Asking men about domestic violence and abuse in a family medicine context: Help seeking and views on the general practitioner role

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Abstract

Reflecting the higher prevalence of domestic violence and abuse experienced by women, and the recognised health impacts of such abuse, studies have focused on the responses of health-care practitioners to women in heterosexual relationships. Comparatively few studies have looked at the health impacts or help-seeking of men who may be perpetrators and/or victims of abuse within intimate relationships. In this paper we report on help-seeking and the health professional’s role based on a survey of 1368 men attending 16 general practices in the southwest of England and 31 interviews with a sample of survey respondents. The survey had a number of questions on experience or perpetration of behaviours which could be considered abusive, on whether respondents had ever been asked about such behaviours by health-care professionals, and on whether they had ever sought formal or informal help for such behaviours. Men were most likely to seek informal support from friends or family. The next most likely source of support was the family doctor. This paper suggests that health-care practitioners in general, and family doctors in particular, have a role in asking male patients about the experience or perpetration of domestic abuse and need training to do so effectively and safely.

1. Introduction

Amongst the wider literature, there is uncertainty about how notions of masculinity influence the help seeking behaviour of men and...
male patients. Möller-Leimkühler found that the ‘masculine stereotype does not allow help-seeking, even if help is needed and could be available’ (2002, p. 6). Galdas, Cheater, and Marshall (2005) point out that their review of gender-comparative help-seeking studies demonstrates that other factors including occupation and socio-economic status are more significant than gender although they also found that amongst the gender-specific literature, there was increasing evidence to suggest that ‘masculinity beliefs’ delayed men’s help-seeking. However, they concluded that there is insufficient research into masculinity and male perceptions of help-seeking ‘to inform policy or clinical practice’ (Galdas et al., 2005, p. 621).

This dearth of research into men’s experiences of help-seeking is even more pronounced in relation to domestic violence and abuse (DVA). In relation to the help-seeking practices of men who have experienced or perpetrated abusive behaviours, the Home Office Statistical Bulletin based on the Crime Survey of England and Wales (CSEW) reported that men who had experienced physical injuries or emotional abuse from partners were less likely than women to tell a medical professional (4% compared to 18%) (Smith, Coleman, Eder, & Hall, 2012, p. 68). The same report also noted that male and female victims of DVA were both most likely to tell family about the abuse (56% women and 43% men) with a friend or neighbour being the next most likely to be told (41% women and 39% men). Canadian research (Mihorean, 2005) reported that despite a reluctance of men to seek help compared to women 44% reported talking to family, 41% reported talking to a friend and neighbour, and 12% reported talking to a doctor or nurse about DVA.

Previous research about the response of health-care practitioners to patients experiencing DVA has predominately focused on women in heterosexual relationships, reflecting the higher prevalence, greater severity and more damaging health impact of DVA on women (Feder et al., 2009; Hegarty, Taft, & Feder, 2008; Kimberg, 2008; Soglin, Bauchat, Soglin, & Martin, 2009; Sprague et al., 2013; Taket et al., 2003). Studies of help-seeking by women experiencing DVA have consistently shown that women talk predominately to friends and family, but health care practitioners, doctors and nurses in particular, are consistently named as a professional source of help (Smith et al., 2012; Barrett & Pierre, 2011; Fanslow & Robinson, 2010; Feder et al., 2009; Feder, Hutson, Ramsay, & Taket, 2006; McGibbon, Cooper, & Kelly, 1989; Mooney, 1994). Qualitative studies of women survivors of DVA report that women want to be asked about abuse by their doctors (Feder et al., 2006) and the majority of women in surveys, find it acceptable to be asked about DVA in health care settings (Feder et al., 2009). Westmarland, Hester, and Reid (2004) found that 73% of female patients and 75% male patients surveyed thought that it would be useful for patients to be asked about DVA.

The primary aim of this paper is to expand the current body of knowledge on male help-seeking in relation to DVA by measuring and characterising help-seeking practices. Using the PROVIDE (Programme of Research On Violence in Diverse domestic Environments) survey (Williamson et al., 2014) of male general practice patients and interviews with a sub-sample of those patients, this paper looks at male patients’ opinions of the role of health practitioners in asking about experience or perpetration of potentially abusive behaviours. It is important to remember however, that this research is relevant to general practice in the UK. Furthermore, the demographic profile of the participants in this study may undermine the generalizability of our findings to other contexts.

2. Methods

Our data are derived from a cross-sectional survey and follow-up interviews investigating the impact of men’s relationships on their health (Buller, DeBries, Howard, & Bacchus, 2014; Williamson, Jones, Hester, & Feder, 2014). The survey was conducted between September 2010 and June 2011. During this period, consecutive male patients attending 16 GP surgeries in the south west of England were approached and asked to complete a two-part survey and to indicate whether or not they would be willing to take part in an interview. The study received research ethics approval from the local NHS research ethics committee (South West REC 10/H0106/22).

2.1. Sample

Of the 2431 men who were asked to complete the survey, 1368 (56% of those approached) completed part one, answering questions about themselves, their health and well-being and their relationships, whilst 669 (28% of those approached) also completed the more detailed questions in part 2. The age of the survey respondents ranged from 18–90 (mean 57.5) and the standard deviation was 18.4.

Attached to the survey was a form asking respondents if they would agree to take part in an interview. Seventy eight men agreed and between March and August 2011, we were able to arrange and conduct interviews with 31 men (mean age of 49, standard deviation = 17.9). Twenty-nine of the men that we interviewed were heterosexual and only two of the 31 interviewees identified as having had sexual relationships with men.

2.2. Survey questions

The survey itself included sections on the experience or perpetration of potentially abusive behaviours; the potential impact of those behaviours; general health and mental health data; alcohol and drug use; as well as questions about the role of health practitioners in asking men about potentially abusive relationships, and help-seeking activities. Survey respondents who had experienced potentially abusive behaviours were asked to complete a follow-up question about whether they had told anyone else about how they were being treated. Respondents were also asked about whether at any time they had been asked by a family doctor, nurse or other health care professional if they had been hurt or frightened by a partner. The survey then asked a further question about whether respondents thought that health professionals should ask if their patients had been hurt or frightened by a partner. The same question was asked again in relation to whether patients had ever been asked if they had hurt or frightened a partner, and whether health practitioners should ask their patients if they had hurt or frightened a partner. Respondents were given three response options to these questions: 1) Yes, they should ask all their patients, 2) Yes, but they should only ask some of their patients, depending on the symptoms they describe, and finally, 3) No, they should not ask any of their patients. At the end of the survey was a separate form for respondents to complete if they were willing to be approached to take part in a semi-structured interview.

2.3. Interview questions

The 31 interviews were conducted using a semi-structured interview schedule, with the majority being conducted by telephone. The interview schedule included questions relating to, first of all, how the participants felt about being asked to complete a survey about relationships whilst they were in a general practice waiting room, about their experiences and perpetration of potentially abusive behaviours, their views about help-seeking, and on the role of health practitioners in asking about relationship issues. The questions were designed to give the participants an opportunity to explain and expand upon their survey responses. The interviewer was blind to those responses. Participants were informed of this at outset; and although most claimed not to recall their survey responses anyway, it did provide them with the opportunity to expand upon or contradict their survey responses without feeling constrained by what they had previously indicated.
2.4. Coding and analysis

With the consent of the participants, all the interviews were recorded. They were then fully transcribed and coded using the qualitative analysis software, NVivo®. The coding framework used on NVivo was developed in conjunction with colleagues across the wider PROVIDE study. Whilst the coding framework was in part informed by the interview schedule, it was expanded upon using a grounded theory approach (Glaser & Strauss, 1967). As Lingard, Albert, and Levinson (2008) explain, the principle of data analysis in such an approach is to facilitate comparison. This method, therefore, enabled full investigation of differences and similarities in the data collected for this element of the PROVIDE study and is also intended to facilitate cross-case analysis of data collected through the wider study.

In order to develop and test the coding framework, three interviews were coded by the three first named authors with a further seven co-coded by the first two authors. All 31 interviews were coded in full by the first-named author, who had also conducted the interviews. Pope et al. suggest that the ‘appropriateness’ of undertaking such inter-coder reliability tests is contested (2006, p. 78), however we found that there was general agreement on the key themes, and co-coding helped deepen the analysis. Some of the participants’ narratives, for example, revealed blurred boundaries between categories of victim and perpetrator and the process of co-coding meant that ambiguities were acknowledged, discussed and further incorporated into the coding framework. By the time we had co-coded ten interviews, however, we had reached saturation point in the sense that no new differences in interpretation were emerging and we concluded that there was no value in continuing to co-code transcripts.

3. Findings

3.1. Health-care practitioners asking men about potentially abusive behaviours

3.1.1. Survey

1280 (91%) of the respondents answered this question. Only 1.6% of respondents (N = 21) said that they had had been asked by a health care professional whether they had been hurt or frightened by a partner. However, 27% (N = 343) of male respondents thought that health practitioners should ask all their patients about potential abuse, 65% (N = 810) thought that practitioners should ask depending on the symptoms presented, whilst 8% (N = 95) thought that health practitioners should not ask their patients about potential abuse.

Only 1.4% of the respondents (N = 18) stated that they had been asked about their own potentially abusive behaviour. When asked if health practitioners should ask their patients about such behaviour, 23% (N = 278) thought that practitioners should ask all their patients, 67% (N = 822) thought that some patients should be asked on the basis of symptoms and 10% (N = 130) thought that health practitioners should not ask at all.

3.1.2. Interviews

Following up on the survey, interview participants were asked whether health-care practitioners should ask all, some, or none of their patients about whether they have been hurt or frightened by a partner or whether they have behaved in such a way towards a partner. Of the 31 interview participants, 15 (48%) disclosed in the survey either experiencing or perpetrating potentially abusive behaviours. Of these, 5 (16%, with a mean age of 52) participants reported that they had both experienced and perpetrated these potentially abusive behaviours, 7 (23%, with a mean age of 40) had just experienced them, whilst 3 (10%, with a mean age of 48) had just perpetrated them. This compared to 23% of the survey respondents as a whole who reported ever having experienced a negative behaviour from a partner, and 14% who reported perpetrating some form of violence against a partner. In the interviews, participants were also asked whether they felt that general practice was an appropriate setting to ask men about potentially abusive behaviours. Generally they agreed that it was, with one commenting on the privacy of such settings: “it’s probably one of the only places that people know that that door is closed” (ID.1190005, aged 39). Another stated that:

“I think it’d probably be a good thing because I bet there’s a load of it going on all the time. Maybe people don’t even consider it abuse until they really question it like that. […] If some kind of simple intervention like GPs asking questions could impact on that big social problem then it would be a good thing.”

Interview participants recognised that the timing of questions about potentially abusive behaviours was important. Questions about experiences of abuse should be asked at “pretty much exactly the right moment” (ID.1190005, aged 39) otherwise people will say nothing. Most who agreed that such questions should be asked, felt that asking all patients would be preferable. A few, however, felt that health professionals should only ask “if there’s physical marks or somebody’s in discomfort” (ID.1110094, aged 24). One participant felt that not all GPs would be confident with asking such questions but others suggested that if there is a pre-existing relationship with the GP, such matters would be easier to deal with because “they’d know that your behaviour had changed and I think then, they’d be able to intervene” (ID.1220015, aged 53). Only one participant (who had disclosed perpetrating physical, psychological and verbal abusive behaviours against a partner) completely rejected the idea of GPs asking all or some of their patients if they had experienced potentially abusive behaviours in their relationships, commenting:

“I wouldn’t’ve liked that. […] ’Cos I would’ve thought it’d been private […], Something I’d have to deal with.”

This participant was adamant that he had not wanted any professional involvement as a result of his behaviour and claimed that after his wife had gone into a refuge as a result of his behaviour, he had “proceeded to rectify the problem [through] self-management basically” (she subsequently returned home).

Men's reluctance to talk about emotional and relationship issues was a theme throughout the interviews and emerged strongly in relation to health practitioners asking patients about potential abuse. Many participants felt that breaking down men’s reluctance to address these issues was important and was something which could be done appropriately in a health-care environment. Most participants were supportive of the idea of health-care practitioners asking about relationships, and potentially abusive behaviour. Most considered that being able to identify and talk about such issues would not only help individual men, but also improve the attitude of men that they could talk about such things.

3.2. Help-seeking

3.2.1. Survey responses

In the survey, those men who completed Part 1 and who indicated that they had experienced potentially abusive behaviours were asked if they had ever told anyone about this. Of the 1368 men who completed this part of the survey, 257 said that they had experienced these behaviours, and of these 36% (N = 92) had told someone about their experiences whereas 65% (N = 165) had not (see Table 1).

As can be seen in Table 1, men who had experienced these behaviours were most likely to disclose to a friend, with family and then doctor being the next most likely options, other responses included: solicitor (2); drug workers (1); educational psychologist (1); employer (1); men’s charity (1); and therapist (1).
3.2.2. Interviews

When we asked in the interviews if there was anyone (including professionals) that they felt they could talk to about any relationship issues, some men mentioned Relate, the relationship counselling service. Others said that they had been referred to counselling by their GP. The focus of such interventions tended to be quite general and not specifically talked about in terms of emotional health and well-being in the context of relationships. For example, one informant had contact with a counsellor relating to his child’s needs and felt that hypothetically he could discuss issues with them, but he had never actually done so.

The men interviewed in this study had not found it easy to talk to family or friends about their relationship experiences, whether or not they involved potentially abusive behaviours. Even where participants stated that they may have friends or family members to whom they ‘could’ talk, further probing revealed that most had not done so, usually because they considered such issues to be “private” or were concerned about confidentiality. One participant told us he had spoken to a friend but felt that had not been helpful because the friend had “posed a question I didn’t wanna know the answer to” (ID.1120069, age 41). Another mentioned that although he had already more or less made up his mind to end his relationship before he spoke to his best friend, she helped make his decision final. As he said:

[…] if you sort of have an inkling towards something and then you speak to someone and they sort of express the same thing or think, “Oh yeah, you’ll be all right to think that or wrong to think that” obviously it’s a big influence if they’re a good friend.

[ID.1150033, aged 21]

Another participant recalled how he avoided asking advice from his male friends as he felt that they would simply tell him to “go out and shag somebody else, or go and get drunk and you’ll feel better” (ID.1200069, aged 41). It may well be, therefore, that some of our participants simply had not wanted to seek advice until they felt that they were ready to accept what they might be told. Other barriers to help-seeking included finding it hard to discuss things openly. One, for example, who had been to Relate, found it unhelpful, saying that he thought that this might be because “I really wasn’t speaking what was really very much inside me” (ID.1120052, aged 63) whereas another commented that “I think I’m a bit of a bottler-upper of emotion” (ID.1120095, aged 74).

A few participants mentioned religious mentors or their own role in religious communities as important resources. For these men, an important consideration with regard to help-seeking was the non-judgemental attitude as well as the confidentiality that they would expect from these advisors. Confidentiality was, in fact, a key issue for participants, with one remarking that despite his own links to a church, he would not turn to them for support because it “pains me to say it but I wouldn’t always trust the church’s approach to confidentiality” (ID.1220030, aged 59). This particular participant would, however, have turned to his GP if he felt in need of support, because he could trust that any discussions would be kept confidential.

Going to the GP or receiving GP-referred counselling for relationship conflict was mentioned by several men. For some this was a hypothetical situation, but others had already asked their GPs for help because of mental health problems. One mentioned that although he had gone to his GP, because he was already receiving relationship counselling, he had not “directly” spoken to the GP about the relationship problems although he “had to say to the GP as many factors as I could think of that were causing me to have broken down” (ID.1120052, aged 63). There were some inconsistencies in what he had to say however, as he also mentioned that she was a female GP whom he had never seen before but who appeared to be particularly intuitive:

I walked into the room […] and she said to me, “I know why you’ve come” cos she could see it. And I knew I could trust [her] and I told her, I told her a heck of a lot.

[ID.1120052, aged 63]

He also suggested that he may have found her easier to talk to because she was female:

[O]therwise doctors I have had have been men. Now I don’t know if that’s significant or not, but I’ve not felt that they can respond in a human way. They can respond medically but not in a sense of counselling and really getting to grips with what’s going on.

[ID.1120052, aged 63]

For those that did mention going to see a GP or receiving counselling, it appeared to be the opportunity to talk through issues that was the most beneficial to them. At least one remarked that the antidepressants he had been put on were not helpful (potentially made things worse), but that the counselling received “enabled me to work through things that needed to be worked through” (ID.1220030, aged 59).

Other men expressed a general reluctance to talk to anyone about how they were feeling about their relationships. Those who defined themselves as happily married, claimed that they discussed how they were feeling about their lives with their wife or partner and rarely with anyone else. As such, when asked who they would talk to if they had problems in their relationship they struggled to identify anyone else that they could actually confide in.

I mean there were times when I just didn’t want to discuss things I suppose because you just don’t want your best friend to think, “God his life’s all so awful.” […] But equally, so I think you tend not to discuss it. You’re more likely to discuss it at the point of you know again when there’s been a blow-up or something, or something to make you need to discuss it.

[ID.1280033, aged 46]

As this extract indicates, the timing of intervening with men is crucial in order to encourage them to acknowledge and talk about experiences, and also increase the possibility of them seeking help. The interviews also highlighted the importance of trust when disclosing any relationship issues:

There’s got to be ultimate trust and that’s where a close friend is so good. It’s got to be a close friend of longstanding. And strangely enough the one is a [European] fellow. Which seems very strange ‘cos it’s […] fairly limited vocabulary. But seems to work very well.

[Interpreter: why that person?]. I think he also has been through rough times. And so in that sense there’s a lot of common ground. And I think that depth of relationship started because he once told

Table 1

Disclosure of potentially abusive behaviours.

<table>
<thead>
<tr>
<th>Disclosed to</th>
<th>N</th>
<th>% of complete sample</th>
<th>% of men who disclosed experience of potentially abusive behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>48</td>
<td>3.5</td>
<td>18.7</td>
</tr>
<tr>
<td>Family</td>
<td>36</td>
<td>2.6</td>
<td>14</td>
</tr>
<tr>
<td>Friends/family</td>
<td>18</td>
<td>1.3</td>
<td>7</td>
</tr>
<tr>
<td>Doctor</td>
<td>21</td>
<td>1.5</td>
<td>8</td>
</tr>
<tr>
<td>Police</td>
<td>17</td>
<td>1.3</td>
<td>6.6</td>
</tr>
<tr>
<td>Helpline</td>
<td>3</td>
<td>0.2</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>0.7</td>
<td>3.5</td>
</tr>
</tbody>
</table>

* In an earlier version of the survey, friends/family was not differentiated, but this was amended in the second version of the survey. As such, an additional 23 men who completed the earlier version, had experienced potentially abusive behaviours, and had told someone about it. Of these 23 respondents, 18 stated that they had told a friend or family member.
me the troubles he had had with his previous wife. And then you feel “Gosh, if he can talk about that, it’s safe territory”. So somebody has to start it when you feel, you feel it remains in confidence.

[ID.1120052, aged 63]

This highlights some of the sentiments of other participants who did not always feel comfortable talking to male friends about their experiences. In this case the friend had initiated the possibility by talking about his own relationship first. Paradoxically, limits to the communication because of language differences, and this friend now living several hundred miles away somehow enhanced the possibility of talking about problems. Although aware of the contradictions here, this participant has specifically identified a ‘friend’ that they could talk to who is in many ways distant. For this participant, this distance makes it possible to communicate about personal issues.

4. Discussion

A key finding of this study is that whilst male patients generally find it difficult to seek help or to discuss potentially abusive behaviours within relationships, they were not averse to the concept of help-seeking more generally. Where they did turn to others, we found it was most likely to be friends and/or family, but GPs were the next most likely to be asked for help. As discussed below, the development of effective interventions to encourage and support men seeking help requires an understanding of the barriers and facilitating factors.

Our survey found that generally male patients are supportive of health practitioners asking about their experience and perpetration of potentially abusive behaviours. Whilst the majority of survey respondents believed that this should be selective (85%), for example if there were reasons to believe that domestic abuse might be an issue, only a minority (8%) of the respondents felt that it was inappropriate for practitioners to ask at all. As noted earlier, most women patients consider it acceptable for health-care professionals to ask about partner violence when this is not their presenting problem. However, it was felt that “the aims of screening should also include information giving and signalling willingness for clinicians to talk about partner violence” (Feder et al., 2009, p. 3). This study strengthens the case for health practitioners to be trained about encouraging disclosure of domestic abuse for all potential victims and perpetrators and about responding appropriately and safely. In the interviews, our participants were aware of the clinical barriers to practitioners asking about such issues, time constraints and lack of training, but were still generally of the opinion that asking was better than not asking. In this respect, participants recognised that if they were in a “difficult” relationship that a consultation with a doctor, or other health practitioner, was an appropriate setting in which to disclose these issues due to the impact that they might have on health, the confidentiality of the interaction, and accessibility. Our findings are consistent with Campbell and colleagues’ research on men’s help-seeking, which suggests that trust and confidentiality are major concerns. For this reason doctors, bound by professional confidentiality, are seen as the obvious source of help (Campbell, Neil, Jaffe, & Kelly, 2010).

In terms of help-seeking, despite the relatively small number of men disclosing experience or perpetration of potentially abusive behaviours and seeking help, where they did seek help from professionals, they were most likely to approach their family doctor. This again is consistent with research with women and highlights the need for training and referral pathways to be commissioned for health services, and primary care in particular. It was striking that many of our male participants expressed difficulties in talking to anyone, friend, family or professional, about emotional and “personal” issues. Even when men named a friend or family member that they had talked to, further probing in the interviews suggested that men found this difficult. Whereas many of these factors are similar to those that impact on women’s help-seeking, we also found that stereotypical expectations around masculinities and male identity roles also played a part in inhibiting help-seeking (Smith, Braunack-Mayer, Wittert, & Warin, 2007). Men, for example, suggested that their physical size meant that they could not easily be intimidated by women, or, that they would be “embarrassed” to call the police for help after being hit by a “girl”. In terms of health behaviours, Evans, Frank, Oliffe, and Gregory (2011, p. 13) note that gender has a powerful impact and that social constructions of masculinities, intersected with other differences such as age and sexuality, help to shape men’s health care practices. In keeping with this, Tsui, Cheung, and Leung (2010) suggest that men who report experiencing abuse find it difficult to seek help for a variety of reasons including not feeling that appropriate support is available; feeling ashamed or embarrassed or not defining their experiences as abuse. Both Tsui et al. (2010) and Rose et al. (2011) also identified fear – for example of being disbelieved, of further violence, or other consequences of disclosure – as a major barrier. These factors all emerged during the course of this study although given the relatively small number of those disclosing potentially abusive behaviors to us, it is uncertain whether we achieved saturation of themes from the men who had experienced or perpetrated abuse. Nevertheless, given our general findings in relation to the experiences and perpetration of domestic abuse, and within the context of other research, it demonstrates that those collating evidence about help-seeking should be clear about the gender of research participants which, as this data shows, may well impact on findings and as a result recommendations relating to service provision.

5. Conclusion

As with the research which has focused on the views of women, the majority of the men from both the survey and interviews felt that it was appropriate for them to be asked by a health care practitioner about relationship issues and behaviours which might be abusive. The interviews revealed a range of reasons why men were ambivalent about seeking support for relationship difficulties and potentially abusive behaviours. In general, they cited the private nature of relationships and the difficulties that they experienced (often due to shame or embarrassment) in discussing problems openly as barriers to help seeking. Facilitators to help seeking included being assured of confidentiality, and the empathetic natures and trustworthiness of potential confidantes. The majority of the survey respondents, we found, had not been asked about their own or their partner’s abusive behaviour by medical practitioners. This failure to raise the issue of potentially abusive behaviours, we suggest, may add to the reluctance of men to seek help. Their reluctance to discuss such issues may be compounded by current medical practice – thus creating a kind of self-fulfilling prophecy. In addition, the gendered way in which participants discussed their experiences of potentially abusive behaviours may well compound the ways in which some ideas of masculinity impede help seeking. However, as noted above we did find that the men thought that if these issues are to be raised, general practice seems to be the most appropriate setting. These findings are also borne out by the wider literature about where men go to access support. Therefore, the provision of relevant training for practitioners, plus ensuring that more visible messages aimed at men, reassuring them that these issues can be raised with practitioners, would help to provide appropriate settings in which to address the needs of male patients in relation to the potential impact of abusive relationships on the health and well-being of them and their families.

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