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THE ROLE OF PSYCHOLOGICAL SUPPORT FOR PEOPLE WITH EXPERIENCE OF DOMESTIC VIOLENCE AND ABUSE (DVA)

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Introductions. Domestic violence is a global health issue that can take many forms and affect anyone. Health and social care professionals play an important role in recognising and helping victims of violent and abusive relationships.

Aim. The main aim of this rewiew is to address the role of gender in domestic violence and emphasize main psyholoical factors to recognise the various forms of violence and abuse.

Materials and methods. We followed various studies with screening tools used within the healthcare professions: Abuse Assessment Screen (AAS), Composite Abuse Scale (CAS), Humiliation, Afraid, Rape, Kick (HARK), Hurt/Insult/Threaten/Scream (HITS), Parent Screening Questionnaire (PSQ), Partner violence screen (PVS), Woman Abuse Screening Tool (WAST),Women's experience with battering scale (WEB) to report the results of the finding. Databases including PubMed, Cochrane Library and Web of Sciences

Results and discussion. The adverse physical, mental, sexual and reproductive health outcomes of domestic violence and abuse (DVA) can lead victims to make extensive use of healthcare resources.

Men, women and transgender people in straight, gay or lesbian relationships can all perpetrate and experience DVA. However, it is important to recognise that DVA is experienced disproportionately by women and perpetrated predominantly by men.

Several psychophysiological components can be considered in a relationship. First of all it is the concept of gender, which is different from sex and have direct

influences on our behaviour. «Gender» and «sex» are terms which are often used interchangeably. However, it is increasingly acknowledged that these terms are very different. The term ‘sex’ refers to the biological characteristics that make someone male, female or intersex. This includes things like genitalia, chromosomes, genes and hormones. Gender, on the other hand, is a social construction related to what we think defines someone as masculine or feminine.

For many people, their sex and gender are the same. However, sometimes, a person’s genetically assigned sex does not line up with their gender identity. These individuals might refer to themselves as transgender, non-binary, or gender-nonconforming.

We as individuals, communities and societies have set ideas about gender and we expect men and women to conduct themselves in a certain way. As a member of society, we also dictate what men and women should and shouldn’t do, how they should dress, how they should behave and how they should present themselves in public or in private. This phenomenon is known as gender role expectation and it can be descriptive as well prescriptive.

Traditionally, gender-role stereotypes ascribe authority and dominance as male characteristics and submission and powerlessness as female characteristics. This contributes to a difference in power between men and women.

In the context of intimate relationships and marriage, this shapes expectations that a man is required to earn money to support the family and a woman is expected to bear and raise children, cook, clean and keep the family together.

Nontraditional gender role expectations, on the other hand, support a different relationship between men and women where household, economic and social responsibilities are shared between both partners.

Our society and culture have a big impact on readdressing these stereotypes about what men or women can or cannot do or should or should not do.

From available research, we know that when individuals have fixed gender role expectations and they are exposed to contradictory situations, they feel stressed, angry and exhibit aggressive behaviour.

Men who hold traditional views about gender roles are more likely to justify and use domestic abuse when feeling neglected, not listened to or challenged.

At the same time, women with gender-equitable attitudes are more likely to be abused by their intimate partners, as they may be seen as challenging and unwilling to submit to their male partners.

It is also possible that an individual's gender role expectation is different from their actual role performance. The world is changing and so are gender role expectations, however, it will take a long time to get to a point where equilibrium is achieved and gender role expectation does not contribute to abuse.

Domestic violence and abuse isn't always physical. DVA is any behaviour that is intended to dominate, threaten, coerce and control someone else in an intimate relationship. It can be useful to categorise DVA in the following five ways: physical abuse, sexual abuse, psychological abuse, financial abuse, controlling behaviours.

Psychological abuse refers to the use of behaviours to insult and control an intimate partner. Examples may include criticising, name-calling, blackmailing, blaming, threatening to beat the victim or their children, restricting their movement, stalking, restricting access to health and social care, restricting access to family and friends, humiliating and belittling the victim in public or private.

Controlling behaviours is a specific characteristic of DVA is the presence of coercive control. This refers to a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour.

Researchers from Stanford University analysed the smartphone data of 717,527 people worldwide over 68 million days of activity. They found that in countries all over the world, girls and women walk less than boys and men. They have called this discovery - the gender step gap.

The results of a Gallup survey may have the answer. The survey asked people from 143 countries: In the city where you live, do you feel safe walking alone at

night? All around the world, men were more likely than women to say that they felt safe walking alone at night in their communities.

Women feel less safe than men in many developed countries. Perhaps surprisingly, this gap was even more pronounced in high-income and upper middle-income countries. In Europe, the global region with the greatest share of high-income countries, 75% of men said that they felt safe walking alone at night compared to 55% of women. Crime rates typically drop as countries develop, but this research indicates that women don't get an equal share in the increased sense of security that social and economic improvements typically provide.

However, domestic abuse also happens to lots of men. Men can experience domestic abuse from a partner or a former partner in heterosexual or same-sex relationships. Men can also be abused by family members: adult children, siblings or others. Family abuse against men includes so-called 'honour'-based abuse, such as forced marriage. Domestic abuse against men is perpetrated by both men and women, as well as people of other gender identities. Domestic abuse against men can include physical violence, as well as emotional and psychological bullying, sexual violence or financial control and abuse.

Recognition of the gendered nature of DVA is not a justification to ignore the needs of male victims. Instead, it needs to inform how we design services to support these men with the understanding that some of their experiences and needs may be similar to women survivors, but others may be different. Men who are being abused may feel ashamed or afraid of judgment by others, but it does not make a man 'weak' or less 'manly' if they experience abuse. Domestic abuse is always a choice by the perpetrator.

We need to challenge cultural stereotypes which still assume that the perpetrators of domestic violence are men and the victims are women. However, at the same time, we must recognise that the majority of perpetrators are men.

DVA is a public health problem of epidemic proportions. It affects women's physical, sexual, reproductive and mental health. In fact, women who have experienced partner violence are more than twice as likely to experience depression.

Other psychological effects can include fear, low self-esteem, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, disassociation, sleep disorders, shame, guilt, lack of confidence, self-mutilation, drug and alcohol abuse and eating disorders. Psychological consequences may also manifest through psychosomatic symptoms, sexual dysfunction and eating problems.

Even if you suspect abuse might be occurring, it can still be difficult to bring up it up. Many professionals have reported feeling reluctant to ask patients about DVA. However, the evidence suggests that patients are not offended when asked. And for those who have experienced DVA, this could be an important first opportunity to disclose their experiences.

Some women who have experienced IPV have reported that healthcare professionals did not demonstrate compassion or concern for their situation (Yam, 2000). A lack of empathy and attentiveness are real barriers for identifying DVA and affect the victim's ability and willingness to disclose their experiences. The first step in starting a conversation about DVA is to make sure you have an open mind and a non-judgemental attitude.

In addition to listening to what is said, watch their non-verbal behaviour to pick up on hidden meaning. Facial expressions, body language and tone of voice can sometimes tell you more than words alone. When you practice active listening, you make the other person feel heard and valued. It also helps you to understand their situation better as well as earn their trust.

In moments of crisis, it can be hard to think clearly and make logical decisions. Having a safety plan laid out in advance can help the victim to avoid dangerous situations and know the best way to react if they are in danger. A safety plan is a personalised, practical plan that articulates where the victim (and children) should go, how they would get there and what they would take with them.

Women who screen positive are more likely to experience DVA in the next few months. Therefore, screening can help to protect them from further victimisation as well as prevent long-term fatal consequences such as homicide or suicide.

Computer-based screening is a particularly effective method as the victim can answer various questions without being interrupted or feeling judged and embarrassed. It provides a sense of confidentiality that may help patients to respond better.

Verbal screening methods can also be effective if you are able to develop a trusting relationship with the patient. In such cases, building rapport and trust will help the victim to disclose information more comfortably.

If doctor suspect a patient may be experiencing DVA, it's important to keep a detailed record of your assessment. It may serve as evidence in any legal proceedings that the patient might want to undertake.

You don't need a patient's permission to make notes but it's important that you directly communicate that as part of your duty of care, you are required to keep a record of their disclosure and injuries.

Record what the patient has said (using quotation marks) and any relevant behaviour you have observed.

If the patient has physical injuries, document any details about them, including the type, extent, age and location. If you suspect DVA is a cause, but your patient has not confirmed this, it may be relevant to note whether their explanation of the injuries is consistent with the presentation. With the consent of the victim, you may also consider taking photographs of the injuries, making sure to date and sign them as proof.

Consequently, the victim must provide information, including details of their abusive experiences repeatedly to different people in different organisations. Recalling the experience in itself can be a traumatic experience and may deter the victim from accessing support.

Conclusions. Health and social care professionals frequently - and often unknowingly - encounter victims of domestic violence and abuse. However, professionals do not always feel adequately trained to identify or support victims. Some may even feel that it is not their role to do so. Domestic abuse is often discussed as a women's issue because the majority of domestic abuse is experienced

by women (and perpetrated by men). However, domestic abuse also happens to lots of men. Every case of domestic abuse should be taken seriously and each individual given access to the support they need.

Victims of domestic violence and abuse are likely to experience serious health problems as a consequence. DVA is a major contributor to women's mental health problems, particularly depression and suicidality.

Women who have experienced DVA also experience high rates of poverty, homelessness, substance misuse, poor mental health and offending. This means that victims come into contact with a whole range of services and organisations.

Routine or universal screening is an effective way to identify victims of DVA. Asking all patients the same standard questions can help to legitimise the need for a conversation about DVA and effectively communicate to the woman that she is not alone in her experiences. Healthcare professionals are well placed to refer those experiencing DVA to services that can better support their needs.