"This is the peer reviewed version of the following article:

Patrick, L., & Jackson, L. (2021). The role of nurses in recognising and responding to violence against women. *Journal of Clinical Nursing*, 1–3. https://doi.org/10.1111/jocn.16147

This article may be used for non-commercial purposes in accordance with Wiley Terms and Conditions for Use of Self-Archived Versions."

https://authorservices.wiley.com/author-resources/Journal-Authors/licensing/self-archiving.html

The role of nurses in recognising and responding to violence against women

Editorial

1 BACKGROUND

Violence against women (VAW) is the threat of or actual harm by physical, sexual or psychological abuse. Male violence, the most prevalent and dangerous form, is the leading contributor towards death, disease and disability amongst women aged 18–44 globally (Ellsberg et al., **2008**). This type of abuse is extremely common; a recent survey of over 22,000 UK women found that as many as 99.7% report having been repeatedly subjected to rape, harassment and physical violence over the course of their lifetime (Taylor & Shrive, **2021**), far higher than previously thought. The Femicide Census, which tracks the murders of women by male perpetrators, also consistently reports over 100 deaths per year; rougly one woman every 3 days (Ingala Smith, **2018**). Violence against women is a clear and serious public health concern with significant implications for the health, well-being and mortality of women around the world. However, violence should not be an inescapable aspect of women's lives; it can be prevented.

Victims, also commonly referred to as survivors, are likely to require care and treatment from healthcare services (Hooker et al., **2020**). Despite this, the nursing response to this issue has been inadequate to date. Nurses and other healthcare professionals can play a vital role in recognising and responding to violence against women and its common expressions; domestic abuse and sexual violence (Bradbury-Jones, **2015**).

How this issue is framed is central to how it is perceived or understood and reflects wider social issues in the UK and around the world. Violence against women is a common term and used throughout this discussion to highlight the health and well-being needs of women. However, this tends to obscure the source of the violence: men. When considering these issues, it is therefore important to remember that they do not occur in a vacuum and instead take place against a backdrop of misogyny, male dominance and women's subsequent inequality. Moreover, the ongoing failure to adequately address this issue within nursing and health care is intrinsically linked to medical paternalism and the dominance of medicine over the healthcare hierarchy.

2 WOMEN'S PROBLEMS

In the not-too-distant past, efforts to address violence against women within health care have been described by medical colleagues as 'ill-considered professional interference' and that it is 'doubtful' women would benefit from support (Fitzpatrick, **2001**). This reluctance echoes broader social attitudes that have historically regarded domestic abuse as a private matter and has contributed to the hidden nature of abuse, stigma and ongoing normalisation of male violence.

Within the constructs of a patriarchal society, where male violence is intrinsically linked to male dominance, women remain subjugated, and their experiences hidden. Typically, women's problems are regarded as being a personal problem for women to fix. This obscures

the perpetrator of violence and places the blame and responsibility upon victims to keep themselves safe, rather than addressing the source of the problem.

However, whilst perpetrators are solely responsible for violence and abuse, literature on perpetrator recidivism is severely lacking. A community approach to this issue has been shown to be the most effective prevention and intervention strategy (Hague and Bridge, **2008**) and forms the rationale for the ongoing implementation of multi-agency risk assessment conferences (MARAC) across local authorities. Nurses, as the largest healthcare professional group, must therefore form an active component of this response, identifying and responding to risk, co-ordinating care and safeguarding women.

3 DEVELOPING KNOWLEDGE

Women who have experienced male violence repeatedly express the importance of supportive, empathic staff and psychologically safe environments (Bradbury-Jones, **2015**). In order to achieve this, staff must be knowledgeable and competent in recognising and responding to signs of abuse and disclosures.

Whilst individual nurses may choose to develop their knowledge and understanding in this area, a small number of nurses scattered across services, boards and trusts are not able to lead care on a large scale nor are they able effect the kind of change necessary. A systemic approach is therefore needed that prioritises learning and development and ensures sustainability.

Investing in training and staff development is vital to ensuring staff knowledge and competence. However, training deficits are consistently noted in research. Nurses frequently report lacking the knowledge, confidence, and training to recognise and respond effectively to domestic abuse and sexual violence (Alshammari et al., **2018**). As a result, nurses avoid asking about abuse since they are unsure how to ask sensitively and how to respond to a disclosure.

The ongoing lack of development in this area is, no doubt, due to the lack of importance placed upon women's lives, health and well-being. Training is not prioritised in undergraduate curricula or CPD, and specialist nursing staff, capable of delivering such training, are vanishingly rare. But this is nothing new, health care, an historically paternalistic institution, has presided over women's health inequalities for hundreds of years.

4 PATERNALISM AND GENDER ROLES

Within healthcare systems, patriarchy and male dominance find expression in medical paternalism. The traditional dominance of medicine, which once excluded women entirely, remains present to some extent within modern health care. Medical staff, afforded the highest degree of autonomy within healthcare systems, continue to lead in research, policy development and service design and delivery the majority of the time. As such, doctors, nurses and patients exist within an operational hierarchy with medicine dominating from above. This dynamic is inherently gendered, with medical staff acting in the masculine role as dominant protectors and patients as passive, feminine and dependent recipients. Within this system abused women are doubly subordinate, to both their abusive partners and to

healthcare staff, and very often must relinquish their autonomy in order to receive the care and treatment of health professionals.

Despite a focus on patient centred care, nursing can often be guilty of participation within these structurally oppressive and misogynistic practices where the patient remains subordinate. The nurse's role is typically one of concern and advocacy; however, even this should be acknowledged as taking place from a position of superiority, control and dominance.

A cursory glance of online patient feedback site Care Opinion reveals many poor experiences for women who disclose abuse to healthcare staff, including nurses of both sexes. This feedback often reflects a lack of staff knowledge and sensitivity, whilst patients navigate retraumatising practices and procedures. Despite being a majority female workforce and being more likely to have experienced male violence than their non-nursing peers (Cavell Nursing Trust, **2016**), experience alone is not sufficient to guide high standards of nursing care or eradicate the possibility of internalised misogyny within the profession.

However, nurses, as the largest patient facing workforce and who frequently lead on the development of models of care, should be well placed to not only identify and respond to violence against women; they are also well placed to lead strategic development in this area. This is not without its challenges since nurses, too, are subordinate to the dominant medical hierarchy. This unique position of being both the dominator and the dominated presents a tension that is not possible to resolve entirely without addressing the structural oppression of women within health care, at every level.

Healthcare leaders, managers and educators must therefore prioritise education, development and training on the issue of violence against women in order to improve knowledge, standards of care and ultimately women's health and well-being outcomes. However, they must also recognise and challenge the structural barriers, misogyny and oppression that has prevented or restricted development for women as patients and practitioners thus far. The influence of nurse leadership has profound implications for patient outcomes (Francis, **2013**), and this is particularly true for the role of health care in addressing violence against women. Whilst the gendered nature of this issue is recognised, nursing leaders, organisations, unions and institutions have a role in challenging the status quo with clear implications for patient care.

5 CONCLUSION

Male violence is a significant public health concern affecting a high percentage of women. Nurses and other healthcare professionals have a responsibility to recognise and respond to the signs of domestic abuse and sexual violence in order to address ongoing health inequalities, safeguard women and ultimately save lives.

Ending violence against women cannot be achieved by individual nurses, however, and ultimately requires systemic change and investment in training, development and research. If nurses are to address the significant risks facing women, then nurse educators, leaders and managers must prioritise and invest in the development of knowledge and care to ensure that registrants are confident and competent to address this issue.

Importantly, they must also recognise and challenge the oppressive and structurally patriarchal systems that present barriers to advancing practice and understanding in this area. Ultimately, it is women who will continue to suffer the burden of inaction.

References

1) Alshammari, K., McGarry, J. and Higginbottom, G. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, **5**(3), 237-253.
2) Bradbury-Jones, C. (2015). Talking about domestic abuse: Crucial conversations for health visitors. Community Practitioner, **88**(12), 44-47.
3) Cavell Nursing Trust. (2016). Skint, Shaken Yet Still Caring—highlighting hardship. *British Journal of Nursing*, **25**(21), 1188-1189.
4) Ellsberg, M., Jansen, H., Heise, L., Watts, C. and Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet*, **371**(9619), 1165-1172.
5) Fitzpatrick, M. (2001). The tyranny of health: doctors and the regulation of lifestyle. London: Routledge.
6) Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office.
7) Hague, G. and Bridge, S. (2008). Inching forward on domestic violence: the 'co-ordinated community response' and putting it in practice in Cheshire. *Journal of Gender Studies*, **17**(3), 185-199.
8) Hooker, L., Versteegh, L., Lindgren, H. and Taft, A. (2020). Differences in help-seeking behaviours and perceived helpfulness of services between abused and non-abused women: A cross-sectional survey of Australian postpartum women. *Health & Social Care in the Community*, **28**(3), 958-968.
9) Ingala Smith, K. (2018). Counting dead women. Retrieved from: https://kareningalasmith.com/counting-dead-women/
10) Taylor, J. and Shrive, J. (2021). 'I thought it was just a part of life': Understanding the Scale of Violence Committed Against Women in the UK Since Birth. Victim Focus. Retrieved from: https://www.victimfocus.org.uk/womens_experiences_violence_abuse_study