THE FRONT LINE OF CARE: A QUALITATIVE STUDY OF DOMESTIC VIOLENCE INTERVENTION IN THE EMERGENCY DEPARTMENT

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ABSTRACT

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THE FRONT LINE OF CARE: A QUALITATIVE STUDY OF DOMESTIC VIOLENCE INTERVENTION IN THE EMERGENCY DEPARTMENT

This study qualitatively explored the practice of domestic violence (DV) intervention in the emergency department (ED) from the distinct perspectives of service users, service providers and co-ordinators of DV voluntary organisations. The research participant group was made up of eight survivors of domestic abuse, fourteen staff members from an ED (including their manager) and eight co-ordinators from a voluntary organisation offering services for DV issues. The study was informed by the dearth of evidence regarding pragmatic intervention for the specific context of emergency departments (EDs), a need to develop system level interventions and a solid theoretical base to inform implementation of a more effective interventional strategy (Feder et al., 2009; Thurston and Eisener, 2006; Ramsay et al., 2002).

The study utilised constructivist grounded theory and feminist perspectives to elicit unique viewpoints from interviews with the three separate groups. A range of meanings and conceptualisations were found which contribute to a more complex understanding of the issues involved and the responses to them. These included how women experience DV, the way DV is rendered invisible by ED culture and, perhaps most importantly, how a lack of policy implementation has influenced the practice of ED staff with regard to DV. Adopting a perspective that takes into account the sensitivity and gendered nature of DV made visible the socio-political and personal influences that affect both health providers’ and health users’ attitudes to seeking help. System-wide barriers to intervention ranged from personal to situational levels within the context of EDs. They included deep-seated ambivalence, fear and trust issues located within the constructs of both service users and providers regarding identifying and assessing the problem, seeking help, and providing support.

Three overarching concepts were identified: 1) meanings and complex realities relating to DV and its intervention 2) barriers to seeking and providing help and 3) strategies for overcoming barriers and developing DV intervention within ED. Using rigorous, inductive, comparative and interpretive attributes of grounded theory procedures, conclusions were reached about the development of DV interventions in the department. These informed the propositions made for a comprehensive and integrated DV intervention including universal interventions which can be helpful irrespective of service user’s disclosure and stage of abuse, providing resources within the ED to enhance DV intervention; improving the ED environment so that it is more favourable for DV intervention; implementing policies that make the experience of psychological abuse visible; and promoting DV awareness. Areas of concern were highlighted for practice, policy, and research relevant to DV intervention in EDs.
DECLARATION

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CHAPTER 1: INTRODUCTION

1.1 Background and organisation of the thesis

The recognition of domestic violence (DV) against women as a serious health issue has created a widespread call for providers in all healthcare settings to address the issue through either universal awareness (O’Campo et al., 2011; American Academy of Family Physicians, 2010; Cherniak et al., 2005; Taket et al., 2003) or vigilant screening (Wathen and MacMillan, 2003; U.S. Preventive Services Task Force, 2004; Department of Health, 2005). Nevertheless, research has shown that integrating awareness of DV intervention into the perspectives of health professionals has yet to be achieved particularly in emergency departments both in the UK and around the world (Feder et al., 2009; Thurston and Eisener, 2006; Minsky-Kelly et al., 2005; Campbell et al., 2001; Loughlin et al., 2000; Waalen et al., 2000).

The UK’s Department of Health (DOH), recognising the reluctance of health professionals to intervene in DV, has published guidelines and a training handbook for responding to abused women since 2000 (DOH, 2000a; 2005). Such steps indicate government concern about DV and indicate a step to encourage proactive involvement on the part of health service providers. However, the guidelines do not adequately address definite strategies and processes that can ensure contextualised integration into specific settings. This is particularly relevant to emergency departments (EDs) in the UK, where both the highest prevalence of DV among women visiting health settings and the paucity of research investigating effective interventions have been reported (Feder et al., 2009; Plitcha, 2007; Olive, 2006; Sethi et al., 2004).

As one of the most common causes of injury to women, DV brings many women to EDs, where they are treated for health problems directly or indirectly resulting from the
abuse (Sethi et al., 2004). However, the opportunity to intervene and support abused women is often missed by emergency staff. Studies from the UK have shown that a majority of abused women passing through departments return to the same abusive relationship without their abuse being identified (Boyle and Todd, 2003; Sethi et al., 2004). Moreover, no further arrangements are made for abused women’s ongoing support or safety beyond treatment for physical injuries (Henderson, 2001; Hamberger et al., 2004; Minsky-Kelly et al., 2005).

This thesis explores the current DV treatment strategies within an ED in the UK, the awareness and practices of ED staff and the experiences of pertinent stakeholders such as DV survivors and coordinators of DV voluntary services. It explores barriers and facilitators to successful intervention, as well as informing a theoretical base from which further possibilities for intervention are examined.

This chapter continues by conceptualising domestic violence and setting out the working definition for the study. The unique characteristics of violence against women are discussed. This is followed by a discussion of the background and historical context of DV policies in the UK. The theoretical considerations of DV interventions are also discussed.

The literature relating to DV and health settings’ interventions is discussed in chapter two. It begins by exploring the magnitude of DV globally and in the UK, including its prevalence within emergency departments and its impact on women’s health. Chapter two also examines empirical studies on interventions for women experiencing DV and the barriers to DV intervention within healthcare settings. It ends by identifying gaps in the literatures and justifying the need for the present study.
Chapter three explains the philosophical and theoretical underpinnings for this study, specifically the rationale for adopting constructivist grounded theory and feminist theory. Chapter four focuses on the methods used to generate and analyse data, and addresses questions concerning ethics and rigour. Chapters five, six, and seven discuss the findings of the study. Chapter eight presents a discussion of the findings in light of existing evidence and the theoretical basis of the study. Finally, chapter nine draws out the implications of the study with regard to practice, policy and research, before discussing its limitations. The thesis ends with some recommendations for further research.

1.2 Conceptualising violence against women

The power to name is the power to give voice to a social phenomenon or experience – and to have it legitimated (Naranch, 1997:21)

Violence against women is a broad term for the multiple, interrelated forms of abuse against women that have become the most fundamental violation of human rights affecting all societies, regardless of race, ethnicity, age, or social and geographical boundaries (United Nations, 2012). Violence against women was a major topic at the 1995 Beijing Fourth World Conference on Women (UN Women, 1995) and was recognised by the United Nations General Assembly Declaration on the Elimination of Violence against Women in 1993 as an infringement of human rights (General Assembly Resolution 48/104; Declaration on the Elimination of Violence against Women, 1993). They defined 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’.
Violence against women includes DV, genital mutilation, honour killing, acid throwing, forced prostitution, sex-selective abortions, sexual violence such as rape, and other violent acts perpetrated exclusively against a woman just because she is a woman (United Nations, 2012). However, DV has been acknowledged by the WHO as the most common form of violence against women worldwide (Ellsberg and Heise, 2005). As the present study is limited to DV against women, the definition of which will now be discussed.

1.3 Defining domestic violence/abuse

A variety of terms are currently in use to denote DV including, but not limited to, domestic abuse, intimate partner violence, spouse abuse, partner abuse, partner violence, and wife battering. In spite of numerous nomenclatures, DV is still a widely used term in literatures; the phrase is often used interchangeably with domestic abuse, intimate partner violence, and sometimes used to indicate violence against women. The controversy in developing a term for the abuse has been complicated by the lack of a universally accepted definition.

The debate on what should be included in the definition has grown over the years. There are four major contentions; whether the acts constituting domestic abuse should be inclusive or limited; whether the definition should be gender specific or neutral; whether the definition should be limited to intimate relationships between adults that exclude the wider family relationships and whether the definition should be widened to include specific age analysis (Home Office, 2012; Harwin, 2006; DeKeseredy, 2000).

The UK Home Office defines DV as:
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. This definition includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. An adult is defined as any person aged 18 years or over (Home Office, 2012:5).

While this definition in part harmonises statistics about the extent of DV by recognising the wider relationships, their concern for operational and terminological dilemmas has been criticised for its restriction to adult (18 years and above) relationships and for not recognising DV as gender-based violence (Harwin, 2006). The Home Office has reviewed its policy in terms of widening the coverage of the definition of DV to include girls aged 16 and 17 years, however this is not being implemented until March 2013 (Home Office, 2012). At present, DV against women 18 years and below is considered child abuse and managed using child protection framework (Home Office, 2012). The British Crime Survey (2009/2010) shows that women between 16 and 24 are more likely to experience DV in the last year than any other age group (Smith et al., 2011). Moreover, many teenagers in the UK under the age of 18 are already parents (Home Office, 2012). The cut off age of 18 years clearly excludes the most vulnerable age groups from support and help provision.

Similarly, while this is not clearly stated in the definition, most organisations, including the NHS, generally refer to 18-59 years as adult and above 60 years as elderly. Just like younger age groups, DV in later life is undoubtedly an issue and should not be ignored in definition and in practice. Elder abuse is often managed within the NHS
using the vulnerable adult framework as the definition of a vulnerable adult covers abuse relating to age. The Department of Health (DOH) defines vulnerable adult as ‘someone 18 or over who is, or may be, in need of community services due to age, illness or a mental or physical disability and who is, or may be, unable to take care of himself/herself, or unable to protect himself/herself against significant harm or exploitation’ (DOH, 2002). Domestic abuse can make a female adult vulnerable; however, meeting the criteria stipulated in the government’s definition of vulnerable adult may be problematic and confusing to health professionals in practice. For example, what qualifies as ‘significant abuse’ is subjective and may be confusing to health care providers.

An expansion of DV definition to include the different but interrelated forms of domestic abuse has also been advocated to acknowledge, expose and respond appropriately to the abuse (Ellsberg and Heise, 2005; Home Office, 2011; WHO, 2012; United Nation, 2012). While broadening the definition in these respects could present difficulties in providing a straightforward estimate of DV for policy makers (Crisp and Stanko, 2001), what is evident from the debate for a more inclusive definition is that it would be in the best interest of victims. For example, the inclusion of those aged 16-17 years will likely increase awareness of available support and disclosure within this age group (Home Office, 2012). Likewise, conceptual clarity with regards to boundaries between DV and elder abuse in terms of terminology and definition is required, for example how ‘vulnerable’ is defined lacks specific guidance to professionals (Mc Garry et al. 2011). Consequently, Blood (2004) argues that the current inclusive definition of ‘vulnerable’ could discourage older women from seeking support of services as well as fails to fully articulate the need for health professional to recognise and work in a more cohesive way with community services. Besides, the
inclusion of more insidious forms of abuse may lead to the prevention of long- term damage that would otherwise go unrecognised.

Unambiguous age analysis and operational definitions are needed to acknowledge and evaluate the specific needs and treatments required for different age groups. For example, current research has shown that the triggers, the needs and the framework for intervening in domestic abuse among older age groups differ markedly from younger age groups (Mc Garry et al., 2011). Although, age analysis has its drawbacks, including inability to cater for an overlap in services. This overlap may be inevitable due to the impact of DV and the wide age range and behaviours involved. For example, health care providers may act differently if they see someone as an older adult (possibly more vulnerable) and coming under different legislation such as domestic abuse. Nonetheless, in order to offer more opportunities for intervention, health professionals need training in using the current definition and interpreting it in a way that is more helpful to DV victims. This may include having a clearer definition of vulnerable adult and its intersection with DV.

For the purpose of this study, the current NHS definition of adult (18-59) has been followed to ensure uniformity of organisational practice as well as comparability of research findings and monitoring processes as recommended by the UK Government (Home Office, 2006). (Other operational definitions for this study are discussed later under 1.3.1). This age boundary will ensure consistency with the NHS as the setting for practice evaluation and the proposed intervention for this study. Nevertheless, this has been identified as a limitation (see 9.3).
Qualitative investigations have contributed, and still continue to add, to the development of a broader definition by unveiling valuable information about the extent, nature and multiple faces of domestic abuse (DeKeseredy, 2000; Ellsberg and Heise, 2005; United Nation, 2012). Perhaps more compelling is the contribution of qualitative research in uncovering the unstated meaning of the abuse to the victim. Sadly, the lack of a shared definition of DV among interested parties can result in mismatched concepts that can further hinder policy recommendations and research development.

A deeper and more political issue in the debate for exclusive definition relates to the possibility of underrating the severity of the problem of DV against women and its implications for policy development. Prevalence is potentially a marker for significance and creates demand for urgent intervention. Adopting a less inclusive definition is therefore likely to reduce perceived prevalence, which will have a negative impact on policy implementation and resource sharing.

Research design-related issues, specifically the difficulty of framing questions about different types of domestic abuse, have been reported to affect disclosure and thus impact negatively on research findings (Walby and Allen, 2004). The same problems beset data gathering techniques and methodological issues so that it is difficult to make direct comparisons between statistical findings (Feder et al., 2009). Moreover, issues relating to under-reporting due to limited definition were raised by the recent supplementary volume to Crime in England and Wales (2009/2010) (Smith et al., 2011). The authors highlighted limitations of the British Crime Survey (BCS) in capturing respondents’ experiences of non-physical abuse, such as emotional abuse, sexual assaults, threats and financial abuse.
In their report, the majority of respondent (95%) who reported being victims of DV in the self-completed module (which uses a broad definition) did not report being a victim in the BCS face-to-face interview (which adopts a limited definition). In addition to notable exclusions like sexual offences, limitations in coverage and insensitivity to the meaning and impact of DV, general crime surveys are often less sensitive to the subjective experiences of victims (Smith et al., 2011).

It must be noted that the ways in which DV is conceptualised, studied, and discussed can reflect researchers’ orientations and the social context of research. Often, the definition is skewed to suit the background, disposition and the perspective of the researcher or author. The legal institution, for example, often uses the perpetrator’s intention for their definitional criteria, although English criminal law does not explicitly criminalise DV (Platek, 2009). Non-governmental organisations (like Women’s Aid) have played a leading role in campaigning for the inclusion of women’s experiences in shaping policies relating to DV against women. As feminist advocates, the definition adopted by Women’s Aid reflects the impact, motive and meaning of the violence on the victims (Women’s Aid, 2012). They define DV as

Physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called ‘honour crimes’.
In their view, DV may include a range of abusive behaviours, not all of which are in themselves inherently violent but they are characterised by a pattern of abusive and controlling behaviour through which the abuser (usually a man) seeks power over a victim (usually a woman) (Women’s Aid, 2007). While they acknowledge that men may also suffer DV, they argued that about 90% of reported cases of such violence are by men against women and the motive is to control and dominate women. Thus, their definition is gender-based but not age-specific and also includes the institutionalised nature of DV and its traditional historical acceptance.

It is perhaps reasonable to assume that, as the choice of terminology used for DV varies extensively, so do the definitions and the acts acknowledged. While this presents a challenge to anyone hoping to investigate the subject, it is a useful indication of the complexity of knowledge production in this field and of the way DV research should be approached. Researchers may not adequately capture the multiplicity of factors involved, even when their approach is responsive to the subjective experiences of victims and inclusive definition is used. Nevertheless, in my view, researchers should not create further problems by obscuring the bigger picture. However, reaching definitional agreement may be easier said than done, due to the diversity of both researchers and domestic violence incidents. As a result, there is a need for precision when defining DV for the purposes of each particular study (Home Office, 2006). In view of the heterogeneity of the term, it is important to state the operational terms and definitions used in this study.
1.3.1 Operational definition

This study shall be limited to domestic violence against women. Hereafter, Domestic abuse and domestic violence shall be used interchangeably, ‘perpetrators’ shall refer to male partners and ‘survivors’ as a participant group shall refer to adult women (18-59 years) who have experienced DV. The purposes of the age limitation are to gain consent from respondents, to make research results comparable, to ensure uniformity with the study setting, and to comply with monitoring processes as recommended by the UK Government (Home Office, 2006). For the purpose of this study, the Women’s Aid definition shall be adopted. Herein, Domestic violence/abuse against women shall be defined as:

Physical, sexual, psychological or financial abuse of a woman that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour.

The scope of this study is limited to abuse that takes place within intimate relationships and excludes forced marriage and honour crimes. This study has embraced a gender-specific orientation as an effective framework for researching and for understanding DV against women for several reasons. Firstly, it is believed that such a perspective will acknowledge that women form an overwhelming majority of victims and recognise the profound consequences of violence on women. Secondly, a gender-specific perspective will help construct women’s experiences by incorporating contextual factors underlying the violence, such as considerations of inequalities, power and control (see 1.5). Lastly, it will locate the problem within a socio-historical and political
framework that acknowledges the need to develop multifaceted intervention. While I am aware that male victims of DV equally deserve support and understanding, failure to include a gender analysis will impede our ability to draw conclusions and develop an intervention that is tailored to meeting specific needs.

**1.4 Contextualising DV against women: Gender and Healthcare**

**Policy issues**

The re-emergence of the feminist movement in the early 1970s (often referred to as second-wave feminism) has largely informed efforts to acknowledge, explain and challenge male violence against women in the western world over the last 40 years. Feminist researchers and international organisations have been conscientious in leading demands for changes in societal responses to abused women. For example, they have opposed conceptualising DV as gender-neutral (United Nations, 2012; WHO, 2005; Dobash and Dobash, 1992). In their view, the context for DV against women is a cultural and political framework which results from and is perpetuated by gender inequality.

The debate to acknowledge the gendered nature of DV has widened recently among DV researchers and feminist activist: their argument is that DV and other violence against women are linked with the historically unequal power relations that exist between men and women. Contextual factors such as motives, frequency of initiation and physical and psychological consequences should thus be recognised. Moreover, plans to address the abuse should be understood from the perspective of sex discrimination (United Nations, 2012; Nixon, 2007).
On the other hand, a move to quantify the number of violent acts by men and women within relationships began a couple of decades ago in the US. Straus (1980) reported that, in a sample of 325 violent couples, both husbands and wives committed at least one violent act in 49.5% of cases. Husbands were violent in 27.7% of the cases and wives were violent in 22.7% of the cases. A follow-up study (Straus et al., 1986) reported that men and women assaulted each other at approximately equal rates, with women initiating minor acts of violence at a slightly higher rate than men. Other family conflict studies (Stets and Straus, 1990; Strauss, 2005) have since reported similar findings: they show symmetrical rates of violence within intimate relationships, which propagates the assumption that partners commit equal acts of violence. Their claims are that violence in intimate relationships basically represents ‘mutual combat’, and that women’s use of force during such combat can be considered battering. They therefore refute the grounds for gender favouritism in DV (Strauss, 2005; Archer, 2000).

Other DV researchers have opposed this conceptualisation, arguing that men who perpetrate violence against women use a variety of means; these include threats, blame, humiliation, denial and isolation as well as physical and sexual violence to gain and maintain control over their spouse or partner (Hamberger and Guse, 2002). Violent men use domestic abuse as a social mechanism to demonstrate and enforce their position as head of the household or relationship, so that women are subordinated to them and unable to attain their full potential (Nixon, 2007). This patriarchal supremacy is the accepted norm in most cultures
of the world; women are expected to honour and obey their husbands or partners, and violence against women often goes unpunished (WHO, 2005).

Issues of gender and power are fundamental in understanding violence against women because they substantiate and connect with the experiences of women; the women and men's experience of violence differ not only in meaning and motive but also in severity and frequency (Walby and Allen, 2004). The abuse that women face is often not an isolated or one-off experience, rather it represents an ongoing pattern of control, fear, and domination that results in emotional pain and injury (Cherniak et al., 2005). On the other hand, in circumstances where men are victims of violence perpetrated by women, the violence is not usually part of a recurrent pattern of behaviour, incidents are not rooted in inequality and the primary motive is not to inflict emotional pain and injury (Hamberger and Guse, 2002). Rather, women’s use of violence against men is largely for self-defence, active resistance or in retaliation for previous violence perpetrated against them (Hamberger, 1997); it is rarely a means to exert fear or dominate their spouse (Miller and Meloy, 2006; Dutton, 2002).

Moreover, men are less likely to be repeat victims, to be seriously injured or report being fearful (Walby and Allen, 2004; Cherniak, 2005). In contrast, women are significantly more likely to sustain severe physical and psychological injuries (Equality and Human Right Commission, 2009) and require medical attention as a result of the abuse (British Crime Survey, 2009/2010). More importantly, men who have been hit by their female partners are not usually frightened, unlike abused women who often experience life-long fear as a consequence of abuse (Yodanis, 2004; Cherniak, 2005). Evidence has shown
that abused women’s reluctance to report their experience of violence to health professionals is linked to the psychological effects of their victimisation (Ristock, 2002; Thomlinson et al., 2002). Consequently, these contextual issues should be considered before making claims about violent acts.

The UK Government has taken significant steps to improve national policies relating to DV against women. For example, the Domestic Violence Crime & Victim Act 2004 was the largest overhaul of legislation on DV to date. The Act aimed to improve the support and protection that victims receive and to introduce new powers for police and courts to deal with offenders (Home Office, 2011). The provisions of the Act made common assault an offence that can result in arrest and introduced new police powers to deal with DV crimes. Consequently, stronger legal protection is now available for victims; courts can now impose restraining orders and protection orders. In 2009, the Government launched ‘Together we can End Violence Against Women and Girls: a Strategy’. The goal of the strategy is to allow women and girls to ‘live their lives free from harassment or violence’ (Home Office, 2009). The strategy focuses on two premises: firstly, preventing actual violence against women and girls, supporting those who have been victims and bringing perpetrators to justice. Secondly, reducing women’s fear of violence and the effect this has on their day-to-day lives. An on-going review has been initiated to prevent future occurrences of DV-related homicide and to review the Government definition of DV (Home Office, 2012). Also, the Home Office Secretary has announced the allocation of £28 million until 2015 for specialist services, such as national help lines (Home Office, 2011).
However, it seems that Government’s actions to end violence and support women have focused mainly on law enforcement and specialist services, with little investment in the health sector (Amnesty International, 2008). While legislation is useful in dealing with offenders, health workers are often the only point of contact for many abused women with public services offering support and information (Plitcha, 2007; Feder et al., 2011).

In addition, the misconception that the abuse is gender-neutral is likely to impact negatively on services for abused women and their children, and perhaps even eliminate them. In particular, Black and Minority Ethnic (BME) women face additional forms of violence, such as forced marriage, female genital mutilation and crimes in the name of honour. BME women experience barriers in accessing support in the UK (Equality and Human Right Commission, 2009). Already, fewer than 1 in 10 local authorities in the UK have specialised services for BME women to address these other forms of violence; almost a third of local authorities have no DV services whatsoever (Equality and Human Rights Commission, 2011). Racial issues further aggravate the experiences of some women who are trapped by DV: BME women face barriers, such as insecure immigration status, which continue to give their male partners opportunities to control and abuse them (Batsleer et al., 2002). In fact, BME women are more vulnerable and continue to experience racism even while in refuge and shelter homes (Chantler, 2006). Perhaps their fears are complicated by misunderstandings about how an unfamiliar culture functions.

Undoubtedly, the distinctive features of power, repeated victimisation, and increasing severity make the abuse of women unique. To discard vital gender
and historic issues and base policies (including definitions) on gender neutrality would be inappropriate. Common ground between government policies and healthcare intervention should be identified, considering the enormous cost of DV, its implications for the health of women, their children, and society. Declaring strategies and issuing DV guidelines alone may not guarantee results. To create safer lives for abused women and their children, policies concerning health professionals’ awareness will be required, as well as fast responses, and recognition of the gendered nature of abuse and its implications for BME women.

This section has examined the debate surrounding the gendered nature of DV and its implications for policy and services for women and men. The next section briefly discusses theories underpinning DV causation and intervention.

1.5 Theories underpinning DV causation and intervention

Theoretical propositions regarding the issues involved in DV are frequently connected with practice and may form the background for the researcher’s choice of intervention (Heise, 1998). There is no consensus among researchers as to what the primary cause of DV is. However, many theories have been postulated to explain the reasons why some men become violent towards women. Explanations differ and some theories overlap, but they share some commonalities which have enriched understanding of the causes of DV and which indicate ways in which the problem might be addressed.

The responses to DV by health workers or community services may be dictated by their understanding of theories underpinning DV and its intervention. For
example, ‘victim-blaming’ and the assumption that women should leave violent relationships have been reported (Chantler, 2006: 27). Consequently, it is important that DV interventions are based on a clearly expressed and uniformly shared definition and theory by all parties involved for successful coordination and effective service provision. Some theories explaining violent behaviours and practical intervention are herein discussed briefly.

1.5.1 Individualist theories

Individualist theorists suggest that violence is a result of early childhood experiences which shape the development and personality of an individual (Heise, 1998). Violence is mainly attributed to the individual characteristics of the perpetrator and, to a lesser degree, the abused woman. As a result, interventions are focused on individual remodelling: this may include anger management, addressing childhood trauma, conflict resolution, cognitive reconstruction and emotional regulation (Dutton and Sonkin, 2003). Treatment may take the form of individual or group support, using psychological and behavioural therapy (Mauricio and Gormley, 2001). Some pathological and behavioural defects have been implicated as underlying factors in the development of habitual abuse; these include insecurity, experience of abuse as a child, disrupted parenting, personality and emotional disorders, substance misuse and low self esteem (Healey et al., 1998; Heise, 1998). While these analyses have been found useful in identifying risk factors associated with violent behaviours, they have been criticised for excusing the behaviour of violent men (Healey et al., 1998). Besides, such analyses do not explore the reasons why men are the predominant perpetrators of domestic abuse. Moreover, the individual theorist viewpoint is rather personalised: it focuses on
characteristics of individuals and ignores the systemic and cultural aspects of abuse.

1.5.2 Social learning theories

This perspective views DV as the product of social norms and attitudes that are learned from the family, or developed through interaction with a social group or broader culture. Longitudinal and ethnographic researchers have observed that relationships during childhood influence later adult behaviour and that they are responsible for the transmission of violence from one generation to another (Jewkes, 2002; Ehrensaft et al., 2003). For example, a son may learn from his father that aggression is appropriate to resolve conflicts, especially within intimate relationships. Family dynamics, structure, and patterns of interaction form the basis from which violent behaviours are drawn (Saunders, 1993; Cunningham et al., 1998). Social learning theorists have also been criticised for failing to hold abusers responsible for their actions, and failing to explain why a substantial proportion of abusers report no exposure to family violence (Healey et al., 1998). Intervention strategies advocated by social learning theorists include efforts to prevent exposure to violence in childhood, early intervention with children from violent households to restore normal developmental processes, and the re-orientation of perpetrators to change cycles of learned behaviour (Cunningham et al., 1998). However, the difficulties of attempting these strategies, and the long periods which must elapse before their efficacy can be judged, can make the strategies difficult to implement.
1.5.3 Couple and family interactions theory (interpersonal theory)

This theory suggests that DV is rooted in faulty interactions within the family or between couples. Interpersonal theorists posit that relationship conflicts may be due to communication problems or an inability to resolve issues in a family setting (Banish, 2004). Thus, intervention is based on therapies for couples or families to improve interaction and communication. This theory has been criticised for ignoring power dynamics (Cunningham et al., 1998; Healey et al., 1998). Similar to ‘individualist’ theory, it focuses on individual families or couples and ignores cultural development and contexts of family relationships. It also has the potential for creating victim-blaming scenarios, where the people within difficult relationships are stigmatised as being in some way faulty by not living up to supposed norms of the happy family.

1.5.4 Socio-structural (Feminist) theories

The proponents of this theory view DV as being deeply rooted in the historical imbalance of power between men and women, which can only be understood by examining society as a whole (Banish, 2004). Based largely on feminist perspectives, analysis focuses on male dominance over women in traditional patriarchal societies and how such societies are structured so that political, physical and economic control remains in the hands of men (Heise, 1998). Feminist perspectives have their roots in the long struggle of women for emancipation and their refusal to be silenced on domestic abuse. The feminist perspective, when applied to the accounts of abused women, reveals abuse to be a form of social rather than individual control: it reflects an ingrained, worldwide inequality that can only be addressed by radical change.
The cultural reinforcement of male supremacy in many societies results in institutionalised gender bias and inequality of employment opportunities (Garcia-Moreno et al., 2005). Even supposedly ‘liberated’ cultures still retain strong patriarchal influences and the exploitation of women is often masked by the supposed ‘freedoms’ of ‘advanced’ cultures. While male supremacy is endemic in many cultures, gender roles change perhaps due to other social and economic shifts. Thus, male supremacy is sometimes challenged by changing gender roles, which is one feminist explanation for why men resort to violence (Ellsberg and Heise, 2005). Feminist theorists aim to intervene by exposing abuse and campaigning for change. Interventions are proactive and often drive towards changes in social norms and macro level structure; this is achieved through political and legal initiatives (Banish, 2004). In addition, intervention often incorporates advocacy and support for women, while men are held accountable for their behaviour.

Critics of this theory have argued that the system of male power in the society is complex and multidimensional (Heise et al., 1999). Focusing on one part of the problem, for example social control, may therefore abridge the complexity of the problem by advocating radical change, and ignoring individual and relationship-specific factors. From this perspective, other factors should not be overlooked in dealing with violent behaviours. Concentration on institutionalised male control overlooks the fact that DV is perpetrated by women on men (Walby and Allen, 2004), raising criticisms of bias towards female victims. However, the results of several cross-cultural studies suggest that hierarchical gender relations are fundamental to DV (Ellsberg and Heise, 2005; United Nations, 2012).
While feminist theorists have been conscientious in leading demands for changes in societal response to abused women, feminist theory may be insufficient to comprehensively analyse DV (Allen, 2011). This is not a specific issue for feminist theory: a single theory may not offer a total, integrated framework for understanding the complexities of intervening in the abuse of women. Nevertheless, feminist perspectives remain an important ingredient in constructing a theoretical explanation for DV against women, and in developing interventions which will be acceptable to abused women (Wuest, 1995; WHO, 2005; Allen, 2011). It would therefore be difficult to achieve a total understanding of DV without incorporating the gender and power construct offered by feminists (Nixon, 2007).

**1.5.5 Ecological theory**

Ecological theorists perceive DV as the outcome of four levels of interaction: the individual, the relationship/immediate environment, the community and the society. It thus provides a comprehensive integrated framework for the analysis of DV issues. Ecological Theory was first introduced in 1979 by Bronfenbrenner (Heise, 1998). The need for an integrated approach to the problem of DV (WHO, 2002) has increased the acceptance of this model among DV researchers (Heise, 1998, Dutton et al., 2006; WHO, 2005). The theory suggests that interaction with others and the environment is crucial to development: we all experience more than one type of nested environmental system, with bi-directional influences within and between the systems. These include the microsystem, which is the immediate environment in which a person is operating such as a family; the mesosystem, which includes the connection
between a woman’s home and health setting; and the exosystem, which includes broader social influences. The last system is the macrosystem, which includes larger cultural contexts, such policies, laws, and ideologies that directly or indirectly affect individuals or groups.

While this perspective recognises the influence that environment has on both health providers and women experiencing DV, ecological concepts may not provide the predictive value of more formal theories involving propositions, testing and verification. An additional theory may be required to fulfil this role. Ecological theory does, however, provide potential points of intervention within which protective and risk factors may be located (Edleson, 2000). As a result, interventional strategies can occur at micro-, meso-, and macro- levels, and can be achieved through efforts between and within systems. Interventions may be aimed at the individual, such as training for staff, or the near environment, such as families’ social network or work environment. They may also be aimed at a wider context, such as changes in policies and practices of social institutions like health systems, educational systems and children’s welfare system. They may even be aimed at the general social level, by the using public posters and adverts that condemn abuse. Secondary preventive efforts, like universal assessment of women for domestic abuse, can reinforce a message of ‘zero tolerance of abuse’ (WHO, 2005) to families and community. It is important to state here that all these interventions have been led by feminists and related organisations, such as Women’s Aid, which highlights the cohesion between the ecological approach and feminist position.
1.6 Chapter Summary

This chapter has discussed the different conceptualisations of DV, the debate surrounding its gendered nature and theories underpinning cause and intervention. While definitional inconsistency can provide an interesting intellectual debate, it has significant consequences in terms of its political and practical connotations. Choosing inclusive definitions of DV is particularly important in estimating its prevalence and the nature of services required to deal with it. Unfortunately, definitional inconsistencies are exacerbated by the complexity of DV itself and the variety of sampling methods used by researchers in the field. The operational definition for this research has been made clear by acknowledging the limitations and assumptions of different definitions used in researching DV.

In spite of controversies surrounding the gendered nature of DV and its consequences for policy, it has been established by research and statistical findings that DV is primarily an act of violence against women by men. The distinctive features of power, control, repeat victimisation, and increasing severity make the abuse of women and the concomitant research approach unique. To conceptualise DV as being gender-neutral is to assume that women and men perpetrate violence of equal magnitude. This will ultimately legitimise equal shares of resources to support abused women and men and the lack of policies to promote health workers’ response is likely to worsen.

Finally, theories underpinning why some men may be violent towards their spouses have explanations originating from a number of different perspectives. This includes individual, interpersonal, social structural theory and the
ecological theory which unifies the different factors identified by the other theories and gives a comprehensive paradigm. The ecological perspective provides a framework to understand the interplay that exists between personal, situational and socio-cultural factors associated with DV. Thus adding power and relevance to DV intervention strategies (Dutton, 1995; Heise, 1998), as does feminist theory in its call for personal and political factors in DV interventions. The next chapter reviews the literature on prevalence, current interventions and barriers within EDs for women experiencing DV.
Chapter 2: A review of literature on DV and ED intervention

2.1 Aim and design of the review

This review of literature aims to identify, collate and examine research relevant to the treatment of women experiencing DV in EDs. Suitable studies were identified by searching electronic databases, specifically, Medline, Embase, Cinahl, Psycho Info and the British Nursing Index & Archive. These databases were searched from their individual inception dates up until 2012. To complement the electronic search, websites concerned with women’s health and domestic violence (such as the Women’s Aid, World Health Organisation and United Nations’ websites) were explored for relevant materials, citations and unpublished studies. While the search was intended to be inclusive in order to avoid the omission of relevant studies, it was sufficiently defined to allow for specificity in relation to the research questions. Searches were limited only to terms (see appendix 1 and 2 for search terms and search results) relevant to the research questions (see 3.2 for research questions). The first part of the review examines the magnitude of DV, both globally and in the UK; the impact of DV on women’s health is then discussed. The second section reviews interventions offered to abused women when visiting EDs. Finally, barriers to DV intervention in EDs were reviewed. Throughout the review, references were made to other healthcare departments where it was deemed applicable.

2.2 The global extent of DV against women

Domestic violence against women represents a major healthcare concern, both globally and for the UK. The United Nations (2012) reported that DV against women is one of the most widespread and socially tolerated public health and human rights violations worldwide. Between 40% and 70% of women who are
victims of murder in Canada, USA, South Africa, Israel and Australia were killed by their husbands, boyfriends or ex-husbands/boyfriends (United Nations, 2005). An American national survey revealed that murder is the second leading cause of death among girls aged 15 to 18, and 78% of these deaths are from homicides committed by an acquaintance or boyfriend (Coyne-Beasley et al., 2003). On average, at least three women die each day in the US (Bureau of Justice Statistics, 2006). In 1997, two women died each week in the UK as a result of DV perpetrated by current or ex-partners (HMSO, 1998). This figure represents 47% of all female homicides for that year (HMSO, 1997).

The WHO, following their review of 50 population studies from over 35 countries around the world, found that between 10% and 50% of women have faced some form of physical abuse, and that around 10% to 30% had experienced sexual abuse from an intimate partner during their lifetime (Heise and Garcia-Moreno, 2002). The authors estimate that one in three women will experience DV in their lifetime. A more recent multi-country prevalence study by the WHO interviewed 24,000 women in 15 sites across 10 countries (Garcia-Moreno et al., 2005). The authors reported that the lifetime prevalence of DV against women ranged between 15% and 71% for physical or sexual violence, or both, by an intimate partner, with a one-year prevalence rate between 4% and 54%. Six of the 15 sites revealed lifetime prevalence ranging between 35% and 50%; another 6 sites had between 51% and 71% while only 3 sites revealed a prevalence of less than 30%. The association between the number of injuries and their severity was consistent and significant for all sites. For example, 86% of women who reported physical violence with injuries had experienced at least
one act of severe violence; only 14% reported that they had experienced moderate violence.

It is noteworthy that Heise and Garcia-Moreno’s study (2002) compiled population studies, predominantly relating to industrialised countries, from different authors, cultures and methodological approaches. On the other hand, the Garcia-Moreno et al. study (2005) involved primary research by interviewing women from both industrialised and non-industrialised countries. While both studies found that meanings of DV and societal acceptance of the abuse varies widely between countries, industrialised countries appear to report a lower prevalence when compared with non-industrialised countries. It is difficult to say with certainty what factors are responsible for such a wide variation in prevalence between and within the two studies. However, some factors were identified by the Garcia-Moreno et al. study as probable reasons for this variation.

First is the link between industrialisation and DV: abused women in highly industrialised countries (where the lowest prevalence rates were recorded) were found to have more opportunities to leave abusive relationships than women in less industrialised countries. Secondly, methodological variation was identified in the two sites with the lowest prevalence. Interviewers in Serbia and Montenegro City had less extensive training compared with interviewers at other sites. Furthermore, although a self-report booklet was used for questions on violence in Japan to provide greater confidentiality and increase reporting (Smith et al., 2011), structured interviews were carried out at other sites by carefully selected and fully trained female interviewers. These seem to have
made a significant difference in ensuring data quality and comparability. Thirdly, the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across different cultures was noted, which may also be a limiting factor on generalisation.

Nevertheless, in both studies, abused women’s experience of physical and/or sexual violence is usually accompanied by emotional abuse and controlling behaviours by their intimate partner. For example, Garcia-Moreno et al. (2005) found that across the countries studied, up to 75% of physically abused women had experienced one or more acts of emotional abuse and up to 90% had experienced controlling behaviours. In addition, women reported that emotional abuse is worse and more devastating than the physical abuse. Acts of control and emotional abuse most frequently mentioned were belittling, insults and intimidation.

Overall, the wide variation in DV prevalence is likely to indicate the degree to which such behaviour is acceptable in different cultures of the world. This should be recognised as an important consideration in proposing procedures for identifying and caring for abused women, as well as preventing abuse in the first place. Arguably, methodological variations, industrialisation and cultural differences will impact on generalisation that can be made from population studies. However, the main message of the two studies is that DV is a common experience worldwide, even if prevalence and meanings can vary from country to country. Another major strength of these studies was their illumination of the severity and prevalence of emotional abuse, and the implications that this has on recommendations for care.
2.3 Magnitude of DV against women in the UK

Feder et al., (2009) reported that the lifetime prevalence of DV among the UK general population ranged from 13% to 31%, with one-year prevalence ranging from 4.2% to 6%. They found that most studies limited abuse to physical violence only; some even restricted physical abuse to severe physical violence, while only a few included threats of physical violence. Similarly, Dominy and Radford (1996) investigated physical, sexual, and psychological abuse among a random sample of 484 women selected at shopping malls and supermarkets in Surrey. They reported that the lifetime prevalence of DV among these respondents was 31%. Although their sample was intended to be representative of the population of married women or those with long-term partners, women in full-time employment and education may have been excluded by the choice of timing and venue. While this prevalence is broadly consistent with Feder et al., (2009) review, sampling bias could place a limitation on the reliability of this study.

The British Crime Survey (BCS), a nationally representative source of information for DV figures in the United Kingdom (Home Office, 2010), has been criticised for its sampling (by limiting coverage to women living in private households) and excluding some assaults (Smith et al., 2011). Nevertheless, their recent survey (BCS, 2009/2010) found a lifetime prevalence of 29% and one-year prevalence of 7.5% for emotional, physical, and financial abuse among female respondents (Hall et al., 2011). While these figures appear to fall within the range reported by Feder, comparison is difficult. Feder's review (2009) noted that the majority of the studies were limited to physical assaults,
while BCS covered not only physical abuse but also emotional and financial abuse, and would thus be expected to report a higher prevalence rate. However, like other national crime surveys, BCS’s figures are based on specific incidents and specific kinds of behaviour. This can limit the survey’s ability to capture complex behaviours and repeated or escalating patterns of abuse. Consequently, the reported figures could have been hampered by this limitation, even though a broader DV definition was used.

While DV against women is often regarded as hidden, abuse appears to be generally accepted within UK society. A survey sponsored by Amnesty International UK (AIUK) revealed that more people in the UK (74%) would report a person for kicking or mistreating a dog than for kicking or mistreating a partner (53%) (Amnesty International UK, 2008). The survey also reports that almost a third of men think that DV against women is acceptable in some circumstances and one in five men will not call the police when they see a woman being mistreated by her partner. Finley (2006) observed that DV is generally perceived by UK society as a private affair: most women are too afraid or ashamed to reveal their abuse and some do not perceive their experience as DV. Similarly, Walby, and Allen (2004) found that only a minority of the worst cases (23%) are reported to the police.

Language barriers, geographical location, cultural differences, immigration issues, secrecy surrounding DV issues and fear of perpetrators are contributing factors in under-reporting in surveys (Feder et al., 2009). Those from ethnic minorities are particularly prone to exclusion from most studies in the UK, and are often unable to access or benefit from community resources (Thiara and
Breslin, 2005). In view of these limitations, it is likely that the figures reported in UK prevalence studies are underestimations of the true figure.

The Home Secretary recently declared that the current level of DV against women is unacceptable. There are over 13 million female victims of domestic abuse in England and Wales, with over 300,000 women sexually assaulted and 60,000 rapes reported each year; more than one in four women in the UK will experience domestic abuse in their lifetime, often suffering years of psychological abuse (Home Office, 2012). Agreeing on the right definition will contribute to exposing and defeating the ‘dreadful crime’ (Home Office, 2012:3). Consequently, a consultation was launched this year to explore understandings of DV across government, health practitioners, abused women and perpetrators. Public views were sought regarding the desirability of extending the definition of DV to include younger age groups and controlling behaviours (Home Office, 2012).

Undoubtedly, this is a step in the right direction, as individual and governmental conception of the abuse will need to change if DV against women is to be prevented. However, it is crucial to acknowledge that the scope of the problem is wider than has previously been estimated. While some researchers may choose to restrict the definition of DV to physical abuse alone due to funding limitation and the difficulty of presenting a simple estimate when broader definitions are used (Tjaden (2005), this critical decision comes at the expense of discerning the true extent and dimensions of DV against women. Consequently it will impact negatively on the development of interventions that are commensurate with the significance of the problem (United Nations, 2012).
DV prevalence in healthcare settings is fundamental in recognising the significance of DV issues and the development of effective strategies to remedy the problem. The next section examines DV prevalence in healthcare settings, in particular in EDs, and the impact of abuse on the health of women and children.

2.4 Prevalence of DV among women attending health settings

Systematic reviews have reported a slightly higher prevalence of DV among clinical populations (i.e. women recruited from healthcare settings), ranging from 13% to 41%, compared with 13% to 31% for the general population (Feder et al., 2009). Arguably, women experiencing DV are more likely to need healthcare, including frequent prescriptions and treatment of injuries because of the impact of abuse on their health. Feder et al. (2009) collated studies from general practice, antenatal, postnatal, EDs, family planning, pregnancy counselling, and gynaecology clinics. Although, the authors noted that study comparisons were difficult due to heterogeneity of research designs and findings, they found that prevalence was highest among women attending EDs (between 22% and 35%) and lowest among women attending antenatal clinics (between 5.1% and 23.5%). Higher prevalence was found among women aged between 16 and 24 and women who were separated or divorced.

Feder’s review (2009) was commissioned by the Health Technology Assessment (HTA) Programme in the UK. HTA forms a key component of the National Knowledge Service, which influences decision-making bodies such as the National Institute for Health and Clinical Excellence (NICE) and the National Screening Committee (NSC). It thereby contributes significantly to quality of
clinical practice in the NHS (Feder et al., 2009:ii). Their earlier review (Ramsay et al. 2002) commissioned by the same body found few rigorous randomised control trials that tested the effectiveness of routine screening interventions and their acceptability to both staff and abused women. Consequently, the authors concluded that it would be premature to initiate routine screening for women in health settings without the benefit of further research. The result of the review was heavily criticised by other researchers as its evidence was limited to quantitative studies alone (Taket et al., 2003; Taket et al., 2004; Plitcha, 2007; Olive, 2007). An updated version of the review (Feder et al., 2009) therefore attempted to mitigate some of the criticisms of the earlier review, by including selected qualitative studies. The review aimed to determine whether women should be screened for DV in healthcare settings using selected NSC criteria. Selected primary studies were synthesised on the basis of the NSC criteria and the views of abused women and health professionals.

The authors reported that screening and intervention by health providers is justifiable on the basis of DV’s prevalence and consequences for women’s health and a high acceptance of screening found among female patients (up to 99%). However, they found no randomised study that measured morbidity and mortality effects of screening programmes on women. Neither did they find robust longitudinal studies that measured the long-term prognosis for survivors or measurement of any reduction in abuse following screening. They also noted that acceptance of screening among professionals was low, even though it ranged between 15% and 95%. On this basis, the authors concluded that insufficient evidence still exists on whether DV screening programmes should
be implemented in either specific health settings or healthcare settings more generally.

This report is likely to have influenced governmental policies on DV screening and consequently the implementation of ‘index of suspicion’ screening (as opposed to universal screening) for abused women visiting healthcare settings. Universal or routine screening occurs when all patients are asked about DV; an index of suspicion means that patients are asked only if a healthcare professional has reason to suspect DV has occurred. The drawback of this selective screening is that it is subjective and based on the provider’s ability to effectively pick signs of abuse and a confidence to ask based on her suspicion. Healthcare professionals are likely to miss opportunities to identify abuse and provide support to women, especially when abuse does not result in injuries that are obviously inflicted by another person. Arguably, research evidence showing effectiveness of intervention is needed in recommending care for abused women. However, study results are influential in determining planning strategies and policies for dealing with DV; inadequate and limited research evidence may reduce the significance of the problem. Investigating current practices of health professionals in specific settings, particularly in relation to the efficacy of index of suspicion screening, will be a useful service improvement strategy.

2.5 Prevalence of DV among women attending EDs

The prevalence of DV among women visiting EDs enables us to understand not only the magnitude of the problem but also its health consequences and the need for proactive responses from ED healthcare workers. Abused women often present themselves to EDs, requiring a wide range of treatments,
including treatment of injuries, emergency prescriptions and hospital admissions (Campbell et al., 2001; Davidson, 2000). As a result, the cost to the NHS of treating physical injuries related to DV alone is estimated to be £1.2bn, showing clear economic implications for society (Home Office, 2009).

The reasons for the popularity of EDs as a source of assistance for abused women are understandable: the department is uniquely located for abused women to access healthcare around the clock and offers relative anonymity. Of course, the high injury rate associated with domestic abuse is an obvious cause. The ED is clearly a locus where women suffering from domestic abuse may be reached by health services. This pool of patients provides an ideal opportunity for the identifying victims and developing strategies to ensure that appropriate support and referral are available.

Estimating precisely the prevalence of DV among women attending EDs can be more difficult than other health settings. This is due to specific exclusion measures such as altered mental state, life-threatening injury or illness and attrition rates resulting from short-term stay among EDs patients (Boyle et al., 2003; Sethi et al., 2004). In spite of this, a lifetime prevalence rate of between 22% and 63% among studies conducted within EDs in the UK has been reported (see Table 1). This figure is high enough in itself to warrant serious concerns about policies and practices for dealing with domestic violence issues in EDs.

Furlow (2010) reported that the majority of non-fatal injuries among women are linked with domestic abuse and such women turn to ED staff for their care. A
recent British Crime Survey reported that almost 70% of incidents of DV against women resulted in injury, 30% of which involved severe bruises and broken bones (Flatley et al., 2010). Similarly, Sethi et al. (2004) noted that women harmed by DV account for more than one in three (about 35%) of patients presenting themselves at UK EDs. This vast proportion should make systems for identifying and responding to victims of abuse a priority in EDs. Table 1 shows the prevalence of DV among women attending EDs, in both UK and international studies.

### Table 1: Studies on the prevalence of DV in EDs

<table>
<thead>
<tr>
<th>Author(s) (Country)</th>
<th>Definition of DV</th>
<th>Design</th>
<th>Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott et al., 1999 (US)</td>
<td>Assaults, threat or intimidation by male partner</td>
<td>Written survey</td>
<td>54.9% lifetime prevalence, 11.9% incidence rate</td>
<td>Wider range of abuse covered, multi-centre study</td>
</tr>
<tr>
<td>Boyle and Todd, 2003 (UK)</td>
<td>Physical and non-physical</td>
<td>Interview based survey (randomly allocated time block). Women and men studied.</td>
<td>22.1% lifetime prevalence for women</td>
<td>Single centre, small sample size, selection bias due to extensive exclusion criteria. Also selection bias due to male interviewer.</td>
</tr>
<tr>
<td>Feder et al., 2009 (UK)</td>
<td>Not applicable (systematic review)</td>
<td>Systematic review (found three primary studies)</td>
<td>22% to 35% lifetime prevalence</td>
<td>Majority of studies did not define types of assault and only measured physical assault</td>
</tr>
<tr>
<td>Hegarty et al., 1998 (Australia)</td>
<td>Not applicable (systematic review)</td>
<td>Systematic review of prevalence of DV against women in ED</td>
<td>2.1% to 28% one year prevalence</td>
<td>Reported lack of a precise definition result in varying operationalised definitions of partner</td>
</tr>
<tr>
<td>Study</td>
<td>Type of Abuse</td>
<td>Methodology</td>
<td>Findings</td>
<td>Limitations/Notes</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Sethi et al., 2004 (UK)</td>
<td>Physical abuse</td>
<td>Questionnaire (women only)</td>
<td>34.8% lifetime prevalence; 6.1% one year prevalence</td>
<td>Single centre study, small size sample and selection bias; limited to physical abuse</td>
</tr>
<tr>
<td>Spedding et al., 1999 (UK)</td>
<td>Not applicable</td>
<td>Retrospective study: case notes reviewed for previous twelve months</td>
<td>0.49% prevalence of acute trauma from DV</td>
<td>Subjects restricted to women who disclose that injury were due to DV and were recorded; lack of disclosure and documentation could hamper the result</td>
</tr>
<tr>
<td>Smith et al., 1992 (UK)</td>
<td>Not determined/not applicable</td>
<td>Retrospective study using computerised accident and emergency data</td>
<td>0.3% of acute trauma resulting from DV</td>
<td>Prevalence may have been underestimated as subjects are restricted to acute trauma presentation, disclosure by victim and documentation by staff; 22% of assaults due to DV; in 41% of the cases, the perpetrator was not recorded</td>
</tr>
<tr>
<td>Wenker and Gorchynski, 2004 (US)</td>
<td>Physical, emotional, and sexual abuse</td>
<td>Anonymous written survey to a sample of 370 women who presented to an ED over a 12 month period</td>
<td>They found an incidence rate of 6.7% and a one-year prevalence rate of 37.0%</td>
<td>Higher one-year prevalence may be related to broader definition of physical, emotional, and sexual abuse rather than focussing on physical violence alone; women who have suffered domestic abuse in the past present with indirect</td>
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Five studies were found from the UK, two retrospective and three primary studies. The first retrospective UK study (Smith et al., 1992) reviewed computerised data of acute trauma presentation resulting from DV and reported prevalence rate of 0.3%. Only 22% of assaults were attributable to DV, and in 41% of the cases, the perpetrator was not determined. The second retrospective study (Spedding et al., 1999) reviewed patient case notes for one year and reported a prevalence rate of 0.49%. For both studies, subjects were limited to women who disclosed that their injuries were due to DV, which was documented in their case notes by health providers. Moreover, the studies were restricted to trauma assaults alone and the lifetime prevalence of DV is unknown. Clearly, both studies are old and their usefulness in a rapidly changing culture needs careful evaluation. However, a lack of disclosure from women and a lack of documentation by staff, both of which are recurrent issues in the literature (Sethi et al., 2004; Boyle et al., 2003) would have hampered the reported incident rate.

In terms of primary studies in the UK, Sethi et al. (2004) measured the prevalence of physical violence by intimate partners among women attending

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<th>Study</th>
<th>Type of Assaults</th>
<th>Study Design</th>
<th>Prevalence Rate</th>
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<tr>
<td>Wright and Kariya, 1997 (UK)</td>
<td>Physical assaults only</td>
<td>Interview (consecutive assault victim over two months)</td>
<td>41% of the 46 women asked had experienced DV in the past 2 months, 63% of survivors had suffered previous incidents</td>
<td>Type of assaults not defined</td>
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<td>Smith et al., 1992</td>
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<td>0.3%</td>
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<td>Physical assaults only</td>
<td>Review of patient case notes</td>
<td>0.49%</td>
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an inner city ED. Twenty-two nursing shifts, representing day, night and weekend hours, were sampled: 198 women who were not intoxicated, confused or critically ill were given a questionnaire regarding their experience of physical abuse and their reaction to being asked routinely about domestic abuse in EDs. The prevalence of lifetime physical abuse was 34.8% (with a 95% confidence interval of 28.2% to 41.5%), with lifetime life-threatening physical abuse prevalence of 10.6% (with a 95% confidence interval of 6.3% to 14.9%). The one year prevalence of physical abuse was found to be 6.1% (with a 95% confidence interval of 3.2% to 10.3%) and the prevalence of acute trauma in women attributable to DV was 1% (with a 95% confidence interval of 0.14% to 3.6%). Sixty percent of the women felt that questions about DV should be asked routinely in EDs while 76% of women felt comfortable about being asked.

This was a single-site study with a relatively small sample and time scale. Additionally, exclusion of participants occurred due to language constraints and incapacitation (35% of potential subjects were excluded on clinical grounds, 3.7% were excluded because they did not speak English, 20% were lost during the study and 5.4% refused to participate). Also, none of those classified as DV cases in the study had DV recorded by medical or nursing staff in their case note review.

In spite of these flaws, the findings show that at least one out of three women attending the ED has a lifetime experience of DV. It is reasonable to assume that a far higher prevalence would be recorded when other abuse such as sexual and psychological abuse are included in the definition. The life-threatening physical abuse rate of 10.6% is similar to the association between
the prevalence and severity of injuries recorded in the WHO’s multi-country study mentioned earlier (Garcia-Moreno et al., 2005).

Another primary study from the UK (Wright and Kariya, 1997) interviewed consecutive assault victims who were visiting an ED in Scotland about DV over a 2-month period. Of the 46 women asked about partner violence, 41% had experienced abuse in the past 2 months and 63% were survivors of previous incidents. This was a very small survey, which has implications for the reliability of its findings. Moreover, it is possible that only physical assaults were measured as a definition of DV was not given.

The third primary study from the UK executed a cross-sectional, interview-based survey among adult male and female patients who attended an ED in Cambridge (Boyle and Todd, 2003:438). It found a lifetime prevalence rate of 22.1% and 2.1% one-year prevalence rate among female respondents. The paper defined DV as ‘illness or injury resulting from the deliberate actions of an intimate partner’ but the severity of violence was not measured. Patients were eligible only if they arrived within a one-day, randomly allocated, time block; prospective participants were excluded if they were considered to be suffering from an altered mental state, had a life threatening condition, or had companions who precluded them being interviewed alone. Patients who had been referred to the department by their GP, those who were unable to speak English or any patients personally acquainted with the interviewer were also excluded.
This study reported a considerably lower prevalence when compared with the other two primary studies from the UK (Sethi et al., 2004 and Wright and Kariya, 1997) despite investigating physical, emotional, and sexual abuse. However, the method used in gathering information is likely to have had a considerable impact on the responses received. Although the questions asked were similar to those used in BCS interviews, and included questions about physical and non-physical abuse, a male interviewer was used. It has been documented that women are more likely to disclose abuse experiences to female interviewers than to male interviewers (WHO, 2005). Moreover, the implications of including both male and female respondents in data collection warrant further investigation.

Besides, face-to-face interviews have been shown to result in lower incidence rates when compared with questionnaires (Smith et al., 2011). The greater confidentiality provided by self-completion surveys has been found to be responsible for increased reporting in supplementary volume of the BCS (2009/2010). Smith et al. (2011) compared the results of face-to-face interviews with a self-administered survey. Only a small proportion (5%) of respondents who reported being a victim in the self-administered survey also reported being a victim in the face-to-face interview. Consequently, selection and reporting bias could have contributed to a lower prevalence in Boyle and Todd’s study, even though a broader definition was used.

International studies from the USA (Abbott et al., 1999) and Australia (Hegarty et al., 1998) have reported incidence and prevalence rates that are much higher than in the UK. Abbott et al. (1999) reported an incidence rate of 11.7% and
prevalence of 54.2% after a cross-sectional survey of women visiting a variety of EDs in USA. It is worth noting that the study was not restricted to injuries attributable to acute DV, and was conducted across a range of EDs. A more recent study from the USA (Wenker and Gorchynski, 2004) administered an anonymous written survey to a sample of 370 women who presented themselves to an ED over a 12-month period. They found an incidence rate of 6.7% and a one-year prevalence rate of 37.0%. Women who had suffered domestic abuse in the past were more likely to present with complaints related to incidents of DV. These incidents had occurred within the previous twelve months and they were not necessarily attending the department for treatment of acute abuse. Also, a higher incidence of physical, sexual, and emotional abuse was correlated with those earning lower income.

Prevalence studies from the USA (Abbott, 1999; Wenker and Gorchynski, 2004) have investigated physical, emotional, and sexual abuse rather than focusing on physical violence alone. While this may explain a higher prevalence rates compared with UK studies, variations in study samples, selection criteria, and definitions do present challenges when comparing findings across populations and countries. However, when the data from the BCS for 2003/2004 was reanalysed using a broader definition of DV, a higher proportion of women reported experiencing DV at least once in their lifetime (26%), and 4.2% reported DV within the past year (Walby and Allen, 2004). Therefore, limiting DV definition to physical abuse could have contributed to a lower prevalence rate in UK studies.
It is also unclear whether the differences between studies conducted in the UK and America are a result of methodological variation or a reflection of the idiosyncrasies of population and healthcare culture. The two countries differ in healthcare contexts, criminal justice systems, the incidence of violent crime, welfare systems, patterns of gender relations, and social relations (Walby and Myhill, 2001). These factors will without doubt affect any overview of such findings and their interpretation.

Nevertheless, what is clear from all the reviewed studies is that the number of chronic abuse cases (i.e. women who have experienced DV in the past year presenting to EDs) is considerably higher than the number of women seeking help for acute injuries. These findings have been corroborated by studies investigating the common conditions of abused women at EDs. Campbell (2002) found that most abused women present to EDs with DV-related complaints such as depressive illnesses, psychosomatic problems, alcohol misuse, self-harm, and even suicidal tendencies which mask the basic issues. Similarly, Muelleman et al. (2004) reported that abused women visiting EDs are more likely to be diagnosed with urinary tract infections, neck pains, vaginitis, foot wounds, attempted suicide, or finger fractures. DV has long-term negative health implications for female survivors which tend to linger even after the abuse has ended (WHO, 2005). Accordingly, the incidence of seeking help for acute DV symptoms might subside over time, especially at EDs.

The WHO’s multi-country study (Garcia Moreno et al., 2005) corroborated evidence that industrialisation, which ensures more economic and educational resources, may not protect women from being abused, but does provide more
opportunities to quickly escape from violence. Sadly, abused women are more likely to suffer from long-term implications of abuse, making it even harder for them to move on. Walby and Allen (2004) found that women are at most risk of serious injury or death when planning to leave, or having just left, an abusive relationship. Similarly, Humphreys and Thiara (2002) reported that 76% of women continued to experience verbal and emotional abuse after separation, and 41% were subjected to serious threats towards themselves or their children.

Undoubtedly, abuse contributes to poor quality of life, high use of health services and poor health status (Campbell, 2002). Further, domestic abuse has implications not only for the abused women but their children and also their unborn children: risks include increased chance of miscarriage, foetal injury, low birth weight as well as more serious outcomes such as the death of the mother or foetus (Feder et al., 2009). Figure 1 below further highlights the consequences of DV on women’s health.

Interventions aimed at these issues are not likely to succeed without addressing the basis of the problem. Consequently, an important first step in establishing evidence-based practice in the area of DV against women is to explore interventions that work for specific health settings. Clearly, EDs are an important gateway for co-ordinating services for women experiencing DV. Nevertheless, these findings suggest the need for ‘high suspicion’ or universal screening as opposed to incidence-based or selective screening. In view of the intertwined relation of domestic abuse and ongoing physical and mental health problems, utilising acute presentations alone to make predictions about risk
may exclude the majority of women in need of help. The next section discusses interventions available for abused women within healthcare settings in general and EDs in particular.
Figure 1: The impact of DV on women’s health and well being (adapted from Heise, 1999)

Health Outcome of Domestic Violence on Women

Fatal Outcomes
- Homicide
- Suicide
- Maternal Mortality
- HIV/AIDS
- Related problems

Non-Fatal Outcomes
- Physical Health
  - Injury
  - Permanent Disability
  - Functional Impairment
  - Physical Symptoms
  - Severe Obesity
  - Neurological Symptoms
  - Seizures
- Reproductive Health
  - Miscarriage
  - Low Birth Weight
  - STI/HIV
  - Unwanted Pregnancies
  - Stillbirths
  - Unsafe Abortions
  - Gynaecological Disorder and Infections
  - Premature Birth
  - Foetal Injury

Chronic conditions
- Chronic Pain
- Syndrome
- Irritable Bowel Syndrome
- Somatic Complains
- Fibromyalgia

Negative Health Behaviours
- Smoking
- Alcohol Abuse
- Drug Abuse
- Sexual Risk Taking
- Physical Inactivity
- Overeating

Depression
- Anxiety
- Post Traumatic Stress
- Panic disorders
- Eating Disorders
- Sleep Disorders
- Memory Problems
- Phobias
- Substance Abuse
- Low self Esteem
- Sexual Dysfunction

Chronic conditions
- Negative Health Behaviours
2.6 Interventions for women experiencing DV in EDs

Health professionals’ intervention in DV has the potential to uncover a significant number of cases that hitherto have been hidden. It could also serve as a form of prevention by reinforcing a perspective of zero tolerance on domestic abuse, reducing social stigma and enhancing measures that improve the safety of abused women. DV Interventions within healthcare settings can be either directly or indirectly targeted towards caring for abused women. Direct intervention focus on helping abused women directly through screening, advocacy and referral programmes. Indirect interventions are often targeted at improving the responses of health professionals who come into contact with abused women. Such efforts include designing training programmes and protocols to aid health providers’ awareness. However, indirect intervention can also be focused on system of organisation, through chart modification and positive environmental influence such as the use of posters and TV media to promote awareness. This section of the review examines the studies investigating training, protocols and system change interventions, after which screening and advocacy are discussed. Barriers to domestic violence intervention within health settings are then examined. The review concludes with a summary of gaps in our knowledge and how this study intends to bridge some of those gaps.

2.6.1 Indirect intervention: training, protocols and system change

DV training is sometimes administered as a stand-alone intervention: this means that training is the only intervention given to providers to improve their response to abused women. Training can also be given as a pre-intervention
procedure for subsequent interventions: introduction to protocols for intervention can be part of a multi-strategy approach.

A US study (Campbell et al., 2001) developed a two-day didactic DV training programme for ED nurses, physicians and social workers to respond more effectively to women experiencing domestic abuse. Twelve hospitals were randomly selected and randomly assigned to intervention or control conditions. The outcome of intervention was measured at a baseline, 9 to 12 months, and 18 to 24 months post-intervention. The authors reported significantly higher knowledge and attitude measures for staff in the intervention hospitals following training. However, there were no significant differences between the intervention settings and control settings regarding DV identification, which shows that the training did not translate into practice for providers. The investigation concluded that training alone is insufficient to change staff routines, and that practice behaviours are likely to be influenced by institutional policies.

Another US study (Hamburger et al., 2004) developed a 3-hour didactic training programme that focused on enhancing skills necessary to identify and respond to abused women. The research involved two EDs, one endoscopy department, one obstetrics and gynaecology department, one labour and delivery department, one women and infants department, and one mental health department. The result show improved staff efficacy and comfort in referring abused women to community service six months after training. In order to answer the question of whether the training actually changed providers’ behaviour towards screening on a consistent basis, a systematic review of
charts was conducted in the various hospital departments involved in the study six months after the training. The charts review revealed inconsistent screening practices in some departments. For example, one ED and the obstetrics department showed screening rates near 0, while the second ED and the labour and delivery wards showed screening rates of between 40% and 50%. Realistically, lack of documentation in relation to DV screening and identification from providers could have affected the results of the charts review.

In the same study (Minsky-Kelly et al., 2005) reported findings from an exploratory interview of staff to evaluate the effects of the training intervention. The interview revealed system-wide and department-specific barriers that mitigate against consistent screening and intervention. Barriers specific to EDs were identified as lack of privacy, frustration arising from lack of expertise, concerns about workload and the screening process, presence of the perpetrator, and time constraints (patients are in the department for a maximum of 2 hours). Staff recommendations from the interview included updating forms to include screening questions, provision of translation services for non-English speakers, and providing private rooms for assessment. The interview also identified a number of factors that are likely to encourage staff to respond more enthusiastically to domestic violence screening. These included the need for further training to address attitudinal change among staff; providing opportunities for screening within the department, such as escorting patients for urine-testing or to x-rays; and giving staff periodic feedback on patients’ outcomes.
Recent researchers and reviewers have advocated exploratory qualitative study as a framework to circumvent department-specific barriers, identify enablers of intervention, and identify how intervention can work in different settings and with different cultures (Wills et al., 2008; Feder et al., 2009; Crip et al., 2010). The post intervention interview study (Minsky-Kelly et al., 2005) was useful in identifying barriers and proposing strategies. However, pre-training interviews would have allowed staff to participate in developing training and intervention, which is likely to promote change in practice. In addition to post-training feedback and evaluation, managerial support for ongoing training and refresher courses has been advocated in the literature (Wills et al., 2008; Hamburger et al., 2004). Gamble (2001) described the three levels for initiating DV training: early professional education, pre-implementation training and on-going education.

Early professional education means that providers are exposed to general DV education at an early stage in their professional training. Although researchers are beginning to advocate awareness of DV among health professionals, Thurston and Eisener (2006) have noted that most nursing and medical schools in the UK do not yet integrate DV training into their curricula. Moreover, there is no evidence of consistent on-going DV training for UK healthcare workers in the literature.

The second level of education described by Gamble (2001) is pre-implementation training, which is given before an intervention is introduced. This is the most popular form of training among DV researchers. It can reinforce early professional training, as well as emphasising the extent, characteristics
and consequences of DV. The training is expected to be more specific and focused to providers’ needs. Schoening (2004) noted the significance of tailoring training towards the needs of the nurses, following an investigation on the effects of DV educational programmes on the attitudes of US public health nurses. While training alone was insufficient to change the nurses’ behaviour towards screening, the author noted that previous experience and previous DV training can influence nurses’ attitudes. Hence, exploring staff experiences and their specific needs should precede training.

The third level of training described by Gamble (2001) is the provision of ongoing education to reinforce, update or modify initial training for better results. Ongoing or refresher training can serve as a follow-up strategy to ensure that intervention is fully integrated into the system. It can also evaluate and reinforce staff efforts. A New Zealand study (Berman, 2005) explored the learning experiences of midwives following an educational programme to prepare them for integrating screening and referral into their practice. The midwives affirmed the importance of on-going training as a vital factor for practice integration.

Structured training can be supplemented with support materials, such as DV protocols. The introduction of a DV protocol has been shown to be effective in acute management of domestic abuse (Fanslow, 1998). However, a long-term approach may be required for full integration of protocols (Waller et al., 1996). A study on introducing DV protocol to EDs found that ensuring adherence and application of protocols was difficult and time consuming (Loughlin, 2000): the protocols needed to be modified to optimise efficacy and acceptance. Ramsay et al. have suggested (2005) that interventions involving protocols should be
reinforced and reassessed from time to time, and that there should be a willingness to redesign protocols as required.

‘System change intervention’ is a more recent comprehensive innovation. It incorporates multiple programme components which can include staff training, institutional support for screening, screening guidelines or protocols, chart modification and referral to support services (Wills et al., 2008; Feder et al., 2011). The literature has shown that interventions that took this approach were successful in increasing DV screening and disclosure rates.

For example, a US study (Wills et al., 2008) used a system change approach to implement Family Violence Intervention Guidelines in a mid–sized hospital’s departments, including a paediatric ED. Components of the intervention included pre- and post-training evaluation from staff, managerial involvement, information resources, a community directory, literature folders, laminated flowcharts on DV intervention; and cue cards. Documentation was also standardised and amended to include a prompt for staff to screen and record DV. Posters and pamphlets were made available in clinical and waiting areas for patients and families, and service numbers were placed discretely in patients’ toilets.

Following this multi-level intervention, more than 6,000 patients’ records were audited to assess staff’s rate of DV identification. Identification increased significantly (from 30 to 80 women per 6-month period) as did referrals to community support centres (from 10 to 70 women per quarter). Although staff needed ongoing support, they reported improved knowledge and confidence in
identifying and referring abused women. Pre-training interviews were identified as being crucial to the success recorded in the study: they identified staff needs and concerns, barriers to intervention and ways to circumvent them. The provision of practical resources such as pamphlets, posters, information cards and intervention guidelines/flowcharts were also identified as vital component. Moreover, success was redefined as empowering victims and allowing them to be in charge of the decision-making process. In order to identify barriers and enablers for intervention, the training was evaluated through qualitative interviews with staff.

The significance of modifying charts and assessment forms to include DV screening questions has been highlighted in the literature. For example, this was proposed by emergency staff following an evaluation of DV training (Minsky-Kelly et al., 2005). Similarly, Olson et al. (1996) investigated the effects of training and restructuring charts to include a specific question concerning DV. This research took place in an ED in Australia. A simple prompt question ('Is the patient a victim of DV?') was integrated into medical charts: the identification of abused women nearly doubled. The authors associated this increase with both chart modifications and training.

Chart modification has also yielded results in other healthcare departments. Findings from primary care settings suggest that a written prompt to ask about DV increases inquiry rates among physicians. Hamberger (2010) introduced a prompt on the records of patients to remind primary care physicians to enquire about DV. The baseline intervention involved training for providers. Following the training, 2% of women had a DV enquiry documented in their records. A
prompt on patient charts was introduced. Following this, 92% of women patients had a documented DV enquiry in their record. The chart was removed to evaluate its impact, and the percentage of women receiving a documented screening dropped to 36%. In a UK study, Feder et al. (2011) tested a system change DV intervention programme in general practices. Intervention components were training sessions, a prompt within the medical record to ask about abuse and a referral pathway. They found improved referral to specialised DV services and increased identification of DV in patients’ medical records.

While these studies have shown that chart modification can be effective and economical in reminding the healthcare provider to enquire about DV, such changes will require organisational commitment to DV identification and intervention policies. DV policies that can encourage health providers to respond more proactively to abused women have been widely recommended by governmental bodies and voluntary organisations. Some have designed guidelines for health workers to follow in the management of DV (DOH, 2000; DOH, 2005; Royal College of Psychiatry, 2002; Royal College of Midwives, 1999; Royal College of General Practitioners, 1998; Women’s Aid, 2011). Accordingly, the UK Government has developed a handbook for health providers to use as a practical tool. However, while guidelines are helpful, just like training, providing guidelines alone may not guarantee results in DV intervention. Organisation changes and factors that can facilitate local integration, such as efforts to determine staff concerns and needs, should be explored and implemented.
2.6.2 Screening and advocacy programmes

Screening involves asking women directly about domestic abuse. It provides a vital avenue for identifying those at risk, raising awareness of abuse, providing an opportunity for disclosure and getting support to those experiencing abuse. Screening women for DV in healthcare settings has long been recommended by researchers, organisations and accreditation bodies as a preventative measure (American Medical Association, 2000; Taket et al., 2003; Cherniak et al., 2005; DOH, 2000; DOH, 2005). Generally, screening can either be routine or based on an index of suspicion. Routine screening occurs when all patients are asked about DV; an index of suspicion means that patients are asked only if a healthcare professional has reason to suspect DV has occurred.

Researchers have identified EDs as being well positioned to institute low-cost screening services and to make information available for women experiencing DV (Plitcha, 2007; Phelan, 2007; Waalen et al., 2000; Olson, 1996). Evidence suggests that many abused women visit the ED for health problems directly or indirectly relating to DV; they have the highest prevalence of DV against women among healthcare settings (Feder et al., 2009). Sadly, screening rates have remained low in EDs: incidents of DV are often undetected, and identified cases are often not recorded in patients’ records (Waalen et al., 2000; Boyle et al., 2003; Watts et al., 2000; Sethi et al., 2004). A systematic review (Waalen et al., 2000) found that only 1.5% to 13% of patients seen in EDs and at primary care clinics had ever been asked by their care providers about possible abuse. The equivalent figure among obstetricians and gynaecologists was only 10%, even though reproductive health organisations have been among the most active in
endorsing DV screening. There is no consensus yet on universal screening for DV in the UK.

The current system of index of suspicion screening in the majority of health settings is likely to be indicative of the conclusions of systematic reviews (Ramsay et al., 2002; Feder et al., 2009) (See 2.4). However, a more recent review (O’Campo et al., 2011) has criticised earlier reviews on the grounds that they failed to acknowledge variations in contexts for DV screening and they combined results from a number of different healthcare and non-healthcare settings. This obscured evidence regarding the success of screening programmes. The authors used a realist approach to review literature from 1990 to 2010 in order to explore the mechanics of DV interventions and their implications for policies and programmes. Seventeen studies designed to evaluate DV screening, both qualitative and quantitative, were identified. Unlike Feder et al. (2009), which combined screening programmes from health and non-health settings, O’Campo’s study focused specifically on screening intervention within healthcare settings. The aim was to understand the complexity of numerous components operating at multiple levels of screening.

Their results revealed that commitments to more effective screening interventions may not show an immediate measurable impact on the health and wellbeing of abused women. However, programmes that took a comprehensive approach by incorporating multiple components (such as institutional support, screening protocols, thorough initial and ongoing training, and immediate access to other support services) were successful in increasing screening, disclosure and identification rates. Screening alone will not be sufficient: abused
women need to be referred or offered help following identification, especially in EDs. However, it is needed as part of an overall comprehensive approach.

Advocacy intervention, such as provision of information, awareness and empowerment, can also play a part in prevention and raising awareness of DV. The aim of advocacy interventions is not to prescribe solutions or set goals, but to support and empower abused women in making sense of their situations. It achieves this by proposing potential solutions that could assist them to respond appropriately to the abuse (Ramsay et al., 2009). Advocacy intervention can include: linking women to community resources, such as refuges, shelters or emergency housing; providing ongoing support and informal counselling; offering legal, housing and financial advice; raising awareness through posters, leaflets and referral cards; listing community services; and offering safety advice. Depending on specific needs, advocacy interventions may be more or less intensive, and may last for a shorter or longer time (Metters, 2009).

A systematic review (Ramsay et al., 2009) investigating the effectiveness of advocacy interventions found ten randomised studies that met their inclusion criteria, nine from the USA and one from Hong Kong. They reported that, although advocacy can offer a wide range of positive outcomes, insufficient evidence exists to support the physical and psychological benefits of DV advocacy. According to the findings, programmes suffer from lack of robustness due to poor design, insufficient evidence for abuse reduction, and a general lack of long-term follow-up for patients involved in evaluative studies. They recommend trials that test what works for abused women. They also support exploring how advocacy can be tailored to different settings and cultures.
A recent American study (Thurston et al., 2009) acknowledged implementation challenges in the context of emergency care settings, such as concerns for time, focus of care and lack of privacy. However, these challenges were readily addressed in this study as they arose. Key features for successful integration identified by the authors were: a supportive environment; strong team approach; and a redefinition of success to mean asking as many women as possible about abuse, to create awareness and opportunities for disclosure.

Although the results of systematic reviews (Ramsay et al., 2002; Feder et al., 2009; and Ramsay et al., 2009) demonstrated a lack of evidence for the effectiveness of DV intervention within UK healthcare settings (see 2.4), it may be argued that their results were likely to have been influenced by their inclusion criteria. These excluded qualitative studies and other pragmatic issues specific to departmental situations and peculiarities of DV intervention. Qualitative studies investigating advocacy programmes have reported evidence of: reductions in physical and emotional abuse; reductions in psychological distress; reductions in levels of perceived stress; and increased use of refuges and counselling among abused women (Muelleman and Feighny, 1999; Kelly, 2007).

Moreover, while long-term follow-up is necessary to observe changes, there is a high probability that studies based in EDs will be influenced by the high turnover of patients typical of such settings. For example, Hyman (2001) examined small-scale advocacy interventions in an ED with a short follow-up period of 3 to 4 months. They reported high attrition rates, which made it difficult to determine
whether the observed benefits were sustained over time. However, there was evidence of reduced psychological abuse and lower levels of perceived stress among those who received the advocacy intervention.

Additionally, the care and support received by women experiencing DV can extend to various agencies outside the ED, such as voluntary organisations, social services, the police and legal institutions. This can make following up cases difficult. Furthermore, the unstable home conditions that may apply more to victims of DV than to non-victims must also be taken into account: such changes are often beyond the control of study subjects (Sullivan, 2001). The difficulty of controlling these conditions can be compounded by the peculiarities of DV issues. Many factors are likely to mediate between the point of intervention and the point where evidence of reduced abuse appears. For example, there is a possibility that abused women will require time to consider their options before making a decision. In addition, DV has escalating qualities that affect the health and wellbeing not only of women but also their children (Campbell, 2002). Intervention outcomes may reflect the stages that abused women go through as they move towards freedom, including a lack of change in behaviour of the perpetrator, regardless of the advocacy intervention received by the woman.

It is therefore possible that the lack of long-term follow-up evidence is a reflection of the unique nature of DV interventions and their delivery in EDs. These issues suggest that abused women visiting ED may not be suitable for long-term interventions. Short-term interventions have been advocated, such as screening, referral and provision of information about community resources and
safety information that empowers women (Olive, 2006; Plitcha, 2007).
Nevertheless, advocacy within EDs may be linked to longer-term advocacy from community services, so that outcomes can be observed for longer.

The lack of long-term follow-up evidence for DV advocacy programmes is not peculiar to EDs. Recent advocacy programmes from antenatal departments in Hong Kong (Twari, 2005) and the USA (Cripe et al., 2010) reported similar findings. Cripe et al. (2010) noted that although long-term measurement of outcomes may be difficult, simply asking pregnant women about abuse and offering helpful information had the potential to raise their awareness of available assistance.

It has been suggested that women find DV screening therapeutic, acceptable and non-threatening. UK studies have confirmed that asking women attending EDs about abuse is highly acceptable (Boyle and Todd, 2006; Sethi et al., 2004). A survey by Boyle et al. (2006) found that over 90% of women across UK healthcare settings were comfortable with routine enquiry. Similarly, Kozio-McLain (2008) compared the effectiveness and acceptability of screening intervention with any potential harmful factors in an ED in New Zealand. A qualitative interview was conducted with 36 women several weeks after undergoing a screening intervention. Almost all women (97%) found the screening acceptable and non-threatening. Also, women did not report any increased risk of harm resulting from the screening. The paper noted that the intervention was therapeutic and educational and that women appreciated the opportunity to tell their stories. Interestingly, non-abused women were
concerned that DV screening may be offensive to abused women, whereas abused women thought screening is essential to identify and help them.

Moreover, evaluations of new DV screening tools for use in EDs and other clinical practice have shown that they are generally effective in identifying physical, emotional and sexual abuse, even when not directly asked (Ernst et al., 2005; Paranjape et al., 2006; Peralta and Flemming, 2003). Phelan (2007) noted that over 20 different screening tools have been shown to be helpful when used by providers, although degrees of sensitivity and specificity can vary. Similarly, Feder et al. (2009) assessed 18 tools using 15 validated studies, 11 of which were conducted in the USA, two in Canada and one each in France and Brazil. The settings involved included five emergency and urgent care departments, six general practices, three antenatal clinics, two women’s refuge home and two women’s healthcare centres. They found that the HITS (which stands for Hurts, Insults, Threats and Screams) scale has advantages over all other screening tools for use in healthcare settings. The acronym HITS makes it easy to remember individual questions and it has a simple scoring protocol.

Given the findings of this review so far, the high prevalence of DV among service users and the health implications and cost of DV against women earlier discussed (2.3; 2.4), screening and advocacy program is clearly valuable to abused women and their children. Simply enquiring about DV in EDs can reinforce the fact that DV is unacceptable and help is available (Taket, 2003), thus forming a part of advocacy intervention. Moreover, the benefits of exploring screening and advocacy techniques is likely to outweigh the increased costs of non implementation, if the potential reduction of costs incurred in
treating repeated incidents of DV in the UK is taken into consideration (Walby, 2004). It is questionable whether advocacy or screening can result in a change for all outcome measures because of the complex nature of DV. A more realistic approach may call for researchers to examine a smaller range of outcomes, evaluate shorter interventions and give consideration to unpredictable situations that abused women go through before positive outcomes can be established. The next section of the review examines barriers to DV intervention within healthcare settings and particularly the EDs.

2.7 Barriers to DV interventions in healthcare settings

Barriers to asking and receiving help for DV are similar among the reviewed studies. Perhaps for convenience, barriers are often grouped into patient-related barriers, provider-related barriers and systemic barriers. However, it is worth noting that the barriers discussed here are interrelated and interdependent: categorising them into the three levels may lead to a false perception that the barriers are straightforward and unrelated. Realistically, barriers confronting DV are as complex as the issue itself and should not be over-simplified by classification. In this review, I have therefore looked at the key barriers to intervention and seeking assistance, showing their commonalities and interdependence. For example, issues common to both providers and abused women (such as fear, lack of knowledge, safety, privacy, and cultural beliefs) have been discussed under the same heading, although their different influences have been stressed.
2.7.1 Fear: a double-sided barrier

A significant barrier to disclosure for women experiencing DV identified in the literature is fear. A recent qualitative study (Rose et al., 2011) explored barriers to and facilitators of abuse disclosure in a UK mental health setting. They interviewed 18 service users and 20 health providers, and found that fear of disclosure is the most dominant and multifaceted barrier for service users. Fears mentioned by the subjects of the study included: fear of family disruption; fear that staff will involve social services; fear of further abuse from the perpetrator; concern for immigration status; and fear of not being believed.

These findings are consistent with the results of international studies. Peterson (2004) interviewed sixty-seven abused women to discover perceived barriers to seeking help or accessing services in the USA. Issues regarding child protection, fear of broken homes, fear of the perpetrator, emotional attachments and the desire to protect the perpetrator were all cited as reasons why some women will not seek the help of health professionals to deal with abusive situations. Research from the UK has shown that abuse of mother and her children frequently continues following separation (Stanley et al., 2011) and the risk of murder escalates when women leaves relationships (DeBecker, 1997). While it may appear unreasonable for a woman to stay in a relationship and not disclose abuse, it might actually be a rational assessment of the risks involved.

Clearly, the fear of losing children as a result of involving social services can threaten any fragile trust developed between victim and health professional, and may eradicate women’s willingness to disclose abuse or seek help. There is a need therefore for a tool that will recognise the coercive controlling dynamics in
DV and child assessment as opposed to a mere ‘dysfunction’ in family system (Hester, 2010:519). She argued that the framework for child protection assessment in England does not separate “parents” into (violent) fathers and (protective) mothers. Rather than ensuring the protection of the woman and therefore that of the children, abused women are continually let down by the pressure from social services to demonstrate that mothers are protecting their children from their abusive partner (Herring, 2007; Lapierre, 2008). Consequently, the biggest fear for abused women is perhaps the fear of losing their children and the fear of the perpetrator and what he will do.

Women’s fear has been established by recent research findings from England. Williamson and Hester (2009) reported that the evidence that the woman made several attempts to protect herself and her children from the abuser was used against her by the social services to take the children away from her. Recognising DV as a platform for child abuse is a step in the right direction. However, assessment of danger to the children of abused women should be conducted with empathy, an approach that recognise gendered meanings of the abuse and a consciousness of the temptation to believe that every abuse of a mother puts her children at risk.

The issue of fear has also been identified as a major reason why health professionals are resistant to asking questions about domestic abuse. Rose et al. (2011) reported that barriers relating to possible consequences prevented mental health professionals from enquiring about abuse. Fear of offending or traumatising abused women were both given as reasons for not making enquiries of patients.
Another US study investigated the barriers to screening for DV among emergency physicians (Elliot et al., 2002): a third of doctors were concerned that screening might offend abused women. Fear of offending victims was also a predominant theme identified among nurses and doctors as a barrier to screening in a paediatric emergency setting (Dowd et al., 2002).

Although fear is a common theme among service users and providers which creates barriers to intervention, this may be related to lack of knowledge on the part of both. For example, providers are generally afraid of upsetting women; meanwhile studies have shown that women actually want their health providers to enquire about abuse and they feel nobody cares when not asked (Koziol-McLain et al., 2008). It is therefore imperative that DV training for professionals addresses women’s hopes and expectations of their interaction with service providers. Such knowledge is likely to improve the confidence of health professionals in enquiring about DV and will empower them to handle interviews to their patients’ best interest. The relationship between knowledge and fear is further discussed in the next section.

2.7.2 Lack of knowledge

A lack of knowledge of domestic abuse has been reported by studies investigating barriers that confront abused women. A study conducted in the UK and Canada (Henderson et al., 2001) found that many women do not consider DV to be abuse; rather they perceive abuse as a demonstration of love on the part of their partner. Varying conceptualisations of DV across cultures and countries also affect its recognition as abuse. A recent New Zealand study
found that 63% of abused women believed that abuse was normal or relatively trivial; this was why they did not seek help (Fanslow et al., 2009). Another study (Dagputa, 2000) found that South Asian women consider physical abuse as DV but they are reluctant to acknowledge sexual abuse as a form of DV. Thus, varying cultural and individual perspectives on the constitution and dynamics of DV affect the way women perceive their need for help. Another area where lack of knowledge has been expressed is in the uptake of services available to victims. Even when abused women recognise the problem of DV, lack of information about services that can provide help can be a barrier to obtaining assistance (Henderson et al., 2001).

Similarly, lack of knowledge has been acknowledged by health providers as a major barrier to intervention in domestic abuse. A US study (Yonaka et al., 2007) investigated barriers to DV screening and referral among ED nurses using qualitative and quantitative approaches. The authors reported that lack of education about domestic abuse is the most significant barrier for nurses. Nurses acknowledged that DV is highly prevalent among their patient group and they are concerned about it. However, they are often limited by lack of knowledge regarding how to handle the situation. This was specifically related to: identifying abuse; offering intervention; asking the right questions; and intervening after disclosure.

The lack of evidence-based standards for intervention has been corroborated by other researchers. Henderson (2001) reports that ED nurses repeatedly identify their lack of education in relation to abuse as a constraint on intervention: nurses said they would happily intervene but they are limited by
lack of skill and expertise in DV issues. Ellis (1999) investigated the barriers to effective screening for DV in US EDs, and found that 42.5% of the nurses said that in-service training and specified procedures for intervention would be helpful steps in motivating them to screen for DV. While this finding may show nurses’ desire for expertise, it may not justify their choice of refraining from intervention.

Although health providers often identify lack of training as a major barrier, studies have shown that increased knowledge does not necessarily lead to higher rates of identification or more effective management of victims, even in EDs (Campbell, 2001; Minsky-Kelly et al., 2005) (see 2.4.2). ED nurses already possess expert critical skills in assessing and managing various health problems: it is reasonable to assume that training will have a positive impact on their knowledge but not necessarily change their practice behaviour. Other studies have identified a lack of protocols as a significant factor in the failure of health providers to intervene in DV issues. However, Loughlin (2000) found that the majority of emergency staff do not screen and intervene in DV despite having training and protocols for care. Similarly, Campbell et al. (2001) found no significant difference in identification and referral rates following training and the introduction of DV protocols. Underlying fears, myths and other working conditions can continue to influence the behaviour of providers, even after training. Identifying, addressing and resolving these issues often requires ongoing training, support and organisational changes (Wills et al., 2008; Thurston et al., 2009; Feder et al., 2011).
2.7.3 Lack of resources and support

The level of support and resources required by abused women after disclosure is often underestimated by healthcare personnel. Sullivan et al. (1992) noted that a lack of resources and support is the primary reason why abused women remain with, or return to, abusive men. The question of the next step after disclosure may be challenging for both women and health providers who offer help. It can be frustrating for staff to give information and make referrals if they are aware that there are no resources for abused women in the community. Also, abused women may become discouraged from seeking help in the future if the information received at earlier visits is not helpful. The availability and accessibility of services have been identified as crucial barriers for women who require help. Many difficulties have been identified regarding the lack of space in refuges and emergency homes (Women’s Aid, 2012). Although these are intended to provide a safe haven for women and their children, temporarily or otherwise, this goal is often compromised by overcrowding, lack of space and facilities and poor standards of cleanliness (Peterson, 2004).

Similarly, health providers will not be able to offer optimal help without resources and support, both for themselves and their patients. Loughlin (2000) stressed the need for staff to have clear referral pathways regarding support services to which women can be sent. In their study, staff blamed failures on limited resources commanded by support services and problems of accessibility to these services outside working hours. They found that referral to social workers was complicated by limited staff at night and at weekends, when their services are needed most. Some have suggested the provision of on-site DV specialists, but this may be dependent on management’s perceptions of need
and available resources. Before DV intervention is instigated, it is imperative that local resources for referral are explored, including expectations and requirements of support services in relation to their interactions with health professionals during the referral process. This knowledge will provide staff with up-to-date information regarding referral processes and access to services.

2.7.4 Cultural and ethnic barriers

Issues of culture, religious censure and racism may further complicate the availability of resources. This has been implicated as a significant barrier, especially among minority ethnic groups, which denies women the opportunity to access DV resources promptly (Chantler, 2006). Fawcett (2005) estimated that, on average, 11 contacts are made with agencies before an abused woman accesses the help she needs; this figure increases to 17 if she is black. Thiara and Breslin (2006) also reported that abused women whose first language is not English face difficulties, especially in settings where interpreter services are unavailable. Access for such women is thus subject to further complications, in addition to the barriers already discussed.

Traditional beliefs, culture and myths can also influence the decisions of many abused women. Such beliefs may encourage women to make choices regarding their freedom, but they may also be an impediment. Some cultures have been described as generally supportive when it comes to leaving abusive relationships (Mortlock, 1996) while others are not. For example, women from South Asian communities are often concerned about the stigma and shame that they believe they will experience within their families and communities, if they decide to leave an abusive relationship (Izzidien, 2008). As a result, some Asian
women would rather stay in violent relationships to preserve their cultural identification and honour (Thiara and Breslin, 2006). However, staying in abusive relationships is not determined solely by culture. Zinc et al. (2004) assert that issues in the lives of abused women influence their ability to manage abusive relationships. These include their financial situation, job stability, health insurance, level of education and government policies. For example, fear of being deported and lack of recourse to public funds have been reported as factors that determine whether women from minority ethnic groups are able to seek help or feel obliged to remain in abusive situations (Batsleer et al., 2002; Equality, 2008). The choices available to such groups of women become limited even when their lives are continually placed at risk.

2.7.5 Privacy, time, and safety issues

The difficulty of finding an appropriate time and place to intervene in DV issues, especially in EDs, has been reported in a number of studies (Thurston et al., 2009; Yonaka et al., 2007; Davilla et al., 2006; Minsky-Kelly et al., 2005; Campbell et al., 2001). Privacy for DV intervention may be inhibited by the public nature of the department, which can compromise the safety of abused women (Ellis, 1999). Furthermore, emphasis on efficiency, targets and timescales within EDs may hinder disclosure of abuse. Olhansky et al. (2002) found that efficient patient processing in EDs (where providers are expected to see and discharge their patient within a specified number of hours) can make it difficult for nurses to recognise abuse unless there is a serious physical injury. This Canadian study found that abuse generally goes unidentified because of the nature of ED practice. This shows that, in spite of training, nurses’ choices of action are enhanced or impeded by factors within their working environment.
Loughlin et al. (2000) recommend increasing staff-patient ratios and introducing external on-call DV advocates as possible methods of extending the amount of time available for domestic abuse screening in emergency settings. These proposals could provide an avenue of support for abused women, while enabling prompt treatment of other medical needs and meeting departmental targets. However, such proposals are subject to the constraints and demands of institutional policies and priorities.

The issues of privacy and safety were identified as systemic barriers in one study where DV screening was ineffective despite staff training (Minsky-Kelly et al., 2005). The evaluation of barriers to unsuccessful intervention revealed that nurses were concerned about safety issues. Nurses in the study noted that when space is not provided for privacy, providers may avoid screening in order not to compromise their patient’s safety. Likewise, women experiencing DV are likely to decline intervention if they sense that their safety is not assured.

In a US study, Early and Arthur (2002) investigated emergency nurses’ experiences of violence in the workplace. They found that 70% of the nurses reported being hit by patients and 40% were assaulted by patients’ partners. Although the authors reported that this did not affect the care nurses gave to their patients, the experience of abuse, either verbal or physical, within the working environment is likely to be a limiting factor on DV screening. This is especially true when privacy and safety issues are not adequately addressed. Similarly, Henderson (2001) noted that nurses reported having felt personally threatened at work, with occasional physical intimidation from patients, relatives
or the public. Although nurses in this US study felt optimistic with regard to physical safety at work, they expressed concern that verbal abuse towards nurses is a commonplace and administrative support is minimal. If nurses are to intervene in DV cases, their safety and that of their patient should be considered a high priority if screening is to be successful.

2.7.6 Staff frustration versus patient disappointment

It is often difficult for health professionals to comprehend the levels of fear and low self-esteem involved in the lives of women who perceive themselves as being trapped in abusive relationships. This lack of understanding results in an inability to empathise when women refuse help that is offered, resulting in high levels of frustration. In a study of factors influencing the emotional responses of staff to abused women, English emergency nurses used terms such as ‘disheartening’, ‘can’t understand it’, ‘disbelief’ and ‘frustration’(Henderson, 2001:1301). Ellis (1999) also reported that emergency staff in this US study expressed feelings of frustration, anger and a sense of powerlessness or hopelessness regarding the choices made by abused women. This research indicates that nurses experience unresolved emotions following encounters with abused women.

Nelms (1999) reported that myths persist among nurses, regarding the reasons why women remain in abusive relationships. Reported myths include the following: abused women stay because they enjoy suffering; women stay because they are weak, dependent, and from a low-socio economic group; intervening in private issues is not part of nurse’s role; and it is useless to intervene because women cannot break the pattern of being a victim. Although
the author noted that nurses’ attitudes and beliefs improved significantly after training, some of beliefs nonetheless persisted. Similarly, Olhansky et al. (2002) found that nurses commonly share a stereotypical concept that DV is only found among poor and ethnic minority women rather than among white, educated and middle-class women. The combined effect of such stereotyping must result in limited effective intervention at an institutional level.

Contrary to these stereotyped understandings of abused women, studies show that many factors influence women’s choices in seeking solutions or coping strategies to deal with abusive situations. These factors make the point of readiness when a woman decides to take control a highly flexible moment, and not necessarily fixed at the specific time of immediate intervention. Izzidien (2008) noted that issues such as loneliness, frustration, low self-esteem, self-doubt, shame, embarrassment, fear of loss, and the desire to protect the perpetrator often militate against abused women’s ability to seek or receive help. Similarly, Fanslow et el. (2009) reported structural factors that complicate choices available to women, including: racism; poverty; poor access to public funds; a lack of systemic support; insensitivity of healthcare providers; inability to access services; and unsupportive legal and social systems. Considering the severity and the complexity of barriers confronting women in abusive relationships, it is perhaps remarkable that some do summon the courage to take steps towards freedom.

Abused women may be subjected to long-term extreme controlling behaviour and threats from perpetrators, which, in time, affect their ability to make decisions (Moss, 1996). Reid et al. (2006) identified the continuous threat of
danger as one reason why women choose to stay in abusive relationships.
Contrary to the popular conception that leaving will end violence, the BCS has shown that women are at particularly high risk of threats and danger following separation from the perpetrator (BCS, 1996). The potential for violence following separation can be further complicated by unsupportive law enforcement systems, with regard to obtaining and enforcing police protection and difficulties in obtaining divorce orders (Rodriguez et al., 1998 and Rodriguez, 2001). In these American studies, abused women preferred not to report to the police because of fears of further abuse. The authors reported that the wishes of women are often not considered by health providers before taking major steps, including reporting to the police. It is important that constraints on abused woman are carefully considered, especially if their decision is to decline offers of assistance. Having autonomy to make independent choices is a right that should not be denied.

Evidence has shown that abused women usually attend EDs while feeling perplexed, frightened, desperate, and not knowing what to expect from health providers (Mortlock, 1996). Acknowledging women’s emotional distress and empowering them to make informed decisions can promote a sense of security and confidence with respect to healthcare providers. Abused women are generally too ashamed to voice their problems. In a study conducted by Rose et al. (2011), abused women felt disappointed that health professionals focused solely on treating their injury, and were not confident that disclosure of abuse would be believed. Another UK study, (Sethi et al., 2004) investigated women’s views on being asked questions while attending EDs regarding domestic abuse:
their findings showed that women lacked confidence in the ability of emergency staff to offer effective help with issues of DV.

Other ED studies agree with Sethi’s finding. Bacchus et al. (2003) reported that women found emergency staff unhelpful with regard to providing information and support, while Yam (2000) noted that women found emergency staff were unconcerned, controlling, lacked compassion and hurried to treat their physical injuries alone. Given that health professionals often concentrate on treating injuries and symptoms resulting from abuse without enquiring about the cause (Olhansky, 2002), women might think disclosure will distract the routine of staff. Lack of disclosure can therefore be a reasonable decision, based on how abused women perceive the risks associated with disclosure.

Peterson (2004) identified motivators for disclosure in abused women, including: gaining knowledge about what constitutes DV; information about available help; reaching an emotional or physical breaking point; and having a growing concern for children’s safety. Thus, it is important that health workers make the most of opportunities to provide adequate information when abused women are motivated to seek help or access services.

2.7.7 Organisational influence

It is clear from the studies discussed earlier in this review that the role played by organisational policies in preparing the context for DV intervention is critical to implementation and success (Campbell, 2001; Wills et al., 2008). Given that there is a reciprocal relationship between behaviour and the environment where behaviour takes place (Green and Kreuter, 2005), organisational policies can
influence, modify and shape providers’ practice behaviour towards DV intervention. Moreover, studies have shown that the quality of implementation and the degree of support from influential people in an organisation often determine the success of DV programmes in EDs (Wills et al., 2008; Loughlin, 2000). Wills (2008) observed that interventions are more effective when: likely barriers to change are addressed; staff are equipped with the right skills; plans to monitor, evaluate, maintain, and enforce changes are strengthened by organisational support.

2.8 Chapter summary and gaps in literature

This chapter has reviewed studies investigating the care of abused women visiting emergency department with specific reference to magnitude of DV, impact of domestic abuse on women, interventions offered in health settings, and barriers to intervention. A number of explanations relating to industrialisation, research design, variations in definition, abuse coverage and sampling techniques have been given for the variations in estimating the extent of DV, both globally and in the UK. Despite these limitations, the literature suggests that between 1 in 3 and 1 in 4 women will experience DV in their lifetime, which includes abuse from ex-partners as well as current partners.

It is essential to acknowledge that the scope of DV is wider than estimated when developing health care strategies to remedy the problem. The prevalence rate of DV among abused women visiting EDs is somewhere between 22% and 63%. Higher prevalence was found among USA studies, which use a broader definition. UK primary studies showed similar findings (Sethi et al., 2004; Wright
and Kariya, 1997). However, these studies are generally small scale and single-centred which has implications for the reliability of their findings.

Considering that prevalence rates in patients who were not eligible for inclusion are likely to be higher in comparison to other healthcare departments, patients attending EDs are likely to have a higher prevalence of DV than is reported in the literature. Furthermore, it is likely that a large proportion of women who attend EDs will suffer ongoing DV-related illnesses that they may not present as their primary reason for visiting the department. Therefore, the extent of health problems associated with abuse warrants development of specific strategies in EDs, and should be a high priority for service providers.

The current literature indicates a paucity of UK studies on translating DV intervention into practice; this review has relied on relevant studies from outside the UK. Clearly, substantial efforts have been devoted to designing training packages, protocols and screening tools. While these are useful, it is evident from this review that stand alone training or protocols interventions have not altered the behaviour of healthcare providers with respect to DV screening. There is also a clear indication that DV training should extend beyond initial pre-intervention training. Sustained change is usually difficult and is likely to be influenced by introducing DV education into nursing school curricula, refresher training, on-going evaluation and initiation of local DV policies.

Further, this review found no study from the UK for validating screening tools in EDs. This could be a reflection of the fact that screening for DV is not currently mandatory within the NHS and has therefore not been given priority. This
absence may also indicate the low priority given to DV screening. Healthcare professionals are likely to miss opportunities to identify abuse and provide support to women, especially when abuse does not result in injuries that are obviously inflicted by another person. The current ‘index of suspicion’ approach screening in UK EDs therefore requires further investigation.

Organisational support for an intervention may be influenced by the way DV is framed as a social problem, the costs of intervention and excessive focus on outcomes. Nevertheless, future visits and health cost may be greatly reduced with higher screening suspicion, increased advocacy and early assistance to manage abusive situations in EDs. It may be difficult to measure the outcomes of DV screening and advocacy, especially its immediate effect on abuse reduction. However, they are likely to play an important role in providing awareness that may move the victim to a point where they see the need to seek active help. Moreover, zero tolerance advertising and raising societal awareness through posters, leaflets and visual media in waiting rooms can be useful interventions, even though measuring their effectiveness can be difficult. It is also clear that studies assessing the effectiveness of advocacy for abused women visiting clinical settings report significant improvement in women’s quality of life, irrespective of whether they receive short-term or long-term measures.

No UK study has explored the implications of environmental context and DV policies on staff responses towards abused women and ED practices although few authors pointed out that research is needed to understand how DV interventions may be successfully integrated into a well-established health
sector. Understanding is also needed of which interventions are acceptable to abused women in the context of ED. Clearly, qualitative studies will be needed to explore these issues as they appear to form the basis for moving healthcare systems towards interactions between organisations and individual components, which is still missing in DV management.

Furthermore, this review has highlighted many barriers which can hamper DV intervention in EDs, ranging from situational to personal issues. Besides, health providers’ interactions are affected by their own highly individual backgrounds, which often determine their responses. Similarly, abused women are faced with many barriers that can challenge their ability to make rational decisions; this can make it difficult to understand why women don’t leave abusive relationships. While it is certainly not safe to remain in an abusive relationship, leaving may actually pose a greater risk. Managing the complexities of DV issues therefore can be emotionally demanding for health providers as well as for abused women. It can be complicated by a lack of knowledge concerning the dynamics of DV, the skills needed to intervene and issues of fear, safety and privacy for staff and patients. There is also a need to explore how child protection issues may be handled with more sensitivity.

Finally, the usefulness of exploring specific organisational barriers to implementing DV intervention in ED has been documented by studies from the US. The context in which nurses choose their approach is strongly influenced by the working environment and organisational priorities and policies. The vital role of environmental context and organisational support for successful implementation of policies should be acknowledged. Undoubtedly, UK practices
differ from the US in healthcare contexts, criminal justice systems, the incidence of violent crime, welfare systems, patterns of gender relations and social relations (Walby and Myhill, 2001). UK study is needed to explore the implications of the ED context for DV intervention.

A renewal of survivor-centred approach was advocated recently by Goodman and Epstein (2008) and the Department of Health (2009). This recognises that DV survivors possess valuable information regarding their unique experiences, which could be utilised by researchers to develop appropriate and effective healthcare interventions. Similarly, DV voluntary organisations and activists have played a long-term role in creating awareness for DV issues and have continued to support women who are victims. Their wealth of experience in developing DV interventions and executing referrals to support services in emergency departments has yet to be explored.

Finally, like any other area of clinical practice, promoting effective DV intervention is likely to require a multi-dimensional approach. Thus, system wide intervention component has been advocated in literatures. This should include: chart prompting; screening questions; guidelines or protocols for intervention and provision of awareness and empowerment. However, research knowledge is generally needed on how to target DV interventions to suit different subgroup needs, and how to adapt them for specific departments within the UK healthcare system (Nurius et al., 2011; Feder et al., 2009). The Department of Health emphasises that interventions should be department-specific, cost-effective, evidence-based and sensitive to the needs of stakeholders in order to be productive (DOH, 2009). This is particularly needed for emergency
departments in the UK where evidence for such a comprehensive intervention is lacking. Such effort will require theoretically sound research approach to elicit systemic and departmental barriers and facilitators from a comprehensive viewpoint; involving both service user’s and provider’s perspectives as basis for intervention. This approach will serve the purpose of discovering potentially effective strategies; identify barriers to intervention from all individuals involved in such interventions; and take account of context-specific and environmental issues for intervention. These are the primary intentions of the present study. The aims, design, and methodology are examined in the next chapter.
CHAPTER 3: Research design and methodology

3.1 Introduction
This chapter details the approach followed in conducting this research by positioning it within a methodological, epistemological and ethical framework. It begins with an introduction that provides a review of the problem and the purpose of the study. The philosophical and theoretical underpinnings of the study are then reviewed. Criticisms of various methodologies are discussed and the justification for selecting the chosen methodology is given.

3.2 Review of the problem and aims of the study
The crucial position occupied by ED in DV prevention, coupled with the high prevalence and severity of physical and psychological trauma arising from DV, makes the lack of identification and support for abused women in these settings disturbing. It is clear from the review of literature in this thesis that effort to integrate awareness of DV and care for women experiencing DV into the practice of ED health professionals has been difficulty. Interventions often focus on linear trends and individual characteristics of health workers. For example, training programmes for staff have failed to adopt multidimensional and comprehensive approaches and demonstrate little progress in instituting care for abused women. The conclusions of the reviews and ED studies particularly from the UK have shown that further research is needed to support our understanding of sustainable DV intervention programmes for women (O’Campo et al., 2011; Feder et al., 2009; Ramsay et al., 2009; Ramsay et al., 2002; Sethi et al, 2004). A sustainable drive for improvement in service quality over time will require understanding of the complexity and uniqueness of DV
intervention for women. It should consider the specific characteristics of settings, and how these impinge on both patients and staff.

In view of this, the present study has explored the experiences and views of significant stakeholders regarding current interventions for abused women visiting an ED, including intervention barriers and facilitators, using grounded theory methodology. The findings suggest particular ways in which ED services might better meet the needs of women who experience domestic abuse. To the best of my knowledge, this is the first UK study to utilise this approach in proposing strategies for DV intervention in EDs.

This study set out to answer the following questions:

- What are the practices of staff and the policies in place in EDs for DV intervention?
- What are the barriers to developing DV intervention for women visiting EDs?
- What are the facilitators?
- What are women’s experiences of using EDs in relation to DV?
- What do women want from DV interventions?
- Which interventions are likely to be effective in the ED setting?

The aims of the study were:

1. To explore the practices and policies regarding DV intervention in EDs
2. To identify the barriers to implementation of DV intervention within EDs, and explore strategies for overcoming barriers from the perspectives of users, service providers and voluntary organisations
3. To investigate what abused women want from DV intervention in EDs
4. To present a theoretical explanation which is grounded in the narratives of the participants regarding developing potential interventions for abused women visiting EDs

To address these aims, a number of methodological and practical decisions had to be made. The following sections discuss how these decisions were made and the philosophical roots of this study.

3.3 Qualitative research methods

Qualitative research refers to a wide range of approaches and methods for inquiring into social problems (Cresswell, 2007). Unlike quantitative research, which relies on quantification and statistical procedures, qualitative research builds theory from the grounds of experience, which requires the investigator to seek an insider view rather than adopting a detached stance (Schostak, 2010).

The decision to engage in a particular field of enquiry should be based on careful consideration of the questions the study aims to answer. Qualitative inquiry has been noted for its usefulness in understanding complex and sensitive issues, and for searching out new knowledge. This characteristic is especially valuable for this study, in view of the complexities surrounding DV issues and the ongoing difficulty in establishing sustainable interventions within the specific context of EDs. Therefore, a major concern for this study is to grasp the nuances involved in DV intervention in ED by exploring and unfolding both users’ and providers’ experiences and views.
Qualitative research is based on several philosophical and theoretical underpinnings including symbolic interactionism, constructivism and critical theory. These foundations have resulted in various methodological approaches to social enquiry, including ethnography, phenomenology, grounded theory and case studies. The next section presents the epistemological and philosophical roots of this study.

### 3.4 Philosophical underpinnings

This section examines the philosophical stance of this study. It begins by attempting to define some terms, after which constructivist and feminist theories are examined. Ontology, epistemology and methodology constitute the three main dimensions of inquiry that primarily influence the researcher’s selection of method and theoretical perspective (Denzin and Lincoln, 2005). Epistemology is related to ontology, and methodology is influenced by both ontology and epistemology, hence the reason why the three are interconnected (Guba and Lincoln, 1994). Ontology comprises the assumptions made about the form and nature of reality; epistemology discusses how knowledge of ‘reality’ may be gained while methodology is the processes of how to discover or construct knowledge (Guba and Lincoln, 1994).

There are two broad ontological approaches to social enquiry, namely realist and constructivist. Realist ontology assumes that reality is ordered and exists independently of the researcher and the researched. An example of a research paradigm that supports this position is positivism: this proposes that ‘reality’ is context-free, driven by laws and generalisations can be made about it (Lincoln, 1997). Epistemologically, a positivist stance suggests that the investigator and
the investigated are independent: the researcher may study an object without being influenced by it and without the object influencing the researcher (Guba and Lincoln, 1994).

In contrast, constructivist theory (from which interpretivist theory is derived) assumes that social reality is produced and reproduced by both the researcher and the researched (Annells, 1996). Interpretivists, in opposition to the positivist stance that a state of complete objectivity is possible in an inquiry, argue that the researcher cannot be separated from the world he or she researches and constructs (Guba and Lincoln, 1994). Epistemologically, constructivism emphasizes the subjective relationship between the researcher and the participant, and their mutual significance in constructing meaning (Norton, 1999).

The complexities of DV and its intervention challenge researchers to go beyond the surface meanings and to search for reasons behind behaviours (Allen, 2011). This study was faced with the task of identifying processes that underlie social experience and the bases for social action, as they relate to service users and service providers. In addition, there is a need to develop knowledge that is both pragmatic and reflective of women’s voices (Campbell and Bunting, 1991). Traditional scientific approaches may be unsuitable to elicit multiple meanings in social interactions. Therefore, the potential to extract perceived meanings constructed from the experiences of service users and service providers made constructivism the desired methodological approach for this study.

It is the intention of this study to incorporate abused women’s experiences and views into the development of DV intervention within EDs. As the primary
beneficiaries of intervention strategies, hearing and incorporating their experiences is likely to tailor service provision to their expressed needs and thus improve the uptake of intervention strategies on offer. Moreover, it may be impossible to reflect the political and social influences on the experiences of abused women without engaging with a perspective that takes account of the sensitive and gendered nature of DV. Therefore, a methodology that will depict other issues outside the main discourse, such as the impacts of gender, political and cultural factors on the experiences of women, is necessary to achieve this purpose.

Feminist theory and feminist activism have played a significant role in creating awareness of DV issues and services for abused women (Schechter, 1982). Accordingly, a study that intends to give voice to abused women should first clarify whether feminist perspectives can assist in developing an appropriate research methodology. Law (2006) suggests that there is a need for new tools to enable researchers to depict the shifting interactions between different realities, especially when investigating vulnerable groups. This is particularly important in this research, where such a complex and sensitive topic is explored among vulnerable women. In order to incorporate such a tool, a feminist perspective has been adopted to augment the constructivist grounded theory methodology.

Based on my motivations and values, I recognise the potential benefits of representing the women who participated in this study. Consequently, my intention is not to simply add another research project to the list of existing studies. Rather, the intention is to give voice to the participants and
acknowledge them as contributors of knowledge. While there may be consensus that feminist research emphasises the diversity of women’s experiences, the social institutions that frame those experiences often take centre stage (Olesen, 2000: 216). In order to avoid this pitfall, this study incorporates a perspective of feminist theory while clearly delineating its boundaries of use. A feminist perspective was employed in this study to provide a reflexive mirror through which women’s experiences may be constructed. Constructivist grounded theory will provide the methods, analytical tools and guidance for constructing meanings; it will also assemble these into usable theoretical interpretations (Charmaz, 2001).

The next section examines the two theoretical perspectives in detail and draws lines of interest. It begins with an overview of grounded theory, its variations and critiques as well as the justification for using the approach. Subsequently, a synopsis of feminist theory is provided and its boundaries for this study are established. Finally, analysis and quality criteria for this study are discussed.

### 3.5 Grounded theory: overview

Grounded theory is an approach that systematically generates theory that is grounded in data acquired from rigorous research procedures (Glaser and Strauss, 1967). It focuses on everyday life and meanings as understood by the participants, and aims to generate theory that describes, explains, interprets and predicts the phenomenon of interest (Charmaz, 2000). Grounded theory emphasises developing an understanding of human behaviour using discovery and induction rather than hypothesis-testing and deduction (Elliot and Jordin,
Fundamentally, it is concerned with social action, and how meaning is constructed in different interactive situations (Schreiber and Stern, 2001).

The nature of this study meant that choosing the most appropriate approach requires careful consideration. To begin with, phenomenology captures the essence of experiences. However, the main focus of phenomenology is not to provide an explanation of reasons or elucidate the causes but rather to emphasise how life is experienced (Denscombe, 2003). Although the experiences of participants are central to this study, the objective of the study is to move beyond explanations of ‘how’ life is experienced to deducing ‘what is going on’. Similarly, founded in the tradition of anthropology, ethnography is an excellent tool for describing, analysing and exploring how cultures function and how meaning is derived from social lives (Jupp, 2006). Thus, ethnography is best suited for describing and analysing a group of people and their culture (Rice and Ezzy, 2000). While understanding the culture of EDs would be useful in developing interventions, generating theoretical explanation underpinning the development of DV intervention is desired to justify and provisionally verify the proposed intervention. On this basis, grounded theory was found to be more suitable than ethnography to fulfil this purpose.

Grounded theory has, since its inception, been accepted as an important research methodology in the investigation of complex social interactions. It has been suggested by a number of authors as the methodology of choice in qualitatively oriented research fields such as medicine, nursing, social work, and education (Wells, 1995; Miller and Fredericks, 1999). In view of grounded theory’s inductive and interpretive attributes, it is appropriate to use this
methodology for the exploring complex interaction that takes place when abused women visit EDs. First, it permits investigation of higher- and lower-level factors (ranging from individual to complex social-cultural factors) which is critical when seeking to explain variability in core human interactions (Miller and Fredericks, 1999; Streubert-Speziale and Carpenter, 2003). Second, grounded theory provides theoretical explanations that are discovered, developed and provisionally verified through systematic data collection as well as data analysis pertaining to the subject (Strauss and Corbin, 1990). Thus, grounded theory may play a unique role in constructing theories regarding what abused women want from an intervention and which intervention will possibly work in EDs.

Other factors influencing this decision included its suitability for exploring a complex subject; its contextual setting, which provides explanations of reasons and associations; and particularly its ability to discover how structural conditions (including systems and policies) can influence patterns of behaviour (Corbin and Strauss, 1990; Ritchie and Lewis, 2003; Wuest et al., 2001). Finally, grounded theory is of greatest value when new knowledge is required; this is likely to be the case in relation to the difficulty of sustaining DV interventions within EDs (Minsky-Kelly et al., 2005; Henderson et al., 2004; Campbell et al., 2001; Loughlin et al., 2000). Overall, the scope of grounded theory’s practical and theoretical suitability as an avenue for qualitative inquiry made it the methodology of choice for this study.

Despite its merits, grounded theory has been criticised for its lack of clear methodological procedures and the danger of violating the underlying premise
in the data analysis process. These controversial issues are well acknowledged and are discussed in the next section.

3.5.1 Grounded theory: critique

Despite the fact that grounded theory is the most widely cited qualitative research method in social science research (Bryant and Charmaz, 2007: 1), an extensive debate has been generated over its epistemological assumptions (Moore, 2010; Suddaby, 2006). This controversy has driven researchers to be more transparent about how they report their specific use of the method, and has lead to a call for an active engagement with the methodological foundations of the approach (Locke, 2001). In response, I shall examine in this section the methodological trajectories and developments in grounded theory that led to its three main traditions. These are as follows: Glaserian, developed by Barney Glaser; Straussian, developed by Anselm Strauss and his student Juliet Corbin; and the constructivist tradition, most strongly associated with Kathy Charmaz.

3.5.2 Grounded theory: Glaser, Strauss, and Corbin

Grounded theory was initially conceived by two sociologists, Barney Glaser and Anselm Strauss. In their first publication, The Discovery of Grounded Theory: Strategies for Qualitative Research (1967), the authors developed a research approach that offered an inductive, theory-discovery methodology. They described it as an approach that systematically generates theory that is grounded in data acquired by rigorous research procedures. According to the authors, these procedures allow the generation of conceptual categories which are related to each other and are used to develop substantive theories regarding the general features of the phenomena under study (Black, 2009).
Using discovery and induction, rather than hypothesis-testing and deduction, grounded theory guides the identification of concepts to form categories that may indicate action and change (Glaser, 1978, 1996). The categories fit together to form a core category, which offers an explanation that ties the categories together. The outcome of the activity is a collection of explanations that describe the subject of the research.

The backgrounds of the two social scientists that discovered grounded theory are significant in understanding their motivation for developing the theory methods. Glaser initially trained in quantitative social research methods, while Strauss trained in the more qualitative research tradition (Jeon, 2004). It is evident that while both have evolved from their original backgrounds, as shown in The Discovery of Grounded Theory (Glaser and Strauss, 1967), the two approaches contributed to grounded theory’s development. Their efforts to filled the theory-research gap, which had not been bridged by the research tradition of logical deductive reasoning (Jeon, 2004).

Strauss and his student Corbin chose to develop the theory along a relativist route that opposes the existence of a ‘pre-existing reality’, stating that they ‘reject [the] positivistic stance’ and their view of truth is that it is ‘enacted’ (Strauss and Corbin, 1994: 279). Perhaps influenced by his original background, Glaser opposes this relativist ontological stance and instead maintains the traditional grounded theorist’s positivist ideology (Glaser, 1978). The separation resulted in the two schools of grounded theory approach: Glaserian and Straussian. This has contributed significantly to the perplexities expressed by critiques of the theory (McCain and Clark, 2003a; Moore, 2010).
For example, with regard to the role of literature in research, Strauss and Corbin have asserted (1990, 1998) that theoretical sensitivity could be enhanced by a preliminary review of literature at the outset. On the other hand, Glaser claims that review of the literature should be left till after analysis, as this would affect the researcher’s view of the field and shape the generation of categories. This was described by Glaser (1992) as the forcing of analyses. On the other hand, Strauss and Corbin (1998) had a more flexible view on generating research problems. They proposed four processes through which research problems could emerge: personal and professional experience, professional or collegial suggestion, technical and non-technical literature searches, and conducting of studies.

In agreement with Strauss and Corbin, some researchers have argued that literature review is fundamental to theoretical development, and that it can offer direction to the researcher. Suspending literature review until the end of a study may be impracticable and/or detrimental (Walls et al., 2010). Likewise, Elliott and Jordan (2010) believe that gaining approval for a study and the allocation of funding will necessitate a demonstration of a thorough knowledge of relevant literature. It may also be impossible for researchers to suspend their prior knowledge and understanding of the research area. Besides, research problems can be generated through more than one approach. Nonetheless, theoretical development should be conceptual rather than concrete so that the theory is grounded in the data and not predetermined by the perspectives of the researcher (McCann and Clark, 2003b; Jones and Noble, 2007).
Although Strauss and Corbin have been applauded for presenting a more detailed account of grounded theory methodology than in Glaser and Strauss’s classic version (McCann and Clark, 2003b, Elliott and Jordan 2010, Moore, 2010), there are major modifications and contradictions between their 1987, 1990, and 1998 versions (Jones and Noble, 2007). Clearly, both approaches are influenced to varying degrees, by positivism and post-positivism. This is evident in their sampling procedures, their establishment of linkages among the categories and their theoretical development (Charmaz, 2006). However, Strauss and Corbin appear to have taken a contemporary shift towards social constructivist ontology and a post-structuralist paradigm, while classic grounded theory has remained in critical realist ontology with a post-positivist paradigm.

3.5.3 Constructivist grounded theory

Charmaz, a student of Glaser and Strauss, propagated the move towards constructivist grounded theory (Charmaz, 2003: 253–6; 2006: 4–12). She defined constructivist grounded theory in the following three points:

Grounded theory strategies can be adopted without embracing the positivist leanings of earlier proponents of grounded theory; grounded theory strategies need not be rigid or prescriptive; a focus on meaning while using grounded theory furthers, rather than limits, interpretive understanding (Charmaz, 2003: 251).

Charmaz disagrees with the traditional objectivist and positivist assumptions of Glaser and Strauss (Charmaz, 2005: 509). She also claims that a review of their combined work (1967), their individual reformulations (Glaser, 1978; Strauss,
1987) and the joint work of Strauss and Corbin (1998) shows that they have all been influenced one way or the other by positivist and behaviouralist traditions. She posits that knowledge creation is a socially constructed process. This process produces a subjective relationship between the researcher and the participant. As a major component of a research process, the values of the researcher shape the outcome of the study: this must be acknowledged by the researcher and should be anticipated by their readers (Appleton, 1997; de Laine, 1997; Guba and Lincoln, 1989; Stratton, 1997).

Charmaz (2003) argues that data do not independently expose their ‘truth’. Rather, the discovered reality or truth is constructed in the course of interaction between the researcher and the participant. Thus, realities that emerge are not neutral and independent: they have cultural and contextual boundaries. As a consequence of researcher-participant interdependency, ontology and epistemology merge: this is because the ‘knower’ becomes inseparable from whatever can be known (Charmaz, 2006). Therefore, the constructivist approach is ontologically relativist and epistemologically subjectivist (Guba and Lincoln, 1994).

Traditional objectivists view grounded theory as the discovery of categories that are exclusive to the data and are observed in an external world by an independent observer. Charmaz (2006) believes that such a position is no longer acceptable following the interpretive turn in qualitative social scientific research. Instead, grounded theories are products of emergent processes that occur through interaction. The overall aim in constructivist inquiry therefore is to understand and reconstruct the meaning that participants give in order to
ultimately arrive at a conclusion, while researchers remain open to new interpretations as further information becomes available (Charmaz, 2006).

In summary, constructivist grounded theory ‘recognises the mutual creation of knowledge by the researcher and the researched, aims toward interpretive understandings of subjects’ meanings and assumes the relativism of multiple social realities’ (Charmaz, 2003:250). Thus constructivist theory takes a middle ground between positivism and postmodernism.

It is worth noting that the launch of more than one approach to grounded theory is not a surprise as similar schisms have taken place in other research methodologies. For instance, in phenomenology, several schools have developed methods of research and there are also varying approaches to the analysis of data (McCann and Clark, 2003a). The practicalities of undertaking research have changed since Glaser and Strauss first described grounded theory, and so has the methodological approach proposed by them. As a result, different approaches to grounded theory should suggest maturity and advancement of the methodology rather than failure (Walls, 2010; McCann and Clark, 2003a). Nonetheless, all the approaches still concur regarding the substance of grounded theory, especially seeking to generate theories that look for explanations of phenomena through systematically collected data through a constant comparative method (Charmaz, 2000).

In this study, using constructivist grounded theory as a guide, I have been able to construct the experiences of service users and service providers while evaluating the policies and services provided to abused women in EDs. The
study also identified other social, contextual and institutional issues that are pertinent to developing intervention for women visiting EDs. In addition, I recognise the significance of exploring a range of perspectives and ‘truths’ as proposed by Strauss and Corbin (1994). This recognition influenced the choice of participants that were recruited for this study. It included both the voices of women experiencing DV as well as the voices of staff that are responsible for delivering domestic violence interventions. Voluntary organisations (such as Women’s Aid) are experts in domestic violence: they have been and continue to be instrumental in raising public and institutional awareness of DV and developing community strategies for intervention (Ramsay et al., 2002; Macy et al., 2009). As this sector has the greatest experience of working with abused women, it was essential to utilize its expertise in developing of proposals for advancing health service-based interventions. Employing this wide range of views enhances the generation of data and enables construction of theory that is rich, proficient and integrated.

The ability to identify structural as well as contextual influences of a phenomenon has been identified earlier as a strong merit of constructive approach (McCann and Clark, 2003a). This allows the exploration of broader influences on DV intervention in this study, such as the influence of policy on practice. Moreover, I have used the structured approach to data collection and analysis of Strauss and Corbin, which is also endorsed by Charmaz. Specifically, this involves phased interviews and comparative techniques. This is preferable to Glaser’s more open and less structured approach. A detailed discussion of grounded theory’s procedures and how they have been applied in this study follows.
3.5.4 Grounded theory: Foundational procedures

A key characteristic of grounded theory is the use of an emergent design. This is defined by Creswell as a process whereby ‘the researcher collects data, analyzes it immediately rather than waiting until all data are collected, and then bases the decision about what data to collect next on this analysis’ (2005: 405). This iterative approach, often referred to as the concept-indicator model of analysis (see Figure 2), is based on constant comparison theory (Schwandt, 2001). According to this theory, concepts are compared with more empirical indicators and with each other to sharpen the concept’s definition and define its properties (Draucker et al., 2007). Theories are formed from proposition of plausible relationships among concepts and sets of concepts.

Tentative theories, or theoretical propositions, are further explored through additional data. Testing of emergent theories is guided by theoretical sampling. Theoretical sampling means that sampling additional incidents, events, activities, populations, and so on is directed by the evolving theoretical constructs. Comparisons between the explanatory adequacy of the theoretical constructs and these additional empirical indicators continue until theoretical saturation is reached. This is when additional analysis no longer contributes anything new to a concept (Charmaz, 2006). The resulting theory is considered conceptually dense and grounded in the data. There are four stages of analysis in grounded theory: coding, concept formation, categorising and theory development.
3.5.4.1 Coding

According to Charmaz, ‘coding is the pivotal link between data collection and the development of an emergent theory which explains the data’ (2006:46). It helps the researcher to define what is happening in the data as they analyse it and construct meaning. Charmaz identifies seven principles which should guide the researcher through the process of coding: ‘remaining open, staying close to data, keeping codes simple, constructing short codes, preserving actions, comparing data with data and moving quickly through data’ (2006:48).

Furthermore, she described three levels of coding:

1. **Open/initial coding** occurs at the preliminary stage of data acquisition and relates to describing overall features of the phenomena under study. Variables are identified in the phenomena, then labelled, categorised, and linked in an outline form.

2. This is followed by more **selective or focused** coding, which uses the most significant or frequent earlier codes to sift through large amounts of data. The researcher decides which codes are most analytically fruitful and thus categorises the data.

3. This third level of coding is **axial coding** where explicit connections are made between categories. This is achieved by specifying their dimensions and properties, as well as clarifying and rearranging them to give a coherent analysis.
3.5.4.2 Concepts and categories

The stage after coding is concept formation. Similar contents that allow the data to be grouped are given a name that defines them in a general way: these are called concepts. More concepts are discovered as analysis continues. Concepts are then grouped into categories based on their characteristics. Concepts are compared and questions are asked about the concepts regarding their similarities and defining characteristics. Answers to these questions are used to create labels for the groups, which then become categories. Finally, similar concepts put in broad groups form the basis for generating a theory. In other words, categories that fit together form an explanation or model.

3.5.4.3 Theory

Theory refers to a collection of explanations and proposition that the researcher tests through the process of the research. Before developing theoretical explanations, the central categories that can explain others are determined, based on meanings or questions exhibited by the data. The properties and dimensions of the core categories are then delineated and used to develop a theoretical explanation. Theories are then tested by revisiting the data with a focus on the reanalysis.
Figure 2: Zigzag iterative approach to data generation and analysis

**Data collection**

- Literature review started
- Tools generated/found
- One-to-one in-depth interview (1st 10)
  - Transcript, analysis, open coding
- One-to-one in-depth interview (2nd 10)
  - Refinement of questions based on analysis
  - Respondents asked to clarify emerging themes and conflicting ideas
    - Transcript analysis, open and axial coding
- One-to-one in-depth interview (last 10)
  - Refocus of interview questions
    - based on analysis and further clarification of emerging themes with
    - participants leads to theory development
    - Transcript analysis open, axial and selective

**Data analysis**

- Transcript analysis, open coding
- Transcript analysis, open and axial coding

### 3.5.4.4 Theoretical sampling

Theoretical sampling consists of systematic, strategic and specific movement back and forth between data collection in order to construct tentative ideas about data, delineate ideas, develop their properties and explain their variation (Charmaz, 2006). Theoretical sampling is pivotal to grounded theory strategy...
and forms the basis for its abductive inferencing. Abductive inference is a logical inference that offers a theoretical interpretation for all possible explanations using a constant comparative method. This helps the researcher to improve and follow on analytical leads. It is achieved by ‘specifying the relevant properties of the categories, increasing the precision of the categories, providing the substance that moves data material from description to analysis, making your analysis more abstract and generalisable, grounding conjectures in data, explicating the analytic link between and among categories and increasing the palimony of the theoretical statements’ (Charmaz, 2006:105).

3.5.4.5 Memoing

This is a vital intermediate step between data collection and analysis (Charmaz, 2006). Data collection and analysis are ongoing and often overlap; memoing is an important integral procedure that enhances the researcher’s awareness of her personal biases so as to minimise distortion during analysis (Elliot and Lazenbatt, 2005). The researcher is also able to cross check that emerging theory fits into her memo. This plays a significant part in controlling the quality of data analysis. It is similar to the reflexive practice in feminist methods discussed later.

3.5.5 Judging the quality of grounded theory research

Undoubtedly, clarity about the perspectives that guides a particular design will strengthen the possibility for rigorous quality checking after. Methodological clarity in terms of identifying and documenting the essential components of grounded theory and how these research methods impact the quality of the
research has been identified as an important criterion to establish quality standards (Elliot and Lazenbatt, 2005; O’Connor, 2008).

In principle, researchers agree on the criteria for evaluating the quality of grounded theory research. Glaser and Strauss (1967: 237-250) and Glaser (1978) propose four criteria for judging a theory as grounded: fit, understanding, generality and control. Charmaz (2005; 2006) and Denzin and Lincoln (2000) proposed similar criteria but using different terminology, including credibility and trustworthiness, originality, transferability and resonance. These standards are understood as follows:

- The concept of **fit** suggests that the resultant theory is applicable to and covers data. In turn, the data delimits the boundaries.
- **Credibility and trustworthiness** refers to the ability of the researcher to demonstrate intimate familiarity with the setting and to use sufficient systematic comparison to ground participants’ claims in the data.
- **Originality** refers to the potential of the study to offer new insights that are able to extend, challenge, or refine current ideas and practices.
- Similar to originality, **control** addresses the potential of a theory to enable the development of hypotheses that could extend knowledge.
- **Transferability** measures the ability of the research findings to be applied to other settings.
- Similarly, **generalisation** suggests the ability make the theory amenable to multiple applications, as a general guide to ever changing daily situations and circumstances.
- **Resonance** is the ability of the study to provide analytical interpretations that portray the experience as a complete whole. The interpretations
should make sense to participants and offer them deeper and better insights about their own lives and worlds.

- Similar to resonance, **understanding** is linked with practical applications and interpretations that should make sense to participants, researchers, and laymen.

- **Usefulness** is the ability of the theoretical explanations offered to inform professional interventions, such as those that could be developed within the ED. It is the intention of this study that the theoretical explanations offered should be useful to emergency staff and other healthcare workers in their day-to-day interaction with women experiencing DV.

### 3.5.6 Limitations of grounded theory approach

Two of the major limitations that have been identified in grounded theory are: a lack of clear methodological procedures; a danger of violating the underlying premise in the data analysis process (Jones and Noble, 2010). These authors suggest that restoring discipline and integrity into grounded theory methodology will require that the researcher acknowledge the various schools of thought that exist, state their subscribed school and remain true to the foundational procedures of grounded theory. Likewise, Walls et al. (2010) advocate that foundational procedures should be consistently endorsed by all the approaches. Researchers can thus preserve the integrity of grounded theory approaches. In view of this recommendation and to safeguard the consistency of grounded theory methodology, I have justified my choice of constructivist grounded theory in this study and made efforts to remain true to the procedures of the school. The major ‘foundational’ procedures of grounded theory have been followed throughout. Furthermore, the central objective of grounded theory analysis,
which is to generate core categories as the basis for theory construction, has been maintained.

Another limitation on grounded theory is the ability of the researcher to judge the quality and applicability of the resulting theory to the investigated phenomenon, following the generation of the theory from qualitative data (Moore, 1994). It is crucial that the researcher is able to justify the conclusions, insofar as they provide answers to the research questions and they are applicable to the phenomena under investigation. Again, the quality criteria employed in this study have been stated. A detailed description of how the study has satisfied the quality criteria is provided in the chapter four.

Finally, the richness of theoretical discussion, as identified by Glaser and Strauss (1967), is another major determinant of the success of grounded theory. It should credibly explains and give meaning to the phenomena being studied (Miller and Fredericks, 1999). This requirement has been satisfied by providing a rich discussion of the findings and a theoretical explanation of this study. This is presented in chapter eight.

3.5.7 Summary

So far, this section has examined grounded theory as the primary methodology for this research. Its usefulness in tackling complex subject matter and its ability to generate new knowledge are some of the reasons why it has been chosen for this study. In spite of its merits, grounded theory has been criticised for lacking clear methodological procedures, the danger of violating the underlying premise in the data analysis process and the problem of ensuring the quality of
the propositions reached. These controversial issues are well acknowledged and particular processes have been undertaken to overcome these limitations in this study. The next section provides an overview of feminist theory and how this study draws on feminist principles to guide this research.

3.6 Feminist theory: an overview

Feminist epistemology explains the influence of gender on our conception of knowledge by identifying how women are particularly deprived and traditionally invisible in social histories (Anderson, 2011). Feminist theory is the extension of feminism (nature of gender inequality) into theoretical or philosophical discourse. (Brabeck et al., 1997). Generally, it provides a critique of women’s social relations; analysing gender inequality and promoting women’s rights, interests, and issues (Andersen, 2005)

Just as different schools have informed the methods of grounded theory research, feminist theory has also grown in its perspectives. Harding (1986) classified feminist epistemologies into standpoint theory, postmodernism and empiricism. According to Anderson (2011), standpoint theory claims an epistemic advantage from having a specific socially situated perspective. Despite its influence in feminist research and theory, standpoint theory has fallen victim to diverse charges. For example, it upholds one group’s perspective at the expense of others and it is guilty of ‘essentialism’; that is, it limits the experiences of women to those that resonate with traditional ‘victim’ identities (Lemert, 1992: 69).
Feminist postmodernism on the other hand embraces a relativistic viewpoint (Anderson, 2011). Its perspective is that ‘truth’ is contextual, being both socially and culturally constructed. Consequently, attempting to define a universal ‘truth’ or seeking out a unifying theory is naïve and unmerited. Instead, multiple discourses accentuate dialogue; they also emphasise that issues outside the sphere of discourse should be constructed (Maynard, 1994; Millen, 1997). However, postmodernist feminism has also been criticised as being relativistic, which implies that a unified approach to theory-building is unfeasible (Allen, 2011).

In empiricism’s view, knowledge is politically neutral and non-contextual. It believes that experience provides an autonomous explanation for all knowledge. Nonetheless, feminist empiricists have been criticised for failing to embrace the postmodern identification of socially situated knowledge (Anderson, 2011).

In view of the variations within feminist theory, it is reasonable to assume that feminist research draws on several philosophical stances thus making it impossible for a single research method to claim complete ownership of the theory (Allen, 2011). The question of whether there is a feminist approach to undertaking social research is thus debatable. While it is commonly agreed in the literature that feminism centres on the unique experiences of women and the impact of power and gender on those experiences, there is no agreement as to how this translates into an explicit methodology (Letherby, 2003; Olesen, 2000). However, it seems that the field has steadily evolved towards a
postmodern approach which investigates the variety of ways gender is implicated in knowledge conception and practice (Allen, 2011).

3.6.1 Feminist principles as a reflexive guide for the study

Although there are different variations of feminist epistemology, some general principles underlie feminist perspectives. These include the influence of gender, emphasise on empowerment, consciousness raising and ethical concerns (Cook and Fonow, 1896; Letharby, 2003; Smart, 2009; Allen, 2011). These allow for reflection on both the practice and progress of research when working with abused women. This study draws on these general principles as a guide for conducting research and the principles are discussed below.

1. Acknowledging the Pervasive Influence of Gender:

In conducting research that interprets and explains women’s perspectives, it is necessary to continuously and reflexively attend to the significance of gender and gender asymmetry as a basic feature of their world (Cook and Fonow, 1986; Ramazanoglu, 1989; Bernard, 1979). Gender asymmetry has been described by feminists as an imbalance of representation, discrimination and a general pattern of controlling behaviours used by one sex to control the other (Dobash and Dobash, 1979; Stark and Flitcraft, 1996). It is reasonable to view women through a ‘female prism’ since women and their experiences of the social world will take account of their relationships with men (Bernard, 1979: 274).

Although these experiences are socially lived, they are personal to the woman: her subjective experiences should not be ignored, denied or discounted. As a researcher, I seek to validate her private, emotional,
and intimate world through the research process (MacKinnon, 1982). Acknowledging gender influence in this study also implies locating the researcher as a gendered being (Eichler, 1980) so that common experiences of women researchers and women subjects are appreciated. This enables the researcher to bring women’s realities into sharper focus in a society characterised by significant gender asymmetry (Cook and Fonow, 1986).

2. **Focus on Consciousness-Raising**: This theme is a central tenet in feminism. I recognise the fact that the process of investigation can have consciousness-raising effects on subjects as well as on myself (Richardson, Fonow, and Cook, 1985). Feminist consciousness can serve as a source of knowledge and insight into gender asymmetry and its management in social life, as well as informing techniques to elicit data from respondents (Cook and Fonow, 1986). As a female researcher, I am aware of my double role as a member of an oppressed class (women) and a privileged class (scholars). This awareness enables me to explore women’s perceptions of their situation on an experiential basis (Reinharz, 1983). Moreover, crisis situations such as investigating a personal and sensitive issue like domestic abuse typically produce changes in participant’s consciousness. This increase the likelihood that the researcher and participants will relate during a self-conscious ‘click’ moment (Cook and Fonow, 1986). For example, if women become upset as they relate their experience to the researcher a rupture may be produced in their concealed life. These ruptures and self conscious clicks moments were useful in this study to expose the reality of participant
experiences and enable them to view issues in a different way (see 8.6). 
Consciousness-raising and social change are thus combined in this 
study as a source of political engagement and as a tool to identify limiting 
and facilitating factors for DV intervention (Cook and Fonow, 1986).

3. **Rejection of the Subject/Object Separation**: Epistemologically, a 
feminist stance challenges the norm of objectivity that maintaining a strict 
separation between researcher and research subjects produces a more 
valid account (Cook and Fonow, 1986). Instead, a stance that dialogue 
between researcher and the researched will accentuate the research 
process is upheld. This relationship has informed the entire research 
process, including the collection of data, formulation of second phase 
interview questions, interpretation of findings, and propositions for how 
results may be implemented (Allen, 2011; Fonow, 1985). Mies (1993) 
termed the bonding that exists between the researcher and the 
researched through this process ‘conscious partiality’. For example, this 
study challenged the objectivity norm by adopting one-to-one semi-
structured interviews. This ensures an interactive conversation with 
respondents and a (reasonable) balanced relationship by placing the 
interviewee on a more equal footing with the researcher. This embraces 
Cook and Fonow’s argument (1986) that a conscious bonding between 
the researcher and the respondent can make the interview process more 
productive for both parties.

4. **Examination of Ethical Concern**: The issue of ethics is a principal 
concern for research investigating vulnerable women. Among other
things, the misuse of language can discount or distort women’s experiences: for example, writing styles and vocabularies such as using male labels to group women, utilising masculine pronouns in writing and describing women’s experiences with offensive adjectives (Cook and Fonow, 1986). Furthermore, feminist ethics necessitate evasion of gate-keeping practices, particularly those that prevent publication of feminist research, knowledge dissemination and social change (Eichler, 1981). Mies (1983) noted that women should be made aware of policies and alternative ways of life that can liberate them. One way to ensure this is to send published documents to research participants so that they can read about their own experiences. The way this practice and other ethical considerations were upheld in this study is further discussed in chapter four.

5. **Emphasis on Empowerment and Transformation:** The ultimate intention of feminism is transformation and empowerment (Allen, 2011; Cook and Fonow, 1986). Although the researcher has to specify which facts from a research finding are necessary for change. Cook and Fonow (1986) identified the inherent attribute of the researcher as having an eye for transformation that is not conservative but portrays the subject as an actor. Consequently, Pagelow (1984) advocates target groups participating in planning and carrying out research on policies. She recommends that research on interventions for abused women should incorporate survivors of domestic abuse and staff who participate directly in their care as subjects. She argues that shelters for example is likely to provide a client population of women potentially available for study, while shelter staff are a vital source of information regarding organisational
characteristics relevant to the delivery of services for abused women. Methodologically, this implies that researchers should adopt techniques that will help subjects to confront their problem and formulate their own plan of action (Mies, 1983). This recommendation has been adopted in this study.

In conclusion, feminist principles are driven by an overarching interest in gender influence, power relations, social transformation, empowerment and ethics. As a study that focuses on vulnerable groups of women, this research has drawn on these principles to guide its methodology. Reflexivity is discussed in 4.13 as a quality criteria as well as a major principle that underlie feminist perspectives. The next section examines the meeting point of feminist perspectives and grounded theory research procedures.

3.7 Feminist and grounded theory: the meeting point

The complex nature of DV against women and its healthcare interventions has called for a challenge to move beyond the scientific method of enquiry to meaning construction to acquire knowledge. Constructivist grounded theory is particularly suited to knowledge development in this area. This is because individual experiences as well as the processes that underlie social interactions are identified, and they become a basis for action (Charmaz, 2006). Likewise, feminist inquiry has been valuable in developing knowledge that is both pragmatic and reflective of women’s voices (Campbell and Bunting, 1991).

Both feminist and grounded theory approaches have evolved in recent years, and both have been affected by postmodern turns. Their ability to respond to
contextual and temporal changes has maintained their importance to contemporary research. In particular, an epistemological affinity has been acknowledged between constructivist grounded theory and feminist inquiry. For example, postmodern feminist views of multiple constructs and contexts not only promote compassion and understanding, but are also compatible with constructivists’ interpretive roles (Charmaz, 2000; Schwandt, 2000). Plummer and Young (2010) identified six areas of theoretical congruence after examining the roots of feminist inquiry and grounded theory. They observed that both perspectives ‘value the central role of human experience in knowledge generation, both recognise that knowledge is generated through social processes, both define meaning through the interpretation of language, acknowledge the importance of reflexivity, both perspectives reject subject–object separation, and can promote social change’ (318).

Nevertheless, concepts are always shifting: the adequacy of models should be tested for usefulness in terms of: everyday problem solving aptitude; illumination of the phenomenon under study; and progression in meeting the objectives in view (Wuest, 1995). While feminist theory may not serve as a complete research method for the purpose of this study, its perspectives can augment grounded theory. Integrating feminist principles into grounded theory will enhance and serve the interests of women, since the particular issues of gender and power that influence their health experience and lives will be exposed. Understanding the life experiences of abused women from a feminist perspective recognises the pervasive significance of a gendered social reality that oppresses women. In addition, It provides the platform to acknowledge and
explore the effects of gender on the research processes and researcher alike (Wuest, 1995).

3.8 Chapter summary

This chapter has presented a discussion of the philosophical and theoretical foundations for this study. I have examined grounded theory, its variations, and criticisms. Also, I have justified the choice of constructive grounded theory and feminist perspective as this study’s theoretical underpinnings. Moreover, the fundamental components of constructive grounded theory and its quality evaluation criteria have been presented. These ideas have shaped each decision within the research design process. The practical application of the elements of the approach shall be discussed in the next chapter.
Chapter 4: Methods

4.1 Introduction

This chapter is concerned with detailed methods; it therefore begins by describing the design of the study, sampling principles and procedures, and inclusion and exclusion criteria. Following this, an account of the recruitment strategy, ethical and safety considerations, data generation, analysis procedures, and evaluative criteria for the study are discussed.

4.2 Design of the study

This is a qualitative study based on constructivist grounded theory approach. The study utilised individual in-depth interviews to uncover the complex experiences and views of various stakeholders regarding DV management. Participants included: ED staff (especially nurses); ED managers/matrons; survivors who have visited ED following an experience of DV; and co-ordinators of local DV services to which abused women are frequently referred. The interviews also provided avenues for exploring the policies, practices, and available resources for DV intervention within the department.

4.3 Setting and selection of the study site

The selection of the study sites was based on both the objectives of the study and on pragmatic factors (such as the distance to be travelled, cost, the willingness of key individuals to be involved in the study and the timeframe). Recruitment of subjects was a major challenge from the outset. Before the study began, the researcher contacted matrons of two EDs and three voluntary services to find women experiencing DV in Derbyshire. One ED could not
participate due to issues regarding relocation and inadequate staff. The second ED, which was the subject of the study, was an NHS Foundation Trust hospital in North Derbyshire. The department receives approximately 54,000 attendances each year and has a diverse range of attendees, including at-risk groups such as the homeless and ethnic minority patients. The department serves the local area and provides a full range of acute services, including 24-hour accident and emergency care.

Only one Women’s Aid centre in North Derbyshire consented to take part in the study as a research site for co-ordinators and women’s interviews. The centre covers a wide area, offering services to women and children irrespective of their age, ability, nationality, class, race, sexual orientation, or religion. The centre accepts referrals mainly from the ED chosen for this study, but also from other surrounding hospitals and general practitioners. It also supports women from outside the area who need to move to escape domestic abuse.

4.4 Recruitment and sampling procedures
Generally, participants were selected for this study purposively on the basis that they have the necessary experience relevant to the research questions. However, a sensitive research topic like DV comes with ethical and practical challenges: as a result, participant recruitment was given careful consideration. As the researcher is not currently working either with a support centre or within the ED, participants were approached in the first instance through the managers and co-ordinators of each organisation. According to Morse (1994:24), this lack of familiarity with the women or ED staff involved in the study is an advantage, as it reduces threats to the validity of the data. Managers and co-ordinators of
the two study centres were contacted and sent a written outline of the study. Before commencing recruitment, the researcher had a meeting with the women’s centre co-ordinators and the matron in charge of the ED regarding strategies for recruiting potential participants.

4.4.1 Recruitment of Survivors

Survivors were recruited mainly from the Women’s Aid centre. It was felt that recruiting from this centre would be appropriate since the centre is situated in the same town as the ED being studied, and receives hospital referrals mainly from there. Hence, sampling from this women’s centre is likely to create a more experientially homogeneous sample given their experience of the same ED. Potential participants included: women living in the refuge home; DV survivors, who are women who have passed through the refuge homes but still come to the centre for weekly counselling or social gathering; and other women who may still be living with the perpetrator of the violence, but visit the centre for counselling and advice. However, the co-ordinators advised that DV survivors who visit the centre for counselling and advice would be more likely to be emotionally prepared to share their experiences.

All potential participants were assessed for safety and suitability to participate in the study by the service co-ordinators. Potentially eligible participants were asked if they wished to receive an information pack following a detailed explanation of the study. Information about the study and invitations to participate were given in group meetings and on a one-to-one basis during visits to the centre. During such meetings, women were given the opportunity to meet the researcher and to ask questions to clarify issues regarding the study.
Interested women were offered an information pack at the centre and they were given a few weeks to carefully consider their willingness to participate in the study.

The recruitment period took about four months. During this period, interested women were asked to drop the tear-off portion of the information sheet in a labelled box provided in the centre. Based on the co-ordinators’ advice and the assessment procedure, some women were considered ineligible for the purposes of the study. This was because they either had ongoing relationship conflicts or were currently suffering from serious emotional distress.

4.4.2 Emergency staff recruitment

Following the trust’s research governance approval, the researcher was formally introduced to the matron of the ED by the research governance co-ordinator for the hospital. The matron organised a forum where the researcher delivered a brief presentation of the study to all members of staff. Following the presentation, the researcher distributed an information leaflet and staff were informed of the eligibility criteria for the study (to have worked in the department for more than one year). The staff were given the opportunity to ask questions regarding the study. Finally, interested members of staff were asked to drop the tear-off portion of the information sheet in a box, which was labelled and placed in a strategic position in the staff room.
4.4.3 Recruitment of ED managers and centre co-ordinators

In order to explore traditions and policies regarding DV intervention in the department, it was vital to identify those who could represent or speak for the department. Therefore, the ED matron agreed to participate, as she also manages the department. Likewise, co-ordinators at the Women's Aid centre who have expertise and were willing to take part in the study were selected following the preliminary introduction and meetings.

4.5 Sample selection and sample size

Selection of participants in qualitative research is driven by an interpretive logic that is based on the research’s approach and the questions that the study intends to answer (Manson, 2002). Selection of participants in this study was based on a theoretical sampling strategy; this is the grounded theory approach to sampling. It dictates that the researcher chooses those informants who have close experience of the social process under investigation ('experts') in order to provide the best data available. The major criticism of this type of purposive sampling is that the sample is biased by the selection process. While this criticism is valid, the purpose of using this method is to ensure that the bias is used positively to facilitate the research process (Morse, 1992). As a result, the sample was selected according to the participants' knowledge of the research topic, rather than sampling criteria such as age, economic status or level of education. Doing otherwise would negate the purpose of the research.

Sample size determination in qualitative study is generally far less prescribed. However, it can be affected by the scope and scale of the research, the
sensitivity of the area under study, the skill of the researcher and resources available (Mohrman et al., 2003). The initial interviews for this study were aimed at an average of 15 to 20 emergency staff and managers, an average of 15 to 20 women who had visited an ED following the experience of DV, and an average of 10 voluntary service co-ordinators. However, due to data saturation and other practical factors such as the availability of research participants (particularly women who have visited ED following DV), the total number of participants was reduced to 30. This included 14 emergency staff and managers, 8 survivors and 8 Women’s Aid co-ordinators. Broom, (2007) argued that the number of participants at which saturation occurs is not rigid in qualitative enquiry in view of the fact that the reliability and the richness of the reporting is more important than the number of participants.

4.6 Inclusion criteria

Inclusion criteria for emergency staff and managers included: their employment within the department (either male or female) and having worked for at least one year in the department, to ensure that that subjects were experienced in departmental practice and were likely to have interacted with DV victims. Managers were required to have enough experience to speak for the department as a whole.

Inclusion criteria for co-ordinators of the women’s centre included: holding a coordinating/managerial position and having enough expertise to speak for the organisation.
The inclusion criteria for survivors required participants to be adult women (aged between 18 and 65) who had visited ED following a DV incident. Other criteria included: having a good understanding of English; the ability to give informed consent; and the ability to successfully complete a safety assessment procedure.

4.7 Exclusion criteria

The exclusion criteria for emergency staff were unwillingness to participate in the study and having less than one year of work experience in ED. Managers who had no expertise/experience to speak for the department will be excluded. Exclusion criteria for co-ordinators of the women’s centre were unwillingness to participate in the study and having no expertise or experience with which to speak for the organisation.

Exclusion criteria for survivors comprised women below the age of eighteen; women who were unwilling to participate in the study; the ability to comprehend, and/or give informed consent; women who were not eligible to participate in the study either for safety reasons or because they were currently going through severe emotional stress; non-English speakers; and those who had special communication needs.

4.8 Ethical and safety issues

The primary ethical concern relating to researching DV against women is the potential for inflicting harm on respondents through their participation in the study (Ellsberg and Heise, 2005). Precautions recommended by the World Health Organisation (Ellsberg and Heise, 2005) for DV researchers were
followed in this study in order to ensure safety and minimise harm to respondents. The authors proposed that participating in a study could threaten the safety of abused women, especially if the perpetrator of the abuse becomes aware of their participation. As a result, potential participants, whether they were living in the refuge home or still with the perpetrator of DV, were assessed by the co-ordinators for safety before receiving the information pack and participating in the research. Women who were currently involved in an extremely dangerous conflict or who were being threatened by a spouse were excluded from the study.

Women who were willing to participate in the study following the safety assessment were given an information leaflet at the centre. No information packs were posted to any participant’s address for safety reasons. All potential participants had a minimum of four weeks to decide whether they were willing to take part in the study. All interviews were held in complete privacy, without the knowledge of the wider community. The researcher interviewed one person at a time and only the respondents and co-ordinators were aware of the time and the venue of the interviews. Interviews were conducted in a private room within the women’s centre for both survivors and centre co-ordinators.

The possibility of respondents becoming distressed by recalling painful or frightening experiences has been acknowledged by researchers (Ellsberg and Heise, 2005; WHO, 2002). These authors stressed the need for researchers to be prepared to handle such occurrences. In this study, the researcher had some training prior to the interview in recognising and dealing with participants’ emotional distress resulting from talking about DV. The Women’s Aid Advice
Centre agreed to take referrals and give support to women who might have experienced distress during the interview, creating a further safety net for participants. ED staff were also assured of confidentiality and support regarding their participation in the study. For service providers’ interviews, a designated private room within the ED was used for both staff and managers. The counselling service within the hospital was informed about the staff interviews; they agreed to take referrals and support staff if necessary.

4.9 Interview procedure, consent, and confidentiality issues

The information sheet described the elements of the study and gave sufficient information for participants to make an informed decision about their participation. The information sheet also emphasised the voluntary nature of the study, and provided the opportunity for potential participants to contact the researcher with further questions. All participants who both indicated their interest and satisfied the inclusion criteria were contacted for a discussion regarding the venue and time of their interview. The researcher met with the women and co-ordinators at the women’s centre while the staff and managers were met individually in the ED.

Before the start of each interview, the information sheet was read to the participant again by the researcher, and participants were asked to sign a written consent form only if they were willing to proceed with the interview. The participants were reminded of their right to refuse to answer any question that they were not comfortable with and also that they were free to stop the interview at any point. Each interview lasted around 30 to 60 minutes, and was designed to end on a positive note that emphasised the participant’s strengths.
Participants were served refreshments before and after the interview. Women received £5 reimbursement towards transport costs to the centre for the interview. Information about the study participants was kept confidential and managed according to the requirements of the Data Protection Act (2005). Data were stored in a locked cupboard and on an encrypted computer that was accessible only to the researcher. Only anonymised transcripts were shared with supervisors.

4.10 Data collection

Data collection was achieved by semi-structured interviews.

4.10.1 Semi-structured interviews

In view of the sensitivity of the topic and the researcher’s commitment to unveiling the complex experiences of service users and providers, in-depth interviews style were considered the most appropriate method. In-depth interviews have the potential to provide rich understanding of the participants’ perceptions, beliefs, and experiences (Bryman, 2001). This high quality of information, as well as great flexibility, makes this method suitable for interpretive inquiry. However, considerable knowledge of the topic is required on the part of the interviewer to facilitate the construction of interview data (Charmaz, 2006).

While focus group interviewing can facilitate disclosure (Smith, 2004), it was considered unsuitable for this research. The aim of the study is to unveil unique individual experiences. Focus groups may hinder this aim if a particular agenda or specific individuals dominate the discussion. As a result, group and individual
experiences and views may become muddled in the process (Memon and Bull, 1999). Moreover, considering the ethical aims of the study, confidentiality could be compromised. Additional practical difficulties may arise in scheduling meeting times and venues that will be safe and suitable for all those attending.

A semi-structured interview approach, as opposed to an unstructured one, was preferred so that the participants’ personal experience and concerns about DV intervention could be explored while allowing a modicum of standardisation in the interests of the research (Britten, 1995). Structured interviews may suppress the power of the participant during the interview process, which could inhibit the flow of communication. Semi-structured interviews, however, can provide avenues to explore unanticipated topics or insights, while ensuring that the interview process is guided by an overall goal and structure. In addition, preparing a guided topic list reduces the likelihood of asking inappropriate questions or using inappropriate language, which demonstrates the researcher’s sensitivity to the topic (Smith and Osborn, 2008).

Research questions were utilised as a guide to formulate lead questions, which in turn were used during the interviews (see appendix 3 for guide questions). Charmaz (2006) advocates that interview guide questions should not interrogate the interviewee. Instead, they should explore the research topic and harmonise with the participant’s experience. She further noted that framing of questions requires skill, practice and knowledge of the subject. Unlike positivist theory approach, constructivist grounded theorists utilise theoretical sensitivity (professional experience, expert advice and literature) to prepare interview guide questions. In this study, the professional experience of the researcher
and her diverse knowledge of the topic were instrumental in framing the questions. Guide questions were also reviewed with supervisors and submitted to an ethics committee for approval.

A conversational approach in combination with open-ended questions is believed to encourage a collaborative and open dialogue between the researcher and participants (Dearlly, 2005). Any leads opened up by the participant were followed where it was perceived to be important to the participant, relevant to their experience or related to the research questions.

Charmaz (2006) noted that the direction and content of interviews might be affected by dynamics of power, gender, age, race and professional status. While achieving an equal status with participants may not be easy, it is important for researchers to be open about their position both with participants and with themselves (Elliot, 2004). This awareness of power differences, especially when interviewing a vulnerable group on a sensitive topic, is essential for both reflexivity and rigour (Mills, 2007). However, conducting grounded theory interviews involves sharing knowledge: the site where the knowledge is constructed is the interview, and the researcher and the participants are co-constructors (Mills, 2007). Consequently, while the researcher should be aware of her influence on the data through thinking reflexively, the process is a reciprocal interaction. The result is a collaborative effort from both parties (Allen, 2011; Mills, 2007). Cooper has noted (1999) that giving participants time to reflect, ask questions and give informed consent before participating in interviews is a way to equalise status. Another way to achieve this is through discussing options for interview location and time.
However, after careful considerations and discussion with survivors, the women’s centre was agreed as the venue for all survivors’ interviews for reasons of safety and confidentiality.

The semi-structured interviews were recorded using a digital recorder. NVivo (a qualitative analysis package) was used to facilitate coding and management of data. In order to preserve the uniqueness of each participant’s experience, transcripts were sent to participants so that they could review or amend statements, provided that they agreed to do this. Also, initial interviews were reviewed with supervisors for support and advice on the process of analysis. The researcher transcribed the initial audio data herself. However, the services of a professional transcriber was later required as the number of interviews to be transcribed increased. The researcher listened to the audio-recorded interviews several times and compared them with the interview transcript to check for omissions. This process also started the process of identifying empirical indicators from the data. The analytical procedures followed in the study are summarised below.

4.11 Data Analysis

Grounded theory provides a step-by-step analytical tool through which theoretical understandings may be distilled from an enormous volume of data (see 3.5.4). The analysis of data in this study was guided by Charmaz (2003; 2006): this assumes that researchers contribute to the construction of participants’ realities through the processes of attributing meaning to their experiences and words. The challenge for this study is therefore to present these words and experiences as much as possible within a framework that can
be understood and utilised by people who have not directly listened to the participants (Charmaz, 2003). However, Charmaz suggests (2006) that constructive grounded theory methodology does not support a static reality. In other words, the presented reality is subject to multiple meanings and interpretations as the sophistication of evidence progresses.

I made efforts to remain true to the foundational analytical procedures of constructing grounded theory. Nevertheless, the stages and procedures are not rigidly fixed (Charmaz, 2006). Though it can be flexible, analysis is an iterative process; the movement back and forth from text to interpretation and construction helped to illuminate the core concepts and theoretical developments (Charmaz, 2006). The practicality of how the foundational stages (3.5.4) were employed in analysing the findings is discussed next.

4.11.1 Coding

Line by line coding, as described by Charmaz (2003), was employed in this study. Coding is fundamental to grounded theory’s analysis process: ‘just as the research participants construct the data, the researcher constructs the codes’ (Allen, 2011: 34). This process helped to generate the bones of the data from which a ‘walking skeleton’ later developed (Charmaz, 2003: 258). Firstly, I read the transcript several times to extract and determine meanings within the data. Codes are generated through the interpretative ability of the researcher which inevitably raises concern about my neutral stance in the process. Consequently, I maintained an awareness of my influence on the data through reflexive thoughts and annotations through the research process. QSR International’s NVivo8 software was used to code each transcript for initial themes (QSR
International, 2006). I combined this computer coding with a paper method: I wrote my comments, initial thoughts and themes behind each transcript paper in the form of annotations. I found this process useful in developing analytic insights as they came to mind. Smith et al. (2009) advocate the use of paper method for initial analyses in order to develop an instinctive grasp of the process and the data.

This process of coding led to the emergence of themes as I delved more deeply to understand, interpret and give meaning to the participants’ worlds and experiences. Charmaz (2006) describes this iterative process as interacting with the participants and subsequently interacting with them again repeatedly as we study their statements. The initial variables were written in short phrases that described the overall feature of each line-by-line transcript reading (see example in table 3 below). I labelled these short phrases that emerge from initial interaction with the data ‘concepts’.

**Table 2: Example of initial coding forming initial concepts (Extract from staff interview (P9))**

| The only thing really, because you can’t force people to have advice and … as much as we might see an unhealthy relationship, it isn’t our business enough to force somebody to leave unless it’s a criminal act or sectioning. It’s not something that’s relevant to our practice because they have to do it themselves because we haven’t got any support. Honestly, I don’t know that it would be worth the resources that it would have to | -NOT TAKEN ADVICE-FRUSTRATION  
-IRRELEVANT TO OUR PRACTICE,  
NOT OUR BUSINESS ENOUGH – RESPONSIBILITY SHIFTING  
-MAY NOT BE WORTH THE RESOURCES  
NEED ON CALL DV PERSONNEL  
MAJORITY COMING AT NIGHT |
have because you’d have to have somebody on call because it would be night times that we get the vast majority in anyway, and I don’t know that.

I think that could be addressed if we knew more about who to signpost to and who to get involved

I think because we don’t know where to point people to. We don’t have enough information on how to deal with it. We don’t get training on how to deal with it. For child abuse and all that sort of stuff you get it constantly, so you know which forms you fill in, who you send it to and all the rest of it, but for domestic assaults you don’t. I don’t think it would work in A&E because everything is too highly charged – the reason they’ve come, the damage they’ve got, they’re very high emotionally up and down, and they change their minds whether they want to stay or want to go because of all that

BARRIERS
-NO KNOWLEDGE OF WHERE TO SIGN POST THEM TO
-NO TRAINING
-NO FORMS TO FILL FOR THEM
-NO INFORMATION ABOUT HOW TO DEAL WITH THEM
-EVERYTHING IS CHARGED IN ED
4.11.2 Concepts and categories

Concepts are the names given to similar content in the data that allows them to be grouped together. This name or phrase captures their meaning in a more general way. More concepts are discovered as analysis continues. Once identified, concepts are grouped or classified, based on their characteristics, into categories. Categories in the data became evident as I compared concepts with concepts and asked questions about their relationship. For example: what is similar in this experience?; what are the experiences about?; what are they instances of? Similar categories, put together in a broad group called core categories, are a step closer to a more abstract theoretical framework which forms the basis for generating a theory. Essentially, the categories that fit together to form an explanation or a model are used to generate a theory. Table 3 below shows an example of similar concepts forming categories.
Table 3: Showing the development of categories from concepts

<table>
<thead>
<tr>
<th>Examples of similar concepts</th>
<th>Examples of categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suspicion rather than diagnosis: we take their word for it.</td>
<td>ED PRACTICE AND POLICY</td>
</tr>
<tr>
<td>• Disclosure and help-seeking pave the way for intervention</td>
<td>INDEX OF SUSPICION</td>
</tr>
<tr>
<td>• Standard practice is treat wounds, ask women to report to police if abuse is disclosed</td>
<td>NO DISCLOSURE, NO INTERVENTION</td>
</tr>
<tr>
<td></td>
<td>PREVILEDGING PHYSICAL CARE</td>
</tr>
<tr>
<td>Am I a victim of domestic abuse?</td>
<td>MEANINGS OF THE ABUSE</td>
</tr>
<tr>
<td>Putting up an appearance</td>
<td>DENYING THE ABUSE</td>
</tr>
<tr>
<td>Public and private self</td>
<td>LIVING WITH THE ABUSE</td>
</tr>
<tr>
<td></td>
<td>HIDING THE ABUSE</td>
</tr>
</tbody>
</table>

4.11.3 Theoretical sampling

Theoretical sampling is a process of data collection that is directed by evolving theory rather than by predetermined population dimensions (Strauss, 1987). It is a pivotal strategy in grounded theory methodology, and involves sampling additional incidents, events and activities (Charmaz, 2000). As concepts began to emerge in this study, tentative theoretical propositions were explored through additional instances of data. Glaser (1997) and Charmaz (2006) recommend theoretical sampling as a strategy for data collection. This could involve: staying open to emerging concepts by changing interviewing styles, sites, or
participants; following up recurring patterns in participant data; and asking key participants to give more information on categories that seem central to the emerging theory. Similarly, Draucker et al. (2007) suggested that theoretical sampling was said to occur when: firstly, interview questions are refocused to gain specific information regarding an emerging concept; secondly interviews are redirected as some categories became saturated and participants introduced new concepts; and finally interviews are modified to validate theoretical concepts. In this study, these strategies were espoused throughout. For example, the process of refocussing interview questions gained specific information that defined core concepts, resolved some queries and on which theoretical analyses were based. In addition, some participants were asked more information on key categories to draw out further information on key categories and for the sake of clarity.

4.11.4 Saturation and theory formation

The point of ‘theoretical saturation’ is reached when no new codes emerge from the data (Strauss and Corbin, 1998). At this point the presentation of data in the form of theoretical analysis is prepared, what Morse describes as ‘the sorting phase of the analysis’ (1994:33). The analytical process in grounded theory enabled me to engage with data, constantly comparing concepts to identify latent patterns in participants’ perspectives, staying primarily in the language of participants (Strauss and Corbin, 1990; Charmaz, 2003). This iterative process facilitates the convergence, reorganisation and relocation of themes. It allows themes to move from a lower level of significance to become major overarching
concepts that are rooted in tangible explanations of the data (Mills, 2007; Charmaz, 2003).

In addition, I used memoing as a tool to ask questions and establish connections between and within concepts emerging from the data. As I involved myself in these tools, actions and processes became clear, so that the study was moved from the level of simple description of concepts to the establishment of theories (Charmaz, 2006). This process is described by Charmaz (2006) as interpretive theorising. The aim is to articulate theoretical claims pertaining to the scope and relevance of the studied phenomena, while acknowledging subjectivity, negotiations in dialogue and an abstract understanding (Charmaz, 2006). Theory refers to a collection of explanations that attempts to examine and describe the subject of the research.

4.11.5 Recontextualising

One of the ways that grounded theory is judged for rigour and quality is by validating the theory against the data. I continued to revisit the data following theory generation to see if it the theoretical explanations satisfies the criteria for fit, understanding, transferability and usefulness (see also table 5 below). Morse (1994: 34) described this as 'recontextualising' and suggests it gives real power to this research method. This process demonstrates the usefulness of an emerging theory and tests its applicability and transferability to other settings (Morse, 1994).
4.12 Criteria for quality

The theoretical basis for the quality criteria adopted in this study has been outlined in section 3.5.4. Table 4 presents its practical application in the context of this research by providing a description of how the current study attempted to demonstrate grounded theory's quality criteria, as identified by Charmaz, (2006); Lincoln and Guba (2000) and Glaser and Strauss (1967). Following this, an evaluation of reflexivity as a quality criterion in this research project is presented.

Table 4: Criteria for quality

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Theoretical description</th>
<th>Practical demonstration in the study</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fit</strong></td>
<td>Demonstrate that the theory is applicable to and cover the data; fitness also draws boundaries of the theory</td>
<td>- Iteration throughout analysis</td>
<td>Glaser and Strauss (1967) and Glaser (1978)</td>
</tr>
<tr>
<td>Credibility and trustworthiness</td>
<td>Study and emerging theory demonstrate intimate familiarity with the setting and use sufficient systematic comparison to ground participants’ claims in</td>
<td>- Findings and data are adequate to merit the ultimate claim - Proposed theory is relevant to those experiencing the phenomenon</td>
<td>Charmaz, 2006; Lincoln and Guba, 2000</td>
</tr>
</tbody>
</table>
|          | the data                                                                 | - Proposed theory provides a workable understanding and explanation of the subject of the study
|          | - Demonstration that the findings and theory fit the substantive area of study |
| Originality and control | Demonstrated by the potential of the study to offer new insight that is able to extend, challenge, or refine current ideas, concepts, and practices while assisting development of hypotheses that should extend knowledge |
|          | - Clear demonstration that the findings provide new insight |
|          | - A theoretical explanation that demonstrates ability to ignite further research in other substantive areas |
|          | - Clear demonstration that the research contributes to knowledge in this area of study by extending and challenging current practice |
| Charmaz, 2006; Lincoln and Guba, 2000; Glaser and Strauss (1967) and Glaser (1978) |
| Resonance | Demonstrated by the ability of the study to provide analytical interpretations that portray the completeness of the |
|          | - Presentation of analysis is consistent with all the fundamental procedures of grounded theory research |
|          | - Detailed and well-documented analytical |
| Charmaz, 2006; Lincoln and Guba, 2000 |
| Usefulness and understanding | Demonstrated by the ability of the theoretical explanations offered to inform professional interventions that would be developed within the ED | - Presentation of theoretical explanations that reveal the generic processes of the study  
- Clear demonstration of its implications for practice  
- Show its ability to ignite further research in other substantive areas  
- Identification of relevance in practice  
- Dissemination of findings |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Transferability and Generalisation | The potential for the findings to be transferred to other settings; generalisation suggests that the theory is flexible in application as a general guide to multi-situation and changing daily circumstances | - Clear description of every process of the research  
- Demonstration that the findings bridge theory and practice by contextualising findings in light of practice  
- Clear demonstration that the findings serve as a guide to action, apply to |
4.13 Reflexivity as a quality criterion

Contemporary feminist researchers see reflexivity as encompassing moments when a researcher turns back experience on herself (Cook and Fonow, 1986). This instinctive action allows the researcher’s perspective to develop by recognising and exploring her contextual position, as an instrument in the construction of meaning. By reflecting on the influence of my social position, perspectives and presence, my examination of personal and interpersonal dynamics has promoted rich insights into unspoken stimuli and inherent prejudices in the research processes that may have otherwise gone unnoticed (Finlay, 2003). This insight has allowed a more transparent and empowering evaluation of the research processes.

Charmaz (2002) argues that in conducting grounded theory study, the researcher–participant relationship is a co-construction. As a result, researchers ‘may gain a processed understanding of how their research participants and they, themselves, construct meanings about self and subjective existence...’ (Charmaz, 2002: 306). Reflexive action has been identified as one of the common grounds for constructivist grounded theory and feminist perspectives (Allen, 2011).

Reflexive activity was incorporated throughout the research process by: writing memos; using annotations during analysis; and through reflexive journaling. I became more aware of my presence and participation in the research process. I
recognise the fact that I am entering the research field from a particular social position, and this position has implications for data collection and analysis. Reflexivity for me, therefore, has been an ongoing process that extends into the planning of the study, meeting gatekeepers of organisations, attending meetings with survivors, conducting interviews and writing up the findings.

Particularly relevant here is my ethnic background as an African female researcher. Meeting with people, such as gatekeepers (some of whom were male) and potential participants from different ethnic backgrounds to discuss and plan for the study took me out of my comfort zone. Such meetings seem to reflect perceived differences in colour, status, and sex. As a means to overcome the power differences that may affect research relationships, it is conventionally believed in qualitative research that the participant and researcher should be matched in terms of ethnicity, age, gender and social position (Hood et al., 1996; Mahon et al., 1996). Conversely, Mallory suggests (2001) that researchers should make efforts to explore the differences between themselves and their participants instead of trying to equalise distinguishing features. Additionally, Allen (2011) contends that believing power imbalances between the researcher and participant can be completely absolved within the short period of their relationship is naïve and unrealistic. She states that the researcher is a stranger who is seeking information about a sensitive and private issue. Rather, recognising the power imbalance and reflecting on it is a more honest approach.
Reflecting on my personal impact on recruitment following one of the visits to the women’s coffee mornings, I wrote field notes about what happened at the meeting and my personal presentation. Table 5 below is an extract from this:

**Table 5: Extract from field notes**

This is the first meeting, not knowing what and who I will be meeting, I dressed smart to portray myself as a responsible post-graduate student. The intention was to appear not to be too much of an outsider; not too different to the potential research participants.

However, I realised the class difference is apparent, as some women were reluctant to discuss freely with me...subsequent meetings, I will try to blend with the group by dressing casually for the next meeting; perhaps this may work. Or may be it’s my colour?....although it’s only the first meeting. One of the women asked me questions like ‘do you really understand what it means to be a victim of DV...? and I know you are not a victim of DV, are you? I had to answer that I am not a victim as the question was quite direct and she was waiting for my response. I said however I have been a DV researcher for few years and I quite understand what it means to be a victim. I am not sure of the effect this answer had on her.

Allen (2011) noted that interviewing is sometimes a more difficult task than researchers expect. Sometimes, a power relationship can be established as we hear or give professional interpretations to the narratives of participants (Black, 2007). This implies that interview data may become dominated by the knowledge of the researcher rather than that of the participant. It is imperative
that the researcher’s view of the world combines both insight and blindness, and this awareness must constantly accompany data collection (Black, 2007). According to the author, this is one way to avoid imposing professional interpretations on participants’ narratives. I think that using in-depth one-to-one interviews reduces the scope of the researcher’s ‘blindness’ while giving more opportunities for participants’ insights. Researchers must be willing to respond to participants in a manner that will promote bonding while simultaneously furthering the goals of the interview. Furthermore, Malory (2001) suggests that researchers must be willing to share their personal and professional values with participants in order to promote collaboration and demonstrate equality. Allen also noted (2011) that while sharing is good practice, the depth of what is shared is likely to vary from participant to participant. An extract from my field notes following my first sets of interviews (Table 6) describes how I have negotiated some of these complex dialogues.

**Table 6: Extract from field notes**

<table>
<thead>
<tr>
<th>Extract from memo of 1st interview day with abused women</th>
</tr>
</thead>
<tbody>
<tr>
<td>She asked if I have experienced DV before. I said no but I told her about my experience of witnessing DV as a child. I hope this helped to promote reciprocity.</td>
</tr>
<tr>
<td>My sensitivity to her emotional pain increases as I hear her stories. She spoke continuously, barely allowing me to ask questions. She said she is glad she could speak of her pain to someone.</td>
</tr>
<tr>
<td>I felt overwhelmed with what I’ve just heard… I had to speak to someone, called one of my supervisors, we spoke at length about the interview…think I feel better now, this</td>
</tr>
</tbody>
</table>
is really really difficult

Extract from memo of 1st interview day with A&E staff
Some agreed to use their lunch break time, quite impressive... surprised to hear some staff experiences, quite personal and private experiences were shared, maybe because I am a nurse or a DV researcher or somebody to talk to after all or the reassurance of my commitments to confidentiality...may be.

The second time the reflexive journal was used was during transcription. Memo-writing is an integral process in this research. It was a valuable, exciting and dynamic tool, as initial thoughts and ideas conceived about codes and their relationships were jotted down in my memo journal at the earliest possible time. Research progression and day-to-day activities were also recorded in paper journals before analysis began and on the back of transcript sheets during analysis. These annotations were later transferred and stored within NVivo 8 where they were compared with emerging themes at a later time (Charmaz, 2006).

Transcribing the first few interviews was useful but time-consuming. Listening to the recording stimulated reflection on the issues arising in the interview and helped to identify the need for more data collection. Charmaz described the practice well: ‘memos catch your thoughts, capture the comparisons, and connections you make, and crystallize questions and directions for you to pursue’ (2006: 72).
My earlier interviews showed commitment to listening and bonding. However as the interviews progressed, I began to balance listening and bonding with focusing on information that could answer the queries in previous analyses. This is because data collection and analysis are iterative procedures in grounded theory research. Moreover, by listening several times to the recorded interviews, the distance was narrowed between myself and the participants. This facilitated further understanding than possible during interview. Table 8 below shows an extract from my analysis journal.

**Table 7: Extract from analysis journal**

<table>
<thead>
<tr>
<th>Interview3- She said it’s all because of fear... also Interview 8-Staff said they are afraid things might go wrong, not knowing how to help, of asking a sensitive or private question, of getting into trouble, women getting offended and not knowing how to help.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing is achieved as women will deny abuse and probably go back</td>
</tr>
<tr>
<td>No protocol to follow, No training received, Not aware of services available, Not confident about helping...</td>
</tr>
<tr>
<td>How is women’s fear related to professional’s fear? How can this fear be eliminated or perhaps reduced, maybe let each party know they are both afraid. Afraid of what? How will that help both parties? Trust versus fear- maybe trust building? How?</td>
</tr>
</tbody>
</table>

It is realistic to assume that in constructing participants' experience, interpretations are modified by the impressions of the person collecting and analysing the data. Since data cannot speak, it has to be interpreted by the researcher (Charmaz, 2006). Complete objectivity is therefore, unlikely.
4.14 Chapter summary

The constructivist approach to grounded theory and a feminist perspective adopted in this study have facilitated a researcher-participant discourse that is transparent, dynamic and recognises both parties as co-constructors of knowledge. It is hoped that this sensitive and complex subject has benefited from the choice of methodological approach; hearing the voices and experiences of abused women and health providers may help inform the development of professional interventions.

My reflection is a product of the recognition of the effect that my background, biases and values may have on research. Using a reflective diary, memoing and annotations, I have been able to recount some subjective interplay within the research process. While matching differences and becoming an insider may not always be practicable, despite commitment to equality and collaboration, the incorporation of reflexivity into this research process has increased trust and disclosure, and consequently validated the findings (Malory, 2001, Hall and Callery, 2001; Allen, 2011). The next chapter presents the findings of the study.
Chapter 5: Findings

The purpose of this study is to qualitatively explore the development of domestic violence (DV) intervention in emergency departments (ED) from the distinct perspectives of service users, service providers, and co-ordinators of voluntary organisations that works to prevent DV. The findings are reported in three chapters, each discussing the meanings elicited from these three groups. The first chapter focuses on findings drawn from interviewing women who have used the ED following incidents of DV while the second chapter focuses on the interviews with staff and managers of the ED. The third chapter examines the interviews with voluntary agency co-ordinators and also identifies and explores overlapping concepts across the groups. Participants W1 to W8 make up the participant group of abused women, P1 to P14 comprise emergency staff interviewees, and the voluntary agency co-ordinators interviewed are labelled C1 to C8. The following section discusses the findings from survivors’ interviews.

5.1 Survivors’ interviews

Eight female survivors of DV, who have used EDs in the past as a result of one or more incidents of DV, were interviewed. The aims of the interview were as follows:

1) to explore their experiences as survivors of DV;
2) to examine their experiences of using the ED as victims of DV;
3) to identify the barriers they experienced when seeking help in the ED;
4) to explore their expectations of DV intervention in the ED; and
5) to explore how they expected to be treated and their perceptions of treatment options, as well as the identification of the level of support that is acceptable to them.

Table 8 shows the basic characteristics of the participants.

Table 8: Basic demographics of survivors

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age range</th>
<th>Marital status</th>
<th>Ethnicity</th>
<th>Type of abuse</th>
<th>Reason for ED visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>25-35</td>
<td>Separated</td>
<td>Black British</td>
<td>Emotional/controlling</td>
<td>Stress related problems</td>
</tr>
<tr>
<td>W2</td>
<td>45-55</td>
<td>Divorced</td>
<td>White British</td>
<td>Verbal/emotional abuse</td>
<td>Frequent asthmatic attacks</td>
</tr>
<tr>
<td>W3</td>
<td>45-55</td>
<td>Divorced</td>
<td>White British</td>
<td>Psychological/emotional abuse</td>
<td>Stress induced heart problems (atrial fibrillation and flutters)</td>
</tr>
<tr>
<td>W4</td>
<td>35-45</td>
<td>Separated</td>
<td>Black African</td>
<td>Control, verbal abuse</td>
<td>Palpitations, hypertension, depression</td>
</tr>
<tr>
<td>W5</td>
<td>35-45</td>
<td>Divorced</td>
<td>White British</td>
<td>Physical and psychological abuse</td>
<td>Physical injuries</td>
</tr>
<tr>
<td>W6</td>
<td>25-35</td>
<td>Separated</td>
<td>Black Caribbean</td>
<td>Physical, verbal, sexual, and emotional</td>
<td>Suicide attempts (Unconscious)</td>
</tr>
</tbody>
</table>
As indicated in table 8 above, majority of this participants group falls within the middle age group, all the women are either divorced or separated and the reason for ED attendance for the participants was unrelated to direct DV incidence (the implications of this is further discussed in chapter 8).

The main concepts that emerged from analysing the survivors’ interviews are as follows:

- Living with abuse: survivors’ account
- Help seeking: the role of fear and other barriers
- Intervening in DV: what women want

Each concept has its own categories and properties. It must be noted here that some sub-concepts appear repetitive: this is because they are interrelated and interdependent. These concepts are discussed in the following sections.
5.2 Living with abuse

A dominant subject which emerged from survivors’ accounts was the various behaviours deployed to conceal abuse, cope with it, and maintain ‘normalcy’ when visiting EDs. The range of meanings attached to DV also contributes to a more complex understanding of abuse and survivors’ responses to it. For example, most survivors’ accounts exhibit a lack of awareness of the different forms that abuse can take and the various ways in which it is labelled. This has implications for their perceptions of themselves as victims, the choices they make, and their attitudes to seeking help. Five sub-concepts were identified within this concept:

- Experiencing DV: Am I a victim?
- Public and private self;
- Internalising and concealing abuse;
- Maintaining societal expectation of ‘normalcy’; and
- Being perceived as a ‘medical customer’.

5.2.1 Experiencing DV: am I a victim?

The question ‘Am I a victim?’ points to patterns in the accounts of survivors that reflect their inability to accept themselves as victims of DV prior to getting help and education from women’s centres. Most people’s understanding of DV privileges its physical aspects, so it is not surprising that women did likewise. Sharing her story, W2 said:

No, because I didn’t even recognise myself as being a victim of DV … because I’ve never been hit. I’ve never been attacked or anything like that … I never
thought about the emotional side as being DV ... domestic abuse was being physically hurt ... that's what I thought in my head DV was ... until they (Women’s Aid) began to tell us what domestic abuse is and that it’s not just being hit (W2).

For some women, partners and husbands’ good behaviour in other respects seemed to excuse their controlling behaviours:

All I knew was I was unhappy and my life wasn’t right. But if somebody had said to me ‘Are you a victim of DV’ I’d have said, ‘No, he never touches me. He’s never raped me. He’s never hurt me physically. He’s a good husband in a lot of respects’. But I didn’t look at the controlling behaviour, and belittling you, and swearing at you, and shouting at you and pulling you down as being domestic abuse (W1).

A limited understanding of what constitutes DV made many participants delay seeking help. Five of the eight women interviewed said they sought help from Women’s Aid because they felt things were not right in their relationship and/or in their health, they could no longer cope and they were desperate for change rather than because they thought they were victims of DV:

It was only the realisation that I could not be well and healthy for as long as I stayed in it [the relationship] (W3).

My husband’s behaviour had escalated to the point where it was literally like sitting on a volcano. I couldn’t stay anyway (W2).
It appears that escalation of abuse, feeling unable to cope any longer, and no longer wanting to live with their husbands often pushes victims to the point of relocating or moving out. One of the survivors described how a housing officer helped her by referring her to Women’ Aid:

I thought I was coming down here just to talk to somebody else about being re-housed … and she knew exactly why this man had sent me here [to Women’s Aid], and I just started crying and everything came out: years and years of pent-up feelings. And she just said, ‘You’re a victim of domestic abuse and you don’t even realise it’ (W4).

Another participant said:

I didn’t realise that I was up there for this specific reason at the time … because I couldn’t cope anymore and I didn’t want to live with him. It’s only since I’ve been in the refuge I’ve realised why these things have happened to me. Yes, because I didn’t class myself as a victim of DV … It’s abuse and control in my case (W8).

Even after receiving help, it seems easier for some survivors (such as W8 above) to call their experience abuse and control rather than DV. Some participants may have interpreted the term ‘violence’ differently, including being hit, raped, slapped, or hurt. Others find it difficult to accept the identity of a ‘victim’ and the connotations of being a ‘DV victim’, particularly in relation to societal interpretations of this concept. This has implications for the way survivors comprehend themselves and their role in conforming to societal expectations, as discussed in the next concept.
5.2.2 Public and private self

This concept describes the various strategies that survivors employed to keep abuse from entering the public domain. Participants’ accounts show that abused women present an appearance of normality in public as a way of protecting their dignity:

I was good at hiding it … part because I think I need to put up an appearance and let everyone believe I’d got a fantastic marriage (W1).

Survivors cover up abuse using a variety of tactics, including lying about the cause of their injuries and pretending that the reason for their visit is unrelated to domestic abuse. Covering up abuse is a way of protecting themselves and their husbands:

That’s why women lie when they go to hospital. They’re protecting their husband but they’re also protecting themselves (W5).

Loyalty. No matter what you’re going through, for some benign reason you still feel loyal to your husband and you don’t want to be disloyal to him and admit that you’ve got a problem. You don’t want other people to know that he’s a bad husband (W6).

Other participants also attributed this spontaneous defence of the perpetrator to the fear of being a failure and the fear of people knowing that you are a victim:

I think it’s fear of people knowing what you’re going through. You don’t want to admit it to yourself. You don’t want to admit to other people that you’re a victim of
control or abuse … It’s not just the physical side, it’s the emotional side of not wanting people to know if you’re not coping (W2).

You feel like a failure. You don’t want people to think of you as a failure because that’s what you already think of yourself (W8).

Feelings of failure in relationship roles were commonly experienced by survivors. This sense of inadequacy was expressed not only by hiding abuse from public scrutiny: it extended to taking responsibility as the cause of abuse. As a result, the complex dynamics of experiencing abuse become internalised, which affect different areas of the women's lives and are influential at different stages of abuse.

In the early stages of an abusive relationship, women feel obligated to stay with their partners because they control access to resources, such as the home and money. Over time, they eventually internalise a sense of worthlessness, having been repeatedly treated as valueless by the one person who is expected to love and cherish them.

That was my mistake, I wouldn’t do anything about it ... he pays the bills ...

Instead I begged and pleaded with him to stop, plus I don’t want to be the bad wife, but he was having none of it (W7).

Victims perceive the withdrawal of love and its replacement by abuse as punishment for their inadequacies, for which they accept the blame. One of the implications is thus to displace responsibility from the perpetrator onto the victim:
After some time you feel that it’s you that’s the bad woman that’s not giving him what he wants … and I wouldn’t do anything about [the abuse] (W7).

I know for me it was the thought that I was always making this happen, and if I was a better wife, if I was more understanding I wouldn’t wind him up. He wouldn’t get to that point (W5).

The participants’ stories indicate that they see keeping their home at all costs as their duty. The price they pay to ensure that this responsibility is fulfilled is to continue to tolerate abuse from their partner. They blame themselves when things go wrong and believe they deserve their partner’s abusive behaviour. One of the participants felt that she was responsible for the problems in the relationship because of the strong influence of her partner:

They’re such strong characters … the other thing that these men are good at is convincing the woman that actually, yes, it is all her fault and so it all becomes a very nasty downward vicious spiral (W3).

It appears that the controlling behaviour of the perpetrator creates a distortion in the way women perceive their self-worth. In addition, survivors experience contradictions inherent in presenting themselves as ‘normal’ when their interior selves are so completely destroyed. Without doubt, it must be stressful to manage these two ‘personas’:

It stripped me more of my confidence and my self worth, and I think that’s what I tried to cover up (W5).
That's what it does to you because it makes you feel less of a person and less in control. It doesn’t take much, but it’s the consistency of what they’re doing and saying to you (W6).

For some participants, verbal abuse not only affects their self-esteem but also renders clear thinking impossible:

Because he’s already messed with your head. He’s messed you up here [pointing to her head] already, so you’re in a fog. You don’t even want to admit it to yourself, let alone somebody else. It makes you feel less than a person (W4).

The process of internalising self-blame, as a result of consistent verbal abuse, is further illuminated in this account:

‘What’s up with you now?’ And I must have heard that 500 times in my marriage, just that sentence ‘Well, what’s up with you now?’ ... After years and years, 30 years of it, you know, it’s me that’s got the problem (W4).

This participants’ account demonstrate how certain words or gestures may continue to trigger fear in the woman, even in entirely unconnected situations. In their opinion, emotional and verbal abuse is more insidious than physical abuse:

The physical effects are quite different and easier to manage because for me the anxiety level is causing quite serious heart problems, which could result in blood clots, stroke, thrombosis, you know, that kind of thing. That is as big a physical danger as being beaten up (W3).
This participant further noted that intelligent men can use glib words to convince their partners that they are at fault. These men are clever enough not to resort to physical violence except as an extreme measure of control:

Middle class men in managerial positions … are very intelligent, well educated and they have a complete arsenal to drive wives absolutely barmy and to the point of hysteria, anxiety, without actually causing a physical problem, they only resort to actual physical violence, for instance, broken arms, et cetera, if there’s no alternative. So it’s [emotional and verbal abuse] more underground. It’s more difficult, and I believe it’s more deadly in a lot of ways (W3).

Perhaps this relates not only to intelligence. Unequal gender relations can give men permission to exert control in their personal relationships. Concealing, internalising, and accepting the blame for abuse is thus a way for survivors to maintain sanity and manage their roles in public life. They have suffered years of conditioning to make them believe that they are at fault, hence their need to suppress their supposed insanity and avoid public ridicule. From this perspective, it is easy to realise how nondisclosure becomes a coping strategy. It avoids perceived consequences of abuse, not only from the perpetrator but from the public. This is discussed in the next concept.

### 5.2.3 Maintaining societal expectations of ‘normalcy’

Some survivors felt that concealing abuse is more important to women of certain social standings. One of them felt that women like herself could not openly discuss DV because of social expectations to appear as an intelligent and equal partner in a relationship. For this participant, women who are well educated and from well to do backgrounds do not complain about their rich
husbands. They have to consider the possibility of exclusion from their social circle as well as the consequences from their partner if they divulge their experience of DV:

One of the reasons for going to A&E and hiding the cause ... two reasons ... partly fear of husband’s reaction that you are disrupting life and causing difficulties, and drawing attention to yourself, the other is very hard to explain, but you’re not only brought up all your life not to make a fuss, not to talk about problems, not to talk about issues. You don’t want anybody to know that there’s a difficulty or a problem, you don’t want to complicate issues for yourself (W3).

I almost grew up with this view of, well, it’s okay for me because I wasn’t dragged up. I did have an education. I did have a profession and a career. I do have a good lifestyle, so I have to put up with what goes – with whatever’s happening (W3).

Another participant felt that such women receive less sympathy from society (including the health professionals) because of their ‘fortunate’ background:

Also, sometimes there’s that society’s attitude ... and also there are less sympathetic attitudes towards women who are fairly well-off, and that is a fact ... You have no financial difficulties. You have holidays abroad whenever you want them. You’ve got a perfect lifestyle. What’s your problem? Why would you want to leave that? Just put up with it and keep quiet. And so all of this comes together to make you cover up (W8).
The survivors’ accounts revealed some commonalities with regard to the stereotype of an abused woman and how difficult it is for women outside that status to complain or disclose DV. It is evident from their statements that the fears of reprisals and being socially ostracised eventually lead to a sense of inadequacy, which makes survivors avoid any relationships with the outside world (including health professionals):

I’ve got to keep this pretence that everything is fine and that I simply had a simple car accident. It wasn’t because my mind was in such a state because I was frightened of what would happen when I got home. I’ve got to keep a lid on it because what is the alternative? And that’s quite frightening. So you want to cover it up because you don’t want anyone to know (W8).

There’s nothing you could do, and what happened to me bore it out that I ended up with no choice, because I will cause utter horror amongst friends and family ... people like me don’t do that, only those stereotypical girls that we’ve talked about (W3).

The survivors told how stereotypical expectations of abused women worsened the likelihood of them disclosing their abuse to ED staff:

The attitude towards women is frequently, particularly middle-aged middle-class type women ..., ‘Dizzy cow wasn’t thinking what she was doing’, and ‘Oh, it’s menopausal’, or ‘Oh, she’s got PMT’, and I think society supports this view because it’s quite endemic in society to assume that women, particularly of a menopausal age are all barmy anyway. Part of menopause is going loopy. It’s nothing to do with the man orchestrating it (W8).
I’ve got this history ... husband saying this is part of her mental health problem because by the time a woman is actually at this point maybe needing to be sectioned or needing very serious mental health intervention ... So by that time the wife is talking about it, which is a miracle if she did, well, you know ... nobody is going to believe what you are living with at home, and I think a lot of mental health and depression issues for women stem from this (W4).

It is interesting that some abused women are misdiagnosed as having mental health problems, including depression, while the underlying problem is not identified. It may be argued that the ED is set up for urgent care: uncovering the aetiology of symptoms is not always in their remit. However, this indicates the importance of routine DV assessment within EDs as some women will present with symptoms different to health workers’ expectations regarding symptoms of DV. The attitudes of health workers are further revealed in the next concept.

5.2.4 Being perceived as a ‘medical customer’

The interaction between the emergency staff and women experiencing DV was expressed in survivors’ accounts. They seem to show that abused women are seen and treated as patients with limited needs (usually physical): staff rarely attempt to look beyond the injury presented, preferring to terminate the transaction quickly in order to meet departmental targets. While acknowledging that treatment of physical injuries is important, women in this study believed that nursing care should be more holistic:
You feel like a customer, more or less, rather than a patient that’s got feelings and needs and wants … They should treat you as a person and that means you should be looked after in total … not just look at your physical health (W2).

Another participant said:

They were just like medically-led making sure that my liver was okay because of what I took … Yes, just my medical because obviously whatever he’s told them, they believed him, but nobody come up and spoke to me. They turned round and said they’d done some blood tests to make sure I’d not damaged my liver … It would have been nice if someone could be there for me, just supportive, talk to me… ‘Are you okay? What happened with your eye? What made you take an overdose?’ (W6).

Similarly, another survivor detailed the failure of emergency staff to look for an underlying cause for her condition:

They’re already professionally minded … but the only thing I cannot understand is why they did not find out why these asthma attacks are happening. There’s a trigger with every asthma attack. Mine was stress, and they admitted it is stress-related asthma, so what was the stress that was bringing it on? Nobody tried to look for the source (W2).

Within this theme, another participant attributed the poor relationship between the emergency staff and abused women to the environment of the ED. In her view, the context of the ED dictates both the relationship and responses of staff and abused women:
Once you get to A&E and you’re on that stretcher, or cart, or whatever, it’s a clinical surrounding … There’s machines, there’s doctors and nurses coming in and out. There’s curtains being drawn and you just feel institutionalised … you don’t feel relaxed and comfortable enough to be talking (W7).

A majority of participants expressed dissatisfaction at the failure of emergency staff to take a proactive stance on DV. They felt that intervention in the early years of an abusive relationship could have made a significant difference to their quality of life, possibly breaking the cycle of repeated hospital visits following incidents of abuse:

So I’d gone backwards and forwards to A&E … where I used to live, having tests and investigations to try and find a cause for the problem … But nobody at the A&E going backwards and forwards for those tests actually said ‘If you’re not drinking, there’s no thyroid problem, there’s no problem with your heart, the Echo’s are clear. Is there something else?’ … That simple question could have made a difference maybe two or three years earlier, but nobody actually picked up on that (W3).

Treating the asthma and sending you back and wait for it to happen again … That would have saved them time, saved you a lot of time and problems as well … I just think of all the years of medication that I don’t need now (W2).

If I had the opportunity at A&E then I could have got out a lot sooner … I hadn’t made any plans to go, but the previous night he threatened to kill me and enough was enough. It scared me too much … and I didn’t know which way to turn, who
to turn to, because he would make people think that I was the liar, I was the bad person and that he’s my goody two shoes (W6).

Some survivors expressed the view that the insensitive attitude of emergency staff made it impossible for them to discuss private issues like DV. In their opinions, emergency staff members need to be more friendly and approachable before women would feel comfortable enough to disclose abuse:

So as an A&E worker for me personally you’ve got to be more approachable, more friendly, and not just medical, clinical … You’ve got to extend your role … so I think the job needs to be extended as a more interpersonal kind of relationship … which will make people feel a bit more comfortable to open up (W5).

The attitude of the doctors and nurses was quite insensitive … I can’t [open up] … I mean I never say never, but I can’t imagine it, but I think that’s because of how A&E is … you come out of there and think ‘If they’re like that with this and this is just my [arm] … what are they going to be like with stuff like DV?’ (W7).

They need to make you feel more like a person than just a number coming through on a conveyor belt. You don’t feel as if you can open up because you’re just answering stereotype questions very often (W2).

One of the survivors gave an account of her visit to the department following an overdose and explained how she would have opened up if somebody had asked her about DV in the absence of the perpetrator:
One night when he wasn’t around I ended up taking an overdose because I had enough and I didn’t know how to get out, and he kept threatening that he was going to kill me … so the other way out was to take tablets. I wasn’t intending to kill myself. It was more of trying to get someone to listen to me, to help me … The paramedic said it was attention seeking … he said to me why did I do it? And I just turned round and said, ‘I don’t know’ because I didn’t know what to say to him. I couldn’t turn round and say ‘You put me in this situation’. If I had the opportunity when he left, if I had the opportunity to speak to someone about it or someone came out and asked me what happened to me, to my eye or anything, because obviously he’s gone and told them whatever he’s told them, but nobody came to me to ask me (W6).

As the first contact for health emergencies, abused women acknowledged that they go to the ED as an indirect means of attracting assistance. To the survivors, this is not attention seeking, but a way of communicating their need for help. Although the survivors agreed that they are unlikely to open up straight away, they expect health workers to understand and make an effort to overcome these barriers. Women also acknowledged that staff members are not mind-readers, but they expect staff to have the confidence to inquire into the root cause of their visit:

This is the thing as well because it’s difficult with DV because unless you open up and are ready to expose it, you can’t reap the help in some ways … because they’re not a mind reader… but as people working in health industries, they should have knowledge about these things and be aware that people are scared to talk about it especially when the man is there (W4).
There appears to be a disparity between these women’s desires for emergency staff to be proactive regarding domestic abuse and their own reluctance to disclose abuse. On the one hand, the women want the abuse to stop, but on the other hand, they are afraid and ashamed of telling anyone. In view of this dilemma, and given the practicalities of the ED, it might be understandable for staff to be confused and frustrated. Even if staff should find the time and sensitivity to address such dilemmas, it is unlikely that victims would immediately respond to these efforts, given their poor self-esteem. These issues relate to the complexities of DV intervention insofar as there are difficulties for ED staff in identifying and meeting the needs and expectations of abused women. Evidently, there is a need to weigh the meanings and the expectations of health providers against their professional competence. This will negotiate an interface between health providers and victims that is discernible in the practice of ED staff. These issues were highlighted when survivors discussed barriers to seeking help, as presented in the next concept.

5.3 Help seeking: the role of fear and other barriers

It was also informative to isolate specific factors that stop women seeking access to services. Earlier sections of this chapter explored a number of factors embedded in women’s experiences including perceived inadequacies; their expectations of ED services; and varying concepts of the nature of DV and victim identity. However, the barrier concept identifies an overarching theme of fear in the women’s accounts. This permits fruitful exploration of the reasons women fail to obtain the help they need to deal with an abusive relationship. Sub-concepts discussed within this main concept include the following:

- Domestic violence and fear;
• Stereotyping the abuse; and
• The ‘ED milieu’.

5.3.1 Domestic violence and fear

Fear was expressed in a number of dimensions: fear of the consequences of seeking help; fear of the perpetrator; fear of not being believed, and fear of not getting help even after disclosure. Survivors also expressed the view that seeking help from health professionals may have repercussions for themselves and their children. Some participants worried about the involvement of social services and the possibility that their children might be taken away from them. Others were more concerned about the effects that disclosing abuse might have on their life, finances, and family relationships:

The root is fear, where do I put my child … Which is fear, isn’t it? That’s just my simple way of explaining it. I know you probably want me to explain it in more depth (W1).

Yes. What will people say if they find out that I’m experiencing … in this relationship … Fear of what people will say. How will people see me if I tell them what I’m going through? (W5).

Fear of different things … Fear of the change and not being able to handle it … how do I keep up with my finances if I left this man … and the help is not there (W6).
Another major fear expressed by the participants is the fear of not being believed and therefore not getting help. It appears that some of the survivors initially felt that not much can be done to help their situation, so saw little point in seeking help:

I felt I can’t get any help. Nobody will understand … you have a husband… who is the manager of a large engineering company, well respected, go ahead, you know, nobody is going to believe what you are living with at home (W3).

A highly respected police officer, well up through the ranks … Who is going to believe that this man is behaving in this manner behind closed doors? Nobody is. It’s just going to reinforce the impression that this wife is cuckoo (W4).

My fear also was even if I talked to somebody … Who’s going to care or take any notice, and what help would I get? And what would the end result be? (W8).

The prospect of financial difficulties and economic changes resulting from disclosure, either through reprisals from the perpetrator or through having to leave the family home, creates a powerful deterrent for women to seek help. This may be particularly true of women who are accustomed to an affluent lifestyle:

The worry for somebody like me, while I was still teaching, my husband wasn’t quite as bad and I always felt I had a backdrop. But once I’d retired and became financially dependent, which a lot of women are, then there was that ‘But I’ve got to live with this. I’ve got to cope with it because what can I do and where can I go?’ (W3).
Because my perception was even if I talked to somebody about what was …
Who’s going to care or take any notice, and what help would I get? I had no
money, will lose my lifestyle, friends, family support … that is very, very
frightening (W6).

It appears that the fear of being alone and the potential prospect of poverty or
financial uncertainty kept many of survivors in abusive relationships and often
prevented them from taking any major steps to get help. One of the survivors
gave an account of how her fears became reality when she eventually sought
help:

All the friends I’d had for years, and a lot of them connected to my husband
professionally too, which doesn’t help, and a lot of my family were horrified that I
actually left my husband and went into a refuge. People like us do not do that sort
of thing. It isn’t cricket. How could you show the family up? ...And so there’s this
horror of you’ve got to keep the status quo (W3).

The fear of fracturing family bonds and long-term social relationships appears to
complicate decision making for abused women. Feeling that you are the cause
of family discord makes it hard for women with active social lives, especially
where they are tied to their communities or have an accustomed role with the
perpetrator in social events. It is doubly painful to be rejected not only by her
partner but also to be rejected by the very people she relied on to ground her
social existence. The majority of the participants felt that the experience was not
pleasant as initial fears proved well founded. They suffered loss of friends,
financial difficulties, and lack of family support. One survivor claimed that fear of her husband’s victimisation was confirmed when she left him:

Yes. I’ve also been through the most appalling experiences with a very vindictive husband whose attitude was ‘You’re going to leave me. I’m going to make sure you pay for it’...(W4).

While these fears mean that women sometimes prefer to endure abusive relationships, survivors’ accounts show that intervention from Women’s Aid made a positive difference to their health and general quality of life. These issues are further discussed within the core concept of what women want from intervention.

For me, the support from Women’s Aid made it possible, but the support is not out there for you (W4).

A distinct underlying sense that women want the abuse to be discovered emerged from their accounts. Clearly, interaction between health professionals and abused women should focus on empowerment and support for victims, to reduce their fears until they reach a point where they are able to accept help. Further issues around the need for staff to be aware of their own prejudices about DV are identified in the next concept.

5.3.2 Stereotyping the abuse

As discussed, some participants felt that emergency staff members make stereotypical assumptions regarding ‘typical’ victims of DV. Some survivors felt
that when women who fit this stereotypical image (specifically, poor, working class, uneducated) present with what are considered orthodox symptoms (for example, black eyes and other visible injuries, obvious wretchedness, and emotional disturbance), then abuse is quickly diagnosed and the sympathies of staff are extended towards them. One participant reported that domestic abuse is less obvious to ED staff when dealing with middle-class women:

I think in A&E if a woman is coming with obvious physical injury that doesn’t tally up with the reported apparent accident then in A&E people will pick it up fairly quickly. But there are women like myself from a different type of background where the damage is less overt. It’s less obvious, and the signs are probably less obvious, but to me equally apparent if you know what you’re looking at (W6).

Another survivor had a similar view:

I think recognising these things is the first stage … to pick it up in women like me, I’m possibly slightly underweight, I’m extremely fit and healthy, I always had a superb diet, I’m well educated, et cetera, et cetera, so this stereotype of somebody overweight with a poor diet and from a poor background, so what’s going on here? We’re not fitting in (W3).

Some survivors described some of the expected stereotypical expectations of abused women:

Often somebody who has had a deprived background and has a lot of deprivation, a lot of financial difficulties within that relationship, a husband who is on benefits, or partner on benefits, drinking, also into substance abuse, taking it out on his wife, hitting out. This is the stereotype that they [ED staff] have and
there's a lot of women who are from completely different backgrounds who don’t have those obvious signs (W4).

You get an 18/19-year-old pregnant girl from a deprived background who has probably been through the refuge system with her own mother and instantly people see and want to help. You get a 50 year old lady with a husband as high as this one that I’m thinking about, no shortage of money, professional job herself, expensive car, you know ‘Dear, dear, poor woman is losing her hair, ha, ha’. This is the kind of attitude you get (W3).

Survivors posited that women who do not fit the stereotype had no choice but to cover abuse. For these women, it is important that emergency staff are aware that DV is not restricted to obvious physical injuries or specific cultural, class, or educational backgrounds. There is a need for staff to be highly skilled in recognising domestic abuse in all social and cultural settings and for them to be aware of their own cultural prejudices about DV. Moreover, the context of EDs may exacerbate women’s fears and thus present barriers to disclosure and intervention. This issue is examined in the next concept.

5.3.3 The ‘ED milieu’

The environment of the ED itself emerges as a barrier to intervention and disclosure. In particular, the lack of privacy, swift patient processing, and crisis-oriented response shapes attitudes, resulting in a tendency towards non-disclosure on the part of victims:

I can’t … I mean I never say never, but I can’t imagine discussing it, but I think that’s because of how A&E is (W1).
I wouldn’t wish this on anybody what I’ve gone through. There’s people out there that have gone through worse, but if there’s more support in ED and more awareness, information then maybe there’s more opportunity for people to get out a lot quicker and a lot sooner (W6).

The manner in which staff approach inquiring about domestic violence and the context in which such interviewing takes place are part of environmental aspects of the ED. They can enhance or restrict disclosure of abuse, as can the lack of information and awareness of DV, within the department. For the survivors, the failure to address these aspects with sensitivity demonstrated a lack of commitment to care and support. The interviews indicate that abused women are conscious of negative and stereotyped attitudes exhibited by staff when women present at the ED. The next section therefore examines these attitudes in more depth, eliciting what women want from DV intervention in EDs.

5.4 Intervening in DV: what women want

One important reason for interviewing survivors was to discover what abused women feel that they need from DV intervention in EDs and to elicit their proposals for improvements in responses to abused women. The concepts identified are as follows:

- Recognising clues;
- Asking about abuse;
- Simple interventions and little steps;
- Providing options and executing referrals.
5.4.1 Recognising clues: discovering reasons for visits

It is often hard to identify DV if there are no physical marks. Notwithstanding this, participants felt that clues are often there for staff to pick up on. The survivors gave examples of clues that should be further explored by emergency staff during their encounters with suspected cases:

The clues are all there if you see them and pick up on them. Why is somebody with quite a serious problem trying to claim nothing is wrong and I’m okay … I’m not going to follow through with the medical advice? There is likely to be a reason for that (W3).

ED nurses should be trained more on body language, the way they respond if their partner’s coming in with them, probably the evasiveness of not wanting to answer questions might be an indication, and things like biting their nails, or picking at their fingers or their clothes. These are all indications probably that this woman has got a problem which she’s trying to cover up and underlying issues that she doesn’t want to admit to (W7).

I think probably they could pick up better on body language (W4).

As part of interpreting body languages, non-verbal communication displayed by victims in the presence of perpetrators was identified as a useful clue in diagnosing domestic abuse. The need to speak to the woman on her own was particularly stressed:

They could probably pick up on body language, especially if your husband is there with you. Why won’t he let her go into that cubicle on her own? Why does
he insist on coming in? Because you’re not going to say things in front of him sometimes that you’ll probably say if you are on your own (W5).

The man is around the woman and you can see that the woman is very nervous, very nervous being around him or very cautious of what I would have to say if he was there and someone was asking me questions … they can use their initiative to know there’s something wrong, and if they are able to speak to the woman on her own then (W2).

Interestingly, none of the women interviewed in this study went to the ED specifically to be treated for the immediate effects of a DV incident. Their visits were triggered by other conditions, such as stress-related asthma, atrial flutter, self-harm, suicide attempts, depression, and car accidents. Moreover, none of the participants disclosed their abuse or had it diagnosed by emergency staff. This shows how important it is for staff to see the links between these issues and DV, especially the link between attempted suicide or self-harm and DV, which has been widely reported in medical literature (Ellis, 1999). One survivor related the account of a close friend who was never identified as a victim of DV throughout all her visits to ED:

Understanding and recognising, and when the physical evidence isn’t tying up then looking at, well, what else could be going on here? In the case of a close friend … nobody has found a physical cause for the hair loss. Nobody has asked or connected the visits to A&E where she’s had a couple of car accidents and been admitted several times with severe palpitations and panic attacks … nobody has tied the two (W8).
The ability to recognise signs of DV requires a thorough yet delicate grasp of the complexities of abuse. For survivors in this study, an intricate understanding of DV issues is still perceived as lacking among health professionals. Other issues identified include the relative benefits of individual direct questioning; universal questions being included on forms; provisions of specialist interviewers; non-male interviewers; and developing rapport to encourage disclosure. These issues are examined in the next concept.

5.4.2 Asking about abuse

Another important issue identified from these interviews is the need for safe and comfortable interview conditions that will be conducive to disclosure. Factors identified by participants were the need for confidence building and trust; the provision of privacy; and the availability of specialist or female professionals to lead questioning and intervention. Although all the participants found enquiring about DV acceptable, they noted the importance of one-to-one interaction, building rapport and of showing empathy when asking about abuse:

Talking to you with empathy … little things like ‘Can we have five minutes with her on her own’ … They’d probably be more helpful asking you alone (W6).

Apart from building a relationship of trust, privacy is likely to enhanced disclosure:

Probably if they’d got like a little sitting room area where you could just sit and have a consultation on a one-to-one like in an armchair or whatever, you would
probably open up more than you would if you were laid on a stretcher thinking this is A&E (W5).

However, another survivor felt asking direct question without initial rapport, empathy, and understanding will produce a negative response:

Instantly asking me if there was a problem at home would have got ‘I beg your pardon?’ But somewhere along the line if somebody picked up, well, there isn’t a physical cause but this is re-occurring. What’s not happening? Can we look further, and with understanding and empathy approaching somebody and trying to look at it from a different point of view ... then you can start to think well maybe we can actually help here (W3).

Another participant felt the question might be incorporated into the assessment form for all women visiting the department to ensure that no particular woman is singled out. Although in agreement with the point made above, (W3) she also thought that direct questions about the presence of abuse can be offensive to women who are often secretive and in denial. There is, however, a contrasting view among survivors on conducting interviews in privacy: incorporating questions into general assessment in written forms out in the open clinic will emphasise a zero tolerance stance on DV form the department:

I know from my experience myself you’re in denial as a woman that this is happening to you, you know. So I think sometimes you can be more secretive... asking directly can come across as ... can offend you and think that you’re being judged...why are they asking you that? So I think if it became a procedure of a leaflet where you write what’s happened to you (W4).
There should be like a procedure of an assessment leaflet where we can fill it out confidentially ‘Have you been through this’, or ‘Was it accidental or has someone abuse you’, or whatever (W1).

Another participant speculated that the point at which a woman might disclose abuse is different for each individual. It is vital that the question is asked at the right time and that the questioner has sufficient skill to judge when that moment is reached. While this might be a very difficult task, this participant felt it will be helpful for disclosure:

I think we’re all different and I think there has to be a right time, too, and maybe at that point where you’re putting two and two together … somebody caring enough to, with empathy, say ‘Come on, there’s more. And how can we help?’ (W8).

The issue of trust and safety in asking and responding to questions about abuse was also identified by participants. The attitudes of the staff and the degree of sensitivity and empathy employed in asking questions about abuse are crucial in determining patient response.

Well, from my experience, you’re split into half because you know it’s wrong … and you want to open up … yet you want the outside world to believe that it’s all happy and jolly … so it’s just finding that crossing over where you can begin to trust someone and be able to confide (W2).

You want to feel safe to talk to someone who is a complete stranger … It’s alright asking about DV but it’s how they are going to handle it sensitively, it’s how they
are going to deal with it, yes, and it’s how they’re going to keep me safe as a patient, basically (W5).

Two of the survivors felt that it is inappropriate for a male health professional to interview abused women:

Definitely not a male… I wouldn’t have confided in a male health worker (W5).

I wouldn’t have spoke to a male doctor because by this time I didn’t trust men whatsoever. They might be very nice, but to me they’re still bad and they all think the same (W4).

In the same vein, another survivor mentioned the need to speak to someone who specialises in DV or to be referred to a specialist if none are available within the ED:

For example, you go into A&E and have the specialists for the arms, specialists for the legs if you broke this, so forth, so I guess if there was a specialist on board … or they can give information about who to contact … if you are going through DV and you do need to desperately talk to someone about it (W7).

It would be quite good to have someone to talk to about that within A&E that specifically works with women that are going through DV. It’s the same with children, I’d say. Put them two together because they are the same – so similar…a basic counselling session, obviously it will be brief – it’s A&E – I think that would help, definitely (W1).
This survivor’s statement questions why DV is not given the same clinical weight as other medical specialisms. The issue of how child abuse and vulnerable adult services relate to DV against women is examined in the discussion chapter. However, some interventions that require minimal efforts on the part of health workers were identified as effective. These are highlighted in the next section.

### 5.4.3 Simple interventions and favourable environment

A majority of the survivors agreed that raising public awareness about DV within the ED would be a practical and effective intervention. All participants believed that awareness can be raised simply by passing information through literature, posters, and visual media in waiting rooms:

> But just simply being aware and having that kind of literature around, even wordlessly passing on this kind of information to women would be helpful (W2).

> Something as simple as having literature and information about Women’s Aid, for help around A&E departments, around hospitals, because for me, had I known that Women’s Aid existed, if I’d seen something, some literature that I could pick up while I was in A&E, I might well have picked up on that (W7).

Moreover, a majority of participants felt that it is not enough for emergency staff to simply ask about abuse: the environment should portray that they are fully aware of DV issues at a departmental level:

> If there was maybe more posters about DV. It’s showing it’s not just heart problems and diabetes … you’re physically showing that you’re interested in DV
too. It’s seeing it around you that, oh, they do care about this kind of thing as well (W1).

The environment should be such that would give you confidence that it’s okay to discuss this because I can see posters about it … Yes, as well … It’s something that is going on here … If in the entire A&E there is nothing about DV you feel it’s out of place to discuss (W6).

Raising awareness about domestic abuse is not only for victims. The perpetrators and general public can also be informed, thus passing a zero tolerance message concerning DV. Some women felt that DV has been a private matter for too long: awareness about DV issues should be encouraged in public information broadcasts, by both major television companies and on private networks such as those provided in A&E departments:

You can get it through to other people, I really think advertising on telly because we have for too long covered it up … It might be that something … you’ve got telly in waiting rooms at hospitals. Put something on there … Yes, even in A&E. If there’s a telly … just something on there. If you’re stuck in a waiting room they watch it (W4).

The channels of information to patients are clearly crucial. Women want to feel confident that their safety is guaranteed and that their interests are at the heart of the intervention. This can take time: asking questions about domestic abuse may not produce a positive response on the first occasion and it may take many visits before the victim is confident or desperate enough to speak out. However,
the seed is sown and grows with successive encounters. The process of trust building begins at first contact as expressed by one survivor:

They might not get everyone saying, ‘Yes, I’ve been hit by my fella’, but it’s tempting for them [women] … and that first start is the most important. The first step is the most important because after that it’s all going to follow (W5).

The logistics of ideal proposals, such as the provision of facilities for private interviews, will need careful consideration in view of the practical demands of the department and availability of resources. The need for privacy may also conflict with the need to establish DV as an important issue for the department. However, difficulties in achieving major changes should not inhibit the introduction of inexpensive, simple interventions and ‘DV friendly environment’, such as information posters and leaflet provision. Moreover, emphasis should be placed on providing auxiliary options, including small steps of empowerment and referrals, as discussed in the next section.

5.4.3 Providing options and executing referrals

Interviews also identified a requirement for staff to develop the skill to match the method of information delivery to client needs. One participant gave an example where she had to confide in her GP that what she had been treated for was actually not the problem. Her doctor gave her information leaflets about Women’s Aid, which became critical to her emancipation. In her opinion, the information leaflet was all she needed. If her doctor had spoken to her directly, she may not have taken acted:
When I said to my own doctor ‘I have to tell you I’ve got difficulties at home because you’re trying to medicate and I’m not giving you all the information’, she gave me the name and address for Women’s Aid and she gave me a leaflet. Had she started to talk to me personally, I might well have backed off (W3).

Although taking a step towards freedom is not without its challenges, some survivors felt the support they had from Women’s Aid helped them through this difficult period. Moreover, some survivors said they are pleased that they took the step towards freedom because of the immense improvement to their health and quality of life in the longer run:

And I’m glad I took the route I did, and it’s certainly literally probably even life-saving in terms of my health, but I did go through all that when I left. When I went in a refuge I had no money, lost my lifestyle, lost friends, lost family support, had to completely change everything to be able to leave, and that is very, very frightening for a middle-aged woman to do and it’s something you can’t do without a tremendous amount of support (W3).

I think I’ve used my pump probably six times in the last year … because the asthma attacks, especially with the night attacks, stopped as soon as I went into C House [refuge home]. It was a fact I think now that I’d got a better quality of life than I had when I was with this man (W4).

One survivor felt it is sad for abused women to remain ignorant, as she did for many years, regarding what help is available:

And I think one of tragedies is there are so many women who are going through and have gone through what I’ve been through who don’t know that they can be
helped … So it's a two-way process, not a one-way, to let women like me know that there is help there. It's as important as a change in staff attitude (W3).

Overall, the survivors’ accounts illuminate women’s opinions on how DV intervention should be approached. The areas identified are the skills necessary to enable professionals to spot signs of abuse and make accurate diagnoses; the professional confidence to make sensitive enquiries of women whom staff suspect are victims of abuse; and a policy of awareness raising in EDs. In participants’ opinion, taking control and dealing with abusive relationships has difficult initial consequences. Nevertheless, they want staff to approach the issue with empathy and understanding and to be given sufficient advice and information to enable them to make the right choices for themselves.

5.5 Chapter summary

In this chapter, the core concepts that emerged from analysing interviews of survivors of DV have been examined. The concepts identified relate to living with the experience of domestic violence; barriers to seeking help; and what women want from DV intervention. The way survivors conceptualise domestic abuse has implications not only for their understanding of the issue but also for their capacity to overcome abuse. Survivors in this study still locate responsibility for the abuse within themselves, as a perceived failure to fulfil their roles as ‘good wives’. This finding underscores the significance of emotional/psychological abuse. The attitudes of ED staff, the environment, and the circumstances and manner in which questioning takes place all impact on victims’ ability to take advantage of intervention opportunities. Modifying factors that obstruct disclosure of abuse is therefore essential to progress.
Although survivors acknowledged that staff members are not capable of reading their minds, they did convey an expectation that the staff should confidently query the root cause of their visit, especially in the absence of the perpetrator. While educating staff in DV dynamics may increase appreciation of the dilemmas that abused women face, the data reveals that abused women need to be aware of the constraints on staff. This will help construct more realistic expectations of treatment procedures in EDs. It is clear that a flexible approach is key to gaining women’s trust and empowering them to make decisions that will assist them. However, in considering the implications of these findings, the practicality of abused women’s expectations warrants further consideration.

Further interviews with abused women and other participants revealed a more pragmatic solution to DV intervention in EDs. This is further discussed in chapter 7 under resolving conflicts and reaching consensus. Chapter 6 moves on to present the findings from ED staff.
Chapter 6: Findings from emergency staff interviews

6.1 Introduction

The interviews with ED staff explored the following:

1. Staff experiences and practices regarding DV intervention in the department;
2. Barriers to intervention as seen from the perspectives of staff in the department;
3. The perceived needs of the staff; and
4. Strategies staff members consider practicable in the arena of DV intervention within the ED.

Table 9: Basic demographics of ED participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Years worked in ED</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Female</td>
<td>2 years</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>P2</td>
<td>Female</td>
<td>24 years</td>
<td>Sister</td>
</tr>
<tr>
<td>P3</td>
<td>Male</td>
<td>5 years</td>
<td>Doctor</td>
</tr>
<tr>
<td>P4</td>
<td>Female</td>
<td>1.5 years</td>
<td>Ambulance staff</td>
</tr>
<tr>
<td>P5</td>
<td>Female</td>
<td>1.5 years</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>P6</td>
<td>Female</td>
<td>26 years</td>
<td>Sister</td>
</tr>
<tr>
<td>P7</td>
<td>Female</td>
<td>1 year</td>
<td>Manager</td>
</tr>
<tr>
<td>P8</td>
<td>Female</td>
<td>1 year</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>P9</td>
<td>Female</td>
<td>3 years</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>P10</td>
<td>Male</td>
<td>2.5 years</td>
<td>Staff nurse</td>
</tr>
</tbody>
</table>
In the testimony, this participant group (ED staff and their manager) generally agreed that many women experiencing DV visit the ED, but they are often not identified, assessed, or supported. The interviews showed a common ambivalence among staff regarding labelling women who are experiencing DV as victims, since they are suspected and not confirmed cases. Moreover, major organisational barriers contribute to the passive attitudes of staff to DV. Thus, the core concepts identified and discussed here are as follows:

- Meanings attached to DV: Experiences and current practices;
- Intervening in DV: Perceived barriers; and
- Exploring strategies for moving forward.

### 6.2 Meanings attached to DV: experiences and current practices

In order to evaluate the current practices in the department, the manager and staff were asked about their experiences regarding DV intervention. Staff accounts of their interaction with abused women described how they have intervened in DV issues. Despite the common occurrence of DV as an issue, staff stated that DV is not something they specifically look for as part of general departmental practice. More often than not, evaluation goes no further than staff suspicions being noted in the patient histories regarding the reason for their
visit. Staff said women often attempt to dispel their suspicions by ‘putting up a story’ (P1). Since women are considered to be autonomous adults they are often not questioned any further about any suspected abuse. Four concepts were viewed as emerging from participants’ constructed accounts of their experience and practice:

- Taking their word for it;
- Unmet expectations;
- Whose responsibility is it? and
- Victim blaming.

6.2.1 Taking their word for it

One general feature of the participants’ accounts was a considerable reluctance to question women when they suspected that domestic abuse had occurred. Despite their reservations, staff often accepted patients’ claims that their injuries were not the result of DV. This was the case even when the injuries showed classic symptoms of DV:

I think it was that the marks were all over her face, whereas if she’d have fallen I’d have thought they’d be in like an isolated place on her face (P1).

Despite the good work begun with effective recognition of probable signs of abuse, staff believed that women are autonomous adults whose rights and privacy should not be compromised by invasive questioning. This prevented them from pursuing such cases beyond the level of suspicion:
I didn’t feel comfortable to say anything because it was just a suspicion I had, so I couldn’t just come out with it to the patient (P2).

Yes, I mean there’re always lots where you think but it’s whether you get them to admit that it’s anything. So a lot of the time, it’s only your thoughts and nothing’s confirmed (P11).

Another staff member said:

I think because you have to take their word for it for a lot of things, and one assault is much the same as another, and to label somebody as a victim of DV when you suspect it rather than it’s being confirmed may be one thing, another is her reaction to it... (P3).

One staff member stated that they would only intervene if they were certain that abuse had taken place:

I think you’d have to be totally confident or have been told it’s happening to actually go in and ask the question. I wouldn’t just go and ask if I wasn’t sure. I don’t think it’s appropriate because it could be then that they just walked out without treatment and they needed it, so I think … I wouldn’t be over-confident in going and ask directly (P12).

There appears to be a strong resistance to confronting abused women by expressing disbelief in their explanations of their condition. Not wanting to label women as ‘victims’ based on suspicion alone is a contributing factor. Sometimes the presence of the suspected perpetrator further complicates
issues for the staff, making it difficult for them to elicit information from the victim:

Her husband was speaking a lot for her ... she wasn’t making any eye contact either and just a few things that were linking together (P1).

The discomfort in dealing with DV is not confined to new or inexperienced staff. Two of the sisters interviewed had worked in the department for over 24 years. One of them said:

Yes. I think there’s definitely more DV than we’re aware of. I think there’s always a different injury that they come in with or an illness that’s not directly ... DV ... and I do find that patients are quite secretive and don’t want you to know anyway, even though you suspect that it is DV ... I’d find it difficult to approach the subject. They seem very defensive, so I wouldn’t feel confident enough (P2).

The account of this sister illuminates how the prevalence and significance of DV may be underplayed in the department: most abused women in this study visited the department with injuries and ailments not related directly to DV. In spite of the participant’s ability to recognise concealed domestic abuse on some occasions, the apparent defensive attitude of women and the difficulty of approaching the issue obstructed intervention. Another participant described seeing abused women present with issues unrelated to DV. This participant’s experience suggested that some kind of rapport could be developed between the staff and the abused woman at the first presentation. Even if the woman was reluctant to disclose at that time, she might return on another occasion, perhaps when the perpetrator would not be present:
I think you’ll find some patients will come up with probably something that’s probably not related to the DV at all. They’ve probably come with something else and then you’ll get chatting and sort of like … and then if they take you into their confidence they will open up a little bit more and you’ll usually find that they’ll probably come when the husband is at work or something like that, when the person that’s inflicting the violence on them is not about (P11).

In this sister's view, having confidence in the staff is a prerequisite for disclosure of abuse. Another sister (P6), who has worked in the department for 26 years, confirmed the high rate of DV incidence among women attending the ED. Like the sisters said, ambivalence and discomfort regarding DV frequently resulted in acceptance of women’s explanations of their injuries:

Well, I’ve worked in this accident and ED for 26 years so … I have seen women come back and come back again … well, you get the people in that come in with the injuries that look quite evident as being DV … others don’t … also you’ll get the people that want to talk about it, and you’ll get the people that don’t … At the end of the day they can say ‘No, I’m fine, there’s nothing happening’ and you’ve just got to take their word for it, haven’t you? (P6).

In spite of the lack of confidence expressed by staff in confronting DV issues, one staff member thought that she and her colleagues were generally confident in their ability to recognise signs of DV:

As A&E nurses we do sort of take a lot in and we know what’s happening when
people come in when they tell us a story that doesn’t fit the crime. It’s very suspicious ... but I think we are quite good at recognising if we get time (P12).

It is surprising that, despite the distinct assessment abilities of emergency staff, many women experiencing domestic abuse pass through the department unidentified and unsupported. Uncertainty as to how to intervene sensitively and effectively, coupled with the resistance from many women to be identified as victims, resulted in a sense of dissatisfaction in the resolution of DV cases. This is discussed further in the next section.

### 6.2.2 Unmet expectation: frustrated yet helpless

Some staff members reported frustration when their expectations that abused women would seek help when they visit the department was not met. Some staff members believed that the decisions of women should be respected as proceeding from the reasoning of an autonomous adult. There is, therefore, a need to exercise caution in order not to offend the woman or exacerbate their situation. One staff member said it is easier to ignore the issue:

> If they say ‘I fell downstairs or I’ve got a black eye’ ... I don’t think you’d do it as open and say ‘I’m not sure about how she’s got that bruise’... as nurses as well we’ve got to respect their rights. So if they don’t want to talk about it then I’ve got no right to delve in there any deeper to be quite honest ... It’s easier to turn a blind eye (P10).
Similarly, other staff members felt they cannot help if women do not make the decision to disclose their abuse, even though this leaves them feeling frustrated:

Really, if they're not prepared to ask for the help, there's really nothing you can do … It's like people with drink problems … until they say 'Right, I've had enough, I need some help' … and off they go for another beating and … you feel a bit awful about that (P5).

You have to be careful what you say if anybody comes in with you, any relatives, or the husband, or the partner, because you don't know if what you're going to say is going to get them another beating when they get home, do you? … It does make you feel frustrated that you can do nothing (P7).

It's very frustrating. I mean all we do is patch them up and send them out back to … you can't make people come away from their personal situation … but I do think as a registered nurse it's something we should be asking about … the only thing really, because you can't force people to have advice (P4).

One staff member who had also been a victim of DV seemed to have a different view. She expressed her dissatisfaction about their response to abused women:

I think there is more than we think … I think if a woman slipped through the net having come in needing help from A&E and it was all over the news it would be everywhere and every department would sit up, do their best to try and do something about it, but until some publicity happens … there's not enough publicity … (P12).
Contrary to other staff opinions, one participant felt that DV is not relevant to his practice and he is not being supported to intervene:

As much as we might see an unhealthy relationship, it isn't our business enough to force somebody to leave unless it's a criminal act or sectioning. It's not something that's relevant to our practice because they have to do it themselves because we haven't got any support (P9).

The fact that ED staff suspected DV could mean that they have some skills in this area. On the other hand, staff autonomy is likely to be reduced if they are limited by fears of creating a victim identity for the patient and by a lack of confidence that prevents them from acting upon suspicions of abuse. Similarly, the autonomy of a woman is subject to question, where their responses are conditioned by the fear and/or presence of the perpetrator. Another issue that emerged from the interviews was the perceived lack of time and support available to staff who intervene. This is further discussed under the barriers to intervention. There seems to be a contradiction regarding ED staff duty towards intervening in DV issues. We are left with the question of who is accountable for staff attitudes regarding responsibilities towards abused women.

6.2.3 Whose responsibility is it?

Issues around DV identification and intervention appear to be shrouded in silence within the ED. The failure to engage with the problem may be due to the fact that staff members felt there are no mandatory requirements in this respect. Comparison was made with child protection protocols where mandatory procedures must be followed to avoid sanctions. One nurse said:
I think we’re very good at child protection in this department and I think our nurses are spot on at it, but I think we must get as much DV as child protection that slips through the net that we’re not good at, at all… and I think child protection and DV go hand in hand … We have child protection, so why not have that too? … How come for DV, you’ve got nothing, no path to go down? … We talk about all the child stuff but the DV by one adult on another adult just gets totally forgotten in the whole scheme of things. It’s just totally forgotten (P12).

Participants mentioned policies and practices they were able to implement and action, such as the provision of medical care and treatment of injuries to abused women; vulnerable adult pathways when elderly people are considered vulnerable; and child protection referrals when children are involved, middle-aged and non-elderly women appear to go unnoticed by the department. (Although the vulnerable adult safeguarding procedure is available and could be useful for anyone over 18; this is further examined in the discussion chapter). The account of one staff member confirms her practice when DV is disclosed. She said:

If they’re vulnerable adults, the elderly we tend to notice it more on and we’ll refer them through the vulnerable adults system. People that are middle-aged and adult generally, it’s not something we highlight. If they’ve said to us that they’ve been assaulted by somebody that’s family member or whatever then it’s not something we progress on very much (P1).

Similarly, another participant felt the silence around DV might be due to lack of procedures for referral:
For child abuse and all that sort of stuff you get regularly trained and you are prepared for it, so you know which forms you fill in, who you send it to and all the rest of it, but for domestic assaults you don’t (P5).

Even new members of staff appear confident in procedures to deal with child protection, as training in these procedures is part of their compulsory programme. One participant, who had only been in the department for about a year, said:

I’ve done child protection things and adult protection for different things, but not in DV really … DV is something that we’ve not got a set form that you could fill in as a referral sort of thing, but obviously we’ve got social services that you can ask for advice and take on that … We’ve probably got a policy somewhere that you could look up, but I think it would be good to have that set referral path (P8).

This account suggests that there is no overall evaluation of staff practice where DV is concerned; there appears to be no policy or a lack of awareness of such polices that staff members are obliged to follow, despite adult safeguarding being a statutory responsibility. However, one staff member remembered taking an issue of DV further. Her account is as follows:

It was some years ago. I don’t know exactly if it’s changed but there was a safe house in Derby I think at the time. And the police came and took them to this safe house. I think it was something to do with the police that did it. But that particular lady had had a good beating, nothing serious but a good beating with plenty of bumps and bruises and cuts. And it had happened lots of times in the past and she’d been in refuges before. So this time she said she was going to press
charges. And I think that’s why the police sort of got involved and took a statement and then took her to this safe house (P11).

It is interesting to find that this participant did not classify a ‘good beating’ with a lot of bumps, bruises, and cuts as being serious; this is probably because they see far worse cases in the ED. From her account, the fact that the woman wanted to press charges initiated police intervention. When asked if she was confident to intervene in DV issues she said:

... lack of knowledge makes you not as confident (P11).

Sometimes the nurses shift the responsibility to doctors. One nurse said she sometimes invites the doctors to come in when they suspect DV:

I asked the doctor to go in and see what they thought about it. If somebody, for instance, came in and admitted to – and said what had happened – and they came in without their husband, and then I’d have to seek further advice because I wouldn’t really know which route to go down with it (P8)98/.

One general feature of participants’ accounts was a lack of knowledge of how to intervene in DV. Evaluating the accounts of nurses leads to the conclusion that abused women are unlikely to get any support, even when the abuse is disclosed and the perpetrator is absent. Some other issues need addressing: the deficit of knowledge; fear of confronting DV issues; and frustrations arising when women do not meet with staff expectations. Nonetheless, nurses appear to be more proactive if children are involved. One participant related a typical
account involving a pregnant woman. The factor of pregnancy was instrumental in encouraging the nurse to elicit disclosure of abuse, which in turn initiated the referral. According to her, the woman initially denied the abuse but after the nurse developed a rapport with her, she disclosed that she had experienced DV:

She's pregnant. It was very complicated. She came in and at first denied everything as they do ... But we were lucky it was a quiet night ... I got her some tea and got her some toast. And I just noticed a bruise on her ... so I introduced myself. I said I'll come back in a bit and we'll have a quick chat. Then I went back about half an hour later with another cup of tea. And then she said I've got something to tell you. She admitted that it was domestic abuse ... I think she was about twelve weeks pregnant then ... He didn't come in [into the cubicle] with her. But I took all the phone calls. And I said she'll be staying in ... the husband came in and he was very protective ... you could tell by the body language that she was scared and he was very very domineering ... So I had to refer her because of the baby (P10).

Another participant said:

It's purely if they're pregnant or if they've got children involved then that's when we act. But for normal DV, we don't have any protocol or anything to really follow ... We have child protection, so why not have that too? (P13).

The accounts of the staff indicate a considerable disparity between their perceived responsibilities towards abused women and what they are able to do for them. To begin with, there appeared to be feelings of frustration and helplessness stemming from abused women's inability to approach the problem
in a way that corresponds with the staff’s expectations. As a result, the staff appears incapacitated. Although participants generally believed that women should initiate intervention by disclosing their abuse, the majority of participants were concerned that a considerable number of their patients experiencing DV were not being supported, excepting cases where pregnant or children were involved. At times, they felt that child protection and DV go hand in hand and they should both receive the same level of attention from staff members. For instance, one staff member (P12) commented that emergency staff should not wait until a major crisis forces intervention. The interviews reveal that paradoxical demands are placed on staff: helplessness at their inability to assist opposed to the need to take action. Faced with this quandary, some participants chose escape routes, such as ignoring the issue or blaming the victim for failure to disclose their abuse.

6.2.4 Victim blaming

The interviews revealed a lack of understanding of why women stay in abusive relationships; this perspective underlies passive attitudes towards abused women. Some staff members felt that no matter what action they took, women would still return to perpetrators. Also, participants’ accounts indicated the opinion that many victims of DV do not take steps towards freedom but repeatedly return to the ED or keep going back to the abuser. Victim-blaming was evident in the accounts of majority of the participants:

Because you know yourself you wouldn’t put up with it. I know I wouldn’t put up with it. And it’s frustrating to think that this modern day and age that women do
put up with it, and I think there’s a lot more than people think because women cover it up, don’t they? (P3).

But she’s been in about half a dozen times since then … she keeps coming back in but she won’t leave him. Social services are now on about taking the baby off her as soon as it’s born because of the DV (P10).

One sister described her experience thus:

I’m just thinking back to a couple that I used to know that used to come in … and he was a police sergeant and she was a housewife, and she was regularly beaten up by him and she used to come into the department quite regularly with really nasty injuries, and he was always with her. I can’t think that anything ever got done about it. She did disclose it all to the staff. In fact she came in with two broken ankles once … and they’d got children. And he was somebody high up in the police force, but she stayed with him. Despite all that she stayed with him. I think she did go away from him for a time to a safe house but then she got back with him. They seem to be able to win them round somehow, don’t they? (P2).

Participants felt that abused women control their own lives and the responsibility for leaving and seeking help is entirely theirs. Thus women are blamed when these responsibilities are not undertaken. One nurse described how he would respond to a DV issue this way:

If they’ve got children in the house, I’ve got to refer them to social services for safeguarding children. Had it been a single woman, we would have said ‘You
need to report it to the police’ and then we can’t really take it any further. That’s how I feel anyway, that they’re a consenting adult (P10).

Reporting to the police seems to be the default option in the minds of some staff. They described their opinions as follows:

If they’ve said to us that they’ve been assaulted by somebody that’s family member or whatever then it’s not something we progress on very much because it’s usually done by the police, or they say they want nothing. It’s either the police or nothing usually … I don’t know what would be relevant for them because I don’t think with DV it’s something you deal with there and then. You either go to the police or you go back (P1).

Yes some of them have said that they’ve already informed the police … So why come to the department since they themselves have sorted that out … So, in that situation you just treat the wound and send them home, because they’ve already informed the police … they are adults, they know what to do (P3).

In sum, the majority of participants in this study group voiced feelings of inadequacy when faced with possible incidents of DV, indicating a real awareness that abused women need their professional help. However, a dearth of policies, protocols, and training appears to result in less confidence for staff at the front line of emergency intervention. Also permeating their discourse is the belief that DV is not treated with the same degree of priority as intervention to ensure child protection. Consequently, feelings of inadequacy, frustration, and compassion place stress on staff. This is reduced by coping strategies such as retreating to a position of avoidance, blaming the victim for failing to take
action, and shifting the responsibility for intervention to other statutory services. Specific issues identified by staff as barriers to intervention are examined as a core concept in the next section.

6.3 Intervening in DV: emerging barriers

From the accounts of the staff, three sub-concepts emerged as barriers to DV intervention in the ED:

- Disclosure as a pretext for intervention;
- Resources and policy issues; and
- Trust building.

6.3.1 Disclosure as a pretext to intervention

A persistent barrier to intervention from staff accounts was the unwillingness of women to disclose abuse, as discussed above under the experience and practice concept. At the heart of their practice behaviour is a perspective of ‘no disclosure, no intervention’ with respect to engagement with domestic abuse:

Very rarely do we do anything. If we know something, if it’s been told us then yes we’ll fill the forms in and things, but otherwise we don’t (P1).

Some staff members said they do not know how to proceed even when women disclose the abuse in the absence of the perpetrator. Others said that following disclosure that the only option is to report the abuse to the police: in most cases, women are expected to initiate these procedures. These statements indicate inconsistencies in staff practices and reveal that responsibility for DV
intervention is a complex issue. However, to believe it is the sole barrier to taking action would be an oversimplification.

6.3.2 Resources and policy issues

Another important factor raised by the staff is the lack of resources in terms of time, space, skills, support, and provision of practical resources that can help intervention processes (such as protocols, flowcharts, posters, cards, and numbers). The most common issue raised within this theme was the shortage of time. Staff members said:

Time … If you’ve got a really busy department, they might want to tell you more but you’re thinking I’ve got a chest pain out there that I need to assess and I haven’t got time to stand here chatting sort of thing (P11).

Time is the biggest barrier … Yes. I suppose sometimes it’s like do you want to delve that much because then what do I do with that information when I’ve got it because I’m too busy to sort it out and I don’t need any more problems, that sort of thing (P5).

Another nurse touched on the issue of privacy:

Obviously it’s the first place they’ll come for injuries but I don’t think it’s a very nice place to have to discuss it with someone. If you’ve just got a curtain and no door, and it’s very noisy outside, there’s people coming in and out, there’s people looking in, it’s not private and they’ll not feel safe or probably not like to speak to you in confidence (P9).
In spite of staff’s recognition that the ED is the first place abused women go for treatment of injuries, the suggestion that DV is not a priority in the department was still highlighted:

I think we’ve got limited resources and I think time is the biggest issue ... there’s other issues that have been more topical, I think such as your coronary heart disease, MI, I think them sort of medical issues have always took preference over non-medical things. I think it’s always been looked at as something not as important as somebody coming in with an MI, do you agree? (P2).

Another participant emphasised the need to provide services rapidly. She believes intervening in DV issues can be very difficult as a result of this:

I don’t think it would work in A&E because everything is too highly charged – the reason they’ve come, the damage they’ve got, they’re very high emotionally up and down, and they change their minds whether they want to stay or want to go because of all that (P10).

This participant further relates failure to address issues of DV to overall expectations regarding targets within the department, which makes it difficult to find the time to intervene:

It’s probably because we don’t have time, which is an awful thing to say. When we’re at See and Treat, you get a maximum of 10 minutes with each patient... You haven’t got the time to delve into somebody’s injuries, you know, to discover whether it was DV. If they don’t come right out (P14).
If it's somebody out at See and Treat, then they want you to assess them in like a few minutes. So unless they tell you my husband's punched me or whatever, then you haven't got that time to sit and probe and probe because you've got a pile of patients waiting to be assessed (P11).

The burden of having a stipulated time to see and discharge patients in the department thus means that the care given to women experiencing DV is compromised. Participants also linked limitations that prevented them from intervening in DV to ignorance of interventional pathways and the fear that things will go wrong:

If we did intervene, I'd be a bit worried that it would all go horribly wrong because nobody would know the right route to follow and the right people to contact, and something might get missed (P1).

Another prominent barrier articulated by all participants is a lack of knowledge about how to deal with the issue of DV that adds to the discomfort felt by some staff about intervening. The participants put it this way:

But I don't know enough places where people can go and I don't know enough details to be able to tell them. I think that's the only thing that may make you uncomfortable is that you don't know (P2).

I wouldn't really know which route to go down with it... because I don't know enough about it at all (P12).

Linked to concerns about lack of knowledge about DV intervention are similar
anxieties regarding women from ethnic minorities. One staff member acknowledged that failure to consider the cultural differences of other ethnic groups prevents intervention:

Well, it’s all to do with the culture [of ethnic minority women], I suppose. We’re not aware of the culture and things. It’s completely out of our remit. We don’t know what we’re dealing with there (P14).

Some of the staff members are more explicit about their knowledge deficits, describing the lack of resources in the department for dealing with DV. The major problems identified were a lack of training; no signpost mechanisms; and failure to provide protocols or simple tools to facilitate the intervention process. Participants often mentioned that such tools and training are already in place for child protection and elderly referrals, but guidelines for dealing with DV are non-existent. One participant, who earlier expressed the belief that DV intervention is not visible in EDs, put his reasons in plain words:

The thing is I don’t think we’ve got the resources or the signposting to send somebody to. I think for somebody in a DV situation, it’s not the sort of situation where generally a visit from somebody in social services saying ‘I think you’re in trouble’ doesn’t help the situation and I think we need somewhere to signpost or someone to see somebody in A&E (P10).

While the majority of staff members think DV is a big issue in the department, one staff nurse (P12) said she does not encounter abused women often, but when she does is prevented from intervening by lack of training; the absence of protocols to follow; and ignorance of routes to follow in referring patients on to
specialist services. She also stressed the sensitivity surrounding DV and felt that knowledge deficits in this area can be offensive to the patient.

I think it doesn’t happen that often that I’m aware of. We don’t get many victims of DV. But if we did … because we’ve not had any training. It’s such a huge thing, and if you get it wrong the implications of not treating it sensitively enough (P12).

There appears to be an apprehension that DV is a sensitive issue with huge implications if mismanaged. The matron (manager) agrees with the idea that DV intervention is a challenge for the staff: they need to proceed with care because victims need sensitive treatment and service delivery needs to be planned with caution:

Yes, it needs a lot of thought really I think. It’s not something that you can brush under the carpet … but you don’t want to do the wrong thing either … you’ve got to be absolutely sure that what you’re doing is right for the individual … and you don’t want to be making rash or wrong decisions because obviously the consequences, you know, for the women could be tremendous… (P7).

The Department of Health has prepared a handbook which is expected to guide health professionals in responding to women experiencing DV (DOH, 2000; DOH, 2005). In order to explore staff knowledge of the handbook, participants were asked about their awareness of policies and guidelines on this issue. All participants demonstrated a lack of awareness of any specific document designed to guide health professionals in their response to women experiencing domestic abuse:
None, I am not aware of any policy (P6).

Not that I’m aware of, no. I wouldn’t know … nothing I can really remember now from school. It’s just all common sense that I’m aware of (P1).

Not that I’m aware of to be honest; I wouldn’t know what’s available (P9).

The matron of the department was asked specific questions regarding the policy for managing DV in the department and what she considers as the correct practice. She confirmed that staff members are not aware of specific policies for dealing with DV:

I’ll be honest with you. I don’t know if there’s any policy that I’m aware of … I mean the only thing that we probably would follow is like the vulnerable adults protocols that if you thought, you know, there was a real issue you could, you know, report it. But I don’t know whether you would for DV … But at the end of the day, you know, when you’re dealing with an adult, you can’t make them move out of the situation (P5).

It is unlikely that the matron will be able to support staff to intervene in DV if she is unaware of procedures prepared by the Government to address this issue. It is not surprising that some staff interpreted the absence of specific guidelines to mean that the issue is not considered relevant at management level:

It’s not something that’s relevant to our practice; therefore they [women] have to do it themselves because we haven’t got any support (P10).
Some participants felt that managers should set the standard by giving them the time and support that will guarantee intervention. One participant said the sister in charge of the shift could determine the response of the rest of the team:

If you've got a sister in charge that understands what you’re doing, that's allowing you the time to do that ... and supporting you, it's a lot better. But if you've got somebody that's just wanting you to quickly do it and then get on with another job then you can't provide the care properly (P14).

Another nurse felt that child protection procedures take time; yet staff members are mandated to follow them. From his perspective, the management is not doing enough. He emphasised the need for adequate training and attention to the safety of staff:

Like I say, we do the vulnerable adult and the child protection, which are time consuming ... if we do DV ... we need to ensure safety of staff because like I say, if the partner is in the building and we’re pushing something on DV then staff come in the firing line ... nobody's given me any sort of teaching to do with DV at all. I think management stand in the way (P10).

Permeating this discourse is an underlying fear that things might go wrong or that women might be upset by intervention. One participant expressed her uncertainty:

But it is difficult that there’s no official or there’s no set 'This is what I can say or this is the help we can give you here’. I think that's difficult because ... sometimes you do flounder a little bit over where the line is and are you crossing it or are you not? Is it advice? Is it going to be taken in the right way? (P5).
It is understandable that staff will be afraid to intervene if insufficient resources are provided by the organisational infrastructure. The matron was asked to comment on some of the challenges staff are facing regarding DV intervention. She said:

I think because there’s so much pressure around workload within the ED it’s difficult because obviously these can be quite time consuming and I’m not saying these ladies or men don’t deserve that time but, you know, when you’re dealing with other clinical emergencies, you know, when you’ve got life threatening conditions, you’ve only got so many staff to be delivering that care and it’s like trying to balance it out.... we talked a bit about privacy and it’s like trying to find somewhere where you can actually sit down with the individual and be able to talk on a one-to-one and try and give as much support as you can and you haven’t always got the facility to do that either (P7).

The account of the manager further highlights issues such as work pressure. She suggested that the availability of someone trained in DV intervention may be effective in cascading advice to the rest of the staff:

So it's work pressures and, you know, location pressures in that is it really the right time and place to be dealing with such difficult issues. It would be nice in many ways to think that there’d be someone that you could at the time they were here, similar to like what we do for mental health services and safeguarding children where you’ve got someone at the other end of the phone that you can speak to and come and .... help or support and I don’t know if that’s available for DV (P7).
The doctor who participated in the study had worked in the department for five years. He claimed that he sometimes experienced dilemmas regarding his responsibilities towards abused women. He repeated factors inhibiting intervention that were outlined by other staff:

I have come across a few people, but we don’t know what to do with them really ... you know, different story even though there is a suspicion of DV ... It’s unlike child abuse ... you always have that in mind ... the awareness is there, whereas when adults come in and show you injuries ... that doesn’t first strike you because you’re not used to thinking that way ... we’ve not been having ... trainings, protocols... (P3).

One male nurse raised another issue: that abused women generally will not discuss abuse with male health professionals:

As a male, if we know there’s a DV case, generally it’s more appropriate that a woman talk to them. I think they probably confide in female because usually it’s a man that’s beat them and do they really want to be discussing it with me? (P10).

Overall, dedication to DV intervention at the management level needs further consideration, as reflected in the lack of training and support for staff. Staff accounts demonstrated an inability to engage with DV intervention with the present level of support and resources. Professionals are likely to be passive in their response if they know DV intervention is not a priority for the organisation. Unlike DV, child protection referral has been highlighted in the department. Awareness, training, and a sense of responsibility have been established: staff members take action without considering the constraints of the busy department, time, and other barriers. At present, taking the initiative when it
comes to intervening in DV issue does not readily come to staff. Even though some felt they should help, the issues of trust further prevent them from taking action, as identified in the next section.

6.3.3 Trust building

Beyond the lack of expertise in managing DV, perceived lack of management support, as well as the spatial and temporal limitations of the ED department is another controversial issue – ‘trust’. Trust building represents another controversial issue. Some nurses felt that abused women do not trust the healthcare provider and are unlikely to disclose or ask for help. An experienced nurse argued that women have lost faith in the NHS because of their past experiences:

Nobody has ever disclosed it to me all the years I’ve worked here that somebody has done it deliberately to them, because I don’t think that they trust any services, professional services at all … maybe because of the previous experiences. I don’t think they trust the system anymore. I don’t think it offers them any safe place. In fact I think it could be worse for them in the long run, so they just put up and shut up (P2).

The nurse underscored her point by narrating a particular incident that she was involved in:

I’ve looked after people that have come from refuges that aren’t from around this area, but they’ve had to move because of DV, and they’re in such states, you know, even after they’ve moved out of the environment when they’ve suffered
DV. Although they’re out of that dangerous environment, their environment that they’re put in isn’t a lot better. That’s what I think anyway (P2).

Another participant expressed similar views:

For instance, I looked after one the other day and she was in a safe house for battered wives but it had caught fire, so all the women and the children had to come in because of smoke inhalation, and it was so sad to see each and every one of them. One was an Asian family and she could hardly speak any English, and she’d got two little Asian children on her knee, and they looked very poor and they weren’t dressed properly, and she looked like a frightened animal (P8).

Participants also claimed that abused women are afraid and often worried about difficulties with authorities regarding the safety of their children. Sadly, the focus is on the woman to leave rather than the man and women sometimes are unable to obtain effective protection from the abusive situation, even in child protection cases, which might be perceived by the woman as punishment or distrust:

I think they’re just frightened. I think they’re frightened to mention it because they’re frightened that they’ll get their kids taken off them and they’re just frightened of the consequences of opening up to you. I think if you’re a person out there that’s getting regularly beaten up by a partner and you’ve got children, I don’t think there’s a lot of help available (P2).

One participant argued that the lack of trust can also proceeds from the disparity between advice given by health workers and both women’s fears of the
possible consequences of intervention. According to her, the rational choice for women may be ‘shutting up’. She gave examples of some issues that abused women may be afraid of and some of the challenges women are likely to face if they choose to disclose their abuse and accept help:

She’ll have to leave. She’ll have to up sticks with the children and leave all her family and friends, and move to an area she doesn’t know, into a house with people she doesn’t know. She’s not going to want to do that. They’re probably even more scared than she would be at home. We have a lot of people from safe houses who come into the department with their children and you just look at them and think this is sad … they don’t come in after being injured. They come in with different issues (P6).

In the manager’s view, the abused woman’s lack of trust may be compounded by meeting a complete stranger in the open environment of the department:

I think, well, with trust issue, firstly, you know, meeting complete strangers … So they might not want to, you know, talk because they don’t feel they’ve got any trust or confidence in who they’re coming up against. Obviously, an A&E department is quite a public place … and obviously they’ll be conscious that there’re other people around them and might not want to talk about anything (P7).

Another participant thought trust building takes time and attention which may not be a viable option in the ED because of the short timeframes available:
If you’ve got a nice shift where you can sit down and talk that’s fine, but it’s at the back of your mind. You’re thinking ‘Oh, I’ve got all these things to do’ and being able to sit and just build up that rapport so you can get a bit of trust (P11).

One sister thought that health professionals need to make abused women feel comfortable to encourage trust in the relationship between professional and client:

Just to make something that could make women feel more comfortable to speak to a complete stranger, because I mean some of them might even live in a family where most of the family know what’s going on but they won’t do anything about it either (P6).

One participant identified an important issue abused women are confronted with a feeling that nobody is doing anything to help. Not only the staff, even family members are unwilling to address the issue of DV against women. One of the participants stressed the importance of honesty in building trust; that is, telling victims what you want to do, keeping to your word, and not making false promises. This honest approach in itself shows concern for abused women:

Don’t make false promises and to do what you say, so nothing behind their back. If you’re going to refer to social services, tell them that that’s your intention. They might not like it initially, but hopefully some of these people will take it up … So you’ve got to have time to sit down and discuss with the patient on their level, not as a patient but as a human being, and I think that can build trust (P13).

Despite staff’s frustration when women do not accept help, they do understand that women have many issues to consider before choosing an option. It is
exciting to find that the issues of trust is shared by abused women and professionals, albeit from different perspectives. While staff may be afraid of labelling women and making mistakes regarding their diagnosis, they also recognise the fears women have regarding an uncertain future once abuse is disclosed. Such awareness makes the issue of trust and understanding crucial in developing a relationship between patients and professionals.

Overall, a range of barriers identified within the participants’ accounts relates to the substratum of staff practices discussed earlier (see 6.2). Exploring these barriers has enabled staff experiences with abused women to be understood in context. Many of the barriers are not surprising and are common to most healthcare settings (Rose et al., 2011). However, some barriers are specific to the ED, such as the peculiarity of the ED in relation to quick processing and lack of privacy. This reveals a need for a level of sensitivity that staff felt unable to attain: these issues are further discussed in chapter 9. Using the concept of barriers to intervention as an analytical tool may provide a nuanced and detailed understanding of the participants’ responses, which go on to inform their practice. For example how the issue of trust may influence staff – patient interaction. Having explored the way barriers restrict the interaction between abused women and their health providers in the ED, the next section examines staff suggestions on ways to improve the situation.

6.4 Exploring strategies for moving forward

A key objective of this study was to explore potential strategies for instituting DV intervention into the culture of EDs, using the perspectives of users and providers. The staff and managers were asked for their thoughts on how
effective intervention might be achieved. Two key types of interventions are identifiable from the participants’ responses:

- Developing protocol and policy to incorporate DV intervention;
- Sensitising and raising patient’s awareness of DV.

6.4.1 Developing protocol and policy to incorporate DV

The majority of staff commented on incorporating DV into the ED’s routine: in their opinion, the department is a good contact point for intervention. Moreover, it is frequently chosen by abused women when they are looking for access to services. One male doctor felt that identifying DV and referral is a safe place to start:

I think it can be incorporated ... it’s not going to take a long time ... you’re identifying it and then directing to the correct source for help ... people can be saved in a sense ... You can reduce the amount of ... violence. I think A&E is one of the good points for such intervention and also GP surgery, and generally when they come with injuries they come to A&E, so A&E is a good point of contact (P3).

However, it is important that staff members are professionally prepared to overcome the challenges of sensitivity needed in dealing with DV. Most staff felt that education and organisational commitment makes a lot of difference to dealing with the complexities of DV issues. A participant noted the importance of training in giving the right information:
I just think give us some more information so we can act on it. Give us more training. I think the police involvement would be very good, just so that we’re more equipped and confident in dealing with it. We’ve just got no knowledge at all really, only the little experiences that we’ve picked up over the years (P2).

I don’t think people will be afraid of it because it’s just the education, isn’t it? I mean we deal with so many things which are quite difficult situations in A&E. I don’t think this is going to be very difficult, although it’s a sensitive, very sensitive issue, but you deal with all sorts of thing (P6).

One of the sisters was also very aware of the professional and ethical reasons for overcoming the challenges of DV:

It is challenging, but at the end of the day if you realise that somebody’s got problems, I mean you’re not doing your job properly, are you, really if you sort of like let them just wander off (P6).

Another staff member said she is relatively inexperienced, as she has only been in the department for about a year. She also acknowledged that DV is a difficult area but she would love to intervene if she felt confident in her knowledge and abilities:

I’d like to know more to offer people more support if they wanted it, but it is a very difficult, sensitive subject, so it’s a difficult one to approach … if I had more knowledge on the subject and some procedures to follow and also was more experienced in this department, I would want to intervene if I felt I needed to (P8).
A health assistant who has had personal experience of DV, said the importance placed on DV in departmental policy should be escalated to the same level as child protection referral:

Being a survivor myself ... I find DV a fascinating subject. I’d like to be more involved in it because I think it links in with the child protection thing as well. And I think you need to be running them more together sort of thing and maybe treating the adults like we do the children (P5).

She further suggested forming links with other community agencies and training staff from different grades as the main strategy. In other words, if a nurse is busy, the healthcare assistant can help:

We need to link up here with the community and women’s aid and refuges. Those to me are the main things. And having link nurses, maybe a sister, a staff nurse and a healthcare assistant, one from each grade because the nurse might not have time to have a proper sit down and chat but the healthcare assistant might (P5).

Another participant suggested have a liaison nurse, who would also be a point of reference for the rest of the staff, as she would be able to cascade the latest information on strategies:

We could have a DV liaison nurse, where sort of like that could deal with things on behalf of the patient (P6).
When this is in place, the participants felt that another crucial step is effective dissemination of information regarding support services to abused women:

I think if we could give them more information we’d probably get better results than having somebody doing a one-to-one. If we give them options of where to go after this event and perhaps make an appointment for them to go, and they can always say to whoever ‘Yes, I’ve got to go for an appointment to have my eye checked again’, it would give somebody a reason to come back after the event and they’ve had some of the seeds sown that there is some help and support (P10).

Finally, one staff member indicated the importance of a simple flow chart to incorporate intervention into departmental routine:

I mean if we just had like a simple flowchart, so the first thing you’ve got to do is contact social services and the second thing you’ve got to do is fill in an adult protection form, just something like that, something in an order where you think you can look and say ‘Yes, we’ve done everything that we need to do. I’m happy that it’s sorted. I’ve not missed anything’ (P12).

Another staff member identified having a card with numbers of local services and a referral system as time-saving interventions:

To save time because time is an issue, maybe like a flowchart with numbers. So if they want help and they need somewhere to go, they ring this number or contact these people or out of hours ring this other number ... something like a card with local numbers. And we need a referral system so that ... there’s a simple way of cascading that to whoever needs to know (P11).
This flow chart procedure forms a guideline which does not have to be rigid. It could include options and suggestions for getting the woman’s input and not just ticking some boxes. Another staff member corroborated accounts given by other participants with respect to the need for such official policy/protocol to back up intervention strategies:

I think it needs to be incorporated. We’ve got the time to do the child protection, which takes a long time, the vulnerable adults, which takes a long time to sort out, so, yes, if there was a policy or protocol to do that then it should be part of our practice because these people are getting repeatedly abused (P10).

Commenting on how the department can incorporate DV intervention, the manager acknowledged that it is an unknown area of practice for ED staff and intervening might occupy nurses’ time. However, there is a need to prioritise DV and equip nurses with skills commensurate with training in child protection procedures:

So I’d have to discuss it with the rest of the team whether they thought that something like that would be something that we could … accept that it will take a nurse out of her normal duties for an indefinite period of time because we do it for other situations … So it’s, you know, where your priorities are … And you do think, well, should this lady have an equal … it’s still a bit unknown really whereas ‘resuscitating’ someone is the bread and butter of things … but dealing with raw DV and that side of things is not (P7).
She also referred to the importance of raising staff awareness; providing training on how to picking signs of DV; and ensuring knowledge of essential numbers for referrals for different staff grades.

I mean I think from the staff's point of view the fact that you're coming in and talking to us now is raising the profile of it and making more staff aware of how they could talk to these women and build rapport … I suppose something probably more structured around the signs and symptoms … if a healthcare worker could have a number they could ring to say this is the situation what can we do because there will be some women who can't go back to where they came from for their own safety … if there was something like I say similar to when we've got children that we think are at risk because that's quite a good system that we've got (P7).

Overall, the manager recognized the need for EDs to equip staff with skills to help abused women and the need to provide protocols commensurate with child protection procedures. Like the manager, many staff voiced feelings of willingness to respond to women faced with possible incidents of DV. This indicated a real awareness that abused women are in need of their professional help.

Clearly, lack of policies, protocols, and training can produce a deficit of confidence in the staff. The belief that DV is not treated as an organisational priority also permeates their discourse. ED staff did not seem to realize the possibility of referring abused women through the vulnerable adult pathway. Ultimately, the policy and protocol strategy warrant serious renovation including providing awareness of policies for dealing with DV; resolving difficulties for
abused women without pathways to follow; and confronting the common belief that the organisation does not take responsibility for initiating intervention. The next strategy considers a more patient-centred approach in awareness raising within the department.

6.4.2 Sensitising and raising patient’s awareness of DV

All staff identified increased awareness within the department as a vital precursor to DV intervention. In particular, the staff felt that the provision of leaflets and DV posters in the department for patients would help to ensure that the issue is discussed more openly. Although they seem to appreciate that the department may be limited to initiating the first crucial steps towards freedom:

Being more aware. I think the whole issue should be more open. I do think in A&E it just has to be that first little step, but everything starts with a first step. And like you say with child welfare, you wouldn’t say, ‘That child’s got a burn, I wonder if the parents did it. Oh, I can’t possibly say anything’ … I don’t think women in an hour, or two hours, or even four hours to sit with a woman, they will decide ‘Yes I’m going to change now and this is what I’m going to do’. It needs to be a continuity, if I can give that leaflet or that support, or that little, that tiny little bit of confidence to a woman that makes her say ‘Yes, I’m at least going to think about change’, then that’s the first step to the next hundred (P5).

This participant appears to understand the nature of DV and pragmatic interventions for victims, staff, and public, as she has had a personal experience of DV. She also suggested half-hour training sessions to sensitise staff to DV, similar to those provided for child protection:
Any new employee, they go for a full week on a rolling programme and go through everything … I mean it’s only half an hour, but you get half an hour with child protection, half an hour how a patient can complain, all these sorts of things, so half an hour to actually discuss and be made aware … and to pick up on that sign and say ‘Do you need a leaflet’, … A woman will open up at probably the most bizarre times, and if you’ve just something that then clicks in and goes (P5).

One male nurse who has also witnessed DV as a young boy gave a similar idea of what he thinks the women will want from their healthcare providers. He also demonstrated an understanding of why it could be difficult for women to escape from DV as quickly as staff think they should. He felt that it is vital that women are supported, shown empathy, and allowed the opportunity to revisit. This agrees with the suggestion above. This suggests these ideas are based on firsthand experience of abuse, which is richer than knowledge acquired through professional preparation alone:

My mum was subject to DV from my dad. It’s a personal thing but I know a lot behind it, and I know that she’s still married to him so it probably still happens … From a patient point of view, professionalism. We’re not here to take sides. I don’t know what the patients feel, but we need to give them empathy and we need to really give them a lot of support because it’s not easy to get out of their situation. We can all say ‘Yes, why is she back with him?’ But it’s not easy to get out of that situation if they’re financially and emotionally tied with families. Where does this person go if she’s married to a wealthy man that holds his hands on the purse string? It’s very difficult for her to see something else in life … we need to support them and know that they can come back and probably us be in touch with them (P10).
A highly-experienced staff nurse also suggested how the department could raise awareness and help women through information, in spite of non-disclosure:

Have plenty of leaflets and posters and things about with numbers on that they can discreetly keep in their purse or something like that, that should they change their mind at any point … or just try and get them that when they do leave the department that you’ve reassured them that much that they can always come back and talk to you if they want to and it will be in strictest confidence really. Well, alright, you say there isn’t but you do know that if you need any help that there is help out there that you can be … Here’s the little number or don’t hesitate to ring me back (P6).

Another participant stressed the need to sensitise society to non-tolerance of DV through increased awareness in the waiting rooms and the use of posters:

I mean a busy A&E department you can be sat there for quite a while, I mean what else have they got to do except read the posters on the wall … a big poster of it so that it’s something that everybody can see, so even the perpetrator can see that it’s not something that’s kept under cover and it’s quite hush hush so that they think ‘God, I’d better watch what I’m doing now because everybody knows about it’ (P4).

She also noted that tear-off slips have been made available in the past that contain numbers of DV services:

But I can’t remember sort of like recently. I mean there might have been something years ago, but I can’t remember anybody going from here to anywhere
in particular … We have some little tear off slips that are in notices in the cubicles where they sit, and they have little tiny telephone numbers on the bottom where they can rip them off themselves (P4).

6.5 Chapter Summary

The ED staff’s interviews have highlighted several problems: the difficulty of identifying domestic abuse; not having confidence in their own suspicions; and ignorance of strategies for responding to and referring victims of DV. These problems combine to determine the responses of ED staff to abused women. Central to staff’s responses is the issue of labelling women as victims. Other barriers to intervention identified by staff include lack of policies and protocols; non-disclosure on the part of abused women; lack of skills required to intervene; issues around trust; lack of support from management; and contextual characteristics of the department.

The majority of staff members voiced feelings of inadequacy when faced with possible incidents of DV. Also permeating their discourse is the belief that DV is not treated as an organisational priority on par with intervention to ensure child protection. Consequently, feelings of inadequacy, frustration, and compassion place intolerable stress on the staff. They are reduced to coping strategies, such as retreating into a safe position of avoidance and blaming the victim for failing to take action to resolve the situation.

It is not surprising that emergency staff do not see managing DV as being within their remit, beyond the treatment of physical injury. Several factors contribute to this: lack of awareness of policies for dealing with DV; the difficulties of
managing abused women without pathways to follow; and the common belief that women are autonomous adults who should take responsibility for initiating intervention.

However, the discussions with ED staff identified a number of markers of good practice to develop more viable intervention strategies. Nevertheless, this revealed a variety of contradictions with respect to current practice, future expectations, and ideal practice. For example, practical suggestions that revealed understanding of repeat victims were discussed, as well as how difficult it could be for women to leave abusive relationship. Moreover, those who have experience of DV brought their knowledge to consider potential intervention strategies. One strength of this study is that it has involved talking with a variety of staff members with differing personal and professional experiences.

Overall, in view of the challenges facing staff members, the development and implementation of integrated intervention strategies will require a comprehensive and multi-system approach. The suggestions made by health professionals and the perspectives of abuse victims have provided richer material than either of them could have produced alone. Incorporating insights from interviews with Women’s Aid co-ordinators will create a fruitful pool of information to enable the formulation of robust proposals for DV intervention. The next chapter presents the findings from this third group of participants.
Chapter 7: Interviews with co-ordinators of Women’s Aid services

7.1 Introduction
This chapter presents the accounts of eight co-ordinators from Women’s Aid, which provided support for the survivors interviewed in this study. Their accounts detail their experiences when attending EDs with clients, explain the barriers to intervention they perceive; and collate their suggestions regarding intervention for abused women visiting ED. The core concepts emerging from this participant group are:

- Intervening beyond physical injuries;
- Perceived barriers to intervention;
- Effective intervention strategies.

7.2 Intervening beyond physical injuries
This core concept examines the experiences of co-ordinators who have accompanied clients to the ED as part of the support given to them. Generally, co-ordinators felt that the management of abused women is limited. Often the abuse is neither identified nor recorded as corroborated evidence, nor are women offered any support beyond treatment of injuries:

So it was just kind of checking out injuries really … and because they’d come with me I think the disclosure about DV was kind of there because I was obviously there working for the women as well. I wouldn’t say they did anything apart from treating the injuries, no (C2).
This co-ordinator said she doesn’t know what the ED policy is regarding the management of abused women. However, she felt that the emergency nurses should extend their roles beyond the treatment of injuries to include practical and emotional support. There should also be a standard procedure for recording injuries in case of the need for corroborative evidence in the future:

I don’t know if they recorded the injuries, I don’t know their policy … but it is important … because obviously you would hope they record the injury so that’s some evidence if necessary (C2).

Another co-ordinator reported a similar experience:

I once had a client who had quite a serious injury … she had a lot of ongoing treatment and visits to A&E as a result of the injury. But I don’t think she was necessarily offered any other support other than actually treatment in terms of her injuries (C1).

The co-ordinators felt that, while some abused women visit the department for treatment of physical injuries, far more will have no tangible injury: they visit the department because they have nowhere else to go. Hence, there are women who run from the situation and visit A&E as an immediate solution:

Some of the women visit the A&E not with injuries as such. But they go to A&E as a place of safety, sometimes when they’ve got nowhere else to go (C4).

Another participant expressed her disappointment regarding the misdiagnosis of abused women in the emergency setting. Women who turned up for non-
accidental issues were sometimes diagnosed with mental health problems, when in fact they had arrived seeking refuge from DV. She felt that a little further exploration of the reason for her client's visit would have revealed the root cause of attendance:

I think A&E were concerned that she had mental health issues because of the way she turned up and the way she presented when she turned up, so they went down that route ... perhaps not necessarily an understanding that she actually was fleeing a situation that she didn’t feel safe in there ... But I think once they’d done a little bit of digging, because obviously there’s records at the hospital about her, that … would identify her as a victim of DV … they should have explored a little bit more, if they’d got support, if they need support or are they safe or ... I would like to hope they do that if a woman turns up on her own (C4).

Another coordinator described her disappointment at the attitude of emergency staff to women who visit the department following incidents of attempted suicide or self-harm:

So I have seen women who have had poor response when they’ve gone in [to A&E] because of self-harm, and the self-harm, like I say, has been directly linked to their emotional health and wellbeing, and the pain around domestic abuse issues ... I think that’s understandable because there’s a lack of understanding about self-harm, you know, cutting and burning. I think in terms of A&E or hospital staff it can be seen to be a wasting of time, attention seeking, which it is on some levels but that’s not … they shouldn’t be viewed in a negative way, you know. And I think lack of understanding can bring about that kind of lack of empathy really (C6).
In summary, the experiences of co-ordinators indicate that DV victims are treated for physical injuries only, or are sometimes misdiagnosed with mental health issues. Furthermore, the correlation between DV, physical health problems and mental health issues implies that a high likelihood that abused women will visit the ED. In their view, treatment should extend to providing support and recording details of physical injury for future evidence. Co-ordinators thought that innovative practice could have life-saving results for this vulnerable group of patients; especially those who have no apparent physical injuries yet who choose to visit the ED seeking support. The next core concept considers other barriers identified from the co-ordinators’ accounts.

7.3 Perceived barriers

As part of their experiences when attending EDs with clients, co-ordinators identified some specific barriers that hinder women seeking help from EDs. Factors preventing effective intervention include specific characteristics of the ED; the focus of care; and inadequate knowledge of staff regarding DV issues. One co-ordinator said:

I think the process, maybe the going up to the counter ... You’re shouting through a glass screen really ... You wouldn’t want to necessarily disclose much there because ... it’s in a big waiting area isn’t it? And it can be busy; I would imagine that could be quite daunting. And then when you go through to triage and you see the nurse, but she doesn’t necessarily close the door. The door’s open and you’re just kind of perched on a chair, just there inside the doorway. That might not necessarily feel very private, because it’s just inside the main door that’s the walkway to all the cubicles (C5).
In addition to lack of privacy, another coordinator pointed out that rapport building can be difficult because of the ethos of the ED in comparison with the focus on care at Women’s Aid:

Here [Women’s Aid centre] you’re focusing on their emotional needs and often trying to empower them and get their confidence back, whereas A&E you’re going there to seek help for a broken arm or whatever it is, and then it’s like depending on the individual staff member … It’s difficult to built a rapport sometimes with a nurse or doctor because they might be seeing to your injury, going next door to see another. They haven’t got time to … ‘Are you okay? What happened? Do you want to talk about it?’ (C2).

Similarly, C7 said:

NHS staff are there for the injuries and then probably emotional support afterwards. Here it’s the other way round. It’s emotional support and then if injuries come about and we notice that, then it’s go and seek help for your injuries … And in A&E time is obviously a problem to offer that (C7).

Although A&E staff members, especially nurses, are trained to offer total care to their patients, some co-ordinators appreciate the difficulty of combining physical care with emotional support. The co-ordinators also identified lack of confidence as a barrier, as the staff did themselves in the previous chapter:

There might be obviously lack of confidence, they don’t feel as expert in … so they stick with obviously what is their expertise, which is physical body. I know a lot of A&E staff that will talk about the most personal and private things, find it
really difficult to ask the question ‘Have you been hurt, has somebody hurt you? Are you suffering from physical abuse at home?’ (C4).

Another co-ordinator felt:

Because we’re immersed in it, we might pick up signs and indicators very quickly and very subtle ones, whereas somebody who’s working in a different environment and isn’t kind of immersed in that all of the time comes across something, may not pick those things up to be able to pursue that a little bit further. So it’s potentially lack of knowledge. It might be fear on the part of the person that’s asking the question because there’s always that thing, isn’t there … A part of that is about a fear that if you say something you’ll upset her and make it worse (C3).

Although participants showed understanding of the challenges facing ED staff, they were deeply concerned at the potential for life-threatening consequences that non-identification of DV victims may have:

I’ve remembered a really bad one… a woman who had been very seriously assaulted by her partner, she thought he was going to kill her because he put her in the bath, and assaulted her, and made her take all her clothes off to assault her as if, you know, the intention was to go and kill her. He left the bathroom to go and get a knife, and I mean he very badly bashed … bruised all her legs and I can’t remember the exact nature of the injuries, but the injuries were significant that she had trouble walking … Somehow she managed to get him to agree to take her to A&E. And when he took her to the hospital he made her concoct some story on the way that she’d fallen down the stairs … The whole time he was there with her. He was very impatient with her while he was there saying ‘Come
on, hurry up, let’s get this sorted out, we need to go’ kind of very impatient wanting to get her out of the hospital as quickly as possible. At no time did the hospital staff ask to speak to her on her own … she would have disclosed what had happened and she would have got the help (C1).

Analysis of this participant’s account reveals two issues: first, the need for one-to-one assessment in a private place when suspected victims of DV arrive in the department; second, abused women repeat what the perpetrator has told them to say about the nature of their injuries. While emergency staff may have no power to prevent perpetrators and abused women from concocting false information, providing an environment where women may feel safe to speak truthfully is likely to yield positive results.

The co-ordinators’ evidence confirmed what has already been discussed elsewhere in this thesis (review of literature, 2.6; and women’s narratives, 5.3) regarding the barrier of low self-esteem and fear of authority:

I guess there’s barriers to women disclosing domestic abuse anyway, because they’ve been told, don’t tell anybody. I know there’s the shame, and sharing that, which is a barrier, the fact they’ve had their self-esteem probably bashed … So even if they then have the confidence to open up about it, they might think nobody will understand, it’s just them, nobody else is suffering with this … because a lot of women will say to me ‘I thought this was just me. I didn’t think like other people suffered this’. (C7).

Relating to the issue of whether private one-to-one assessment or universal questions on general assessment forms is more useful, some co-ordinators felt
that publicly asking every woman is likely to reduce women’s fear that they are alone. This also provides the opportunity to send a zero tolerance message to the public. Moreover, considering the difficulty of providing the privacy required for a one-to-one assessment in the context of EDs, this may be a preferred option.

In addition to altered confidence and emotional insecurity, the co-ordinators understand women’s fears concerning the repercussions of disclosure:

I think it’s fear of the unknown of what’s going to happen after they consult the doctor or go to A&E for their injuries. How is their partner going to react or ex-partner? Are they going to get into trouble? How are the family going to react? And also I think they think that if I go and seek help for my injuries and admit there’s a problem, that’s the end of the relationship and then they’re left on their own and they’re thinking ‘How am I going to cope financially,[with] the children?’ (C2).

I think because I’m Asian I can relate to it as well, and I see a lot of it but they’ll hide their injuries or they’ll say ‘I burnt it on the pan when I was cooking’. There’s always that concern about the family pressures and cultural barriers that they don’t want to cause a bigger problem, and that again prevents them from seeking help around their injuries because they know that once they open up it doesn’t stop there (C3).

Co-ordinators felt that embarrassment and the fear of being judged could further stop women from making their abuse known:
The biggest ones are about them being judged because bearing in mind if a woman has been to [A&E] several times, it’s very difficult to not feel that people are going to be looking at you. There’s an embarrassment, there’s a shame, a sense of feeling stupid that I’m in this situation but I’m helpless to do anything about it ... So that can be a massive barrier for people (C4).

One participant asserted that language could be a huge barrier on the path to disclosure:

Obviously, language skills can be a massive barrier. We have recently done work with a lot of Eastern European women who have come over whose language is very limited. Well, if you’re in a situation where you’re in a different country with a different setup and you don’t know. You might be saying it and then people don’t pick up on that's what it means because you might be using language that can mean something different (C3).

Overall, the co-ordinators’ statements in this section have covered the following:

a) Barriers related to victims;

b) Barriers associated with EDs;

c) Co-ordinators’ views regarding the need for effective strategy; and

d) Their suggestions for improved practice.

Co-ordinators’ accounts are particularly valuable because they appreciate the barriers that prevent disclosure. These barriers may be related to personal insecurities that women develop as a result of the influence of the perpetrator, as well as perceived cultural expectations. Furthermore, barriers caused by EDs were acknowledged, which related to the attitude of staff and the nature of the
ED itself. Additionally co-ordinators identified loyalty to the perpetrator, feeling isolated, embarrassment, and the fear of taking on the identity of a victim of abuse as factors that will prevent women from disclosing abuse. While recognising the difficulties staff face in combining physical care with emotional support, the co-ordinators stressed that life-threatening issues may be involved. In view of this, strategies advocated by co-ordinators could be valuable. Their suggestions regarding such strategies are discussed in the next section.

7.4 Intervention strategies

In the course of interviewing the co-ordinators, the participants were asked, based on their expertise and experience of working with DV victims, to identify what interventions they consider to be useful and how emergency staff might intervene more effectively in DV issues. In this section, the co-ordinators’ ideas are compared with the suggestions put forward by the other two participant groups as to how intervention within the ED could be improved. Three sub-concepts were viewed as emerging from the discussion:

- Value of sensitive questioning
- Raising awareness
- Encouraging autonomy and empowerment

7.4.1 Value of sensitive questioning

Asking sensitive questions about DV was identified by all co-ordinators as a valuable intervention for women. However, they qualified their statements with concerns about the circumstances in which questioning takes place. Notably, the importance of finding the right person to conduct interviews with abused
women was mentioned by all three participant groups interviewed in this study. One ED professional (P10) and some survivors (W4, W8) said having a male health professional conducting interviews is unlikely to result in disclosure. This view was also corroborated by one of the co-ordinators:

Well I mean the other issue is male staff isn’t it, often it’s the male doctors and whether they’re ever asked if they want to see … especially if a woman’s just been assaulted, she might have had a sexual assault as well as a physical assault. And you would hope they’d ask if, you know, if there is a possibility of there being a female interviewer, if they could offer that (C4).

Questioning needs to be done in private to build rapport, trust, and confidence before tackling the subject of the abuse. The interviewer also needs to show empathy when speaking to the patient:

You need to get the victim on their own and I guess it’s the way the question’s asked. Ultimately, it’s about the woman feeling there’s some trust or safe space … It’s about staff being able to convey some kind of compassion and empathy for the woman … It’s about being tentative about how they open up the possibility of what’s going to happen for them without blaming, or accusing, or interrogating (C5).

It’s about helping somebody to explore whilst you hold and protect that other person, almost. So it’s about not accusing, not blaming. It’s about sometimes not directly asking the actual question, because actually if you say ‘Are you experiencing DV’, they may never have considered that it is DV. They may not recognise DV as being what they’re experiencing (C8).
Another co-ordinator suggested:

Just give them an overview of the services and just give them that reassurance that you’re here for them ... you just let them take it in their own pace and just be ready for them. And I think we’ve all got that sort of personality and tone of voice and things like that to help someone in that situation feel relaxed (C2).

Despite differences in proposed solutions, we can infer from these statements that the circumstances of asking questions about abuse are important in obtaining a positive response.

Overall, the co-ordinators expressed the opinion that ED staff need to develop skills to identify indicators of DV rather than accepting women’s accounts at face value. Talking to victims about domestic abuse also involves recognising the need to prepare for specific interventions, whether or not the victim chooses to disclose abuse. This agrees with some of the ED staff’s suggestions (P5, P6, P8) and confirms the findings from the survivor group regarding denial or concealment of abuse:

I mean a lot of women will turn up and will either be in denial or will be covering up what has actually happened. So some kind of skills around checking that out, the women who say ‘I’ve fallen downstairs’ or some training, some skills to be able to kind of explore that a bit more and try and help them to feel safe and confident and that they can trust, that it’s okay to share, that the perpetrator won’t be told, if they do disclose ... and if they do not disclose, a reassurance that there is support when they feel ready (C5).
It is essential that interventions are sensitive to considerations of the appropriate moment for disclosure. Women may not avail themselves of the options offered until a considerable period of time has elapsed. However, supportive words from the outset will encourage victims to reflect on their options and may empower them to make informed choices in the future:

They might not be able to volunteer the information, but if somebody just asked the question they might just be able to think and say ... so, it's true, and maybe have such a relief that somebody had actually asked a direct question and somebody cares (C3).

The co-ordinators, in agreement with ED staff, also suggested the need for an extra person within the department who can be available to support victims of DV. This might be a trained member of staff, a trained volunteer, or an outside specialist in DV issues. This person could operate in the same way as mental health leads, who are on hand to assess patients in the A&E department:

I mean it could be a voluntary worker, you could get a voluntary domestic abuse worker to come in or a counsellor or someone who has those empathetic skills and knowledge about domestic abuse (C2).

Someone present who can offer that emotional support while someone else is seeing to their injuries because it’s difficult for doctors and nurses to offer that time you know, and it does take time (C6).

An extra body who is specifically there for that reason and who can be focussed to give that information (C5).
This suggestion appears common to most co-ordinators; the same suggestion was made by several participants in the staff group. However, the logistics of having specialist staff on hand, given the vagaries of shifts and staff movements that are common to ED departments, were not explored by either group and would need to be considered before implementing such a strategy. One co-ordinator felt it would be more helpful if there was a specific person or contact organisation to whom they could refer women for further assessment. Some co-ordinators also suggested that ED staff should be given details of their organisation and staff can ring them up for referrals:

Yes, they could ring up and say 'We’ve got somebody here at the moment’, ... I mean with outreach service it would be possible – I’m not saying always – if there was somebody up at A&E that needed a worker to go up and talk to them that we could potentially get a worker to go up. Now that obviously depends on who’s free, where they’ve got appointments, because they’re very, very busy obviously, but it’s not outside of the realms of possibility (C3).

In sum, the value of sensitive questioning was emphasised in the responses of all participant groups, but achieving the sensitivity necessary to encourage disclosure will be challenging in the busy environment of the ED. The viability of this suggestion needs further exploration, especially late at night when DV victims are more likely to present (P5) and the co-ordinators are not at work. A feasible alternative might be to provide information and raise awareness, for example, regarding 24/7 DV helplines. (Although, this also might need consideration in light of recent cuts to these services). The importance of such awareness raising is identified in the next section.
7.4.2 Raising awareness

Raising awareness of domestic abuse support services through posters and leaflets at strategic locations is another significant intervention identified by co-ordinators:

So perhaps maybe posters around the place to show that actually DV is an issue ... and then obviously leaflets, and posters, and just have it everywhere so that they can see (C6).

It might not be that that woman’s ready to receive that support but just handing them a piece of paper or a number or letting them know what services are available (C3).

Ladies toilets, we normally have the number on the door ... it’s just putting these numbers and details in somewhere it’s safe, that only women are going to be present (C1).

Interestingly, the strategy of providing information and creating awareness in EDs was common to all the participants in this study (survivors, ED staff, and co-ordinators alike) and this has been discussed at length in chapter 5 and 6. The next section discusses the importance of empowering abused women visiting the EDs.
7.4.3 Autonomy and empowerment

The co-ordinators emphasised the need for staff to acknowledge women’s strength over abusive situations, while recognising their own limits when offering options to women. Offering choices and leaving women to make their own decisions empowers women and it is likely to reduce feelings of frustration that staff experience when women refuse offers of help:

It is the woman’s choice ultimately and you can’t take that responsibility away from her. It is her choice, but it’s about respecting that she has a choice and not thinking ‘Stupid woman. Get out. What are you doing? Look at the state of you. You can’t stay’. You may feel those things but actually saying those is not going to help. It’s going to close her down (C4).

So it’s kind of bearing those things in mind and recognising your limitations as a worker and remembering that even if all you’ve done is heard her and she’s felt heard, that’s empowering. That’s showing respect that she might not have had. Even if all you were able to do is to say ‘There is support if things are difficult, if things at home are hard at times’ because you’re not blaming anybody then if you couch it in that language (C8).

Some co-ordinators were asked to comment on how they would manage issues of DV that may involve child protection and referral to social services. They stressed the need to support the woman from the beginning, explaining what you can offer and where you have a duty of care to intervene, as in child protection referral. This agrees with the idea of some ED staff that staff should be honest with women saying what they intend to do and what they cannot do. In co-ordinator’s view, the reasons for child protection referral should also be
clearly explained: the decision is based on the need to protect the child if the parent is unable to do so, without the intention of punishing the parent:

There’s obviously the issue around safeguarding children and obviously that’s a key thing … ultimately a child doesn’t have the choice to make its own decisions. A woman does. It might be difficult but she is an adult making choices for herself. If she’s making choices that are impacting on the children and she can’t protect them then obviously that’s when a worker will have to make a decision and step in on that … and I think that’s probably one of the most negative experiences [from health professionals] that women come to us with is when they feel they’ve been pushed, and pulled and bamboozled into doing things that they’re not ready to do. And all that does is you’re taking the power away if you’re doing that as a health worker and you’re only repeating what the abuser has been doing (C2).

There are times when a woman might disclose certain things, certain incidents, and we know that’s reached safeguarding, that’s child protection, and we will say to them this is something we can’t keep to ourselves. When they start to talk about it, it’s because they need to talk about it. It’s very rare that anybody slips it out by accident. So sometimes maybe they want help but they don’t want the responsibility and they’re frightened of the repercussions. They’re frightened that if social care get involved then the partner’s going to know somebody has been talking. So what we’ll do, sometimes we’ll work with social care to say they have to say it’s come from a neighbour, an anonymous neighbour, that they’re called to come and do an assessment, not that it’s come from the woman or Women’s Aid because she’s been talking to us about the domestic abuse. So their cover story is one that’s plausible and that won’t increase her risk (C8).
The co-ordinators’ accounts show an awareness of the interrelation between domestic abuse and child protection issues, which is largely absent in both the women’s and staff accounts. The ability of co-ordinators to negotiate with social services may be a valuable example for health professionals when dealing with abused women. One co-ordinators commented:

The threshold for taking children away is pretty high. People would be very surprised, you know. So social services often will go in and do an assessment and say ‘Alright, there’s domestic abuse and we need to be watching what’s going on, and we need some support in there’, but they don’t just run away and take the children away, and we know that so we can support them to understand that better because they have a fear that they’re going to have the children taken away (C1).

Again, these perspectives appear quite different from the majority of emergency staff interviews, where most seemed to be critical of ‘repeat presenters’. Perhaps this is because emergency staff are used to seeing immediate results. One co-ordinator stressed that allowing women to feel in control of their situation is not only crucial in transferring power to the woman but also in cementing a trusting relationship between victim and support provider. From such a standpoint, any intervention is hugely effective; even if it is just a word or a leaflet, the woman will experience some empowerment:

When you start to give the impression that they are in charge ... that’s very, very empowering because she then has a link to you. She thinks ‘She knows what I’m feeling’. And that is incredibly empowering. That’s where the sense of trust builds. That’s where people are more likely to start to open. If that’s as far as it goes and
the perpetrator comes in or a doctor comes in and ruins it at that point, And if that’s all she goes away with, that’s a really positive experience and that may be the start of the seeds that actually people might believe me (C1).

The perspectives of coordinators further illustrated how knowledge can defuse fear. As both abused women and health professional have insufficient knowledge about social services intervention, interaction is stifled by fear on both sides. Moreover, the timing of disclosure should be determined by women. Sometimes, all they need is to be given the relevant information and to be left to make their own choices. This echoes what ED staff said about women having autonomy, although they are coming from different perspectives. It is important for women to feel that they are taking charge of their futures and making their own decisions. While their choices may be limited, the act of choosing in itself is enabling and empowering. Women, who have had power and autonomy denied to them for long periods, need to feel that they have options and that their choices are understood and respected by others.

7.5 Chapter summary

This chapter has examined the accounts of voluntary service co-ordinators. It has detailed their experiences and the barriers to intervention that they observe. It has also examined suggestions regarding effective intervention for abused women. Issues identified include the following:

1) The need to extend care for abused women beyond treatment of physical injuries and provide support in terms of understanding domestic violence and recording details for future evidence.
2) Specific barriers to intervention within the department including characteristics of the ED; the focus of care in the department; and inadequate knowledge of staff regarding DV issues.

3) The comparison of co-ordinators’ view with the suggestions put forward by the other two groups as to how intervention within the ED could be improved, which revealed the importance of sensitive questioning, raising awareness, and facilitating empowerment.

Although many barriers can militate against successful DV intervention within EDs, the co-ordinators felt there are valuable interventions that can reduce the risk of the abuse getting worse, even when abuse is not disclosed. Some of their suggestions were in agreement with those of the survivors and ED staff. These include the benefits of universal assessment and referral; one-to-one interviews; asking about abuse in a professional manner; the importance of publicly available information within the department to reinforce zero tolerance attitude to DV; providing training for staff; giving options to women; and empowering them in their decisions.

Differences between the co-ordinators’ view and ED staff’s view include the coordinators’ long-term view of the DV situation; this recognises that women may suffer for many years before the abuse comes to anyone’s attention, or before the woman is ready to make life-changing decisions. This long-term vision enables co-ordinators to see that women develop coping strategies and appreciates the strength in their ability to survive. This contradicts some ED staff’s ‘quick fix’ approach for abused women. The co-ordinator’s approach emphasised avoiding blaming the woman or showing signs of annoyance.
regarding her coping strategies or her refusal to accept the staff recommendations. Instead abused women should be supported to make their own choices without criticism or reprisal. Understanding is dependent on knowledge of the dynamics of DV: this may not be achievable without training to correct misunderstanding and initiating policies that ensure positive response to DV in EDs.

Chapters 5, 6, and 7 have presented the findings of this study. They have discussed experiences and practices, barriers to intervention, and participants’ suggestions regarding the development of effective intervention strategies from the perspectives of three groups. The next chapter presents a discussion of the findings, incorporating the perspectives of all three participant groups and presenting theoretical conclusions arising from the study.
Chapter 8: Discussion

8.1 Introduction

The overall aims of this study are to fill gaps in existing knowledge about current interventions for women in ED settings who have experienced DV and potential strategies for implementing integrated intervention. To achieve this, the study explored the perspectives of service providers, service users, and coordinators of voluntary DV services. The interviews explored their needs, attitudes, and suggestions for DV intervention, which helped to formulate proposals for DV interventions in the ED. Combining the ideas and perspectives of the three participant groups provides a number of opportunities. It allows us to assess contradictory and complementary ideas and beliefs; identify barriers to intervention from both service users and providers; and begin constructing a multi-faceted strategy for DV intervention that is grounded in the experiences of all those involved.

In this chapter, the concepts identified in the findings (chapters 5, 6, and 7) are consolidated by demonstrating the relationships within and between participants’ constructs. Using the constructivist grounded theory research process (see 3.5.3), theoretical propositions were developed that credibly explain, justify, and give meaning to the research questions of this study. In addition, I have drawn on some perspectives of feminist theory and ecological theory to address some of the weaknesses in constructivist approaches. These weaknesses include the failure to engage with issues of power and the recognition of a nested environment for approach (see 1.7.5 & 3.7).
This chapter therefore begins by discussing the core concepts and categories identified in this study. Following this, the rationale for the theoretical propositions, and their implications, are examined. The conceptual framework for DV intervention in ED is then presented. Figure 3 below illustrates the conceptual schema, showing the links between the concepts and categories discussed.
Each of the concepts shown in the conceptual schema (Figure 3) is now discussed.
8.2 Meanings of DV: a conflict of interests

This study has shown the complex realities related to DV by illuminating the diverse perceptions of domestic abuse held by the participant groups. This focus on diversity produces a multidimensional picture of domestic violence which should enable better understanding and more useful intervention strategies. The categories discussed under this core concept include the following:

- Conceptualising DV: issues around definition and perception;
- Privileging physical abuse and stereotyping issues;
- Responsibility and blame construction; and
- Trust issues and institutional bureaucracy.

8.2.1 Conceptualising DV: issues around definition and social perceptions

The power of naming is at least twofold: naming defines the quality and value of that which is named … That which has no name, that for which we have no words or concepts, is rendered mute and invisible: powerless to inform or transform our consciousness or our experience, our understanding, our vision; powerless to claim its own existence … This has been the situation of women in our world’.

Du Bois (1983:106)

The different groups involved in this study appear to have different views on DV and how it should be responded to. Even within groups, there were conflicting perspectives. While DV generally covers coercive and controlling behaviours,
including physical, sexual, psychological, or financial abuse (Home Office, 2012; Women’s Aid, 2012), survivors in this study did not perceive themselves to be victims of DV when behaviour was controlling or abuse was psychological. They were only able to see their experience as a form of domestic abuse after consciousness-raising (see 3.7.5) was achieved through discussion at the Women’s Aid centre. Equally, cultural and individual perceptions of DV played a significant role in health providers’ ability to appreciate and respond to abused women. In this study, health providers’ perceptions of domestic abuse and survivors’ circumstances appear to bring about negative outcomes when it comes to assessment, intervention and treatment practices. Many health professionals voiced feelings of inadequacy with respect to identifying and intervening in domestic abuse; the majority perceived abused women to be secretive, uncooperative, and unwilling to leave the abusive relationship or request help. This has implications for health providers’ sensitivity. It includes the ability to provide care that recognises the multiple realities in the life of survivors, such as potential risks to their safety and that of their children; social and financial implications; and potential language and ethnic barriers (see barriers 8.4).

Additionally, the lack of a shared definition of DV among interested parties may result in mismatched concepts that can further hinder policies for active response. One outstanding issue relates to under-reporting of DV due to a limited definition, which was raised by the recent supplementary volume of the British Crime Survey in England and Wales (2009/2010) (Smith et al., 2011). The authors highlighted limitations in capturing respondents’ experiences of non-physical abuse, such as emotional abuse, threats, and financial abuse.
According to the report, insensitivity to the meaning and impact of DV contributes to underestimations and overall impassiveness regarding the subjective experiences of victims.

This study found that the way survivors conceptualise DV has implications for their internal power to pursue independence or overcome the abuse. For example, the escalation of abuse and survivors’ inability to cope with the relationship, rather than the perception of themselves as victims, were the triggers to seeking help. They employed different strategies to keep abuse hidden from the public domain, such as presenting an appearance of ‘normality’ in public as a way of protecting both their husbands and themselves. Women’s beliefs that the perpetrators were good men in many respects persisted throughout the controlling behaviours: women remained silent out of loyalty to the perpetrator and covered up the abuse using a variety of tactics.

Unequal power relations and fear of the perpetrator also accounted for the difficulties in making their abuse known; they maintained the pretence that the reason for their visit to the ED was unrelated to domestic abuse. Similarly, international studies have shown that varying conceptualisations of DV across different countries affect its recognition as abuse (WHO, 2012; Garcia-Moreno et al., 2005): the term ‘violence’ may be interpreted differently by different cultural groups both within and across societies. For example, the right to control one’s wife is still accepted in many cultures (both developed and developing countries) of the world; citizens including women, believe that wife-beating is a form of chastisement and sometimes a sign of love (Garcia-Moreno et al., 2005; Heise, 1999; Heise et al., 1998).
The problem of DV against women is primarily an issue of control: the lack of a balance of power in relationships is the single unifying factor in the variety of psychological and physical symptoms encountered in situations of domestic abuse (Gelle, 2000). As a result, feminist scholars negotiate meanings of DV through its gendered nature and its roots in patriarchal control (DeKerseredy et al., 2000). While the terminology of abuse as ‘domestic’ encourages the belief that it is a ‘family affair’ and not a serious crime, such conceptions are complicated by traditional social conditioning of women to place ultimate respect in the institution of marriage; that is, they must ‘love, honour and obey’ their husbands (Bowen, 1998). This perspective redefines domestic abuse as an extension of patriarchal beliefs in a male-dominated society, and not merely an interaction between two partners (Gelle, 2000; Hester, 2009). Further, deep-rooted beliefs of the patriarchal system are indoctrinated into women as well as men, which accounts for women’s acceptance of their partners’ dominance. This social conception of DV has implications for intervention (see 2.3).

Clearly, the way in which survivors in this study tried to negotiate their view of themselves and pressure to conform to the wishes of their partner and society is very complex. The distinctive features of power and control can make the abuse of women and its intervention approach complex; there is a need to recognise underlying gender and historic patriarchal issues associated with abuse when formulating policies. While the Home Secretary is currently reviewing the policy in the area of widening DV definition (Home Office, 2012), it is also important that the definition of DV is harmonised: it will thus recognise meanings and terminological dilemmas for both service users and providers.
8.2.2 Privileging physical abuse and stereotyping issues

Hiding abuse is exacerbated by the psychological nature of domestic abuse: the majority of the survivors in this study attended the ED presenting unrelated symptoms, such as heart problems, asthmatic attacks, and stress. They felt these were overlooked by ED staff as symptoms of domestic violence. This study has clearly shown that the opportunity to offer life-saving support is often missed by ED staff as they fail to extend intervention beyond the treatment of physical injuries. The correlation between DV, psychosomatic problems, and mental health problems (Golding, 2002) implies that the likelihood of abused women visiting EDs with non-physical, indirect symptoms will be high. In particular, denying identification and provision of support for psychological abuse does not reflect a holistic interpretation of DV. Moreover, the lack of standard procedures for recording injuries results in missed opportunities for corroborative data, which can be used for research and legal evidence.

The significance of psychological abuse over physical abuse expressed by the survivors in this study reflects the wider literature (see 1.2). Arguably, indirect symptoms can complicate the identification of emotional abuse in the ED; it may be further obscured by women’s attempts to conceal abuse. However, in the survivors’ view, these symptoms reflected hopelessness in the face of an apparently inescapable situation. There is an additional burden of having their bid for help interpreted as attention-seeking and time-wasting. Self-harm and suicidal intent, as expressed in survivors’ accounts, are rarely an absolute desire for death. Instead, it is usually a cry for help or coping strategy (see Table 10).
Stereotypical beliefs identified among providers in this study included the following: women will always go back to an abusive relationship, no matter what you do or say; women will be offended by intervention; and women will always lie about the source of their injuries. For their part, some survivors (who are highly educated and from affluent background) were concerned that health professionals have a stereotypical image of abused women as poor, non-working class, uneducated, and sometimes coming from particular ethnic groups. According to them, educated, affluent, British women do not fit this image. For this group, awareness of how they are perceived by others including their health providers, their social position, and the ‘horror of having to keep the status quo’ (W3) make them reluctant to disclose their abuse. Social expectations are different for each social group, but are constraining nonetheless: one survivor, who is white, British, highly educated, and comes from an affluent background, said her experience of rejection by family and friends, as a result of her decision to leave her abusive relationship, was appalling. Some of the comments she received from friends and family included:

People like us do not do that sort of thing, what else does she want ... it isn’t cricket, how could you show the family up? (W3).

The specific experiences of two women in this study, who are British, highly educated and come from affluent backgrounds, contradicts the notion that British culture is supportive when it comes to leaving abusive relationships. Although survivors from this study were either White British (4) or African (4), the findings indicate that ‘keeping the status quo’ by hiding abuse is a common
experience irrespective of ethnic group. Other studies (Izzidien, 2008; Thiara & Breslin, 2006), have found that women from the South Asian community are often concerned about the stigma and shame that they believe they will experience within their families and communities if they decide to leave an abusive relationship. As a result, some Asian women would rather stay in violent relationships in order to preserve their cultural identification and honour. In agreement, one of the co-ordinators, who is of Asian ethnic origin, noted that ethnicity, cultural beliefs, and language barriers can be huge obstacles to getting help. From her experience, this is especially true among women from Asia or Eastern Europe who have recently come over to Britain:

I’m Asian I can relate to it as well, and I see a lot of it but they’ll hide their injuries ... there’s always that concern about the family pressures, cultural and even language barriers (C3).

The findings of this study and evidence from Asian women (Izzidien, 2008; Thiara & Breslin, 2006) suggest that while traditional beliefs and myths may be more pronounced in certain ethnic groups, hiding abuse is likely to be a widespread phenomenon. This indicates the need for intervention strategies that recognise the general difficulty women face in disclosing domestic abuse. Such interventions should also ensure that staff members develop awareness of cultural diversity in understandings of domestic violence and its victims. They should be skilled at recognising and providing help, including interpreter services, to women from different social and cultural backgrounds. ED staff should also be aware of their own social and cultural prejudices about DV and its occurrence.
8.2.3 Responsibility and blame construction

Survivors in this study locate the source of blame and responsibility for abuse within themselves; they perceived a failure to fulfil their roles as ‘good wives’. Embedded in the wider structure of self-blame are feelings of inadequacy and powerlessness. They reached the conclusion over time that abuse was triggered by their perceived shortfalls and inability to make their men happy.

The sense of powerlessness is built up by constant condemnation from the perpetrator, fear that the abuse will worsen, and fears of social ostracism. This results in a lack of self-esteem that makes relationships with the outside world, including health professionals, increasingly difficult. With time, they became habituated to a life without power, autonomy, or the ability to take immediate responsibility to end the abuse.

I had little or no self-confidence to take responsibility for my lives and actions (W4).

For survivors in this study, shifting responsibility becomes an internal process. Specifically, they shift the responsibility for the abuse from the perpetrator onto themselves, and they feel powerless to take responsibility and or deal with the violence.

Conversely, health providers in this study expect the act of requesting help to start any form of intervention in ED. They respect the decisions of abused women, presuming they are based on the reasoning of an autonomous adult; they therefore exercise caution in order not to exacerbate the situation or offend
women. However, their feelings of frustration when they suspect women are concealing abuse, conflict with their felt sense of responsibility and sympathy for the victims. Furthermore, staff members face the restrictions of the department, in terms of its organisational priorities and the absence of official support. Consequently, some members rationalised their inability to act by falling back on stereotypical beliefs about the nature of DV and the characteristics of its victims. For their part, survivors leave the department disappointed and frustrated, given the apparent uncaring attitudes exhibited by healthcare providers in the ED.

A recent Swedish study (Edin et al., 2010) reported similar feelings of powerlessness among pregnant abused women. They found powerlessness and a lack of self-confidence resulted from persistent control and threats from the perpetrator. Abused women in their study lacked the confidence to make their abuse known to their midwives. Instead they used different strategies to enable them to endure the abuse such as loving the perpetrator more and accepting that the abuse was their fault. Beyond these findings, the qualitative examination of both staff and patients in the present study reveals interaction between health provider and victim has not fulfilled its potential for developing a positive relationships and successful interventions.

Moreover, this study has shown that ED staff and the abused women suffer similar dilemmas. The autonomy of the health professional is inhibited by their fears of exacerbating the situation, of upsetting the woman unnecessarily, and of the consequences of getting things wrong. Similarly, abused women are unable to make decisions about disclosure due to fears, further abuse should
the perpetrator find out, lack of knowledge about the options open to them, and a lack of self-esteem. These mutual fears and frustration, while undefined and unresolved, inhibit the possibility of building trusting relationships. Consequently, the autonomy and independence of both nurses and abused women may be context-bound extending beyond the control of either group.

8.2.4 Trust issues and institutional bureaucracy

This study has shown that the issue of intervening in DV goes far beyond ED staff and the women experiencing abuse. Both the survivors and ED staff voiced a lack of trust in the health service’s ability to help and provide support for abused women. Some nurses felt that women will not disclose their abuse or ask for help because they have lost faith in the NHS due to past experiences, where they have not received support after leaving a perpetrator. Similarly, abused women said they are often worried about difficulties with authorities regarding the safety of their children, as well as the financial consequences of leaving. In agreement with this finding, other studies have shown that some abused women are unable to obtain effective protection from abusive situations despite seeking help (Women’s Aid, 2007; Batsleer et al., 2002).

Moreover, ED staff in this study showed little consensus regarding action to be taken once women disclose abuse. While some felt it is irrelevant to their practice, other felt that non-disclosure often prevents them from taking steps to intervene. Yet more said they would be unlikely to intervene even if women disclose their abuse due to a lack of skills to handle the issue. Part of the problem appears to be caused by mixed messages from the health service organisation to the providers, where they are encouraged to intervene if they
suspect abuse. In agreement with this finding, another UK study (Haggblom, 2006) found that although health visitors felt strongly that they should be able to respond effectively to abused women, their understanding of DV issues, their experiences of dealing with victims of abuse, and their comfort with screening varies with the individual. Health professionals need consistent guidance from all levels of the organisational hierarchy if they are to develop a systematic body of practice with regard to DV intervention. Thurston and Eisener (2006) have argued that integrating awareness of DV intervention into the perspectives of health professionals may not be achieved without efforts to incorporate DV policies and interventional strategies into staff routines. Ambiguous policies and inconsistent pathways for referral clearly perpetuate insufficient intervention, thus excluding a large proportion of abused women from getting assistance. This also influences women’s trust in the ability of health service to provide help.

The lack of a mandatory requirement to screen for domestic abuse and the failure to provide training, resources, and policy guidelines signal an inadequate national commitment to dealing with this issue. This is then reflected in the attitudes of healthcare organisations, including ED staff in the present study. Additionally, the use of an index of suspicion at a higher level of the NHS contributes to uninformed staff practices and insufficient commitment to addressing DV. The Government’s recent proposal to review the definition of DV is a step in right direction. However, it is vital that any future DV policies increase the awareness of guidelines and improve practice. This study has shown lack of awareness among staff of policies and referral pathways for women experiencing DV. Clearly, EDs can only be part of the solution;
government decisions including recent closures of women’s services should be reconsidered, as these services provide critical support to abused women.

In conclusion, this section has explored a number of meanings embedded in participants’ accounts of their experiences, including definitional and stereotyping issues; responsibility and blame constructions and their implications for positive user-provider relationships; and institutional bureaucracy and their implications for building trust. The next section discusses a range of barriers to intervention from both the users’ and providers’ accounts, as this has further implications for building relationships and potentially successful intervention.

8.4 Barriers in participants’ constructs

Barriers to seeking and providing help as a specific concept proved useful in isolating factors that both deny women access to services and prevent staff from providing support. These barriers have been discussed under the following headings:

- Fear, trust, and knowledge issues as common barriers to intervention;
- ED context and environment; and
- DV and health service policy.

8.4.1 Fear, trust, and knowledge issues as common barriers to intervention

A diverse set of fears were identified in survivors’ accounts as reasons for concealing abuse: fear of being blamed for the abuse; fear of being called a
failure; fear of indignity and suffering humiliation in society; fear of loss; fear of escalation of the abuse; and fear of the perpetrator. These fears are complicated by a need to protect the perpetrator, from which we might also infer that women are afraid of public exposure, criticism, and the consequent loss of self-respect. Perhaps the most disturbing fear of survivors in this study was their fear of involving health professionals in their problems. Participants believed that they might end up worse off if they disclosed the abuse, due to the effects of official intervention particularly the possibility of losing their children, the financial effects of terminating abusive relationships, possible censure and isolation from family relationships and lack of trust in statutory service providers’ help.

Likewise, there is a considerable reluctance on the part of staff to question women when they suspect that abuse has occurred, even when the injuries showed classic symptoms of DV. Staff members were apprehensive about compromising the privacy of women with invasive questioning, especially since their suspicions are neither based on evidence nor corroborated by disclosure. This prevents ED staff from pursuing such cases beyond the level of suspicion. Their apprehension on this count is further complicated by fears of the consequences of their intervention. They identified consequences such as reprisals from the perpetrator; imposing a victim identity on the women; and the possibility of upsetting the women.

Given the need for professionals to protect themselves, there may be a temptation to believe that abuse experienced by mothers puts their children at risk (Dowd et al., 2002). Undoubtedly, the fear of losing children can threaten
any fragile trust developed between victims and health professionals. Consequently, there will always be a conflict between developing trusting relationships and the mandatory requirements to which professionals are subject. Sadly, this conflict not only hinders the development of trusting relationships but also compromises the likelihood of accepting help.

Survivors said that the insensitive attitudes of emergency staff made trusting relationships almost impossible. This is in agreement with other studies that have pointed out that the attitudes of service providers impede disclosure (Chang et al., 2003; Feder et al., 2006; Edin et al., 2010). The present study has extended the findings from these studies by locating a parallel concern among staff: a lack of strategies to support abused women after disclosure was perceived by staff as a major barrier to developing trust in the professional/client relationship.

One UK study found that fear is a shared barrier to DV intervention for both mental health nurses and abused women (Mills et al., 2011). Again, the findings of the present study have extended our knowledge in that specific underlying trust and knowledge issues were identified as being fundamental to such mutual fears. The involvement of co-ordinators in this study has provided nuanced insights into how the shared fears of service users and providers may be circumvented through knowledge; both groups’ awareness of each other’s fear might become beneficial to relationship building and potentially successful intervention.
8.4.2 ED context and environment

Another major barrier to intervention and disclosure identified by both service users and providers is the context of the ED itself. In particular, the lack of privacy, pressure to process patients quickly and crisis-oriented response further shape existing attitudes. This results in a tendency to neglect issues of domestic abuse. Some staff believed that the ED environment does not allow for one-to-one intensive intervention; the department is lacking in private spaces, away from perpetrators or family members; and the context of the department inevitably means that patients requiring urgent treatment take priority in receiving staff attention.

ED staff were aware that building trust can take time, but ‘getting the time’ to intervene was identified as a major barrier. On a similar note, survivors want to take their time to thoroughly consider options before making decision. However, staff members are required to prioritise dealing with immediate care: four-hour time targets in the ED mean that time is at a premium. It is unlikely that immediate offers of help will be appreciated or accepted; a substantial amount of time must be invested for an abused woman to develop trust and confidence in her health professionals. In view of this conflict, a productive relationship between the user and the provider is unlikely to develop naturally: both the user and provider’s perspective will need to be modified.

This finding has been established in other research, where ED staff have identified time issues, effective patient processing and the nature of the ED as reasons why DV intervention has been overlooked (Hamburger et al., 2004; Minsky-Kelly et al., 2005). In extending the evidence of these findings however,
the accounts of ED staff, including their manager, reveal that organisational policy is a fundamental barrier: it both informs practice behaviour and influences the ED environment with regard to DV intervention. The ED’s culture places responsibility for disclosure on the client and is only responsible for intervention when there is suspicion. This leads to an unspoken policy of non-intervention, so that victims only receive assistance when they present physical problems. The implications of this situation are further examined in the next section.

8.4.3 DV and health service policy

The current health service approach to assessment and intervention in DV contributes to a passive attitude towards intervention; this is ill-suited to building the trust and engagement required to meet the needs of abused women. In spite of decades of acknowledgement of DV as a serious healthcare issue, some staff in this study consider DV irrelevant to their practice. In their view, failure to provide specific training for staff in this area is in essence an indication that DV is not an organisational priority.

This finding has implications for how the NHS supports the staff in carrying out DV interventions. Even though the UK Department of Health (DOH) has provided intervention guidelines and training tips for healthcare workers to use in situations where DV is suspected, a significant finding in this study is a general lack of awareness of any documents or policy covering this area. The staff’s descriptions of their practice certainly do not indicate the use of any guidelines. When asked, all staff members including the manager said they were not aware of any specific guideline or policy to follow when confronted with
DV cases. This situation could be interpreted as insensitivity to the issue of DV against women.

Perhaps organisational responsibility lies with the influence carried by the DOH in determining NHS policy. It is clear that national bodies directly and indirectly influence and determine local organisational policies. Such inability to establish awareness of the severity of domestic abuse within the healthcare system could be a reflection of the social and political construction of DV at different levels.

In addition to the lack of awareness among staff, this study found that vulnerable adult pathways, which can be used for any vulnerable adult over the age of 18, are perceived by many staff as being reserved for the elderly. Consequently, interventions for younger women (18-64) either do not occur or they were recommended police involvement.

If they’re vulnerable adults … the elderly we tend to notice it more on and we’ll refer them through the vulnerable adults system. People that are middle-aged and adult generally, it’s not something we highlight … It’s either the police or nothing usually (P1).

In the absence of additional intervention for younger women living with domestic violence, local health services are failing to meet the threshold duty of care. Although adult safeguarding is a statutory responsibility for health providers, not evaluating staff practice concerning DV and not providing mandatory requirements for identification and intervention (as applicable is to child abuse) contributes to a failure to engage with the problem.
Intervening in domestic violence only when there is a risk of harm to children may not be sufficient to ensure that abused women and their children receive support. Stanley reported that separating a woman and her children from the perpetrator does not guarantee their safety, as the risk of harm from the perpetrator often increases following separation. Besides, while child protection will be relevant in some cases, it may not be appropriate for all families (Stanley et al., 2011).

In agreement with this study, Robinson and Spilsbury (2007) in their systematic reviews of qualitative studies conducted in UK, Australia and the USA reports that adult women experiencing DV experience difficulties in accessing health services. The difficulties were attributable to the appropriateness of referral and support. The vulnerable adult pathway should provide avenue for assessment, referral and support for adult women experiencing DV. However, inappropriate responses by provider indicate a lack of awareness of vulnerable adult policy and its use in DV intervention. This has implication for a comprehensive intervention approach in ED as well as a review of the legislature underpinning vulnerable adult referral.

The stereotypical belief that many abused women do not take steps towards freedom but repeatedly keep going back to the abuser may have contributed to the passive attitudes towards abused women. This shows a lack of understanding of why women stay in abusive relationships. In agreement with
Stanley (2011), the findings of the present study stress the need for service providers to understand the intricacies of DV and social service referral; in the co-ordinators' view, the decision to refer should be based on the need to protect the child if the parent is unable to do so, not with the intention of punishing the woman for not leaving. Hester (2009) argued that the notion that DV is a mere family dysfunction where the protection of the children takes priority denies DV as a gender based coercive and controlling issue. Recognising DV as a platform for child abuse is a step in the right direction. However, assessment of danger that is only based on having children or being pregnant can further perpetuate lack of trust in the ability of health service to support women. Instead, assessment should be conducted with empathy, an approach that recognises gendered meanings of the abuse and a consciousness of the temptation to believe that every abuse of a mother puts her children at risk.

Additionally, this study has shown that providers do not have confidence in their own suspicions, which has implications for the effectiveness of the current ‘index of suspicion’ screening practiced by majority of the health institutions in the UK, including EDs. The system of index of suspicion screening means that patients are asked about domestic abuse only if a healthcare professional has reason to suspect that an incident of DV has taken place (Olive, 2007). An index of suspicion is based on subjective indications and privileges physical injuries: as a result, staff may choose to disregard their personal convictions, as they are not bound by any institutional policy to ensure effective intervention and consistent group practice. The staff showed little consensus regarding actions to be taken once women disclose abuse. Some felt intervention is irrelevant to their practice; some felt that non-disclosure often prevented them
from taking steps to intervene; others said they would be unlikely to intervene even if women should disclose their abuse, due to a deficit of skills with which to handle the issue. Evidently, ED staff in this study found DV intervention uncomfortable and many acknowledged a lack of competence and expertise in this aspect of their role. Undoubtedly, all these factors underscore the attitude of ‘turning a blind eye’ and sometimes the shifting of responsibility which was evident in participants’ constructs.

In sum, this section has examined user and providers’ perspectives on barriers to DV intervention. Issues discussed include fear and knowledge issues as common barriers to intervention, the impact of ED context/environment and DV and policy bureaucracies. The next section compares participants’ suggestions regarding practical DV interventions in the ED; these are examined in the context of the conflicting perspectives that emerged from the data.

8.5 Constructing grounded theories for DV intervention

Grounded theory’s strategic approach to data collection and analysis allowed concepts to be distilled from an enormous qualitative data set through induction and comparative techniques. Core concepts from the data form the basis for constructing theories as they provide explanations for similar concepts and inform a framework for viewing and understanding the phenomenon critically. Grounded theories delineate, refine and define key issues that move participant’s account from basic description to in-depth explanation and useful interpretation (Kelly, 2009). Thus, apart from explaining the phenomenon of interest, it provides a practical guidance and a framework for moving forward.
However, constructive grounded theory assumes interpretive traditions by acknowledging shared experiences and relationships between the researched and the researcher. The process of theory construction is enhanced through looking at the phenomenon from ‘multiple vantage points, making comparisons and establishing connections while building on leads and ideas’ (Charmaz, 2006:135). The emerged theory and its explanations are inherently verified through grounded theory’s technique of analytic induction and constant comparative procedures. Yet they have contextual boundaries which must be acknowledged by the researcher and anticipated by the reader (Charmaz, 2006). Knowledge construction in qualitative research is not mechanical; as a social process, theory construction inevitably bears the imprint of the researcher’s background and values as well as reflects the historical context of the phenomenon. In contrast with positivist and objectivist view of theorising, the emerging theory is interpretive, explanatory and eclectic while making clear propositions about what is happening and what fits the substantive area of study (Charmaz, 2006). Nevertheless, the researchers do not gain an ‘autonomous theory’; rather one that is amendable to modification (Charmaz, 2006:149).

This study has incorporated multiple and diverse perspectives which helped to illuminate the emerging concepts and enrich emerging grounded theory. In addition, theoretical sensitivity has been gained through pondering and asking questions about the studied phenomenon as well as placing priority on patterns, relationships and differences rather than linear reasoning (Charmaz, 2006). Through this process, a comprehensive theory has emerged from the participant’s construct namely- ‘Towards an integrated DV intervention in EDs’
(see 8.6). Seven explanations have been constructed for approaching and intervening in DV against women. These are presented as ‘theoretical propositions. It is expected that further testing and modelling within the EDs will ensure that they become a coherent theory for DV intervention in the department. The process of concept comparison and theorising is now discussed, after which the theoretical propositions and their explanations and implications for practice will be discussed.

8.5.1 Comparing and evaluating perspectives for developing theoretical explanations.

Incorporating multiple voices in this study was useful for illuminating specific and general factors from the groups regarding DV intervention. Apart from following on participants’ leads and ideas during analysis, making comparisons and establishing connections within and between participants’ construct proved valuable for theory construction. For example, some shared issues were identified as barriers such as fear, trust, knowledge, and the ED context. These issues are common to both survivors and staff in this study, even though survivors do not see these barriers in staff and vice versa. On the other hand, what women want from intervention and staff perception of helpful interventions appear to be different. To begin with, the parallel and conflicting view in participants’ construct are highlighted below in Table 10:
Table 10: Parallel and conflicting views in participants’ constructs

<table>
<thead>
<tr>
<th>Components of intervention</th>
<th>Staff</th>
<th>Survivors</th>
<th>Co-ordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy</strong>: institutional DV policy as bedrock for DV intervention.</td>
<td><strong>Policy</strong>: in terms of Universal intervention-assessment form, ask about abuse.</td>
<td><strong>Policy</strong>: standardised referral and intervention procedure for ED.</td>
<td></td>
</tr>
<tr>
<td><strong>Skill building</strong>: Training for staff to ensure efficacy and confident intervention.</td>
<td><strong>Skill</strong>: training for staff on body language; asking about abuse; ascertain real reason for visit; correct stereotypical beliefs; recognise small and persistent steps; show understanding and support.</td>
<td><strong>Skill</strong>: knowledge that dispels fear; training on dynamics of DV; trust building techniques, each encounter reinforces empowerment; small steps strategy.</td>
<td></td>
</tr>
<tr>
<td><strong>Environment</strong>: supportive and encouraging staff to intervene; privacy.</td>
<td><strong>Environment</strong>: ED environment should be DV friendly.</td>
<td><strong>Resources</strong>: advocacy; awareness and information; useful numbers in toilet; posters; leaflets; on call DV personnel.</td>
<td></td>
</tr>
<tr>
<td><strong>Resources</strong>: wordless intervention such as information and awareness raising—posters, leaflets, cards with numbers; DV experts among staff.</td>
<td><strong>Resources</strong>: awareness and information through posters; leaflets and useful numbers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome / Result of intervention</th>
<th>Staff</th>
<th>Survivors</th>
<th>Co-ordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term perspective</strong> (influenced by professional gold standard). Expect victims to accept immediate options.</td>
<td><strong>Long-term perspective</strong>: want to take their time and want staff to understand. Appreciate little steps: rapport building, support, information and positive ED environment.</td>
<td><strong>Long-term perspective</strong>: a notion that each encounter contributes to success rather than achieving immediate success; should empower the victim and build trusting relationship.</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Staff</th>
<th>Survivors</th>
<th>Co-ordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of DV policy and commitment to DV intervention as fundamental barrier that spawns other barriers; lack of knowledge, time, privacy, fear and trust</td>
<td>Fear of consequences; lack of internal power to take decision; ED environment; staff attitudes; lack of trust and confidence in staff ability to help.</td>
<td>Fear of perpetrator and consequences of leaving; lack of knowledge, time and privacy; ED environment; and lack of uniform policy for referral and intervention.</td>
<td></td>
</tr>
<tr>
<td>Issues and ED environment. Non-disclosure.</td>
<td>Leaving</td>
<td>Leaving equals freedom from abuse, should be an immediate option.</td>
<td>Leaving is difficult and challenging: often considered late due to consequences, lack of information and lack of support.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Critical of repeat presenters; self harm and suicidal attempts sometimes construed as waste of time and attention-seeking.</td>
<td>Repeat presenter(s), self harm and suicidal attempt</td>
<td>Felt misunderstood by staff. ED visit is seen as a refuge, a bridge, a temporary escape, a cry and call for health providers’ help.</td>
<td>Coping strategies for inescapable situations, strength and ability to survive in the mean time; ED a place of escape from harm and refuge for victims; missed opportunities for ED to document for legal and research evidence and provide assistance.</td>
</tr>
<tr>
<td>Makes the staff feel frustrated, helpless and unable to proceed.</td>
<td>Non-disclosure</td>
<td>Viewed as coping strategy; a way to protect self, the perpetrator and to avoid consequences and societal objection, ambivalence, responsibility shifting.</td>
<td>Viewed as coping strategy; expected attitude from victims as a result of consequence of abuse on their self esteem until trust and confidence in themselves and the ability of staff to help is gained.</td>
</tr>
</tbody>
</table>

In addition to highlighting conflicting and shared views, it became important to assess the contribution of each participant group in the light of the evidence of the other groups. Thereafter, it was possible to build on those suggestions most likely to be useful as a premise for potential interventions. For example, while the perspectives of co-ordinators of DV services revealed an extensive body of knowledge about intervention strategies, ED staff and survivors’ views incorporated an awareness of the complexity of domestic abuse and its relationship with other issues such as the emergency department’s focus on
immediate treatment and women’s readiness to disclose abuse. The challenge for this study therefore is to resolve key issues and conflicts to find a balance between the differences in users’ and providers’ perspectives while reflexively examining ‘what is happening and what fits’. It was also vital to recognise the asymmetries to determine how such conflicting views impact on the future development of DV intervention in ED.

Theoretical sampling (See 3.5.4) is a useful pivotal strategy in grounded theory methodology for resolving issues and construing propositions. Draucker et al. (2002) suggest that theoretical sampling is said to occur when: (a) interview questions are refocused to gain specific information regarding an emerging concept; (b) interviews are redirected as some categories became saturated and participants introduced new concepts; and (c) interviews are modified to validate theoretical concepts. As concepts emerge in this study, tentative theoretical propositions were explored through additional data and refocusing/modify interview questions. Glaser (1997) and Charmaz (2006) recommendations for construing theories were also followed, such as being open to emerging concepts; following up recurring patterns in participant data; and asking key participants to give more information on categories that seem central to the emerging theory. The ED manager, the chief coordinator of DV voluntary service, and one of the survivors (W3) were asked more information on key categories for clarity.

These processes allowed the researcher in this study to gain specific information that defined core concepts and resolved some queries on which the theoretical analyses were based. Basically, categories that fit together form an
explanation or model that generates the propositions. However, validating these against the data further ensures quality: revisiting the data with the focus on analysis for fit, understanding, transferability, and usefulness (See Table 5). This process demonstrates the usefulness and applicability of the emerging theoretical propositions (Morse, 1994).

Moreover, I used memoing as a tool to ponder, ask questions, and establish connections between concepts emerging from the data. As I involved myself in this method, actions were further elucidated and processes expounded; the study moved from the level of simple description of concepts to the establishment of theoretical explanations (Charmaz, 2006). Observing these vital processes has helped the construction of core concepts as premises for formulating a conceptual framework for DV intervention ED. The overarching theory and its seven theoretical explanations for the development of DV intervention in ED is now discussed.

8.6 Towards an integrated DV intervention in EDs: a comprehensive grounded theory

The integrated theory illuminates the diverse perceptions of domestic abuse held by the participant groups, which contributes to the way DV is viewed and responded to. It has shown the multifaceted realities of the issues involved in DV intervention, and has produced a multidimensional framework that will enable better understanding and more effective intervention strategies. The analysis of the complex data emerging from participants’ perspectives, regarding the diverse meanings, barriers, and expectations of DV intervention for women visiting EDs has informed propositions for understanding the theory
and improving the care provided to women experiencing DV. These are valuable in balancing conflicting interests with respect to DV intervention in the ED such as the specific characteristics of the ED which are likely to impact on the extent of practical intervention for abused women. However, the participants’ views reflected a consensus in the efficacy and suitability of some interventions. This was due to a number of constraining variables including ease of implementation; economic viability; potential for empowerment; immediate visual effect; and the provision of an environment that encourages feelings of safety and trust. Moreover, successful intervention was identified as the development of collaboration with community services and the empowerment for women at each encounter to make choices without experiencing prejudicial feelings. Further, in agreement with the review of literature, approaching the problem through isolated units of cognitive functioning is a limited approach. Equally, this study found that both barriers and facilitating factors cannot be attributed to any single component or strategy. Rather, complex, multilevel components involving organisational, environmental, and individual factors are necessary; thus requiring an integrated approach.

This section presents and discusses the seven theoretical propositions. They are not theories but strategies/components proposed for understanding, addressing and explaining the overall synthesised theory. These are:

1. Universal intervention and sensitive questioning
2. Holistic interpretation of DV
3. Balancing expectations
4. Redefining success/effective outcome
5. Environmental support for intervention.
6. Consciousness raising and awareness at all levels
7. Looking beyond the individual

These theoretical propositions and their implications for practice are examined one after the other in the following paragraphs.

8.6.1 Initiating universal intervention and sensitive questioning
Universal intervention implies that every woman coming to the ED should be treated as a potential victim of DV: assessment, information, and awareness should be provided irrespective of disclosure. This should also include integrating DV questions into ED assessment proformas. Universal interventions give women the control of making independent choices in their own time and without prejudice. It also makes asking about DV a routine and relieves staff of the burden of the ‘index of suspicion’ model and the fear of making things worse.

All participant groups in this study agree on some universal interventions, including: asking every woman about DV; availability of leaflets, posters and local numbers within ED for all; improved staff attitudes that reflect understanding of abused women’s situations; and standardised referral for abused women. A few studies have reported increased disclosure following routine questioning or integrating DV-related questions into assessment forms (see 2.5). However, this study proposed a multidimensional model that is not limited to routine questions or chart modification alone. Instead a universal
intervention proposed in this study incorporates resource and environment component e.g. providing resources like posters and leaflets that ensure that the ED environment is positive with regard to DV intervention.

It must be noted however that this study has shown a disparity between the views of participants regarding how women experiencing DV should be identified in ED. Some participants advocated a specific one-to-one approach. This process involves the initial development of rapport, followed by offering one-to-one confidential interviews in a relaxed atmosphere where abused women can feel confident to talk. The other perspective appeared to recognise the nature of the ED: it offers a universal approach of asking every woman about abuse and laying out options for the victim to consider.

Arguably, the adoption of the private method remains somewhat idealistic and unworkable in the busy multi-tasking environment of the ED unless for example DV co-ordinators could be on call to offer more time. In order to circumvent the problems of who, when, and where, a universal questioning and referral system appears a safer way of intervening. It also sends a zero tolerance message to society without prejudice or singling out any particular woman. Moreover, considering the number of abused women who may not perceive themselves as victims or who have culturally-specific definitions of abuse or who are ambivalent about disclosure, it would be misleading to assume that specific intervention will be beneficial to all abused women. Further, it may be difficult for staff to discern whether an abused woman is at a point where she is able to accept help (WHO, 2005). On the other hand, universal assessments are useful
irrespective of the specific situation of the abused victim, type of abuse or the 
level of psychological harm experienced.

In addition, attempts to achieve universal improvement in staff attitudes towards 
abused women may be difficult (Campbell et al., 2001). A universal assessment 
form has been found useful in standardizing practice in ED (Olson et al., 1996). 
Moreover, a universal intervention will be likely to receive widespread NHS 
acceptance as it increases safety for both survivor and ED staff. Also, it is 
economically viable in terms of cost effectiveness and time management (Olson 
et al., 1996; Feder et al., 2011).

In spite of this merits, the channels of information and the methods of 
communicating with patients are clearly crucial. The value of sensitive 
questioning was set out by the responses of all participant groups and is 
therefore one significant intervention that might be further developed within the 
ED. The review of literature on assessment tools for DV has documented the 
cultural bias inherent in ‘objective’ measures (Brookoff et al., 1997; Plitcha, 
2007). While the tools provide useful information about abused women, 
integrating other kinds of data, such as past medical reports, has been found 
valuable (The Family Violence Prevention Fund, 2004; Suzuki et al., 2000). This 
evidence makes one-to-one interview an essential part of DV assessment 
process, in agreement with some survivors’ and co-ordinators’ views. Besides, 
any cultural or language issues relating to DV can be further explored. While 
developing such cultural awareness within ED may be difficult and time-
consuming, the failure to address this issue means that some abused women 
will continue to fall through the net. On the basis of this, there should not be a
strict ‘either/or’ approach to adopting a universal assessment or one-to-one sensitive questioning. Sensitivity of questioning should be improved in some ways, especially following identification even if resources are concentrated on universal intervention like assessment questions, information resources and referrals.

Finally, it is important that as part of universal intervention, ED staff are professionally prepared to overcome the challenges of dealing with DV. Otherwise, universal assessment may descend into ‘box ticking’ and shunting abused women off to specialist services. Such training ensures that interventions are designed to include sensitive consideration of the appropriate moment for disclosure. Women may not take up the options offered until a considerable time period has elapsed, but supportive words from the outset will encourage victims to reflect on their options, and may empower them to make informed choices in the future.

8.6.2 Holistic interpretation of DV

A holistic interpretation of DV implies that ED staff (as well as their patients) understand DV beyond physical injuries. This study has shown that diverse perceptions of domestic abuse are held by the participant groups, which contributes to the way it is viewed and responded to. It may be impossible to achieve a more effective intervention strategy without recognising the multidimensional nature of domestic violence (DeKeseredy, 2000). These facets relate to the multiple forms of occurrence; exclusive and uniform definitions among providers; correction of stereotype and prejudices; and the recognition
that women may need emotional support. Equally, cultural, societal and individual perceptions of DV play a significant role in service providers’ ability to appreciate and respond to abused women. The perception that abused women are generally secretive, uncooperative and unwilling to leave abusive relationships or request help has implications for the sensitivity of health providers. For example, there are still gaps in the providers’ understanding of the multiple realities in the lives of survivors. These include potential risks to their safety and that of their children due to leaving, social and financial implications and potential language and cultural barriers to receiving help (see barriers 8.4). These factors are likely to contribute to repeat visits to the ED, which leaves the ED staff more frustrated. Moreover, a holistic interpretation will also involve correcting stereotypical beliefs among providers, for example, that women will always go back to abusive relationships, women will be offended if you ask them about DV, women will always lie about the source of their injuries and that women have to disclose abuse before staff can intervene.

Survivors also have some stereotypical beliefs about ED staff, including the perception that they are too busy and help should be sought elsewhere. A shared definition of DV among service users and providers may facilitate holistic interpretation. Nonetheless, the attitudes of providers and the ED environment give tacit interpretation of what services exist in the department and which services have priority.

Smith et al. (2011) affirm that limitations in capturing respondents’ experiences of non-physical abuse, such as emotional abuse, threats and financial abuse contribute to impassiveness with respect to the subjective experiences of
victims. In view of the evidence that abused women often present with symptoms not directly related to acute incidents of abuse, it is vital for ED staff to develop a more holistic understanding of DV. They also need to adopt a mechanism for documenting cases as future evidence for legal and research needs. In the absence of this, underestimation of the extent of DV is likely to continue, which also has implications for resource provision.

Clearly, efforts to develop interventional strategies should not only focus on physical abuse alone. They should recognise the multiple faces of abuse, as well as its socio-cultural dimension and gendered nature. Such recognition makes explicit the hidden forms of emotional and psychological abuse which so often go unidentified; and the different characteristics of DV against women also make intervention strategy different to those for abused men (WHO, 2012). Given DV’s various meanings, it is vital to initiate a standardised definition and assessment questions should be validated to ensure that they are meaningful/relevant for the patient group to which they are addressed and that they reflect the socio-cultural meaning of the abuse.

8.6.3 Balancing expectations

Balancing expectations is significant in this study both for service users and providers alike. This implies a need for providers to have more realistic expectations of abused women’s attitude towards disclosure and acceptance of help. On the other hand, abused women also should understand the limitations of ED staff in meeting their expectation. Achieving a healthy balance is likely to reduce the frustrations experienced by both parties. The addition of co-ordinators’ viewpoints has been useful in balancing the contrasting perspectives
of survivors and ED staff. For example, coordinators pointed out the difficulty of combining physical care with offering emotional support, especially in the absence of suitable training. Likewise, they identified survivor dispositions, such as lack of self-esteem, as reasons why health professionals should not expect immediate disclosure. There is also a need to examine ED staff’s assumption that abused women are independent and autonomous adults. They need to understand that survivors may not be capable of making rational, independent judgements, especially during the acute stage of the abuse as fear of the perpetrator is all pervasive. However, it should also be noted that leaving a relationship at this point is likely to increase the risk of further retaliation by the perpetrator.

Moreover, coordinators highlight coping strategies, as evidence of strength and the ability to survive, despite being placed in an intolerable situation. These include behaviours such as excessive alcohol intake, drug dependency, and self-harm. The view expressed by some ED staff that repeat visitors are a waste of time is significant to this study, though it is not a view shared by co-ordinators and survivors.

But she’s been in about half a dozen times since then … she keeps coming back in but she won’t leave him (P10).

The co-ordinators’ views are similar to survivor’s in that they recognise that abused women may suffer for many years before the abuse comes to anyone’s attention, and that there are other prevailing circumstances in the lives of women which can hinder immediate action. It may seem that fear of the
consequences of disclosure force women to endure abusive relationships rather than confront their situation. However, survivors in this study gave the impression of wanting their abuse to be discovered. It appears they want someone to take responsibility for revealing abuse but submerge this wish in cries for help; this is one of the reasons for frequent visits to the ED. Coordinators, while understanding staff’s problems of context and time, noted that leaving can be challenging, and can place women at higher risk of acts of revenge from the perpetrator. An understanding of abused women’s situations should make every encounter with health professionals an opportunity for empowerment, until such a time that women feel ready to make changes.

Likewise, this strategy of balancing expectations necessitates women appreciating the constraints on providers to meet their needs at all times. Other studies have recognised that the nature of ED settings poses a barrier to intervention (Davis & Harsh, 2001; Ramsdeen & Bonner, 2002). In agreement, this study has identified shared recognition of this barrier among users and providers, as well as infrastructural barriers such as a dearth of time and privacy. Nevertheless, one evaluation of routine screening for DV against women (Thurston et al., 2009) concluded that while these barriers are not easy to overcome, their approach to problem solving and the number of women helped makes the ED the best setting to implement intervention.

We may conclude from survivors’ statements that they desire nothing short of consistent commitment from highly-skilled ED staff, capable of recognising DV and having an awareness of their own cultural prejudices about DV. However, many of the practical innovations that they suggest involve small, simple steps
to make this commitment visible and effective. Some survivors do appreciate the nature of the ED setting and the fact that time is at a premium. Small simple interventions, such as showing understanding and providing information, are preferable to no interventions whatsoever. However, ED staff need to develop a good understanding of the dynamics of domestic abuse and a greater awareness of policy mandates e.g. adult safeguarding as a prerequisite for productive interactions with their patients. This understanding will contribute to acceptance of survivors' limitations and will improve the option of immediate resolution when abused women are identified and offered help. Each encounter with professionals should present women with options, respect their choices, avoid blaming them for their situations, and avoid signs of frustration with regard to their coping strategies or failure to accept staff recommendations.

8.6.4 Redefining success

Successful intervention was identified as the development of collaboration with community services and the empowerment for women at each encounter to make choices without experiencing prejudicial feelings. The coordinators’ and survivors’ interpretation of successful intervention is that each encounter with the provider should contribute to success rather than achieve immediate success; each encounter should empower the victim and build a trusting relationship. While staff seek quick and easy resolutions, survivors’ accounts show that slow but persistent intervention eventually made a positive difference to their health and general quality of life. Hence repeat presentations should be seen as a renewed opportunity to build on and offer support rather than frustrating and ‘time-wasting’. Just as balancing expectations is important for achieving the goals of DV intervention, there is also a need to redefine success.
This should acknowledge the fact that survivors take a long-term perspective on what they regard as successful intervention. This means taking their time to make decisions, which staff should understand. However, in the meantime they appreciate staff showing acceptance of their long-term perspective. Encounters with staff should provide information, build rapport, and the ED environment should be supportive and positive.

Redefining success in DV intervention has been endorsed by recent DV researchers as a useful strategy for success. For example, one evaluation of advocacy for abused women in GP practice in UK (Feder et al., 2011) defined success to be identification of abuse and offering safety advice. Likewise, a US study (Thurston et al., 2009) evaluated routine screening in an ED and defined success as asking as many women as possible about DV. Similarly, a New Zealand study (Wills et al., 2008) in their system-wide evaluation of DV intervention defined success as empowering women at each encounter.

The result-oriented attitude to intervention of ED staff is likely to have been shaped by their specific training, which rewards immediate outcomes. This study has shown that such perspectives run contrary to survivors’ expectations (see Table 12). The result-oriented perspective is perhaps the accepted norm of society in general; it is likely, therefore, that ED staff have come to their training with this viewpoint already embedded in their cultural makeup. This is subsequently reinforced by the influence of general NHS outcomes and the specific demands of a busy ED. However, it may be difficult for staff to adjust to a long-term perspective with respect to DV treatment without a shift in their thinking and the organisational support needed to embed a longer term
perspective. Ongoing training and managerial support has therefore been identified as necessary by both the present study and other studies (Wills et al., 2008; Thurston et al., 2009; Campbell et al., 2001).

This redefinition is necessary not only in the context not only of the NHS, but also in relation to national policy and commitment to DV. The small steps advocated by survivors may be interpreted as ineffective outcomes, since their success may be difficult to demonstrate. While outcome research to assess the success of DV intervention in ED can be difficult (see 2.7.3) and expensive (Thurston et al, 2009), it is clear from the present study that women want to be given time to consider their options. In my view, the question of whether or not to implement DV intervention without research to show its efficacy is more political than practical.

Overall, changing the parameters of successful intervention will be necessary for staff to appreciate the potential benefits of these strategies. This study has shown that redefinition of success as showing understanding and acceptance of the long-term perspective of survivors will be appreciated by abused women. Beyond this, a reorientation of staff thinking to this perspective will be likely to increase staff satisfaction, insofar as they have offered help even if abused women takes no drastic steps towards leaving the relationship. This study therefore supports taking small interventional steps to encourages a redefinition of success based on the long-term perspective of abused women. This is in spite of the difficulties in evaluating the efficacy of such interventions.
8.6.5 Consciousness raising, training and awareness

The theme of consciousness-raising is a central tenet of feminism, which recognises that the process of investigation can have an awareness-raising effect on both subjects and researchers (Richardson, Fonow & Cook, 1985; Cook & Fonow, 2007) (see 3.6). In relation to this principle, this study has produced a rupture in both the normal routine of ED staff regarding DV management and the hidden life of survivors. This exposes the reality of participant experiences and enables them to view issues in a different way. This awareness was evident throughout the participants’ discussions. In particular, this awareness was evident in issues regarding meanings associated with DV and its intervention, barriers to providing and receiving help and suggestions for interventional strategies. Thus, consciousness-raising in this study serves both as a source of political engagement and as a tool to identify limiting and facilitating factors for DV intervention (Cook & Fonow, 1885).

This study has shown the need for consciousness raising for both ED staff and survivors. For instance, the staff-survivor model of interaction revealed in this study showed that communication is inhibited by fear on both sides. Regarding the involvement of social services, staff practice resulted in the avoidance and silencing of abuse, especially when younger women with no children are involved. There appear to be conflicting feelings of frustration for not intervening, concern about getting things wrong and apprehension that intervening may upset women and worsen the problem.

It’s not something that you can brush under the carpet ... but you don’t want to do the wrong thing either (P7).
Similarly, survivors are concerned about taking a wrong step. Non-disclosure works as a defensive mechanism; repeat visits to the ED without disclosure are really a cry for help. There appears to be a double bind between the fear of taking the first steps to disclosure and the realisation that if they do not take some kind of action the abuse could get worse. Unfortunately, the abuse could also get worse if they decide to leave (Stanley et al., 2011), thus highlighting the complexity of the decisions involved for the women.

However, circumventing this shared uncertainty around asking and providing help may be possible through awareness raising. The perspectives of the co-ordinators illustrate how knowledge can defuse fear and how this can form the basis for redesigning intervention. Clearly, consciousness raising for staff includes training: this is likely to be the start. Staff needs a re-orientation to accept that every encounter may not result in an ‘expected’ outcome, even then the opportunity has to be given. However, it is to be regarded as a positive outcome when real trust, self-confidence, and empowerment is achieved by both parties.

Similarly, co-ordinators’ ability to negotiate with the time pressure, privacy and social services would be a valuable skill for health professionals when dealing with abused women. For them, supporting abused women means clearly stating what you can offer and explaining where you have a duty of care to intervene, such as in child protection referral. This will lead to a trusting relationship. Moreover, giving women a sense of being in control of their situation is crucial for transferring power to the woman and in cementing a relationship of trust.
between victim and support provider. Beyond building trust and empowering women, the provider also ends up being empowered insofar as they have sense of satisfaction and confidence in delivering proficient care (as discussed under the need to redefine success).

To further corroborate the significance of consciousness raising, a majority of the staff, including the manager, saw this study as a welcome wake-up call. Staff felt that participating in this study made them reflect on their interaction with abused women; it produced an awareness of barriers specific to the ED and provided an insight into the need for increased levels of sensitivity, which they felt unable to attain within the parameters of the department. For example, they compared DV intervention with procedures such child protection referral, where they are able to provide time and space to assess children and offer support. Staff suggested that similar resources and training could be deployed to achieve successful intervention for abused women, as part of adult safeguarding.

Similarly, survivors found that consciousness raising was achieved through participating in this study. Apart from finding that sharing their experiences with the researcher was emotionally relieving, participating in the study enabled survivors to see themselves and their suggestions as valuable: they have contributed to efforts that may influence policies relating DV management in ED.

Pagelow (1984) advocated the participation of target groups in the planning and the conduct of research. She recommended that research on interventions for
abused women should incorporate women living in shelters and their staff in the sample. Shelters provide a client population of women who are potentially available for study; at the same time, shelter staff are a vital source of information regarding both organisational features and interpersonal group processes relevant to the delivery of services for abused women. This technique has been espoused in this study, by helping subjects to identify their barriers and formulate their own plan to overcome these barriers.

Combining the strategy of consciousness raising and organisational change can be a useful strategy for political engagement and policy change in DV intervention (Mies, 1983; Cook & Fonow, 1986). Feminist principles are not only driven by an interest in gender influence and power relations, but also social transformation and empowerment (Cook & Fonow, 1986; Andersen, 2005; Ramazanoglu & Holland, 2002). While the ultimate intention is transformation, the researcher should specify which research findings are necessary to influence the subjects and bring about change. Feminist consciousness raising has been innovative in this study as a source of insight, not only for survivors but for the organisation and the staff, into DV issues and its management. This qualifies it as a contributory approach to eliciting strategies from respondents in this exploratory study. However, the next step of the study which will involve implementing and evaluating the proposals will require incorporating principles for social and organisational change.

8.6.6 Supportive environment for intervention

Another proposition from this study is ensuring a supportive environment for DV intervention in the ED, for both the provider and the service user. There is a
universal human tendency to underestimate the impact of the environment and social circumstances to explain people’s behaviour; we tend to base explanations on individual factors alone (Green & Kreuter, 2005). In the context of DV intervention, this is reflected in an inclination to ignore the complexity and the multidimensional nature of DV intervention, which undoubtedly requires a more holistic approach. Instead, most intervention approach has focused on individual factors from both service users and providers (Thurston et al., 2006). Whilst individual factors do play a role in providing and accepting of help for DV, other studies (Campbell et al., 2001; Loughlin et al., 2000; Wills et al., 2008) have shown that organisational and environmental factors are much more important for success: the quality of interpersonal relationships and the availability of support networks influence individual action.

In terms of putting suggestions into practice, it is unrealistic to expect staff to continue to balance conflicting requirements whilst remaining emotionally committed to their work. Instituting a positive working environment for DV intervention in terms of managerial support, training, and provision of resources was recognised by staff as crucial to beginning and sustaining DV intervention in the department. Staff thought the resources available at both environmental and policy levels would need to be evaluated. This is particularly relevant to the organisational culture in which people work, and the training and supervision provided to staff. Added to this is the lack of statutory requirements for procedures to address DV and the failure at a local level to enact policies related to DV intervention.
It was also clear from survivor and co-ordinators’ views that support for DV intervention is still lacking in the ED. They advocated a number of measures to mitigate this: commitment to universal assessment and referral procedures; an ED environment that articulates support for DV intervention; a standard procedure for recording injuries in case corroborative evidence is needed in the future; and policy that supports the extension of roles beyond the treatment of injuries when dealing with abused women, to include emotional support.

In agreement with this study, other non-UK studies have shown that a supportive environment in the ED leads to successful intervention programmes (Wills et al., 2008; Thurston et al., 2009). The ED environment can shape providers’ practice behaviour as well as the behaviour of victims towards DV intervention. Participants in this study advocated creating environmental changes by using posters, leaflets, and TV/media adverts. This could be influential in creating awareness for victims, sensitising staff and sending a zero tolerance message concerning DV to society in general. Survivors also felt that the ED environment should be more conducive to the discussion of private issues like DV.

Green and Kreuter (2005) have argued that there is always a reciprocal relationship between behaviour and the environment where the behaviour takes place. As a result, both the immediate environment in which a person is operating and broader social influences, including cultural contexts, policies, laws and societal ideologies, are all crucial to interventional success. The need to provide training and resources to the individual on a day-to-day basis was identified by staff as crucial to successful intervention. For example, none of the
ED staff in this study had had any training specific to DV intervention while in the department. Failure to provide this and other resources signals a lack of supportive working environment that is then reflected in the attitudes of staff.

Finally, the cumulative blend of risk factors and barriers to intervention identified in this study suggests that programmes will be more effective if they address a broad spectrum of cognitive, interpersonal, and social factors. A model that recognizes the intricate relationship that exists between the individual and their social environment is therefore recommended. This stems from the recognition that while individual factors may be identified, individual behaviour is determined to a large extent by the social environment (Green and Kreuter, 2005). Consequently, an ecological perspective has been found to be useful as a unifying approach that brings together the propositions as well as the attributes of constructive grounded theory and feminist perspectives.

### 8.6.7 Looking beyond the individual: an ecological model for integrating intervention components

Clearly, the strategies offered in this study calls for the movement of healthcare system traditions towards a broader interaction between organisational, environmental, and individual components within the ethic of care. This collaboration is vital for the success and stability of the strategies. Thus, this final component recognises interactions with others, including interactions between health providers and service users; with the environment; and bidirectional influences within the systems.
The need for a comprehensive framework to address the complexity of DV intervention has increased the support for an ecological model among DV researchers (Heise, 1998; WHO, 2002; Butchart et al., 2004; WHO, 2005; Dutton et al., 2006; Kearne et al., 2008). The ecological model comprehensively addresses public health problems at broad and multiple levels: DV is viewed in the context of a web of relationships, including the individual, the organisation, the environment, wider society and wider policies (see 1.7.5). A key feature of the ecological model is that it highlights how health and wellbeing are affected by changes at various levels of the social system (Heise, 1998; WHO, 2005). While the ecological framework operates on many levels, its inherent flexibility allows for step-by-step implementation or modification. Thus, interventions may be aimed at different levels; they may involve one or more components at a time and may be achieved through efforts between and within levels and components.

For example, intervention may be focused on the individual, such as training for staff or providing wallet-sized information cards for abused women. Intervention can also focus on environment such as the work environment, the family, or social network. This could change the institutional set-up of the ED institution, such as by modifying assessment forms or developing a victim-friendly ED environment by placing posters and advertisements within the ED. This also demonstrates a zero tolerance attitude, which may deter perpetrators of domestic abuse.

While age dimension in this study may not offer a strong analytical conclusion due to sample selection bias and limitations in sample size, I found it important
to note the diversities in the participants’ group. Half of the participants are White British (4 out of 8), 2 survivors are black British and the other 2 are from black origin (1 is a Black African and 1 from Caribbean). This ethnic intersection and variation in background characteristics highlights the need to account for multiple grounds of identity and thus a broader scope of intervention characteristics prescribed by ecological model.

Clearly, the ED has an important role because women experiencing DV visit the ED because of its place on the front line of care, but the ED cannot provide all the answers. The support of a wider integrated system of care is necessary for effective interventions in the ED. While the ED is a specific environment, it exists within the wider environment of healthcare and society. Therefore, there is a need for the ED to develop wider relationships with other healthcare providers, voluntary organisations and other ethnic specific systems within which (interested) women can be supported (such as Asian women help lines and African women help lines). For example, the coordinators in this study indicated the willingness to take referrals and offer support to ED staff when the need arises.

Overall, the review of literature in this study shows that many interventions have not been successful because they did not include the components recommended in this study. Crucially, there has been a focus on training provision alone and an emphasis on short-term results (screening, referral, action by woman) rather than taking a longer-term view (even if the impact of this is more difficult to measure) and addressing organisational and environmental factors. Furthermore, they did not include perspectives of
survivors and co-ordinators, which consider resolution on an experiential basis.
Finally, achieving change in DV intervention in the ED will require a multi-component strategy, including a co-ordinated system beyond the ED as shown in the conceptual framework below.

**Figure 4: Conceptual framework for integrated DV Intervention propositions**
8.8 Chapter Summary

This chapter has so far provided a rich analysis of the complex data emerging from participants' perspectives, regarding the diverse meanings, barriers, and expectations of DV intervention for women visiting EDs. It has also formed propositions for improving the care provided to women experiencing DV. This study has illuminated the diverse perceptions of domestic abuse held by the participant groups, which contributes to the way DV is viewed and responded to. It has shown the multifaceted realities of the issues involved in DV intervention, and has produced a multidimensional framework that will enable better understanding and more effective intervention strategies.

Intervention propositions (such as universal interventions, long-term focus, the influence of consciousness raising, the position of environmental support in practice behaviour and redefining success) and their implications for ED practice have been discussed. These are valuable in balancing conflicting interests with respect to DV intervention in the ED such as the specific characteristics of the ED which are likely to impact on the extent of practical intervention for abused women. However, the participants' views reflected a consensus in the efficacy and suitability of some interventions. This was due to a number of constraining variables including ease of implementation; economic viability; potential for empowerment; immediate visual effect; and the provision of an environment that encourages feelings of safety and trust. Moreover, successful intervention was identified as the development of collaboration with community services and the empowerment for women at each encounter to make choices without experiencing prejudicial feelings. Further, in agreement with the review of literature in this, approaching the problem though isolated
units of cognitive functioning is a limited approach. Equally, this study found that both barriers and facilitating factors cannot be attributed to any single component or strategy. Rather, complex, multilevel components involving organisational, environmental, and individual factors are required.

Thus, the three approaches embedded in this research - constructive grounded theory, feminist perspectives and the ecological principle - have informed the theoretical proposals which in turn form the basis for developing an integrated DV intervention strategy. The framework incorporates all the components of intervention while accommodating a unique blend of factors (for example locating intervention within its gendered meanings) which are relevant to the strategy. While the barriers indentified are multifaceted, the framework (Figure 4) provides a useful illustration of how the components are connected and bidirectional to achieve an integrated intervention in the context of the ED. The next chapter specifically discusses the contributions and implications of this study, as well as its limitations and recommendations for further research.
Chapter 9: Implications, limitations, and recommendations

This study has generated such a wealth of material that any conclusions offered in the preceding chapter and this chapter can only be considered preliminary and indicative rather than exhaustive. Even so, it is clear that the study has opened up new areas of inquiry and debate that have urgent and important implications for policy and practice. This chapter therefore clarifies the claims and remit of the study by establishing its contributions and limitations, in addition to discussing its implications. Finally, recommendations and further research are outlined.

9.1 Contribution to knowledge

To my knowledge, this is the first UK study to qualitatively (utilising a grounded theory methodology) explore the development of DV intervention in ED from the distinct perspectives of service users, service providers and voluntary organisations dealing with domestic abuse. This study adds to the insights of existing non-UK studies by investigating the practice of service providers and experiences of service users (Wills et al., 2008; Wallace, 2002; Campbell et al., 2001). However, in addition to this prior knowledge, this study has identified what women want from DV intervention in the ED, provides outstanding insights into intervention strategies by involving voluntary service coordinators and uses theoretically explicit procedures to develop an interventional strategy in the context of the ED.

By utilising a combination of approaches, this study has provided unique insights into DV intervention by drawing out the different meanings embedded in the experiences of service users, service providers, and co-ordinators of
voluntary DV services. This may be instrumental in informing future practice. An additional ‘tool’ to grounded theory methodology - feminist perspectives - has enabled depiction of other issues, such as the influence of gender, political and cultural factors on the experiences and perspectives of participants. These are deemed necessary for the purposes of the study. In particular, such perspectives takes into account the sensitivity and gendered nature of DV, which is made visible by the socio-political and personal influences that affect abused women’s attitudes to seeking help. These influences are further discussed under the section on implications. In addition to the issues which will be outlined in the recommendations and implications of the study, the following points are considered significant:

- The study has documented how different meanings associated with DV (held by health providers, abused women, society and the Government) have effectively deprived abused women of a voice and have assisted abusers in perpetuating cycles of violence. This has denied an arena to support victims and has, in fact, masked the very existence of DV.

- The study has revealed the unspoken non-intervention policy in EDs, the ambiguity of ‘index of suspicion’ screening and a general lack of institutional commitment to training and awareness raising. These factors form the bedrock of EDs’ failure to address the treatment of DV in a sustained and sensitive manner.

- The study has shown a clear demand for ED services from DV victims, and how the department is sometimes the only lifeline for many abused women who are seeking escape and refuge from abuse, especially in the evenings and at weekends. The study has criticised the failure of EDs to record suspected incidents of DV: these may be required as evidence at
later legal proceedings, which provide a vital opportunity to protect women at risk of serious injury or homicide.

- Also, the study has revealed the complexity of the ED environment: it has been designed for immediate treatment of urgent (mostly physical) problems and lacks the space and time for private interaction. It has also revealed complexities in the intervention of suspected cases of DV, such as victim’s ambivalence and the diversity of conditions that give rise to a visit to the ED. The ED is only one piece of the puzzle in terms of what should be a system of care for women. The ED may be on the front line of care, but there are other components in the overall system that needs to be addressed.

- In addition to suggesting possibilities for service development, the study has contributed to the creation of a multilevel awareness of the significance of DV intervention. It has caused the survivors, ED staff and their manager (using consciousness raising) to consider how intervention might be integrated into departmental practice.

- The study has elucidated how expert contributions from co-ordinators of voluntary organisations are valuable in developing sustainable healthcare interventions for abused women in EDs. For example, their contributions revealed how issues around social services involvement in child protection can be circumvented through proper information, understanding of the role of social services and good working relationships with DV voluntary services.

- The range of barriers identified by the three groups of participants has contributed to a more complex understanding of the issues involved in DV. While the barriers to DV intervention identified by participants were
similar to those described in the wider literature (Minsky-Kelly, 2005; Mills et al., 2011), the study has identified that deep uncertainty is embedded in both service users’ and providers’ attitudes to intervention. This implies the need to build trust and change practice policy.

- The study has explicitly made theoretical propositions for components of DV intervention strategy in EDs, which are grounded in data acquired by rigorously inductive and interpretive research procedures. The design of the study, in adopting a variety of perspectives, has offered an array of implications for policy, practice, and future research. Further, while the survivors shared the experience of being abused, they were not homogeneous in terms of their demographic characteristics.

- Incorporating perspectives from less qualified and less experienced staff members provided a fresher approach to strategy. The in-depth individual interviews allowed a close analysis of each individual to create complex narratives. Concurrent data collection and analysis, as well as phased interviews, allowed both similarities and differences to be considered. This also provided verification of accounts to support theoretical robustness.

- In addition, the researcher relied on the use of reflexivity during data collection, transcription, analysis, and writing in order to consider the inter-subjective and relational aspects of the research.

- Finally, this study has taken a feminist stance that challenges the norm of objectivity, by adopting an approach that accentuates the dialogue between the researcher and the participants (Abdullah & Zeidenstein, 1978; Barndt, 1980; Fonow, 1985). This relationship has informed the entire research process, including how data is elicited and how findings
are interpreted. Mies (1993) termed the bonding process between the researcher and the participant ‘conscious partiality’. First, adopting one-to-one semi-structured interviews ensured interactive conversations with respondents; it also allowed a balanced relationship by placing the interviewee on a more equal footing with the researcher. Secondly, a conscious connection between the researcher and the respondent demonstrates the inherent transformation of the participants in confronting obstacles and formulating their own plan of action (Mies, 1983; Cook & Fonow, 2007).

The following sections outline the implications of this research for policy, practice, and future research.

9.2 Implications for policy and practice

This study, whilst exploratory in nature, has several implications for current health policy on the management of DV, particularly in EDs. While publication of a DV handbook for health workers in the UK is a commendable indication that it is taken seriously as a healthcare issue, this study found a lack of awareness among ED staff. This extended not only to the handbook but to any guidelines that could inform practice with respect to DV intervention. In agreement with this study, the wider literature shows evidence that, in spite of Government guidelines, DV intervention is not an explicit aspect of service delivery in EDs (Olive, 2007; Ramsay et al., 2005; Feder et al., 2009; Sethi et al., 2004). The literature not only reveals a general reluctance to identify women experiencing DV but it also shows the difficulties of integrating consistent intervention strategies into the practices of health providers (Thurston & Eisener, 2006;
Plitcha, 2007). These failures may be caused by the current dearth of evidence reported by systematic reviews (Ramsay et al., 2002; Feder et al., 2009).

Unfortunately, the conclusions of the reviews could have delayed the implementation of universal DV intervention programmes, both across health services generally and specifically in clinical settings in the UK.

Staff practice is an indicator of how national guidelines regarding intervention for abused women have been interpreted by local policy makers and health organisations. For example, this study showed that staff behaviour is the outcome of pressure on staff to only assess physical risk, while little time is invested in providing staff with the knowledge and resources required to offer help to, or empathise with, abused women. As part of a wider policy regarding DV intervention in the department, further consideration should be given to how the conflicting discourses in this study on ‘priority’ and the duty of care may impact on effective provision of DV intervention. The focus on physical care and the ways in which frequent visits by abused women to the department are construed by staff need to be re-evaluated. Policy makers and service providers would benefit from greater clarity concerning the dynamics of DV intervention as a gateway to further care.

Given the complex, sensitive nature of DV issues, the index of suspicion currently being utilised will require reconsideration. It may be fruitful to consider how DV is being conceptualised by abused women, service providers, and society at large (see 8.3). This may reduce the huge responsibility placed on women to behave autonomously by asking for help. The complexity of survivors’ lives has been demonstrated by this study, where the fear of the dominating
partner extends to a fear of authority and people in general. The fear that no
one will believe that they are innocent victims of violence extends to a belief that
DV is a common relationship phenomenon. Independence and autonomy are
often subordinated; the dominant experiences are ones of lack of control,
isolation and powerlessness. Understanding this complexity is currently absent
from the health service recommendations, in terms of ‘index of suspicion’
screening and reliance on self-disclosure. Similarly, it is largely absent from the
service provider discourse, which mostly focuses on a particular view of repeat
presenters as attention-seekers and time wasters. Perhaps more critical is the
absence of any consideration of this complexity in recent systematic reviews
(Ramsay et al., 2002; Feder et al., 2009), which recommend that there is no
justification for DV screening in healthcare settings. The key question is whether
the problem comes down to a lack of evidence or a lack of efficacy. I argue that
this is more of a lack of efficacy, based on how interventions have been
implemented and evaluated: they have focused on training alone and have
mainly evaluated immediate results.

This study recognises the complexity and multifarious nature of the problem
through its examination of the perspectives of both service providers and
service users. Offering ‘universal intervention’ to abused women, as
recommended by this study can offer a starting point in building a richer
understanding of women’s requirements from DV intervention. Developing staff-
patient interactions that go beyond treatment of physical injuries alone and
engage on a personal level with patients’ stories will be the starting point for
productive intervention.
In addition, more attention should be paid to executing child protection referral in families where DV is an issue if it is to be beneficial. The current practice privileges the abuse of children while ignoring the abuse of the mother. Moreover, the woman bears the consequences of protecting the children (if there are any) as well as having to leave (her home and standard of living) and stay in a refuge. Such negative perceptions experienced by abused women create psychological barriers to engagement with service providers. However, a more positive encounter that explains social service procedures and incorporates support for women is likely to inspire confidence in survivors. Otherwise, women are likely to interpret the procedure as primarily a device to take their children from them and to protect the hospital and the staff from government sanctions rather than being for the women’s own benefit. It is important that staff convey their desire to help the patient, and to obtain the right care for them by ensuring that the process is positive and empowering. If not, women will find it difficult to connect and collaborate with child protection procedures.

Unlike cases involving child protection or vulnerable elderly patients, where procedures are in place for referral to social services, interventions in DV against women with no children and who are not considered elderly appears to be shrouded in silence within the ED. Failure to engage with the issue may be due in part to the lack of awareness of requirements for assessment and intervention. Whereas child protection protocols are perceived by participants as mandatory practice protocols, young adult and middle aged women receive inappropriate responses such as seeking help from the police and not the EDs. In the absence of explicit, comprehensive and fully integrated local DV policies,
adult women (under 65) who have no children will continue to experience difficulties in accessing health services. Adult safeguarding procedures should be part of the institutional response to DV which should also be embedded in practice protocols.

The key processes of relationship formation identified in this study include developing compassionate connections, tolerating women’s inability to accept immediate or temporary solutions and understanding the patient with a view to encouraging empowerment. These qualities are desirable in comparison to the descriptions of being treated as a ‘medical customer’ expressed by survivors in this study. Abused women valued being asked about DV when the perpetrator was not present, engagement on an individual level and being accepted as a human being worthy of care. Sadly, from the patients’ perspectives, the current approaches of the staff are likely to restrict the process of relationship formation and create the impression that staff do not care about them. Connected to this is the expectation of staff that it is the responsibility of patients to disclose abuse, and that they will act when assistance is offered – although staff themselves mentioned that they would not know what assistance to offer if a disclosure was made. Abused women often have vague desires for assistance or rescue, although they are not necessarily able to define the nature of help that might be available. Nonetheless, they leave the department concluding that it is an institution that is not ideal for discussing DV issues.

For their part, staff are concerned about intruding in women’s privacy and making them less autonomous. It is vital therefore that policy is in place that gives specific interpretations of DV, so that the staff are empowered to execute
interventions. Such policies should also pay attention to the department’s environment, including waiting rooms. The right atmosphere will suggest that help is available for abused women and that the issue of DV is given priority and treated with sympathy. Whilst the long-term experience of lack of control and dependency could influence women’s emotional and psychological readiness to disclose abuse, their perceptions of the staff’s engagement with them as individuals was valued and encouraged openness in return. For instance, one of the nurses said she ‘introduced herself, got the woman some tea and had a quick chat, and then the woman said “I’ve got something to tell you”, and she admitted that it was domestic abuse’ (P10). What the findings of this study emphasise is that abused women want staff to see them as individuals rather than as customers seeking immediate medical treatment.

Self-blame, the experience of abuse, and fear of stigma in general constituted a common thread in survivors’ accounts. ED staff are in a powerful position to challenge these negative self-evaluations. Disappointment, loneliness, fear and powerlessness were common experiences for victims; they felt they deserved a positive response from services, and were further upset as their feelings of worthlessness seemed confirmed when no response was forthcoming.

Communication between hospital and community services will be essential in ensuring that any therapeutic benefits derived from hospital interventions are maintained in the community. The fragile rapport established between the patient and staff can be lost through the lack of proper referral procedures; this may decrease patients’ likelihood of seeking further assistance. Therefore, a closer alliance should be maintained between the department and community
services following referral, to ensure that prompt and patient-focused care is provided.

Finally, in view of the evidence that abused women often present with symptoms not directly related to acute incidents of abuse, it is vital for the department to develop a standardised definition, assessment procedure and mechanism for documenting cases to provide future evidence for legal and research needs. Such documentation will also assist care should the patient visit on another occasion. Care should not be restricted to those visiting with direct DV injuries: universal assessment, referral processes, and the general provision of information on where to get help should be offered to all women. While focusing only on EDs for the solution may be unrealistic, in view of its specialisation in emergencies, interventions should build links with other services in the community, such as GP practices, health visitors and voluntary DV services.

9.3 Limitations of the study

This study was a small-scale exploration of the experiences and views of service providers, service users, and voluntary services regarding the development of DV intervention in EDs. While the study provides a valuable starting point in this understanding, it is limited in its transferability because only one ED department was used, and the numbers involved in the sample were small. It would be useful for further research to adopt similar methods at different sites, firstly to explore the reliability of the views derived from this sample, and secondly, to create a stronger evidence base for the re-evaluation of DV intervention in EDs. Further research may wish to consider an alternative
recruitment strategy, as it may be possible that patients recruited directly from EDs may perceive the staff in a slightly different way when the experience is still fresh. Moreover, some of the survivors had multiple experiences of ED services, which may have led to inconsistencies and confusion of incidents in their recollections.

Also, recruiting samples from the ED may aid the separation and identification of the reasons for repeat presentations, to enrich our understandings of meanings for service providers and users. The sample of abused women was limited to survivors who attended Women’s Aid coffee morning who had also visited the ED following an incident of DV. Thus, the perspectives of those not visiting EDs are not included. However, a strategy employed was to find a compromise between ethics, methodology, and practicality. It became evident that it was more ethical and practical to recruit survivors of DV from here for certain reasons: first, the practicality of assessing and identifying abused women from among the ED’s patient pool would be challenging; second, there are ethical implications in involving women who have acute experiences of DV in research. Therefore, a hospital-based recruitment strategy for abused women was considered to have flaws: it might bias the sample, affect the quality of the data, and adversely impact safety and the mental state of abused women. With the decision to recruit via the Women’s Aid service, survivors were assessed by the co-ordinators in terms of safety, security, and emotional state before the study.

By recruiting survivors around the area where the ED was located, it was hoped that the patients would have comparable experiences of emergency care, so
that the analysis could focus on depth rather than breadth. The downside of this strategy however was that the number of women recruited from the centre was very low - five survivors - and recruitment had to be extended to surrounding Women’s Aid centres. However, it is unlikely that this had a significant impact on the data: one of the inclusion criteria was attending a local ED following DV incidents, and it is important that all survivors had had an experience of a similar ED.

While the combination of approaches in this study may in some ways fill in the gap for the shortcomings of a single approach, the limitations of using grounded theory as the primary methodology for research has been acknowledged (see 3.5.6). The quality criteria employed in this study have been stated and a detailed description of how the study has demonstrated these criteria has been provided (see 4.12).

In addition, observation as a research method could have provided a direct access to the staff as they respond to women experiencing domestic violence. Although, the dialogue between researcher and the researched in this study accentuates the research process by providing a relationship that enhances information generation and theory formulation. Nevertheless, observation in principle avoids the wide range of problems associated with an interview situation and would allow the researcher to verify practice without complete reliance on participant’s testimony. Likewise, the restriction of participants in this study to women aged 18-59 years is a limitation as this excludes the older and the younger age groups which are by no means less affected by the abuse (see 1.3).
Moreover, the limitations of proposing theories have been acknowledged (Moore, 1994): the researcher has expressed theoretical claims pertaining to the scope and relevance of the phenomenon being studies while acknowledging subjectivity, negotiations in dialogue and an abstract understanding (see 4.13). Thus, the theoretical propositions offered here are not ‘autonomous’ but subject to modifications: as an interpretive theory, there is a possibility of moving the current evidence beyond its present claims when more sophisticated evidence becomes available (Charmaz, 2006:149).

Finally, discourse analysis may be valuable in considering the discursive strategies of both staff and patients; conversation analysis may also prove fruitful in investigating the use of words, concepts and phrasing.

9.4 Recommendations

We have not seen the same rigorous and systematic approach to DV agenda as has been applied to other areas of NHS work such as diabetes or stroke services. Exactly the same need for high-quality care, early intervention and evidence-based practice applies to the issues of DV against women and children. This is an area where urgent action is needed. It is a disgrace that so little has been done by the NHS so far - The report of the UK Taskforce on the Health Aspects of Violence Against Women and Children (Alberti et al., 2010:4).
On the basis of the evidence, analysis, and discussion presented in this thesis, the following recommendations have been formulated:

1) The NHS should institute local guidelines for DV intervention for specific settings so that uniform and consistent assessment, case documentation and referral procedures are universally implemented for women experiencing DV, in different healthcare settings and particularly in EDs.

2) Individual health organisations should develop and implement strategies for consciousness raising regarding DV intervention so that the staff are prepared to identify, support, and provide information for abused women who are visiting their department.

3) The Government should invest resources for improving ED environments to reflect recognition of domestic abuse and availability of support and resources for female victims.

4) The Government and NHS should adopt a comprehensive definition of DV that reflects its gender and socio-cultural meaning to victims in a positive way. While the Home Secretary is currently reviewing policy in the area of widening DV definition (Home Office, 2012), it is also important that DV definition is harmonised so that it resolves operational and terminological dilemmas for both service users and providers.
5) Psychological abuse among abused women should be made more visible in EDs through a zero tolerance message and a comprehensive, inclusive definition of abuse.

6) The ED should embrace a broader interventional strategy and referral process for abused women including collaboration with key agencies such as voluntary organisations, DV helpline services and the police. However, a balance should be struck between survivor autonomy and the seriousness of the assault.

7) ED managers should support and continually encourage their staff to respond to DV issues; evaluation should be built into their intervention design from the outset to recognise progress and to evaluate long-term effectiveness, not just immediate gains.

9.5 Future research

It is important that future research advances knowledge in this field by implementing the findings of this research and testing the proposed strategies. One of the key findings that emerged from this research is the fundamental importance of positive, supportive interpersonal relationships and environments that promote DV awareness both for service providers and service users. Moreover, the focus should be on system-wide interventions rather than focusing solely on individual factors. Stemming from the recognition that DV is a complex issue, multilevel strategies and wider community collaboration are essential to sustaining intervention. In acknowledgement of the fact that evaluating the components of intervention identified in this study can be
complex, future studies should consider the ecological model’s recommendation of flexibility and stage intervention while implementation of interventions. These should include a broad spectrum of facilitating factors, such as cognitive, interpersonal, and environmental factors identified by the present study and change theory.
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### Appendices

**Appendix 1: Search terms for literature review**

<table>
<thead>
<tr>
<th>Search terms for population (Women experiencing domestic violence)</th>
<th>Search term for intervention</th>
<th>Search term for specialities/personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>Intervention</td>
<td>Emergency staff</td>
</tr>
<tr>
<td>Partner abuse</td>
<td>Identification</td>
<td>Nurses</td>
</tr>
<tr>
<td>Spouse abuse</td>
<td>Screening</td>
<td>Doctors</td>
</tr>
<tr>
<td>Wife battering</td>
<td>Care</td>
<td>Social services</td>
</tr>
<tr>
<td>Wife beating</td>
<td>Evaluation</td>
<td>Midwives</td>
</tr>
<tr>
<td>Abused women</td>
<td>Assessment</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>Treatment</td>
<td>Practitioners</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>Education</td>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td>Hospital staff</td>
</tr>
</tbody>
</table>
## Appendix 2: Search Result for literature review

<table>
<thead>
<tr>
<th>Database</th>
<th>Population</th>
<th>Population &amp; study design</th>
<th>Population &amp; intervention</th>
<th>Population &amp; personnel</th>
<th>Population &amp; study design, intervention and personnel</th>
<th>Population &amp; study design &amp; personnel &amp; (accident and emergency or emergency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Nursing index &amp; archive (Reception date – 2012)</td>
<td>234</td>
<td>8</td>
<td>95</td>
<td>21</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CINAHL (Reception date -2012)</td>
<td>3397</td>
<td>646</td>
<td>2072</td>
<td>408</td>
<td>64</td>
<td>18</td>
</tr>
<tr>
<td>EMBASE (Reception-2012)</td>
<td>1911</td>
<td>294</td>
<td>1518</td>
<td>187</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>OVID MEDLINE (Reception date-2012)</td>
<td>5132</td>
<td>1129</td>
<td>3254</td>
<td>931</td>
<td>251</td>
<td>29</td>
</tr>
<tr>
<td>Psycho INFO (Reception date – 2012)</td>
<td>4117</td>
<td>431</td>
<td>2231</td>
<td>568</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>14791</td>
<td>3675</td>
<td>9170</td>
<td>2115</td>
<td>251</td>
<td>59</td>
</tr>
</tbody>
</table>
### Appendix 3: Intervention for women experiencing DV in EDs showing research aim and design

<table>
<thead>
<tr>
<th>Study/country/setting</th>
<th>Intervention/design</th>
<th>Results</th>
<th>Comments/conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Campbell et al., 2001 (US) EDs</strong></td>
<td>Two-day didactic training and team planning intervention. Experimental design, pre and post training evaluation using questionnaire, interview and medical record review.</td>
<td>Experimental hospital showed increase in knowledge and attitude of nurses and patients' satisfaction. There was no significant difference in the identification rate of battered women.</td>
<td>The system change model including training and protocol appears effective in improving staff attitude. However, actual clinical practice change is difficult and is likely to require institutional policy.</td>
</tr>
<tr>
<td><strong>Gadomski et al., 2001 (US)</strong></td>
<td>Multifaceted intervention involving training of providers, disseminating hospital protocols among staff and other interventions such as cards, posters and a newsletter within the department. Based on organizational change theory.</td>
<td>2-year post-training follow-up showed significant change in the knowledge, attitudes, beliefs and behaviour of healthcare providers, but a minimal change in the rate of identification of DV victims when compared with the pre-training figure.</td>
<td>System change and staff training resulted in significant long-term changes in the knowledge, attitudes, beliefs and behaviour of emergency staff. Intervention lacked refresher training and staff feedback mechanism.</td>
</tr>
<tr>
<td><strong>Fanslow (1998, 1999) New Zealand Two EDs</strong></td>
<td>Implementation and evaluation of a protocol of care using a questionnaire and randomly selected medical record review</td>
<td>No significant difference was found in overall identification but there was a significant increase in acute management of abuse and documentation in the intervention hospital.</td>
<td>Reliance on record review for measuring outcome could be a limitation but assessment of the acute management of DV victims was a strength for this study.</td>
</tr>
<tr>
<td><strong>Fanslow (1999) New Zealand</strong></td>
<td>One year follow-up evaluation of a protocol of care using a questionnaire and randomly selected</td>
<td>One year evaluation showed lack of integration of the protocol, even the initial modest</td>
<td>The authors concluded that intensive institutional efforts may be required for successful protocol.</td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Intervention</td>
<td>Outcomes</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>Two EDs</td>
<td>medical record review.</td>
<td>benefits observed post-implementation (Fanslow, 1998) were not maintained.</td>
<td>integration.</td>
</tr>
<tr>
<td>Hyman (2001) An ED in US</td>
<td>Impact of one- and- a-half hours advocacy was investigated using a longitudinal, randomised trial involving intervention and control group.</td>
<td>There was evidence that advocacy led to a reduction in physical and emotional abuse, in psychological distress and in levels of perceived stress at three to four months (interview) follow-up.</td>
<td>A brief advocacy intervention found no significant difference between the intervention and control groups in some of the outcome measures. High attrition rate was reported; 49 of the 102 women recruited were lost to follow-up.</td>
</tr>
<tr>
<td>Hamburger et al., 2004 (US) Two EDs and other departments</td>
<td>3-hour didactic training</td>
<td>Improved staff efficacy and comfort in referring but inconsistent screening practices six months post-training.</td>
<td>Training alone may not be sufficient to change ED staff' attitude towards DV screening and intervention, barriers and contextual issues needs evaluating.</td>
</tr>
<tr>
<td>Feder et al., 2009 (UK)</td>
<td>Systematic review to determine whether women should be screened for DV in health care settings using selected UK National Screening Committee (NSC) criteria.</td>
<td>Implementation of screening not justified until further evidence of effectiveness with specific patient groups and contexts becomes available in specific health settings and within health care settings generally</td>
<td>Combined case-finding approaches; combined screening programmes from different health and non-health settings may failure to acknowledge the mechanism of DV intervention in different context</td>
</tr>
<tr>
<td>Loughlin et al., 2000 New Zealand Two ED</td>
<td>Pilot protocol training was developed, implemented and evaluated to improve staff identification and care of abused women. One intervention and one control hospital were involved, pre- and pos-t intervention interviews were</td>
<td>Respondents were very positive about the program and it helped to motivate and sensitize staff to signs of abuse. Protocol was suspended after one month and a revised one was introduced. Evaluation revealed barriers to intervention such as</td>
<td>Authors concluded that training staff to use a protocol is insufficient to improve staff’s response to DV, organization support, policy development and changes to the organization climate are essential. Staff concerns were not addressed before intervention.</td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Intervention</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------</td>
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<td>---------</td>
</tr>
<tr>
<td>Muelleman and Feighny (1999). An emergency hospital</td>
<td>One day advocacy termed BRIDGE was provided to be a bridge between the department and community service for abused women. Advocacy lasted 30 minutes. It involved before- and after-design evaluated using historical controls obtained through data from medical records, refuge and police/judicial documentation rather than self report from women.</td>
<td>No reduction in experience of abuse as measured by repeat ED visit over a mean period of 65 weeks but the women who used the advocacy program increased their use of refuges and refuge counselling when compared with the pre intervention controls.</td>
<td>A short, small scale intervention. No long-term follow-up period to assess whether the observed benefits were sustained over time.</td>
</tr>
<tr>
<td>Muelleman, 1999 (US) An ED</td>
<td>An advocacy programme for women visiting the department due to injury resulting from DV.</td>
<td>Advocacy increased shelter use and access to counselling services. No reduction was found in violence to participants, no significant difference in repeat police calls, full protection orders or repeat ED visits.</td>
<td>A brief single intervention. The author did not determine other resources used by women during the study period, which made it difficult to justify the claim that the outcome measures were achieved.</td>
</tr>
<tr>
<td>O’Campo et al., 2011 (UK)</td>
<td>Systematic review informed by a realist approach to re-evaluate the evidence on programme mechanisms, universal screening and disclosure of DV within a health care context.</td>
<td>Programs that took a comprehensive approach (i.e., incorporated multiple program components, including institutional support) were successful in increasing screening and disclosure/identification rates of DV in health</td>
<td>Findings supported a multi-component and comprehensive screening programme for women experiencing DV in health care settings</td>
</tr>
<tr>
<td>Reference</td>
<td>Setting</td>
<td>Intervention</td>
<td>Outcome</td>
</tr>
<tr>
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<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>Olson et al., 1996 (US) ED</td>
<td>ED</td>
<td>Evaluation of training and chart restructuring to include a specific question about DV using prospective data</td>
<td>Chart significantly increased the recognition rate of DV. An educational intervention did not significantly improve this rate. The profile of a woman presenting to the ED differs from those of other women with respect to chief complaint and time of presentation.</td>
</tr>
<tr>
<td>Paranjape et al., 2006 USA ED</td>
<td>ED</td>
<td>Validation of the STaT against the Index Abuse Score (ISA.)</td>
<td>STaT showed a moderate specificity but a high sensitivity for physical and emotional abuse when compared with ISA.</td>
</tr>
<tr>
<td>Ramsay et al., 2002 UK</td>
<td>ED</td>
<td>Systematic review on the acceptability and effectiveness of screening women for DV in healthcare settings.</td>
<td>DV has major health consequences for women and has a high acceptance of screening among women patients but screening not justified due to insufficient evidence</td>
</tr>
<tr>
<td>Salmon et al., 2006 (UK)</td>
<td>ED</td>
<td>Pre, post and 6-month follow-up questionnaire to survey 79 community midwives following a 7.5-hour educational programme in UK</td>
<td>Programme led to a significant increase in knowledge and efficacy but did not translate into a significant increase in levels of enquiry: mean value for screening before training was 4.2 and after training it was 4.3.</td>
</tr>
<tr>
<td>Wallace, 2002 (UK)</td>
<td>ED</td>
<td>DV awareness training for selected staff from different departments including A&amp;E</td>
<td>Participants’ knowledge base increased by an estimated 25%.</td>
</tr>
<tr>
<td>Wills et al., 2008 (New Zealand)</td>
<td>Paediatric emergency setting.</td>
<td>Multi-system intervention including obtaining training for staff, post training evaluation and feedback from staff, managerial involvement and support, information resources such as leaflets and wallet size cards and community partnership.</td>
<td>Improved knowledge and confidence in identifying (from 30 to 80 women per 6-month period). Increased referrals to community support centres (from 10 to 70 women per quarter).</td>
</tr>
</tbody>
</table>
Appendix 4: Interview guide questions

TOPIC GUIDE FOR SEMI-STRUCTURED INTERVIEWS

ED STAFF

Have you ever had experience where you suspected that a woman patient was a victim of domestic violence?

Can you tell me some of your experiences in this department of interacting with women experiencing DV?

What do you do when you suspect that a woman might have experienced DV?

Do you have policies or protocols that you follow when managing such women?

What are the challenges/difficulties you encounter in caring for these women?

How can you be helped as a nurse to improve the care you give to women experiencing DV?

What barriers do you think abused women might have in seeking help from ED nurses?

Have you had DV training? Has the training been helpful? How

Apart from training, what other things do you consider useful/necessary for DV intervention to be successful within ED?

MANAGERS

What barriers do you think abused women might have in seeking help from ED?
How can these be overcome?

What policies and protocols exist within ED for staff to follow when caring for women who have experienced DV?

What challenges/difficulties have been reported by staff regarding caring for women experiencing DV?

Are there organisational or systemic barriers to DV intervention within ED?

What factors can enhance DV identification, management and referral within ED?

**WOMEN**

Can you tell me some of your experiences when you visit ED following a DV incident? (e.g. Did the staff ask if you had experienced DV? Were you offered any help? What did you find useful? What did you find not so useful?)

What do you think is the most important thing to say or do in responding to abused women when they visit ED?

What do you want from staff when you visit ED following a DV incident?

What barriers do you think abused women might have in seeking help from ED?

How can AED nurses/staff be of help?

In what other ways can the service given to abused women in ED be improved?

**DV SERVICE CO-ORDINATORS**

Do you frequently see abused women who have been referred from ED?

Are you happy with the process of referral? How can it be made more effective?

Do you think visiting ED has helped such women in any way?

What do you think abused women want from DV intervention within ED?

What barriers do you think abused women might face in seeking help from ED? How can these be overcome?

In what other ways can the service given to abused women in ED be improved?
20 November 2012

Participant Information Sheet (For survivors)

Title of Project: Developing a domestic violence intervention for women visiting accident and emergency departments: Pilot study

Name, position and contact address of Researcher
Name: Olufolakemi Tokode
Position: Postgraduate student of the University of Manchester
E-mail: olufolakemi.tokode@yahoo.com
Telephone: 01332510051 /07577890464

You are being invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it entails. Please read the following information carefully and take time to decide whether or not you wish to take part. You can ask for more information from the researcher using the details provided. Thank you.
What is the purpose of the study?

Women who have experienced domestic violence often attend accident and emergency departments (EDs) because of injuries or other problems caused by the abuse. In this study we want to find out what experiences women have had when they have visited the department following the incident, what kind of help was offered/ received, and what sort of help they would like to receive in future. Talking about your experiences and giving your views about the kind of help you would like to receive can be useful in improving services provided to women when they visit the department following domestic violence.

Why have I been invited to participate?

You have been invited to participate in this study on the basis that you have the necessary experience to provide information that can answer the research questions. In order to provide information that is based on your experience, you must have visited an emergency department following your experience of domestic violence. Other participants include emergency nursing staff, managers or matrons and co-ordinators of domestic violence voluntary organisations. In total, 15-20 members of emergency staff, 15-20 women and 2-4 coordinators of domestic violence voluntary centres will be interviewed.

Do I have to participate?

No. It is up to you to decide whether or not to participate. If you do decide to participate, you will be expected to give written consent before the interview begins. You will be free to withdraw at any time and without any obligation to give reasons. However, if you withdraw from the study after the data has been analyzed, we will need to use the data collected as removing your data at this point will affect the validity of the study. Nevertheless, all data, including your words, will be anonymised and people will not be identifiable.

What happens if I decide to take part?

If you decide to take part, please fill in the tear-off portion of this information sheet and return to one of the staff in the centre. Interview arrangements will be made by the staff when you return the form. All interviews will be held in complete privacy and will take place in a designated private room within the women’s centre. Interviews will last about 45-60 minutes and will be recorded.
using a digital audio-tape recorder. Before the interview, consent will be taken. This will last about 10 minutes.

**Will my taking part in the study be kept confidential?**

Yes. All information collected about the participants will be kept strictly confidential. Privacy and confidentiality will be upheld before, during and after the study. You can share personal information freely, because all data, including your words, will be anonymised and people will not be identifiable. However if you disclose possible danger to yourself or harm or abuse to a third party during the interview, I would have a duty of care to report this to the relevant bodies in order to protect you and the person/persons involved.

Data generated in the course of the research, including tapes, must be kept securely in paper or electronic form for a period of five years after the completion of a research project in accordance with the University’s policy on academic integrity.

**What are the possible benefits of taking part?**

Although it is difficult to be certain about benefits to participants, there is some evidence that interviewing women who have experienced domestic violence may help to relieve their painful feelings about these frightening events. Furthermore, the information from the study will assist in improving our understanding of the topic and might help to improve care given to women when they visit emergency departments and the healthcare system at large.

Participants will be given a token (£5 each) to cover their transportation expenses to the women’s centre. Childcare facilities will be provided within the centre during the interview. Snacks and drinks (tea/coffee) will also be provided before or after every interview session for all participants.

**What are the possible risks to me of taking part in this research?**

The World Health Organization guidelines for minimizing risks to respondents will be followed throughout the interview period. For example, the interview will be conducted in complete privacy and participants will not be identifiable. Your views will be respected. You do not need to answer any questions that you do not want to, and the interview can be stopped if you wish. Also, a local domestic
violence service has offered to take referrals and give support to participants if talking about domestic violence becomes distressing.

What will happen if I don't want to continue with the study?

You may withdraw at any time without any obligation to give reasons. However, if you withdraw from the study after the data has been analyzed, we will need to use the data collected as removing your data at this point will affect the validity of the study.

What will happen to the results of the study?

Your experiences and concerns will be used to write the final report of the research. The outcome of study will provide useful information to show what women want from intervention and will help to identify factors that are likely to help improve domestic violence management. The results will also be used as part of my studies towards a doctorate and may be published in journals. However, all individuals who take part in the study will be kept anonymous in publications.

Who is organizing and funding the research?

I am conducting the research as a student of the University of Manchester, School of Nursing, Midwifery and Social Work, and it is self sponsored.

Who has reviewed the study?

The research has been reviewed by academic supervisors and examiners from the University. The research has also been approved by the local Research Ethics Committee, NHS ethics committee, trust R&D and the departmental lead.

What if there is a problem?/Contact for Further Information

If you have any concern about any aspect of this study, you should contact the researcher using the contacts provided or write your questions in the tear-off sheet provided and I will do my best to answer your questions. If I am unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk
09/02/2010
Thank you for taking time to read this information sheet.

02/01/2010

(Please fill this tear off portion if you are interested in the study and return it to a member of staff)

I am interested in participating in the study

Name:

Contact details (all contacts will be made via the women centre)

Questions (please write your questions below):

Version 3 09/02/2010
20 November 2012

Participant Information Sheet

(For accident and emergency nurses, managers and coordinators and coordinators of domestic violence centres).

Title of Project: Developing an intervention for women experiencing domestic violence in accident and emergency departments: Pilot study

Name, position and contact address of Researcher

Name: Olufolakemi Tokode

Position: Postgraduate student of the University of Manchester
E-mail: olufolakemi.tokode@yahoo.com
Telephone: 07577890464
You are being invited to take part in this research study. Before you decide, it is important for you to understand why the research is being done and what it entails. Please read the following information carefully and take time to decide whether or not you wish to take part. You can ask for more information from the researcher using the details provided. Thank you.

**What is the purpose of the study?**

The purpose of this research is to explore the viewpoint and experiences of accident and emergency department (ED) staff, ED managers, domestic violence (DV) service coordinators and women who have visited ED following a DV incident. Women who have experienced domestic violence often attend EDs because of injuries or other problems caused by the abuse. In this study we want to find out what experiences women have had when they have visited EDs following an incident, what DV intervention is available within AED and what is likely to work, and to establish factors that may prevent DV or facilitate DV intervention within ED.

**Why have I been invited to participate?**

You have been invited to participate in this study on the basis that you have the necessary experience to provide information that can answer the research questions. In order to provide information that is based on your experience in accident and emergency, you must have worked in the department for more than one year. Other participants include emergency department managers or matrons, co-ordinators of domestic violence voluntary organisations and women who have visited emergency department following an incident of domestic violence. In total, 15-20 members of emergency department staff, 15-20 women and 2-4 coordinators of domestic violence voluntary centres will be interviewed.

**Do I have to participate?**

No. It is up to you to decide whether or not to participate. If you do decide to participate, you will be expected to give written consent before the interview begins. You will be free to withdraw at any time and without any obligation to give reasons. However, if you withdraw from the study after the data has been analyzed, we will need to use the data collected as removing your data at this
point will affect the validity of the study. Nevertheless, all data, including your words, will be anonymised and people will not be identifiable.

**What happens if I decide to take part?**

If you decide to take part, you will need to fill the tear-off portion of this information sheet and drop it in the box provided in the staff room within the department. I will then contact you to arrange a time and date that will be convenient for you. All interviews will be held in complete privacy and will take place in a designated private room within the ED/women's centre. Interviews will last about 45-60 minutes and will be recorded using a digital audio-tape recorder.

**Will my taking part in the study be kept confidential?**

Yes. All information collected about the participants will be kept strictly confidential. Privacy and confidentiality will be upheld before, during and after the study. You can share personal information freely, because all data, including your words, will be anonymised and people will not be identifiable. However, anything you say which could be potentially harmful to you or to others will be passed on to relevant bodies in order to protect you and the person/persons involved. Data generated in the course of the research, including tapes, must be kept securely in paper or electronic form for a period of five years after the completion of a research project in accordance with the University's policy on academic integrity.

**What are the possible benefits of taking part?**

The information from the study will assist in furthering our understanding of the topic and might help to improve care given to women experiencing DV within accident and emergency departments and the healthcare system at large.

**What are the possible risks to me of taking part in this research?**

The World Health Organization guidelines (Ellsberg and Heise, 2005) for minimizing risks to respondents will be upheld all through the interview period. For example, the interview will be conducted in complete privacy and anonymity. Your views will be respected. You do not need to answer any
questions that you do not want to, and the interview can be stopped if you want. Also, a local domestic violence service has offered to take referrals and give support to participants if talking about DV issues becomes distressing.

**What will happen if I don’t want to continue with the study?**

You may withdraw at any time without any obligation to give reasons. However, if you withdraw from the study after the data has been analyzed, we will need to use the data collected as removing your data at this point will affect the validity of the study.

**What will happen to the results of the study?**

Your experiences and concerns will be used to write the final report of the research. The outcome of study will provide useful information to determine what women want from DV intervention within ED and to establish factors that are likely to help improve DV management. The results will also be used as part of my studies towards a doctorate and may be published in journals. All individuals who take part in the study will be anonymous in publications.

**Who is organizing and funding the research?**

I am conducting this self-sponsored research as a student of the University of Manchester, School of Nursing, Midwifery and Social Work.

**Who has reviewed the study?**

The research has been reviewed by academic supervisors and examiners from the University. The research has also been approved by the local Research Ethics Committee, NHS ethics committee, trust R&D and the departmental lead.

**What if there is a problem? / Contact for Further Information**

If you have any concern about any aspect of this study, you should contact the researcher using the contacts provided or write your questions in the tear-off sheet provided and I will do my best to answer your questions. If I am unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.
Thank you for taking time to read this information sheet.
10/11/2009

(Please tear off this portion and drop it in the cupboard provided in the staff room)

I am interested in participating in the study

Name:

Contact details (e-mail and telephone number):

Questions (if any):

04/01/2010
Appendix 7: Consent form for survivors

CONSENT FORM (Women)

Title of Project
Developing a domestic violence intervention for women visiting accident and emergency departments: Pilot study

Name, position and contact address of researcher
Name: Olufolakemi Tokode
Position: Postgraduate student of the University of Manchester
E-mail: olufolakemi.tokode@yahoo.com
Telephone: 01332510051/07577890464

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

Please initial box
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. However, if I withdraw from the study after the data has been analyzed, my interview will be used in the analysis, but written materials will not contain a direct quote from my interview.

3. I agree to the interview being audio recorded.

4. I agree to the use of anonymised quotes in publications.

5. I understand that my personal information will remain confidential and not shared with anyone but anything I say which could indicate harm or abuse to me or to others would need to be reported to the appropriate bodies.

6. I understand that relevant section of my research records collected during the study may be looked at by individuals from regulatory authorities, from the University of Manchester or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my research records.

7. I agree to take part in the above study.

________________________________________  __________  __________________________
Name of Participant                        Date                        Signature

________________________________________  __________  __________________________
Name of Researcher                         Date                        Signature
20 November 2012

CONSENT FORM (ED staff and coordinators)

Title of Project
Developing a domestic violence intervention for women visiting accident and emergency departments: Pilot study

Name, position and contact address of researcher
Name: Olufolakemi Tokode
Position: Postgraduate student of the University of Manchester
E-mail: olufolakemi.tokode@yahoo.com
Telephone: 01332510051/07577890464
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. However, if I withdraw from the study after the data has been analyzed, my interview will be used in the analysis, but written materials will not contain a direct quote from my interview.

3. I agree to the interview being audio recorded.

4. I agree to the use of anonymised quotes in publications.

5. I understand that my personal information will remain confidential and not shared with anyone but anything I say which could be harmful to either myself or to others will be passed on to appropriate bodies.

6. I understand that relevant section of my research records collected during the study may be looked at by individuals from regulatory authorities, from the University of Manchester or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to have access to my research records.

7. I agree to take part in the above study.

Name of Participant

Date

Signature
<table>
<thead>
<tr>
<th>Name of Researcher</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
</table>

One copy for the research file, one copy for participants

Version 2 04/01/2010