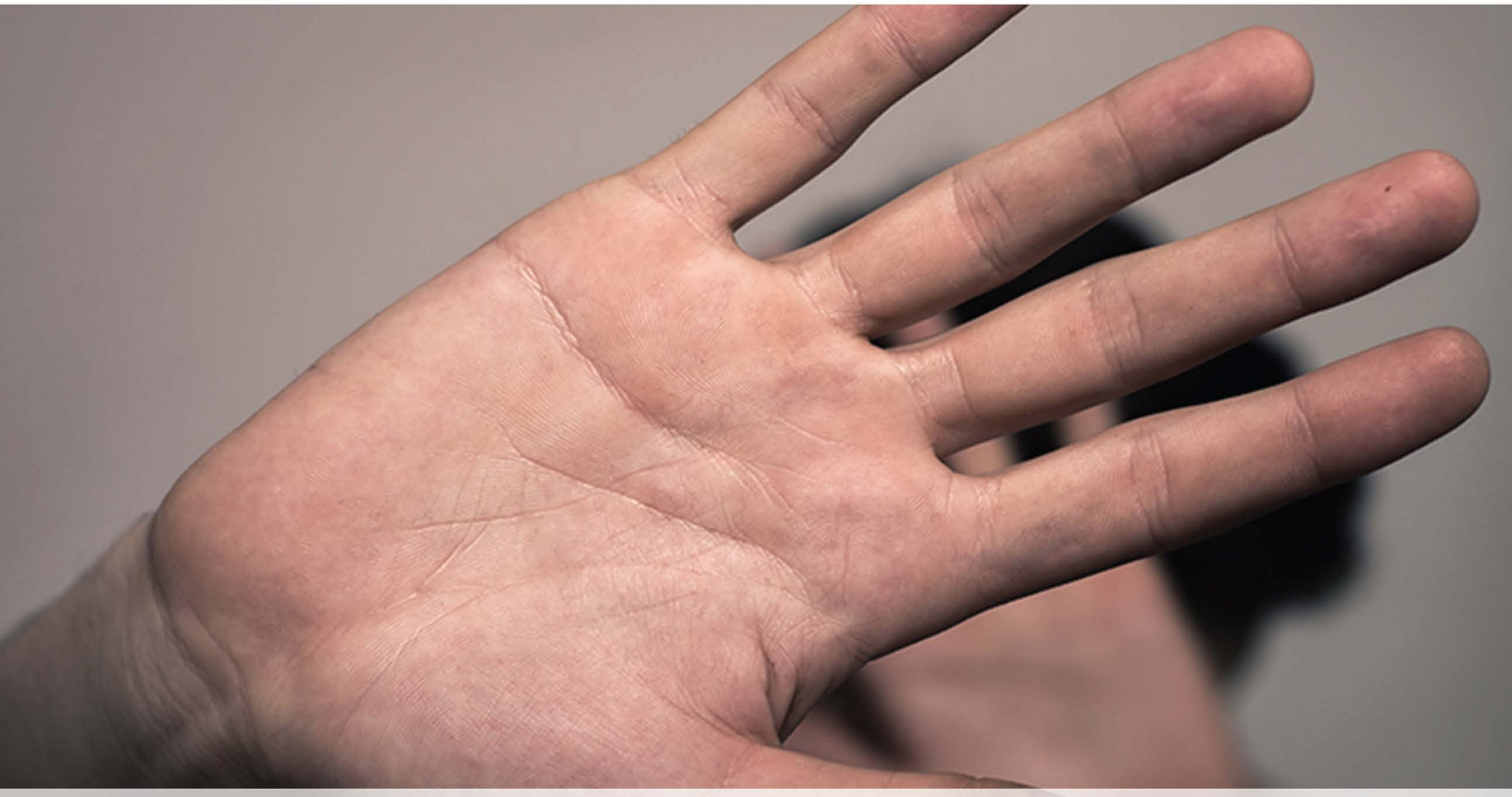
ABC of Domestic and Sexual Violence

Edited by Susan Bewley and Jan Welch



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ABC of

Domestic and Sexual Violence

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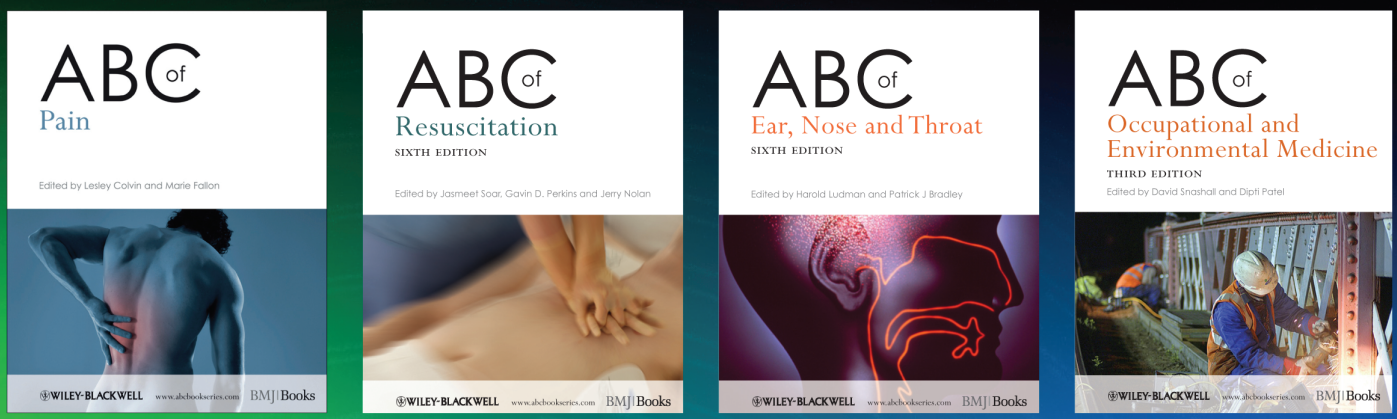

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Domestic and Sexual Violence

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BMJ Books

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Registered office: John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication Data

ABC of domestic and sexual violence / edited by Susan Bewley, Jan Welch.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-1-118-48218-6 (paperback)
I. Bewley, Susan, editor of compilation. II. Welch, Jan editor of compilation.
[DNLM: 1. Domestic Violence. 2. Sex Offenses. 3. Battered Women. 4. Crime Victims. WA 308]
RC569.5.F3
616.85'822–dc23

2013044785

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: Photograph by Jade Turnbull, Copyright © 2014, Jade Photography
Cover Design by Andy Meaden.

Set in 9.25/12pt Minion by Laserwords Private Ltd, Chennai, India

1 2014

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Foreword

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Domestic and sexual violence have almost certainly been with us ever since human history began. For centuries they have been largely ignored and even now all we see is the tip of the iceberg. Fortunately more attention is now focused on them as major societal problems. Nonetheless there is still widespread ignorance, particularly in the health professions, as to the nature and scale of the problem. I recently chaired a Department of Health Taskforce on Violence Against Women and Children and was appalled by the numbers of people affected – not just by serious sexual crimes but also by all forms of domestic violence. I was particularly impressed by the numbers of unrecognised cases in general practice, emergency departments and hospital outpatient services even when obvious triggers were present – with some notable exceptions. I was also disappointed by the lack of attention given to sexual and domestic violence in medical school curricula and postgraduate training programmes. There should be much more focus on multidisciplinary working with close contact between different agencies. Often mechanisms are in place but are underused.

The Taskforce brought some attention to the issues involved but did not solve the many problems. The present volume goes some way to rectifying this. It is a superb vade mecum which should be required reading at an early stage for all health professionals but particularly those working in general practice and long-term conditions. It should also be freely used in training health care professionals. I cannot commend it to you strongly enough!

Introduction

Susan Bewley[1] *and Jan Welch*[2,3]

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Purpose

Why do health care professionals need to know about domestic and sexual violence? Surely these are either private issues or someone else's business (e.g. the police)? In recent years it has increasingly been recognised that this is not the case. 'Privacy' has allowed serious crime to go undetected and perpetrators to act with impunity. Health care professionals look after patients whose lives are blighted by violence and abuse, whose health is impacted – and who can be helped if the professionals understand how.

Even though domestic and sexual violence affect far more people than do conditions such as diabetes and inflammatory bowel disease, they have featured much less on medical school and postgraduate curricula, and are sometimes entirely absent. Many doctors are not aware of how common these problems are, how to identify them or what to do next. This book aims to provide practical support to learners early in their careers.

Historical perspective

Allusions to domestic and sexual violence occur in some of the earliest written works and feature in ancient stories, such as the rape of Antiope by the Greek king of the gods and sexual predator Zeus. While rape was recognised as a crime in ancient Rome, 'wife beating' for correctional purposes was criminalised only much more recently and remains the norm in some cultures today. Rape is an expression of power. It has long been both a weapon of war and a means of oppressing the vanquished – men as well as women. Following the capture of Berlin by the Red Army in 1945, an estimated 2 million German women and girls were raped by Soviet troops. More recently, in the Rwandan genocide of 1994, many thousands of Tutsi women were subjected to rape, many acquiring HIV as a result. Some were also sexually mutilated in order to destroy their future reproductive capabilities.

Women's position in society has changed over the centuries. In most countries, women are no longer considered to be legal minors: the possessions initially of their fathers and then of their husbands. Attitudes to violence against women have changed in parallel and legislation has followed; for example, during the last 30 years marital rape has been criminalised in most Western countries.

Modern relevance

Sadly, abuse and rape remain common in modern societies, whether resource-poor or heavily industrialised. Much is covert, as victims experience fear and shame, which often inhibit disclosure. Many victims wait until the right moment to disclose – perhaps to a practitioner they trust. The health impacts can be immediate or can only become evident much later. In the UK each week two women are killed by their partners, but this is just the tip of the iceberg: many more seek help for nonspecific physical symptoms or mental health problems related to previous abuse.

While anyone can be assaulted or abused, the presence of co-vulnerabilities increases the likelihood. Perpetrators are adept at identifying those with vulnerabilities, whether long-term (e.g. learning or other disability), situational (e.g. being in a conflict zone) or transient (e.g. when someone is under the influence of alcohol or drugs).

Language

Language is dynamic and nomenclature can be problematic, as words inevitably carry connotations (or 'baggage') with them. For example, some writers prefer the term 'abuse' to 'violence' as it is more inclusive; it may make it clearer that the damage is not merely physical, but mental, lasting longer than the processes of physical healing and going deeper than the outward, superficial scars.

The term 'survivor' is generally preferred to 'victim' when discussing people who have been subjected to domestic violence, as it recognises the individual strength necessary to carry on in difficult circumstances and often to protect others, such as children. When encountering people who have suffered extreme human rights abuses or torture at the hands of others, however, this could seem trite.

'Empowerment' might be trivialised by cosmetic product advertising slogans ('because you're worth it'), but is a real process for the most disadvantaged, abused and voiceless members of society. Other terms, including 'patient', 'complainant' and 'client', vary in their suitability and acceptability. Although there are gender differences in the perpetration and experience of violence, abuse has no limits for people of any age, sex, race, sexuality, class, creed or political persuasion.

The National Health Service has a 'universalist' perspective; that is, it is available to all on the basis of need. We have tried to maintain this stance throughout, although most case studies refer to women and children. The chapter authors come from a wide variety of backgrounds: professional and voluntary sector; medical, legal, academic and lay. They bring different values and 'cultures' with them, reflecting the fact that a multi-agency response is required for these persistent societal wrongs. Thus, although terminology varies throughout the book, we have tried to ensure that the words used are appropriate for the context, while recognising that others may disagree.

We hope that the variety of examples of questions and responses given in the chapters will act as templates while you develop your own strategies and practice styles. Reflective practitioners pay careful attention to the exact words patients use, as well as to gaps, silences and alignments with nonverbal cues. They also choose their words carefully, while modulating their tone and body language, in order to build rapport, diminish fear, overcome stigma and prejudice and demonstrate trustworthiness. Lessons learned from this book can be applied to many other settings.

The role of doctors

It is important for future good doctors to recognise their role, which is to *recognise*, *empathise* and *witness* and to *refer* to appropriate multi-agency services. Violence does not fit the traditional 'medical model' of diagnosis, prognosis and plan, and should not be 'medicalised' as something that can be 'fixed' by doctors using conventional treatments. However, it may coexist with other conventional comorbidities, may explain patient presentations and behaviours and may interfere with the ability of patients to trust or comply with their doctor's advice.

Uncovering our patients' narrative, or story, may make sense of otherwise unresolvable medical presentations (and explain the old maxim that 'there is no such thing as a difficult patient, only a patient with difficult problems'). Even when there are time constraints, or when patients are unwilling to talk or disclose, an acknowledgment can help a patient feel known and understood. Kindness costs nothing; compassion takes no time. They may make all the difference to a vulnerable person feeling empowered to speak now or at a later date. Whether abuse, violence, mental illness, substance misuse or another 'life problem' lurks in your patient's or their family's background, failure to respond sensitively may lead to misattribution or dismissal of symptoms, misdiagnosis of disease, repeated inappropriate investigation and at worst, retraumatisation or even abuse by professionals.

Boundaries and difficult issues

Both patients' and doctors' interests are protected by the vital professional promises of confidentiality and boundaries of consent. It is within these formal, legally and professionally binding constraints of the doctor–patient relationship that value, skills and even creativity lie. Only very occasionally can they be broken, and this must only be done with transparency and senior and expert support.

Some readers will inevitably have experienced violence themselves, first-hand or in their friends and families, or will experience it in the future, either on the giving or the receiving end. Doctors may be fearful of involvement with the topic or may have personal concerns for their own safety. Alternatively, they may be fearful of raising concerns about patients or team dynamics if they fear reprisals or are being bullied at work. Doctors may find they feel powerful negative emotions towards patients, including hostility, anger or frustration, or even unanticipated or inappropriate feelings of intimacy or attraction. The art of professionalism is to recognise and control these feelings, to put them to one side and not to act on them. But we are not automatons. We need quiet time and 'headspace' to recover and reflect both 'on practice' and 'within practice'. '*What do such feelings say about the patient and about me, the practitioner?*' '*What do the team behaviours, dynamics and "jokes" say about us and our ability to empathise?*' '*Where can I find reliable sources of support, learning, guidance and wisdom?*'

Lifelong learning

As doctors who had virtually no knowledge of or training in domestic and sexual violence as students, we learnt the hard way – from our patients and from our mistakes, by trial and error and by carving out services and research from scratch. Looking back over our combined 6 decades of medical practice, we dreamt of a book that we wished had existed when we started out. Although few readers will end up majoring in responses to violence (as we have), everyone will encounter it – whether explicit or hidden – in the clinics and wards, and everyone can make a positive health contribution. Our authors have distilled their accumulated wisdom in the hope of accelerating your learning and making you better practitioners. We hope that the lessons in this book will stand you in good stead and that you find fulfilling careers wherever you end up. Keeping the care of your patient as your first concern and safety at the forefront of your mind will also act as a reliable guide.