

Skills and tools for social- and healthcare professionals to address domestic violence Section 4, 1 ECTS













Co-funded by the Erasmus+ Programme of the European Union

Content

- Trustful atmosphere
- Professionals' skills to identify domestic violence
- Professionals' working tools for prevention of domestic violence
- Professionals' own protection and support



Building trustful atmosphere with a client

- Creating an open and trustful atmosphere with a client is a starting point for helping process of the victim of domestic violence.
- As a professional always be open, honest and compassionate towards the client.
- Tell client about confidentiality related to your discussion. Tell what you are documenting on the discussion.
- Be mentally present at the situation.
- Give client permission to speak and be ready to listen.



Building trustful atmosphere with a client

- If you suspect that your client is a victim or is at risk of domestic violence address your concern.
- Ask about violence directly.
- As a professional you have the right to tell what is right and what is wrong. Tell client how diverse violence can be.
- Tell that violence is a crime, and that violence usually continues unless it is addressed.



Building trustful atmosphere with a client

• Assess the safety and need for assistance of family members. Find out if it is safe for the client to return home.

• Tell that client will get help and guide she/he to the available services.

• It may be that the client is unwilling to talk about violence despite suspicions. Then agree a new appointment time.



- Social- and healthcare professionals are in a key position to identify domestic violence and to initiate support and safety for victim.
- To tackle domestic violence, it is essential that victims are identified and disclose their abuse as early as possible.
- According to research people experiencing domestic violence are more likely to come into contact with health services than other public services. Therefore, as a professional you will be a first contact for many.



Possible signs of domestic violence:

- <u>Inconsistent relationship with health services;</u> frequent appointments for vague symptoms, frequently missed appointments
- <u>Physical symptoms</u>; multiple injuries at different stages of healing, problems with the central nervous system – headache, cognitive problems, unexplained long-term pain
- <u>Reproductive/sexual health issues</u>; unexplained reproductive symptoms, including pelvic pain and sexual dysfunction, vaginal bleeding, recurring sexually transmitted infections



- <u>Emotional or psychological symptoms</u>; symptoms of depression, fear, anxiety, posttraumatic stress disorder (PTSD), sleep disorders, self-harming or suicidal tendencies, alcohol or drug abuse
- <u>Intrusive "other person" at appointments</u>; partner, parent, grandparent or family member always attends appointments unnecessarily, the client is afraid to speak in front of them.
- None of these signs automatically indicates domestic violence. However, even if the patient chooses not to disclose the matter at this time, knowing that you are aware of the problems, builds trust and gives them the grounds to turn to you or another professional later.



Early identification

- know and recognize the risk factors, signs, present problems or conditions
- facilitate disclosure in private without any third parties present
- be attentive and use selective, routine enquiry to questions what you hear and decide if the appearance of the client warrants concern



Why it can be challenged for the professionals to ask about domestic violence?

- Violence is a multidimensional phenomenon, challenging professionals to look at morality, attitudes and themselves.
- Violence is a part of humanity, when it can be recognized, in one's own thoughts, speeches and actions, it can be naturally recognized and spoken to by another.
- There is a consensus on signs of assault, such as contusions, bruising, burns and fractures. Opinions are divided when it comes to forms of mental violence.



Why it can be challenged for the victim to speak about domestic violence? The victim may consider thoughts like:

- Is speaking safe, is the listener trustworthy and does the listener believe me?
- Will I be understood?
- I have experiences of worthlessness. Low self-esteem and shame, maybe I'm just over-reacting.
- What if I will be left alone?
- But I still love my partner. I cannot harm him/her.
- What will happen after I tell listener about domestic violence?



- In many European countries there are national recommendations for the social- and healthcare professionals for assessment and screening of the domestic violence.
- However, even social- and healthcare professionals are aware of the traumatic consequences of domestic violence they still address their concern too seldom.
- Studies have shown that professionals describe their discomfort in domestic violence issues with factors such as lack of time, the behavior of women who have experienced violence, lack of training and effective interventions, the complexity of treating the whole family, the presence of a partner.



- It has been shown that strong leadership and prioritization of the issue have facilitated the development of the care process to detect and manage domestic violence.
- Training and organizational change within social- and healthcare systems can increase the identification and knowledge of domestic violence, as well as health professionals' readiness to ask victims about it.



• There are various screening instruments for risk assessment of domestic violence, i.e:

Domestic violence Screening Instrument (DVSI-R)
The Innsbruck Domestic Violence screening questions (IDV-3)
Danger Assessment (DA)
Ontario Domestic Assault and Risk Assessment (ODARA)



- Screening instruments with support questions can be used as an aid when addressing concern in discussion with client.
- Using screening instruments systematically may give the professionals confidence to identify domestic violence and to talk about it with clients.
- After recognizing domestic violence, it is the professional's responsibility to take the necessary interventions.



Motivational interview as an intervention

- Developed by Miller & Rollnick (1991) originally for addiction care. Was later adopted as a method in client situations where change is desired.
- Respecting client's autonomy via "therapeutic relationship".
- It aims to raise awareness, the clients' self-esteem and enhance decision making and self-efficacy.
- A way of interacting with an attitude that values and respects the person interviewed.
- Aims to get to know the client's own goals, values and the meanings of the desired change.
- Is a set of techniques and counselling style.



- Motivation rises in inter-person interaction.
- Motivation can be awakened, increased, built, strengthened or destroyed.
- The goals and resource-oriented interaction process are defined together with the client.



Basic elements of motivational interview:

INDEPENDENCE AND DECISION-MAKING POWER

the professional respects the client's ability and right to choose own goals

COOPERATION AND CONFIDENCE

between the client and the professional

AWAKENING

The conditions for change already exists, they just need to be brought out



Principles of motivational interview

- Express Empathy
- Avoid argumentation
- Roll with resistance
- Deploy consistency
- Support self-efficacy
- Give practical advice





The importance of interprofessional support

- As a professional always map the need for multi-professional customer support.
- In addition to the support you provide, victim of domestic violence may need support and help from other professionals, for example, the police, child protection, lawyer, shelter or other service providers.
- With the support of a multi-professional team, the best way to recover from violence can be ensured.



Professionals' own protection and support

- Professionals who work with victims of trauma (including victims of violence) are exposed to their own experience indirectly when they listen to, and discuss other traumatic events reported by clients. Exposure to secondary trauma can lead to many negative consequences and above all to the development of secondary traumatic stress (STS) symptoms.
- Many factors can determine the occurrence of STS symptoms. These include things related to the work environment, such as work experience and workload, including the number of clients and time spent helping victims of trauma and previous persomal trauma.
- Professional emphaty, expressed in the form of empathic concern, has been connected as a risk factor for STS.



Professionals' own protection and support

- Empathy and openness to the suffering of others enable the burden of the primary trauma carried by the client to be transferred to the helper.
- Emotional aspect of empathy seems to increase the risk of STS, while its cognitive aspect may play a protective role. According to earlier studies, the cognitive aspect of empathy, i.e., perspective taking was negatively correlated with STS.
- Findings indicate that self–awareness and emotion regulation (cognitive components of empathy) seem to be factors that protect against STS.
- The cognitive efforts of a person exposed to traumatic events, both directly and indirectly, can be reflected in the form of various cognitive coping strategies: positive cognitive restructuring, downward comparison, resolution/acceptance, denial and regret.



Professionals' own protection and support

- Researchers recommend prevention programs for professionals who help victims of trauma to focus mainly on cognitive processing of the trauma.
- As a professional facing traumatized victims of domestic violence, it is important to be aware of possibilities of STS symptoms.
- Regular work supervision is recommended for professionals who encounter and care for victims of domestic violence at their work.



References

- Beck, T., Berger, A., Stix. L. & Riedl, D. 2022. The Innsbruck Domestic Violence screening questions (IDV-3) effectively help to identify victims of domestic violence during clinical routine Results of an observational single-center study. General Hospital Psychiatry, 76:55-56.
- Beynon, C.E., Gutmanis, I.A., Tutty, L.M., Wathen, C.N. & MacMillan, H.L. 2012. Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. MBC Public Health 12: 473.
- Campbell, J.C., Webster, D.W. & Glass, N. 2008. The Danger Assessment. Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide. Journal of Interpersonal Violence, 24 (4): 653-674.
- Domestic Assault and Battery Advisory Board. 2018. Domestic Violence Evaluation Screening/Assessment Tools.
- EIGE. European Institute for Gender Equality. 2019. Gender-based violence. Risk assessment and management of of intimate partner violence in the EU.
- Miller, W. R., & Rollnick, S. 1991. Motivational interviewing: Preparing people to change addictive behavior. The Guilford Press.
- NHS. 2017. Domestic abuse: a resourse for health professionals. Department of Health and Social Care. Uk Gavernment. United Kingdom.
- Ogińska-Bulik, N., Juczyński, Z. & Michalska. P. 2022. The Mediating Role of Cognitive Trauma Processing in the Relationship Between Empathy and Secondary Traumatic Stress Symptoms Among Female Professionals Working With Victims of Violence. 2022. Journal of Interpersonal Violence, Vol. 37(3-4).
- Radatz, D.L. & Hilton, N. Z. 2021. The Ontario Domestic Assault Risk Assessment: Predicting Violence Among Men With a Police Record of Intimate Partner Violence in the United States. Criminal Justice and Beehaviour, 49 (3), 371-388.
- Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. 2005. Motivational interviewing: a systematic review and meta-analysis. The British journal of general practice : the journal of the Royal College of General Practitioners, 55(513), 305–312
- Soleymani, S. 2019. Motivational Interviewing for Enhancing Engagement in Intimate Partner Violence Intervention. Doctoral thesis. University of Canterbury. New Zealand.
- Sosiaali- ja terveysministeriö. & Etelä-Suomen lääninhallitus. 2007. Ota väkivalta puheeksi.
- Williams, K.R., & Grant, S.R. 2006. Empirically Examining the Risk of Intimate Partner Violence: The Revised Domestic Violence Screening Instrument (DVSI-R). Public Health Reports, 121(4): 400-408.

