DOMESTIC VIOLENCE – TIME FOR A RETHINK?

Domestic violence is a phenomenon which pervades throughout societies worldwide and one that needs to stay ever present on the healthcare / nursing agenda. It has probably touched the personal lives of many people reading this journal. It is a multifaceted and serious problem which requires a comprehensive and sensitive response by all who come in contact with both victims and perpetrators. Significant health effects resulting from domestic violence have long been recognised by the World Health Organisation (Krug et al. 2002). Nurses and indeed midwives are key players in the prevention and minimisation of harm arising from domestic violence by virtue of the nature of the unique access they have to individuals, either in the community or in the health care setting. Men and women with poor health are more likely to experience intimate partner abuse than those in good health (Watson and Parsons 2005, Finney 2006). This is an important consideration for practitioners as we may be caring for patients with regular medical conditions without ever considering the possibility of screening for domestic violence. In the UK, the Royal College of Nursing (RCN) have identified five areas where nurses through the course of their practice, can assist victims of domestic violence. The five areas are; identifying the victim, assessing for signs and symptoms of abuse, accurate recording and documentation, conducting a safety assessment and providing referral advice (Royal College of Nursing 2000). As with most nursing care, the efficiency and effectiveness of these crucial interventions are underpinned by a practitioner who exercises informed clinical judgement.

There are many conflicting areas in the literature relating to domestic violence and intimate partner abuse. For example, contradictory data exists regarding its nature and prevalence. Focussing on data sources which represent one perspective has the capacity to polarise our knowledge base and potentially affect our clinical judgement when dealing with this important issue. If we are to operationalise the actions mandated by the Royal College of Nursing, I suggest that there is a need to have a re-think about what domestic violence actually means. We need to challenge our beliefs and assumptions about this phenomenon. McHugh et al (2005), asserts that how we define domestic violence, determines what we find. If in practice, we define domestic violence in narrow terms (i.e. when a husband hits his wife at home), we are invariably narrowing our scope for identifying and responding to other victims who are in unsafe situations. Whilst much has been done in the spheres of nursing practice, education and research, there is clearly a lot more work required, particularly if we want to make a difference in detecting and managing victims. Even the term 'domestic violence' is narrow by its very nature. This term may suggest that what happens at home it is a 'family affair' and is not a serious crime. Secondly, although abuse happens at home, modern technologies such as the internet and mobile phone have shifted the locus of abuse directly to the victim – regardless of location. Violence as a term, conjures notions of physical assault and injury, and whilst, clearly a form of abuse, it is not the only form of abuse. Using the term domestic violence has the potential to overlook other forms of behaviour which are equally if not more

harmful to a victim. I prefer to use the term Intimate partner abuse as I feel it better reflects the pattern of physical, psychological, and sexual aggression, stalking, controlling behaviour and neglect associated with abuse between two partners who are/were intimate. It also has the capacity to acknowledge abuse which occurs between same sex couples.

Another area where there is a re-think required relates to our immediate thoughts about intimate partner abusers. Traditional conceptualisations of intimate partner abuse were almost always constituted as something which females experienced at the hands of men. Most of the theoretical literature (and policy documents) seem to reflect this notion also; although some have acknowledged the fact that female perpetrated violence exists. It is suggested that within most of the literature, there is an implicit assumption that females are not aggressive. This unilateral view minimises the existence of other forms of domestic violence/ abuse, in particular female to male, but also male to male, and female to female. The assumption of female passivity has been supported and continues to be reinforced by historical data, feminist theory, conceptualisations of masculinity, particular research studies, the media, and societal norms and assumptions (Gelles and Straus 1988, Giddens 2001). When these factors are considered, it is unsurprising that the possibility of conceptualising violence against men by women has been very slow to emerge. The acknowledgement of male as victim would go against the 'hegemony' of men as being in control and perhaps threaten the very definition of manhood. Similarly, it could be posited that society would resist the notion that females could be aggressive as this potentially damages our stereotypical view of femininity (Richardson 2005). Indeed, the suggestion of a woman beating a man is also often viewed as comical; something not to be taken seriously. I have memories of being a third year student nurse and witnessing a staff nurse laughing out loud at a male patient's disclosure of domestic violence, ridiculing him again later at coffee break by telling her colleagues about it 'and the size of that man and his tiny wife'. This example illustrates the added difficulties men face in disclosing experiences of domestic violence. If nurses don't acknowledge that it occurs, how can they care effectively for such patients?

Much research has been conducted in the area of intimate partner abuse. Although research suggests that there is a higher prevalence of female victims worldwide (Krug et al. 2002), there is also clear evidence of female perpetrated intimate partner abuse. According to the British Crime Survey, 18% of men had experienced one or more incidents of intimate partner abuse since the age of 16, with 5% (translating to one in 20 men) experiencing abuse in the last year (Finney 2006) . Other measures of intimate partner abuse which define abuse at the level of an individual action have found even higher rates of victimisation amongst men (Straus 2004). When considering findings of studies relating to intimate partner abuse, it is necessary to consider how power and subsequently abuse of power is exercised within relationships. It may involve one or all forms of abuse (i.e. physical, psychological, sexual, controlling behaviour etc).

Women are proportionally more likely to require the services of health care providers due to the nature of physical injuries sustained (Watson and Parsons 2005). Bearing this in mind, it is important to be cognisant of the many victims both male and female who go un-noticed within the health services perhaps due to a lack of visible injury. As highlighted above, victims of intimate partner abuse are 'hurt' not just physically. This is not to say that men do not seek help from healthcare providers – clearly they do, as highlighted in the example above. However, we need to prepare for the possibility of also encountering male victims in our practice – in particular from a community and mental health perspective. A broader re-think about what intimate partner abuse might 'look like' would enhance the chances of recognising, responding and referring male victims accordingly.

The health service is a crucial force in the prevention, detection and management of those affected by intimate partner abuse. Nurses are key individuals who by virtue of their role have the capacity to alter the course of a victim's life by routine screening for intimate partner abuse. Routine screening or selective questioning about intimate partner abuse regardless of gender or physical presentation of injury would prove a useful first step for practitioners. This editorial does not intend to minimise violence experienced by any other group. It intends to contribute to a greater understanding of the phenomenon from the perspective of men. Only when all perspectives of intimate partner abuse are understood, can realistic solutions be contemplated to tackle this world wide problem.

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For further support contact:

UK:	http://www.mensadviceline.org.uk/	Telephone 0808 801 0327
	http://www.broken-rainbow.org.uk/	Telephone 0845 260 4460 (Support for gay, bisexual and transgender people)
Ireland:	http://www.amen.ie/	Telephone 046 902 3718

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