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TITLE: First Contact: Acute stress reactions and experiences of emergency department consultations following an incident of intimate partner violence

CONCISE TITLE: Intimate partner violence and ED consultations

AUTHOR: Dr. Philippa Olive, PhD Sociology; MSc Research and Development; BSc Nursing; PgCE TLHE; RGN; RSCN.

Senior Research Fellow in Health Services Research.

University of Central Lancashire

Preston

PR1 2HE

United Kingdom

POlive1@uclan.ac.uk

+44 07948 285 839

@philippaolive

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ABSTRACT

Aims and Objectives

The aim of this research was to explore women's emotional and affective responses following an incident of intimate partner violence experienced during emergency department attendances.

Background

A growing body of research has explored women's experiences of emergency department following intimate partner violence though little remains known about the experience and impact of emotional and affective responses during these attendances.

Design

A descriptive qualitative design was used, underpinned theoretically by critical realism and post-modern complexity theory to attend to multiple, intersecting mechanisms that lie behind events and experiences.

Methods

Semi-structured interviews with six women who had attended an emergency department directly following an incident of intimate partner violence. Interview data were transcribed and thematically analysed in NVivo9 using a coding framework.

Results

There were three interconnected key findings. First, was the commonality of acute stress experiences amongst women attending an emergency department following partner violence, second was that these acute stress reactions negatively impacted women's consultations, and third was the need for specialist domestic violence services at the point of first contact to assist service users navigate an effective consultation.

Conclusions

Acute stress reactions were an important feature of women's experiences of emergency department consultations following intimate partner violence. Attending to psychological first aid; providing a safe and quiet space; and affording access to specialist violence advocacy services at the point of first contact will limit harm and improve health consultation outcomes for this population.

Relevance to Clinical Practice

This research provides an account of emotional and affective responses experienced by women attending emergency departments following intimate partner violence and explicates how these acute stress reactions impacted their consultation. This research has relevance for practitioners in many first contact health services, such as urgent and emergency care, general practice, community public health and mental health.

SUMMARY BOX

What does this paper contribute to wider global community?

- Women attending health services following an incident of intimate partner violence may be suffering acute stress reactions.
- Not only do these acute stress reactions following intimate partner violence impact health and well-being, they extend to negatively impact the person's health consultation.
- Psychological first aid and specialist violence advocacy service from the point of first contact to assist victim-survivors of intimate partner violence navigate their health consultation will likely improve short and long term health and well-being outcomes for this population.

KEYWORDS

Domestic Violence; Intimate Partner Violence; Violence Against Women; Trauma; Acute Stress Reaction; Mental Health; Emergency Service, Hospital; Emergency Department; Triage; Psychological First Aid.

INTRODUCTION

Gender-based violence has many forms and which affect men and women differently (Merry 2009). Women are disproportionately impacted by intimate forms of gender-based violence such as kin-perpetrated and sexual violence (Britton 2012, Johnson 2006, Stark 2007).

Intimate partner violence is the most commonly reported form of gender-based violence against women, affecting 30% of women globally (WHO 2013a), and in England, an estimated 900,000 women were subject to some form of abuse by their partner in 2010/11 (Britton 2012).

The World Health Organization (2012) defines intimate partner violence as:

“Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours” (WHO 2012)

The impact of intimate partner violence on health is extensive. Women subjected to intimate partner violence may suffer physical injury, sexual and reproductive health problems, mental health problems (WHO 2013a), and are at greater risk for long term conditions such as asthma and heart disease (Black *et al.* 2011) than women not abused. The extent of these health consequences is enormous; intimate partner violence is a leading cause of disability and premature death for women worldwide (IHME 2013).

The World Health Organisation has called for all health service providers to take action to respond to intimate partner violence (Krug *et al.* 2002; WHO 2013b). The mobilisation of health policy advocating health services as sites of intimate partner violence intervention is well established worldwide and in England national guidance for health practitioners on how to respond was first introduced in 2000 (Olive 2007). The most recent policy guideline in England (NICE 2014) calls for integrated multi-agency (justice, health, social, and third sector) partnerships to develop integrated care pathways to prevent domestic violence and abuse and its secondary harms. For front-line health services this means the provision of health service environments that enable reporting of intimate partner violence and clear

protocols to mobilise sensitive, personalised support plans that include referral to specialist domestic violence services (NICE 2014).

Emergency departments have long been identified as a health service at which women seek healthcare following intimate partner violence (Olive 2007). Indeed, studies undertaken in England, Australia and the United States identified that women attending emergency departments because of injuries caused by their partner constituted between 1% and 3.5% of total emergency department caseloads (Olive 2007). However, findings from the British Crime Survey of England and Wales (Britton 2012) estimated that just 1.4% of women attended an emergency department directly following intimate partner violence. Importantly, this suggests that although emergency departments see a minority of women abused by their partner, it is likely they see the most severely abused. Given that emergency departments likely see the most severely abused, the aim of this research was to explore women's emotional and affective responses following an incident of intimate partner violence experienced during emergency department attendances.

BACKGROUND

Accessing healthcare following intimate partner violence has been found to be difficult for women for a number of reasons that include: controlling behaviours of their partner (Stark 2007; Reisenhofer & Seibold 2012); intimate partner violence associated stigma (Taket *et al.* 2003); feeling embarrassed (Rose *et al.* 2011); being judged (Feder *et al.* 2006; Reisenhofer & Seibold 2012); being seen by people they know (WNC 2010); and perceived threat of social services involvement in terms of child protection proceedings and loss of children (Feder *et al.* 2006; Rose *et al.* 2011). Despite these challenges to access, research in Norway illustrated that women were active about which agencies to contact based on “different interactional consequences of intimate partner violence” (Vatnar & Bjørkly 2009, p. 239). This study found that women were more likely to contact police if they felt their lives were at risk and more likely to contact health professionals when they had suffered severe

injury (Vatnar & Bjørkly 2009). More recently however, Olive (2013) found that women were instrumental in reporting and accessing emergency services following intimate partner violence, and that the police and ambulance service played an important role in women's access to emergency departments.

Reflecting the policy steer for health services to respond to intimate partner violence, research has increasingly been undertaken to document women's experiences of emergency department services following partner violence. This body of important research has found that intimate partner violence was not always asked about or identified by health practitioners during emergency department consultations (WNC 2010, Robinson 2010) and further that women were selective about their disclosure practices often weighing up the benefits of seeking emergency department care (Vatnar & Bjørkly 2009) and reporting intimate partner violence against the consequential life intrusion and loss of control that identification could bring (Catallo *et al.* 2013). When access and report is self-initiated, positive consultation outcomes are more likely (Catallo *et al.* 2013). Empathetic and good emotional care, though frequently lacking, were important features of health services, which when received, contributed to positive healthcare experiences and self-identity (Reisenhofer & Seibold 2012).

This body of research increasingly signals importance of people's emotional and affective responses for emergency department service experiences and outcomes. Though the association between being subject to intimate forms of violence and experience of post-traumatic stress disorder (PTSD) symptomatology is beginning to be better explicated (Forbes *et al.* 2014), little remains known about the range and scale of acute, affective and emotional, responses experienced by women attending emergency departments during the immediate period following intimate partner violence and further, how these acute mental health impacts effect people's health outcomes. Contributing to this field, this research explores women's experiences of emotional and affective responses following an incident of

intimate partner violence experienced during emergency department attendances and addresses the question of how emotional and affective responses may impact emergency department consultations and outcomes.

METHODS

Design and ethical review

This research was part of a larger study of intimate partner violence diagnosis in emergency department consultations and classification in hospital administrative data systems (reference anonymised for review). This study was theoretically shaped through critical realism (Bhaskar 1978) and post-modern complexity theory (Paley & Eva 2011; Cilliers 1998). This approach attends to ontological and epistemological depth in terms of dynamic, multiple and intersecting, properties of systems that lie behind patterns of events and experiences. An applied qualitative, descriptive and explanatory, design was employed that involved semi-structured interviews with service users to produce thick, descriptive accounts of events and experiences. Favourable ethical opinion was granted by the Social Care Research Ethics Committee and site permissions from each participating organisation were obtained. This paper presents a subset of findings from semi-structured interviews undertaken with women victim-survivors of intimate partner violence about their experiences, emotions and feelings, during emergency departments following an incident of intimate partner violence.

Participant recruitment

Three community-based specialist domestic violence services in the north of England agreed to host this research. Information about the research was communicated in person to staff and service users at local meetings and by distribution of posters at the centres. Participation was on an opt-in basis and potential participants could contact the researcher via domestic violence service staff, email, or telephone. Access to potential participants was multifarious; one centre facilitated meetings between the researcher, service staff and

service users and here four participants were recruited; one centre facilitated meetings between the researcher and service staff who then spoke to potential participants and two participants were recruited, and one centre gave the information flyers to service staff to pass on to service users and no participants were recruited. Participant recruitment was more successful at sites where meetings between researcher, service users and wider staff members took place. A criterion-based participant recruitment framework was developed to maximize diversity and breadth of experiences for an imagined twelve participants, though in practice this was not achieved. The six participants for this subset of the research met the criteria of: being female, having been subject to intimate partner violence, and attending an emergency department in the immediate period following intimate partner violence.

Data collection

Semi-structured interviews were carried out between December 2011 and January 2012, by one female researcher in a private room at specialist domestic violence services centre known to participants. An interview protocol developed for this study attended to participants' rights, privacy, comfort, safety and well-being, and funding for participant travel expenses, child care and interpreter service were available. Participants were aware they could stop at any time and retract participation until the final research report was written. Participants were informed about the limits of confidentiality should they disclose that they or someone else was at risk of harm and informed consent for the interview and management of their data was obtained. Demographic information was not collected to minimise possible perceived burden of participation given the complex and sometimes difficult relationships between victim-survivors of intimate partner violence and statutory agencies.

An interview guide developed from previous research and stakeholder consultations was used to direct questions, although as semi-structured, interviews were responsive to participants' priorities and direction. Interviews lasted from between twenty and fifty-five minutes. Interviews were brought to a close when the topics of the interview guide had been

addressed and/or when it was clear participants had exhausted what they wanted to say. Participants were invited to contact the researcher at any time to add any further material. Interviews were audio taped and transcribed by secure transcription service and anonymised. In the anonymising process participants were assigned a code made up of two letters 'SU' (service user) followed by two digits, the first number refers to a district that the participant was recruited from and the second was a randomly assigned interview number for that district. The anonymised transcripts were checked for accuracy and entered into NVivo9 (computer-based qualitative research software), for data management and analysis.

Data analysis

Analysis was framed by a descriptive, interpretative approach to capture and interpret women's representations of their experiences of being at an emergency department following intimate partner violence. Data analysis was undertaken by one researcher who had undergone training in qualitative research analysis and computer assisted qualitative data analysis. Initially data analysis employed a 'tight' rather than 'loose' design (Miles and Huberman 1994) meaning analysis structuring took place pre-data collection in terms of the formulation of research questions and interview topic guides based on what was already known about intimate partner violence and health consultations. Applying Ritchie *et al.*'s (2003) Framework method for qualitative data analysis, an initial analytical coding framework was formulated in NVivo9 nodes with which to tag and code interview transcript data and which facilitated retrieval of focused sections of interview data for analysis. The NVivo9 nodes or thematic categories of information drawn on for this paper were 'experiences of being in the emergency department' and 'health environment'. In a process of transcript readings and familiarization a further thematic sub-concept 'violence and me' emerged. Data were analysed for patterns, recurrences and dissonance, and three key themes holding substantive meanings were identified.

RESULTS

The preservation of victim-survivor voices was a central tenet of this research and the presentation and interpretation of results reflects this approach. The key themes evidenced by participants' thick descriptive accounts are presented here in the Results section and these are then further interpreted in the Discussion section to develop meanings, explanations, and recommendations for practice.

During the interviews women spoke about the violence perpetrated against them by a current or (in two cases) ex-partner that had led to their consultation. The forms of intimate partner violence respondents had been subjected to were multiple and included emotional or psychological abuse, controlling behaviours, isolation, sexual violence, physical and life-threat violence, drugging, false imprisonment, and ill-treatment or willful neglect (Table 1).

Insert Table 1 here

There were differences in the number of times women had attended emergency departments following an incident of intimate partner violence. Four women (SU24, SU25, SU28, SU43) drew on experiences from a number of (more than three) attendances and two (SU27, SU49) had attended once. The period from emergency department attendance to interview varied from two to twenty-four months.

The three key themes identified from analyses of participants' thick descriptive accounts of experiences, emotions and feelings from first contacts with emergency departments following intimate partner violence were:

- Affective and emotional responses: On not being 'there'
- The other side of it: what about *me*?
- Navigating the consultation

Affective and emotional responses: On not being 'there'

Four women spoke about their acute, affective and emotional responses to intimate partner violence experienced during their emergency department attendance; they spoke of the “emotional side” (SU24), of being “in shock”, of their mind “not there” (SU28), of being “on edge”, of not being able to “think straight” (SU43) of being “in a daze”, and “in a whirl” (SU49). These everyday vocabularies of respondent’s affective and emotional responses resonate with common understandings of symptoms of Acute Stress Reactions (Lawson 2013), such as ‘anxiety’, ‘poor concentration’, ‘feeling detached’ and ‘feeling numb’. These acute psychological, affective and emotional, stress experiences were an important feature in respondents’ accounts in this study and further data in this and subsequent sections further illustrates their scope and significance.

In this next account one respondent articulates how affective and emotional experiences of not being able to think straight and make sense of what was happening impacted her ability to field triage questions.

SU43: *(...) after something like that happening to you, you feel quite... it's just horrific, I can't even explain it, to be honest. And then you've got somebody there and they're asking you all these questions and they can be quite in your face kind of, they just want the answers and they're not giving you as much time as you need and I can't really answer them as quickly as they want me to answer them, I'm not understanding all the questions that they're asking me, my injuries, I'm not even probably aware of all of the injuries that I've got at that particular moment.”*

Following this difficult triage experience of not being able to comprehend and respond in the triage consultation this participant then recalls going into the waiting room.

SU43: *I didn't like going into the waiting room. I was very on edge, erm, obviously with my injuries, what had happened. To be honest, I couldn't at that particular time feel my injuries or..., it was more emotional, what was going on in my head. I really could've done with being somewhere quieter than sat in a room full of people.*

In this account there are expressions of anxiety, numbness and hyper-emotion, this respondent then described her experience of then being in the waiting room.

SU43: *The interim period I remember seemed to take an awfully long time sat in that waiting room, waiting to be seen, and I understand that's an A&E department and that there's other people there, it's emergency, people can be dying and... but I think with it being, because it's an emotional psychological thing that you've just suffered from, your head's... all I can describe it is, it's like my head feels,... discombobulated's not in it, it's like fragmented, my head felt very fragmented and I just couldn't concentrate, you know what I mean, I didn't want to be there, I wanted it to hurry up, I wanted it to hurry up, hurry up, hurry up, I just wanted to be seen and be gone. (...) I found being around so many people after that sort of incident wasn't good, it wasn't good at all*

In her vivid account of acute affective and emotional experiences and urgency to be gone, this participant describes her head as 'beyond discombobulation', her head felt 'fragmented'; she reports being unable to concentrate and not wanting to be there, only wanting to be seen and be gone. Similarly, another respondent also recounted feelings of further discomfort and unease being in the waiting room:

SU49: *When I got to A&E I was put in a waiting room with drunks, (...) and I felt very vulnerable, and obviously I was in a very bad way, and when I've looked back in reflection I just felt that as a victim of such a violent attack I should have been isolated from drunks in an A&E department and I should have been responded to quicker than what I was.*

For these respondents the waiting room was uncomfortable, further distressing and difficult to negotiate in the immediate period following intimate partner violence.

Experiences of acute stress (affective and emotional) responses and vulnerability whilst in the waiting room were further compounded by being around other people and stigmatising discourses surrounding intimate partner violence as these following accounts indicate:

SU43: *You feel like you're on show kind of. And it's not handled in a way where... it's not kept private. You know, looking back over it, if it would've been handled I think a bit more delicately, I think I would say it should've been really. (..) you feel unsafe but you feel like people are staring at you and you feel like people are judging you as well. I felt like all those people were judging me. (...)*

Furthermore combinations of feelings in response to stigmatising discourses, such as being judged or feeling embarrassed, with acute affective and emotional responses, such as anxiety and shock, may work to potentially constrain access to healthcare as this respondent explains:

SU43: *I think I was in shock, to be quite fair, at that time. I think I was in shock at what had happened, how it had even got to that. Erm, and I was embarrassed, I think I was embarrassed. And it was only through the persistence of the police officer and the persistence of my brother that I went through and I went to A&E. I think if they hadn't persisted I probably wouldn't have bothered, I would've just continued to let it, to leave it.*

These findings illustrate complexly layered psychological and emotional feelings that women may have to overcome even before their first contact with an emergency department.

Furthermore, given the respondents' mobilisation of reactions such as people avoidance and of not wanting to be there, these findings suggest that people attending an emergency department following an incident of intimate partner violence may be at greater risk of leaving the emergency department before their consultation is completed.

The other side of it: what about me?

Respondents in this study also reported receiving empathetic healthcare and the following accounts example positive consultation experiences:

SU24: *The nurse who sat with me that day, she was lovely. She was really, really nice. She just listened. Sometimes it's just nice to have someone to listen. I know that A&E staff*

are busy. I understand that. But I suppose when it's a crisis you just need that, even if it's just five minutes, just to let it all out.

SU43: *One thing I will say that stood out for me in that hospital was that particular doctor, he was just really, really nice. He came in, he was friendly, he asked me how I was, which was important because nobody was really asking me how I was, you know what I mean.*

SU25: *he [A&E doctor] was actually really nice to me about it all. Like, they just kept saying like, "We're not worried that you're wasting our time. We just want to make sure you're okay," (...) and I was actually quite surprised that he was nice to me like, I wasn't expecting it. But he was quite gentle with me really and made me feel a bit more at ease, and relaxed a little bit more, and I felt a bit better about why I was there and stuff.*

In these respondents' accounts, and in congruence with previous research (Reisenhofer & Seibald 2013), emotional care of the person was important and valued. This last account however also illustrates the respondent's perceptions about the legitimacy of intimate partner violence as a reason for emergency department consultation. Importantly though, these positive experiences reported by respondents in this study likely reflect positive shifts, although these may be unevenly distributed, in socio-cultural understandings of intimate partner violence and health sector responsibility for responding.

Although these respondents reported positive healthcare experiences in terms of good routine medical care and compassionate practitioners, respondents also reported unmet care needs in relation to having been subject to intimate partner violence. In the following account the respondent articulates unmet care needs for 'the other side':

SU49: *don't get me wrong, the A&E are there and they come across so many different things, they come across heart attacks and everything, and they do a fantastic nursing job dealing with an emergency, but I just didn't feel the other side of it was in place for the situation like me. I was an emergency but there wasn't the support there.*

The importance of attending to intimate partner violence care needs above routine medical care was echoed across all respondents' accounts. The significance of specialist care and support in relation to having been subjected to intimate partner violence as a key factor impacting emergency department consultation outcomes for this population was poignantly articulated by two respondents (SU49 and SU43). Both SU49 and SU43 reported positive practitioner-patient relations and routine medical care experiences and both had support from family members during their consultations (SU49 from her adult daughter and SU43 from her brother), yet in coexistence with these positive aspects were experiences of isolation and unmet need powerfully expressed in their accounts:

SU49: *When you've never had this done to you before you have no idea, and there's nobody there, you're totally vulnerable and on your own. And that's where I think the A&E could be that support, (...) It's a very raw issue with me to be truthful, I just feel that I was let down a lot (...) there was nobody there for me, nobody.*

SU43: *(...) I was in there and there was never anybody there, do you know what I mean, there was just never anybody there.*

Navigating the consultation

Recruited from community-based specialist domestic violence services participants in this study had first-hand knowledge of the positive impact that specialist domestic violence practitioners could make. Respondents in this study believed access to a practitioner with specialist domestic violence knowledge during emergency consultations to be of central importance. Speaking from their experiences respondents described the practical ways in which they could have benefitted from first contact access to specialist domestic violence practitioners.

SU49: *I just feel that when the police came and I got put in that ambulance somebody should have been waiting. "Oh, there's been a violent attack here, there's a woman coming in, she was left for dead, she's coming in". (...) I think maybe somebody in that staff should have been trained to say, well hang on a minute, these are really bad injuries,*

we should be getting these photographs or where's the police, alarm bells, police, why has nobody phoned? It was like complete no communication at all between anybody.

SU43: *(...) having somebody to talk to, you know what I mean, to calm you down really and really to help you realise what's just happened to you because you don't... the overwhelming thing with me was I just didn't understand what had just happened to me. (...) you don't expect it and you're just in shock and you just need somebody to sit you down and help you realise what's really just happened to you, and that takes a bit of time and I think time is probably one thing that an A&E department really hasn't got. But if they could make that time it would make a big difference.*

SU24: *I think you really need to have someone on site who deals with domestic violence and only deals with domestic violence.(...) Why can't you have a Women's Aid thing inside a hospital? (...)These people that deal with it want to do this job, not because they've got to do it [respondent's stress]. (...) I think you need to have the right kind of people, like I say, who want to do that side of the job.*

For these respondents a specialist domestic violence practitioner at the point of first contact is vital for assisting people to navigate their emergency department consultation by supporting the person to make sense of what had just happened and what was happening, reducing experiences of isolation, and coordinating multi-agency care and services during and beyond the consultation.

DISCUSSION

Acute Stress Reactions

A key finding of this research, and not described elsewhere, was the multiple, vivid descriptions of forms of acute affective and emotional responses experienced by women attending an emergency department following intimate partner violence. Women in this study expressed experiences of anxiety, being in shock, being on edge, poor concentration, wanting to be alone, wanting to be somewhere quiet, feeling numb, not being able to feel injuries, feeling detached from others, and wanting to avoid people. These expressions are

representative of forms of Acute Stress Reaction. Acute Stress Reaction refers to psycho-physiological symptoms many people experience after traumatic life events and which may be psychological and/or physical. Lawson (2013, p.1) describes Acute Stress Reaction as experiences of “anxiety, low mood, emotional ups and downs, poor sleep, poor concentration, wanting to be alone, flashbacks, recurrent dreams, feeling numb, feeling detached from others, avoidance of anything that will trigger memories, reckless and/or aggressive behaviour that may be self-destructive, palpitations, nausea, chest pain, headaches, stomach pains, and breathing difficulty” (Lawson 2013, p. 1). It is usual for people to suffer acute stress reactions following a traumatic event (Adshead 2014) and the onset is usually quick developing during the event or in its immediate aftermath. Sometimes these symptoms resolve quickly and treatment may not be required but for many people they do not resolve quickly, causing ill-health and affecting lives long term. Indeed, even ‘normal recovery’ may take 6 months (Adshead 2014, p. 19). In England, people are advised to seek medical attention for acute stress reactions if symptoms are moderate or severe, i.e., affecting usual day-to-day activities, or if they continue for more than 2-4 weeks (Lawson 2013).

The findings of this research suggests that acute stress reactions are likely a common feature among women attending an emergency department following intimate partner violence. Furthermore, Forbes *et al.* (2014) found that victim-survivors of intimate violence (assault by intimates or carers or sexual assaults) were significantly more likely ($p < .001$) to report PTSD symptomatology (re-experiencing, avoidance, hypervigilance, detachment, startle response and emotional suppression) than those subject to non-intimate or non-interpersonal (accidents, natural disasters) violence, indicating that people subject to intimate partner violence are at much greater risk of acute and enduring stress reactions and thus warrant early intervention. Whilst the association between being subject to intimate partner violence and the development of long term mental health conditions, such as anxiety, post-traumatic stress disorder and depression (WHO 2013a, Ferrari *et al.* 2014) is

beginning to be better explicated, much less is known about the incidence, severity and duration of intimate partner violence associated Acute Stress Reaction.

Responding to acute stress reactions: Psychological first aid

Respondents in this study reported good routine medical care during their emergency department consultation, however there was simultaneously something missing from their care in relation to their sense of being, not feeling safe, and not being able to make sense of what had happened. Forbes *et al.* (2014) articulate a particularity of interpersonal trauma, as “the experience of an environment as unsafe and unpredictable, due to the potential of human threat” (2014, p. 147). In Reisenhofer & Seibold’s (2013) qualitative study of women’s emergency healthcare experience following intimate partner violence, care of the self was important, and which along with empathy and respect, meant a sense that their self was safe. Intimate partner violence has particular affective and emotional attributes that likely add layers of complexity to the experience of acute stress reactions following violence and that demand attention during emergency care in its immediate aftermath.

Recognising and responding to victim-survivor experiences of acute stress reactions following intimate violence is well established in the health literature on responding to sexual violence (WHO 2013b, Walby *et al.* 2015), but is less well reported in relation to intimate partner violence. Drawing on this body of knowledge of responding to sexual violence, first response mental health care interventions following traumatic events are straightforward involving, what the IASC (2007) terms, ‘Psychological First Aid’. Psychological First Aid is defined as “a humane, supportive response to a fellow human being who is suffering” (IASC 2007, p. 119). In addition to a humane, care conducive environment (Walby *et al.* 2015), psychological first aid aims to protect the person from further harm, respect the wishes of the person to talk or not talk about events, identify and respond to people’s concerns and practical needs, encourage positive coping methods, and provide options for further support and follow-up (IASC 2007, Walby *et al.* 2015). In addition, to Psychological First Aid,

emergency department practitioners, as first responders, could also provide verbal and written information about acute stress reactions to help people understand their experiences and what to expect, and when to seek medical follow-up should their symptoms endure or worsen.

It is recommended that people who are experiencing incapacitating or severe acute stress reactions, or other mental health crises, be referred immediately for assessment by a specialist, fourth tier, mental health service, and preferably one that specialises in gender-based violence (Walby *et al.* 2015, WHO 2013b). Approximately one third of people suffering acute stress reactions will develop Post-Traumatic Stress Disorder and other long term mental health conditions such as depression and anxiety, so early intervention for Acute Stress Reaction is important to aid recovery and prevent long term mental health problems becoming established (Adshead 2014). Embedding Psychological First Aid along with the provision of information about acute stress reactions and follow-up referral pathways, into emergency department, first contact services responding to intimate partner violence would likely limit harms from intimate partner violence and improve peoples' health outcomes.

Responding to acute stress reactions: Maximising attendance completions

Previous research has indicated that women attending an emergency department following an assault by a partner may leave while waiting to be seen because of fear of being recognised, and/or the perpetrator finding out about their attendance (WNC 2010).

Perceptions of being judged and its implicit affirmation of socio-cultural discourses of victim-survivors' culpability in intimate partner violence found in this study, and which has congruence with the findings of Reisenhofer & Seibald's (2013) research in which women reported concealing intimate partner violence to deflect the judgement of others, may also contribute to people leaving before their consultation completion. This study further and importantly adds to this body of work by illustrating that acute stress reactions in response to

intimate partner violence may further mobilise people to leave before their attendance completion as 'triage' and 'waiting room' were specified as particularly difficult locations to navigate through the acute, affective and emotional experiences following intimate partner violence. 'Left without being seen' is an emergency department performance indicator because those who leave are at greater risk of adverse outcomes (RCEM 2011). To reduce the risk of leaving and preventable harm, this population would likely benefit if fast-tracked through to medical assessment and treatment.

Responding to acute stress reactions: Specialist services and navigating an effective consultation

The service user participants in this study were recruited via community specialist domestic violence services and thus recognised the advantages that access to specialist domestic violence advocacy services at the point of emergency department first contact would have made to their consultation and future recovery. Advocacy, defined as a role to "engage with individual clients who are being abused, aiming to empower them and linking them to community services" (Ramsey *et al.* 2009, p. 5), has emerged as the most effective intervention for women experiencing domestic violence in terms of reducing risk of violence (Coy & Kelly 2010), increasing social support, increasing safety behaviours (Ramsey *et al.* 2009), and increasing uptake of services (Muellemann & Feigny 1999). Specialist domestic violence services are increasingly being employed by emergency departments in England. Basu & Ratcliffe (2013) report on the introduction of an Independent Domestic Violence Advocate (IDVA) service in an emergency department, which along with staff training and formalised multi-agency system of assessment and management massively increased the number of referrals to community based specialist services as well as improving staff confidence in addressing domestic abuse and mobilising professional responsibility for domestic abuse interventions. Another initiative in a large regional emergency department has introduced a domestic abuse nurse specialist post to provide training and clinical support for practitioners to respond to domestic abuse (McGarry & Nairn 2015). Immediate

access to a specialist domestic violence practitioner is likely to mobilise women's engagement with services earlier as accessibility (WNC 2010, Coy & Kelly 2010), and personal cost/benefit impact of seeking aid (Catallo *et al.* 2013) have been found to be important factors on women's decisions to report or not. This study found that acute stress reactions adversely impacted service users' negotiation of triage processes and navigation of their emergency department consultation. Access to a specialist domestic violence advocate at the point of first contact would assist this population to navigate an effective emergency department consultation for their situation.

Limitations

This research is limited by its number and diversity of respondents and although the sample size is small it is considered to offer a 'fuzzy slice' (see Paley & Eva 2011) of service users experiences of emergency department consultations in the north of England. More significant perhaps is the contested status of qualitative interview data with debate oscillating between qualitative interviews being understood as direct access to respondents' perspectives on the world versus being understood as social interactions in which respondents present accounts of themselves through which they can be deemed favourable, competent and moral (Murphy *et al.* 1999). Following Hammersley (1992), this research proceeds with caution, understanding participants' interview data as cultural witness accounts of events and experiences of those events. The claims made in this research are understood in the critical realist position as not necessarily true, rather that they are credible, yet fallible, explanatory accounts of phenomena.

CONCLUSION

This research found that acute, affective and emotional, stress reactions are likely to impact a person's access, experience and completion of their emergency department consultation following intimate partner violence. There were three interconnected key findings. First, was the commonality of acute, affective and emotional, stress reactions amongst women

attending an emergency department in the immediate aftermath of intimate partner violence, second was that these acute stress reactions negatively impact women's consultations, and third was an identified need for specialist domestic violence service provision from the point of first contact. This research has illustrated that acute stress reactions were an important feature for people attending an emergency department following intimate partner violence, still further research is needed to better explicate the incidence, severity, and duration of acute stress reactions in this population.

The respondents in this study have made a claim for priority in emergency department services and for specialist intimate partner violence intervention and service provision during consultations, and rightly so. The findings from this study endorse previous research and recommends that attending to privacy and safety should be an immediate and routine intervention for intimate partner violence. Furthermore, people attending an emergency department following intimate partner violence should be fast-tracked through triage and provided with a safe and quiet space. The provision of psychological first aid is imperative. Finally, it is recommended that a skilled, specialist violence advocacy service is available from the point of first contact to assist service users navigate an effective consultation for their situation, make sense of what has happened to them, and be fully informed of the range of options and services available so that earliest intimate partner violence and mental health interventions are possible. Implementing these recommendations will aid the health and well-being, safety and security, future recovery, and health outcomes of women attending an emergency department following intimate partner violence.

RELEVANCE TO CLINICAL PRACTICE

This research provides an account of acute stress reactions experienced by women attending emergency departments following intimate partner violence and explicates how these acute stress reactions impacted their consultation. Acute stress reactions adversely impacted service users' negotiation of triage processes and navigation of their emergency

department consultation. Services responding to victim-survivors in the immediate aftermath of intimate partner violence can improve health consultation outcomes for this population by attending to psychological first aid; fast-tracking through triage; providing a safe and quiet space; and affording access to specialist violence advocacy services at the point of first contact. This research has relevance for practitioners in a range of first contact health services, such as urgent and emergency care, general practice, community public health and mental health.

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TABLES

Table 1 Forms of intimate partner violence suffered prior to consultations.

Form of violence	SU24	SU25	SU27	SU28	SU43	SU49
emotional /psychological abuse		x	x	x	x	
controlling behaviours						
isolation					x	
sexual violence		x		x		
physical violence	x		x	x	x	x
drugging					x	
life-threat violence	x				x	x
false imprisonment,					x	x
ill-treatment / willful neglect	x			x	x	x