This is the published version


Available from Deakin Research Online

http://hdl.handle.net/10536/DRO/DU:30030494

Reproduced with the kind permission of the copyright owner

Copyright: 2010, Taylor and Francis
Conclusions and implications for research, policy and practice

Within the Press release that launched the VVAPP programme in November 2006, Professor Louis Appleby, National Director for Mental Health said:

Childhood physical, emotional and sexual abuse and neglect, and domestic violence can have long-lasting, devastating effects on the mental health and well-being of those who are victimised. Developing effective preventative and therapeutic interventions is an important part of the mental health modernisation programme.

While Professor David Colin-Thome, National Director of Primary Care acknowledged:

I know that we GPs are not always fully equipped and supported to identify and respond to the needs of domestic abuse, or rape or childhood sexual abuse. This work should help to increase awareness and understanding and improve the care provided.

This book summarises the steps that need to be taken to respond to the analysis encapsulated in these two quotes. It has covered an enormous breadth of material. Taking a life-course approach, it has situated the findings from a major study of the views of experts by profession and experts by experiences, and other studies of the pathways that individual victims/survivors have traced through services in their journeys towards healing, within the research evidence accumulated from decades of studies into the epidemiology of violence and abuse, and primary, secondary and tertiary interventions in this field. The book has focused on sexual and domestic violence and abuse; however, it has emphasised the need to see these as inherently situated within social structures nested from the local up to the global level – a socio-ecological framework was introduced in Chapter 2 and used throughout. These social structures interact differently to influence individuals’ experiences according to characteristics such as age, gender, sexuality, ethnicity and (dis)ability.

Chapter 2 emphasised the value base that the Delphi experts considered important for practice, with a human rights/equalities framework regarded
as an essential basis for policy and practice, this was re-emphasised throughout the contributions in Part III of the book on addressing inequalities. Chapter 2 also emphasised the importance of practice guidelines and codes of professional conduct. While there was no consensus about whether these needed to be distinct sets for different areas of practice/professions or not, there was a clear need for survivors to be made aware of the existence of these, and how to raise any concerns they might have. The need for regular updating of all sets of guidelines and for systems for assuring adherence were also strongly emphasised.

Although, as chapters throughout the book have emphasised, knowledge is not complete, enough is known to clearly set out what needs to be done and how to achieve it. This is not to say, however, that making the required changes will be easy. A number of major challenges remain. First and foremost is achieving the necessary political will to support, and resource, the relevant services and initiatives.

As the next section explores, changes are necessary throughout all sectors of society in order to achieve the necessary whole of system/society implementation to address violence and abuse adequately. Political will is necessary, not just in the short term, but into the medium and long term, as the necessary changes and implementation of a public health prevention framework cannot be achieved in the short lifetimes of single governments. A major component in what is necessary is effective interagency collaboration, based on clear understanding of the complementary roles that different agencies have to play within an overall public health framework, and clear protocols to permit information and resource sharing. The case studies presented throughout the book and the analysis presented in Chapter 7 demonstrated very clearly the importance of such collaboration.

Success will not be complete, however, without breaking through the silence and shame that still cloaks much violence and abuse; silence and shame on the behalf of the victims or survivors who fear condemnation and blame from those individuals and agencies who should provide support and services, and silence and shame on the behalf of perpetrators who wish to hide their responsibility for their acts and actions and refuse the possibility of change. This requires a major change in attitudes in society, from a view that sees violence and abuse as perpetrated by the evil stranger to views that see violence and abuse as things that need to be tackled throughout the fabric of society, in private as well as public spheres, as something that individuals need to address within themselves. As the foundation for this change, recognition of the centrality of human rights, and respect for diversity and difference, are essential to addressing the needs of both victims/survivors and perpetrators.

The remainder of this chapter is presented in three sections, the first of these summarises the public health prevention framework that represents the summation of what has been discussed in Chapters 2 to 9. A second section then examines the key conclusions in terms of improving outcomes for individuals, focusing in turn on policy development, service and practice improvement and finally on further research needs. The chapter finishes by discussing important principles underpinning this work.

A public health prevention framework

The book has emphasised that a public health approach is required to respond to this major public health problem. Figure 10.1 summarises the public health prevention framework that represents the summation of Chapters 2 to 9. The Delphi experts overwhelmingly emphasised the importance of a public health approach to prevention, first and foremost aimed at changing societal attitudes to violence and abuse. The later chapters of the book presented the research evidence that underpins this approach and identified some key components.

Greater awareness among the general public about sexual and domestic violence and abuse is important. Public awareness campaigns need to stress...
personal responsibilities and rights, and there needs to be careful work with the media to try and ensure that sensational coverage (which attracts good audiences) does not overshadow the informational and educational content that those who are quietly or secretly living with memories prior to disclosure need. Other important interventions at societal or community level include legislation and the provision of helplines. Within the UK, Crime and Disorder Reduction Partnerships (CDRPs) potentially have a key role in leading the partnership effort that is necessary, but issues around confidentiality and information sharing will need to be resolved for their full potential to be realised.

Awareness and information sessions need to be provided in schools as part of the Personal, Social and Health Education curriculum. Sexual and domestic violence and abuse need to be made priority issues for education services, with additional support for teachers who are supporting pupils who disclose.

The need for application of a basic public health model (of identifying risk factors and strengthening protective factors in the individual, the family, the community and society within various age bands) has been emphasised. Prevention needs to be approached as any other major public health campaign, with appropriate components for primary, secondary and tertiary prevention; these components are summarised in Figure 10.1.

Children and young people are most likely to be safe and keep safe if they: understand their right to be safe, have been helped to develop the confidence to speak out if they feel danger, or don’t like what is happening; have a secure base within a family or substitute family, there is at least one adult they can talk to. Therefore building children’s self-esteem and self-worth and listening to and taking them seriously should be at the core of all universal services and should be part of a strategy in, say, PHSE for equipping children to grow safely and healthily, with an understanding of healthy relationships and consent. This needs to be developed through adolescence into knowledge and understanding about safe dating. Education of learning-disabled people about sexual activity and relationships is also required.

The issues of lack of funding, lack of political will, lack of priority and lack of public visibility and the need for societal-wide action come through in every single programme area – along with support for a broad public health approach and the need for an integrated high-profile national strategy (with some differences about the extent to which integration is possible/ desirable). Policy-makers need to resist the temptation to impose unitary solutions to the huge diversity of different situations and recognise that the keys to successful policies are likely to be sensitivity and flexibility.

The current lack of joined-up approach at national level needs to be addressed through a comprehensive national strategy that recognises the need for action in all sectors of society. Three particular components are particularly important. The need for widespread change in public attitudes and knowledge about the extent and nature of abuse had already been mentioned, but here it is important to keep an appropriate balance between the coverage of ‘stranger danger’ and abuse by known and trusted adults, with recognition that men are also victims/survivors of sexual violence and abuse. There is a need for government departments to work with the media to give clear messages that people can recognise and take appropriate action about abusive behaviours. Second is the need to challenge the silence about abuse and sexual abuse.

There is also a need to challenge the problem of abuse not being seen as relevant in NHS settings, e.g. not a ‘mental health’ issue. This relates to services still being organised around diagnostic categories and medical models of care where links are not made between experience of abuse and presenting distress or ‘symptoms’. Once a person has a diagnostic label (e.g. ADHD, Personality Disorder’, OCD, etc.) all too often it is assumed that there is no need to ask any more questions; this inhibits disclosure and addressing the underlying needs in favour of mere symptom management.

In terms of funding, the need for long-term funding for all different sectors is vital. Funding for the NGO sector on a long-term rather than short-term basis, thereby retaining NGO expertise, is particularly important since not all victims/survivors feel safe to access statutory sector services (assuming that such services exist).

Throughout all sectors of society, organisations need to proactively ‘model’ non-abusive and empowering behaviours, and workplace bullying and harassment policies have an important role to play here.

A less punitive and more therapeutic approach is required towards the perpetrators, who must be treated firmly and appropriately and not let off or cautioned. Adequate resources to be able to offer and strongly encourage the uptake of treatment must be available. There must be zero-tolerance of violent and abusive behaviour. Other important components of service provision include an increase in the availability of advice to those who know they have a sexual interest in children, such as confidential free phone numbers and a need to have facilities available for those who have no criminal record but who are concerned about their behaviour/desires. Also relevant here are restrictions in availability of pornographic material, given the role of such material in increased risk of developing pro-rape attitudes, beliefs and behaviours, and committing sexual offences (Itzin et al. 2007).

**Improving outcomes for individuals**

Therapy has three stages – building trust, working through and letting go. Trust takes time to establish. The therapist needs to be consistent in approach and clear about boundaries. Timing is important, sessions must begin and end on time. The demeanour of the therapist must be consistent. Low self-esteem means that every step is a hurdle to be overcome – we simply do not believe that we are worth people’s attention. Therefore the therapist needs to be prepared to be tested by the survivors who will expect to be rejected and will try to ensure that rejection occurs. In my own case this initial stage took many sessions as I worked through...
Policy development and service and practice improvement

Diversity, inclusion, equal treatment and basic human rights principles were strongly suggested as fundamentally important, suggesting that a human rights/equalities framework was a required basis for policy and practice, with explicit attention to gender, sexuality, ethnicity, and disability within this. A second overarching theme was the notion of the importance of a victim/survivor-centred approach (associated with characteristics such as empowerment, giving control and choice to victims/survivors); this was suggested, by some, to include choice for victims/survivors in terms of the gender, sexuality and age of the person they work with.

As the quote that opened this section emphasised, belief in possibility of healing is vital for those who would work as healers, coupled with an appropriate humility that their role is as a facilitator. The counterpart of this for those who work with perpetrators is the belief that their change is possible and lies within their control.

A lack of availability of resources is the key obstacle to realising the potential for making a significant difference to the lives of those who have experienced violence and abuse. All too often, individuals suffer in a form of postcode lottery as to whether access to therapeutic services is achieved in a timely fashion.

Further research

As has been emphasised above, research has given us insight into a variety of different approaches that work in terms of providing for positive outcomes. The amount of evidence from well-designed, well-executed studies is still low in some cases (below what some sets of criteria regard as sufficient). To a great extent this reflects the limitations on available research funding – particularly for studies with the long follow-up periods necessary to allow for healing of complex, long-lasting and multi-faceted abuse. As has been emphasised earlier in this book, an absence of evidence is not the same as evidence of absence. Further research is necessary to increase the amount and quality of evidence available, and to enable us to better understand how to tailor a package of services and responses to the needs of particular individuals.

Earlier chapters in the book have identified issues where no clear research evidence exists and where Delphi experts hold diverging views. These indicate areas that would benefit from future research attention to understand better the task of tailoring appropriate therapeutic interventions to the specifics of each individual's history and experience.

Another need is better understanding of what promotes and facilitates resilience in individuals, families and communities. Research that investigates this is still all too rare, although there are some signs that this is beginning to change. For example, Thomas and Hall (2008) describe a narrative study of thriving adult female survivors of child abuse, which identifies a wide range of different turning points and their role in women's life trajectories.

Overarching principles

Hope and recovery

The importance of hope and recovery in the treatment of both victims/survivors and abusers cannot be overestimated. Here, the clear view of the therapist that healing and change are possible has an important part to play. Just as educational research has taught us that the expectations of teachers about individual pupils' chances of success or failure influences those pupils' educational outcomes, so expectations of therapists can influence outcomes for clients.

Addressing the gendered nature of domestic and sexual violence and abuse

Chapter 6 above examined the gendering of interpersonal violence and abuse; and the implications of sexuality for the experience of interpersonal
violence and abuse by heterosexual, lesbian and gay individuals. While the literature on violence and abuse often considers gender and sexuality as separate issues and phenomena, processes of gendering and issues related to sexuality are by no means discrete, and Chapter 6 explored some of the overlaps, links and implications of difference. Gender is of crucial importance to understanding the impact of interpersonal violence and abuse on individuals, and understanding what may work in overcoming victimisation (Itzin 2000a). At the same time, sexuality creates different experiences and outcomes. The social construction of masculinity, as embodied in heterosexual men, helps to explain, for instance, domestic violence as the exertion of power and control by men over women in intimate relationships within contexts of gender inequality (Hester 2004). In same-sex relationships gender is not as prominent in positioning individuals within relationships and in interactions and constructions of power and violence. There is, however, still evidence of gendered norms impacting on experiences and outcomes of violence and abuse for lesbians and gay men (Hester and Donovan 2009).

The contentious issue of men as victims of domestic violence and abuse and women as perpetrators has dominated the past decade, and in particular the use of the CTS (Conflict Tactics Scale) in producing findings of ‘symmetry’ between women and men as perpetrators and men more than women as victims (Archer 2000). However, the use of CTSs to measure IPV is problematic, as a result of methodological flaws in the instrument. The nature of the problem with CTSs requires explanation because of the perverse effects their use has had on public policy in the US, in particular, but increasingly in the UK and Europe.

The problem lies in the CTS’s use of act-based measures without examination of context in terms of physical or social power differentials. This has led Archer (2000) to conclude that measured by the CTS, men’s and women’s use of acts is symmetrical, but the consequences are not symmetrical. Dobash and Dobash (2004) have offered a more sophisticated critique. The first issue is the use of ambiguous items, for example, in one version of the CTS, men and women were asked if they had ever ‘thrown an object at your partner’, when it is clear that throwing a lamp at a partner is very different from throwing a pillow. A second issue is that of multiple or compound items, for example: ‘hit or tried to hit your partner with something’, when actually hitting a partner is very different from trying to hit a partner. This type of act-based approach makes no distinction between the physical impact/consequences of a slap delivered by a slight, small woman with a blow delivered by a heavier, stronger, taller man.

In their paper, Dobash and Dobash identify an additional problem with act-based measures: that the usual scoring methods are such that it is only necessary for a man or a woman to indicate that they have committed one single act on the list in order to be defined as violent. This means that those who have perpetrated several violent acts (no matter how serious) and those who have reported committing only one act (no matter how trivial) are both defined as violent. Thus the woman who admits that she tried to hit her partner is equated with the man who reports beating his partner up: both are deemed to be violent and it is concluded that there is symmetry in their use of violence. They identify another problem as ‘the conflation of violence (physical and sexual acts) with other non-violent acts of abuse (shouting, name-calling etc.)’ (p. 331). The danger is that researchers may conclude that women are just as violent as men when what may, in fact, be under discussion is men’s acts of physical and sexual violence and women’s acts of arguing or shouting. From their own research with men convicted of violence and their partners, using a context-specific method, Dobash and Dobash found that serious intimate partner violence is asymmetrical, with men usually violent to women. Johnson’s (2008) analysis is pertinent here; he criticises CTSs for failing to distinguish between the different types of domestic violence — that which involves coercive control (IPA in the terms defined in Chapter 1 and ‘intimate terrorism’ in Johnson’s terms) and that which does not — situational couple violence in Johnson’s terms.

In later chapters in Part 3, the importance of gender was also illustrated. Chapter 7 showed how the intersection of gender, race and culture produce specific risks of violence and abuse for different black and minority ethnic populations. As Chapter 8 showed, the experiences of disabled people are also shaped by gender as well as ethnicity, as the different case studies described amply illustrate. Finally, in Chapter 9, intersections of gender and profession again produce particular patterns of risk and experience.

Sexual and domestic violence and abuse as everyone’s responsibility

One of the major challenges to achieving appropriate responses to sexual and domestic violence and abuse within the health sector has been the mistaken perception that these are not health issues, that they are social problems. The enormous wealth of evidence about the serious short-, medium- and long-term health effects for violence and abuse that Chapters 2 to 6 in this book have summarised demonstrate that this mistaken belief must be firmly countered by ensuring that all health professionals, as a part of their basic, pre-registration training, are introduced to the basic epidemiology of violence and abuse and its health consequences. Asking about experience of violence and abuse needs to become an integral part of the basic history-taking that is expected wherever any of the sign/symptoms that are associated with violence and abuse occur. Without this, important opportunities for prevention and early intervention will be lost.

But tackling violence and abuse is the business of not only the health sector — it needs to be part of the core business of all health, mental health and other relevant services across all sectors. As this book has illustrated throughout, especially in the various case studies presented and in particular the section by Hamner in Chapter 7.2, multi-agency approaches are
necessary for responding to and providing interventions for domestic and sexual violence. Sharing information between agencies is important for multi-agency work, but issues of confidentiality and data protection define and limit the sorts of information that may be shared and with whom, and providing appropriate protocols in this area remains a challenge for the future. Appropriate primary prevention work aimed at changing attitudes to violence and abuse needs to take place across all sectors in a coordinated fashion for maximum effect. In terms of funding, the need for long-term funding for all different sectors and in particular retaining NGO expertise was emphasised, since all not all victims/survivors feel safe to access statutory sector services (assuming that such services exist).

**Addressing health inequalities and social exclusion**

As various parts of the book have emphasised, the health consequences of violence and abuse are enormous; this is one of the reasons that the issue is such a public health priority. The implementation of an appropriate framework to tackle violence and abuse will make a vitally important contribution to the reduction of health inequalities.

The book has also discussed the stigma and shame that attends the experience of domestic and sexual violence and abuse, and how this reinforces the negative effects of violence and abuse, interferes with the processes of seeking appropriate help and support, and can maintain those who have experienced violence and abuse in states of social isolation and social exclusion (see also Taket et al. 2009 for an amplification of these arguments).

In order to fully address the challenge of the social exclusion of those who have experienced domestic and sexual violence and abuse, widespread societal change in terms of attitudes to violence and abuse is necessary, overturning the different stereotypes that place the blame and shame on the victims, and recognising the operation of coercive control for what it is, an abuse of an individual's basic human rights.

**Human rights and social justice in domestic and sexual violence and abuse**

Domestic and sexual violence and abuse represent a violation of the basic human rights of victims/survivors. Through the exercise of coercive control on the part of the abuser, the rights of victims/survivors to live in freedom and safety, to autonomy and self-determination are compromised, often severely, and with short-, medium- and long-term consequences to health and well-being. This provides a strong mandate for supporting the implementation of policies and practice to respond to domestic and sexual violence and abuse through early intervention and prevention. Throughout this book, it has been emphasised that a human rights framework that seeks to address rights violations and promote social justice offers a strong foundation for progress in the future.

**Looking forward to looking back**

All abuse occurs from an absence of love for self and others. The essence of our humanity is love, which is an unlimited and free resource that resides within us all. It is time that we, as individuals and as a society found the courage and commitment to reawaken to and manifest that love. For love does not hurt, love does not judge. Re-connect with the love within, then abuse will not occur. Love empowers. Fear does not exist where there is love. ... Professionals cannot share what they deny/repress within themselves. A complete change of attitude and approach from one of judgement, fear and indifference to one of professional objectivity combined with love and detached compassion. We live in a society in which individuals have judged themselves not worthy of their own love and therefore do not value themselves. If we do not love and value ourselves then we cannot love and value others nor respond effectively to their needs. When children are judged unworthy of love/live with criticism, abuse, etc., then they internalise those judgements and accept them as their own, this causes deep emotional pain which can be anaesthetised through drugs, drink etc. and/or manifests as depressions/rage. This is the source of abuse, mental illness etc. We need to address the fundamental cause of the mental illness within society, the absence of love through judgement and not continue to react to the symptoms. (Delphi expert)

To finish, it is useful to consider the question of what might be found in a future where the public health issue represented by sexual and domestic violence and abuse had been successfully tackled. This would be a future where every child and young person, regardless of gender, ethnicity, religion, class, sexuality or ability, believed in their right to nurturing and loving care, and understood their right to make their wishes clear, and could count on those wishes being heard, understood and supported by their family, community and the wider society. All individuals would be equipped with skills and understanding about their own worth as individuals and about the creation and maintenance of healthy relationships, both intimate and friendship. Service agencies would work to support the creation of healthy relationships and the healing of those where something had gone wrong, but, owing to the growth in skills and understanding throughout society, residual demand for services would be small. Research would have filled in some of the gaps outlined above, so that it is better understood how to support and facilitate resilience in individuals, families and communities, and to tailor interventions and services to the particular needs of individuals.