researchers

Looked after children are significantly more likely than other children to go missing. They face significant risk of harm through, for example, exposure to alcohol, drugs and sexual victimisation. While research identifies some factors which may reduce the likelihood of looked after children going missing, it is recognised that a greater understanding of effective practice is needed. The aim of the study was to investigate young people’s experiences of going missing from care and to identify the issues that contributed to them running away, trigger factors that prompted episodes of going missing; support received during or following instances where they went missing; and factors that might prevent future absconding. Research on children’s experiences is often reported from the adult’s perspective rather than allowing children to have a voice. We therefore recruited two young people to collaborate with the researchers as peer researchers. A qualitative study was undertaken using the Critical Incident Technique. Twenty-eight young people with a history of running away were recruited from different locations in Scotland. They took part in six focus groups, which were held during May 2012. Data were analysed using a framework approach. Four themes were identified regarding reasons for running away: authority and power; friction; isolation; and environmental issues. Commonly cited consequences were being ‘grounded’ and having shoes removed (to prevent further running away). Young people were critical of a lack of support on return and a lack of boundaries. They stressed the importance of being heard, being treated with respect, being able to exercise autonomy and feeling that someone cares.

KEY PRACTITIONER MESSAGES:
- Looked after children are significantly more likely than other children to go missing.
- When missing, young people are exposed to significant risk of harm.
- Reasons for running away are: authority and power; friction; isolation; and environmental issues.
- Approaches to responding to young people who go missing should be supportive and facilitative rather than punitive.
- Being heard, being treated with respect, being able to exercise autonomy and feeling that someone cares are crucial preventative factors.

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Children and co-researchers – ‘they put ketchup in my shoes’
Risk of vicarious trauma in nursing research: a focused mapping review and synthesis

Julie Taylor, Caroline Bradbury-Jones, Jenna P Breckenridge, Christine Jones and Oliver Rudolf Herber

Aim and objectives. To provide a snapshot of how vicarious trauma is considered within the published nursing research literature.

Background. Vicarious trauma (secondary traumatic stress) has been the focus of attention in nursing practice for many years. The most pertinent area to invoke vicarious trauma in research has been suggested as abuse/violence and death/dying. What is not known is how researchers account for the role of vicarious trauma in research.

Design. Focused mapping review and synthesis. Empirical studies meeting criteria for abuse/violence or death/dying in relevant Scopus indexed top nursing journals (n = 6) January 2009 to December 2014. Methods. Relevant papers were searched for the extent to which researchers discussed the risk of vicarious trauma. Aspects of the studies were mapped systematically to a pre-defined template, allowing patterns and gaps in authors’ reporting to be determined. These were synthesized into a coherent profile of current reporting practices and from this, a new conceptualization seeking to anticipate and address the risk of vicarious trauma was developed.

Results. Two thousand five hundred and three papers were published during the review period, of which 104 met the inclusion criteria. Studies were distributed evenly by method (52 qualitative; 51 quantitative; one mixed methods) and by focus (44 abuse/violence; 10 death/dying). The majority of studies (94) were carried out in adult populations. Only two papers reported on vicarious trauma.

Conclusion. The conceptualization of vicarious trauma takes account of both sensitivity of the substantive data collected, and closeness of those involved with the research. This might assist researchers in designing ethical and protective research and foreground the importance of managing risks of vicarious trauma.

Relevance to clinical practice. Vicarious trauma is not well considered in research into clinically important topics. Our proposed framework allows for consideration of these so that precautionary measures can be put in place to minimize harm to staff.

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The Focused Mapping Review and Synthesis: A new way of reviewing literature
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Conclusions

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