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Engaging with abusive fathers but not with children? General practice clinicians' perspectives on involving and supporting children and adult perpetrators in families experiencing domestic violence and abuse

Running Head: Engaging with abusive fathers but not with children?

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Abstract

Background. Government and professional guidance encourages general practice clinicians to identify and refer children who experience domestic violence and abuse (DVA) but there is scant understanding of how general practice clinicians currently work with DVA in families.

Objectives. The study explored general practice clinicians' practice with children and their parents experiencing DVA and reflected on the findings in the light of current research and policy guidelines.

Methods. Semi-structured interviews with 54 clinicians (42 GPs and 12 practice nurses/nurse practitioners) were conducted across six sites in England. Data were analysed using current literature and emerging themes. Data presented here concern clinicians' perspectives on engaging with family members when a parent discloses that she is experiencing DVA.

Results. When a parent disclosed DVA, clinicians were more likely to consider talking to abusive fathers than talking to children about the abuse. Perspectives varied according to: whether consultation opportunities arose, risks, consent and confidentiality. Perceptions of 'patient-hood', relationships and competence shaped clinicians' engagement. Perpetrators were seen as competent informers and active service users, with potential for accepting advice and support. Clinicians were more hesitant in talking with children. Where this was considered, children tended to be seen as passive informants, only two GPs described direct and on-going consultations with children and providing them with access to support.

Conclusion. Clinicians appear more inclined to engage directly with abusive fathers than children experiencing DVA. Clinician skills and confidence to talk directly with children experiencing DVA, in child sensitive ways, should be developed through appropriate training.

Introduction

Domestic violence and abuse (DVA) includes any controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or are family members. It is a widespread phenomenon that impacts on victims' health¹ and exposure to DVA in their home has adverse effects for children's health and social development.^{2,3} In many countries, clinicians have a professional duty to identify children in need of special support from social services.⁴ Current guidance in England suggests General Practitioners (GPs) take a 'lead professional role' providing and coordinating support services from an early stage⁵ and GPs are advised to provide advocacy and services 'tailored to ... risk and specific needs' which include 'specialist domestic

violence and abuse services for children and young people'.⁶ Whilst a body of research is emerging on the general practice response to adult victims of DVA,⁷ uncertainty remains about the best general practice response to children and young people.

Family physicians (GPs in the UK), are uniquely privileged in working with adult and child family members over sustained periods.⁸ In the UK, they are the first point of access to health care, for both children and adults, and potentially the first professionals to identify early signs of child maltreatment.⁶ Victims of DVA see GPs as a source of support⁹ but clinicians are uncertain about whether they have sufficient knowledge and competence to respond.^{10,11} Clinicians feel relatively competent in making a child protection referral when risks are high and apparent¹² but are hesitant where levels of risk are less clear.¹³ Conflict of interests between protecting children and sustaining relationships with all family members arise.¹⁴ Research has shown consistent potential for the needs of children experiencing DVA to be overlooked in favour of a focus on adults.¹²

This paper draws on 54 interviews with general practice clinicians in England to illuminate current practice and attitudes towards engaging with other family members (children or adults in the family other than the disclosing parent) when a parent discloses DVA. Interesting contrasts emerged in clinicians' perspectives on engagement with children and abusive fathers.

Methods

Qualitative semi-structured telephone interviews with 42 GPs and 12 practice nurses (PNs) and nurse practitioners (NPs) were conducted by a multidisciplinary academic research team in 2013. A mix of metropolitan, urban and semi-rural practices were recruited by email from

across six clinical commissioning areas covering locations of both higher and lower levels of specialist DVA service provision in the north, south and midlands of England. The majority of practices approached (up to 83% in some areas) chose to not participate, usually due to lack of time. The total number of interviewees was not pre-determined. It was based on ensuring geographical spread and recruitment continued until no new themes were identified (saturation)¹⁵. Table 1 details the gender, age, and experience of the interviewees. It shows a slightly higher proportion of female GPs (59.5%) compared with the national figure (50.8%).¹⁶ Only half of clinicians had experience or awareness of at least one DVA case.

Interviews lasted on average 30 minutes. The interviews started with a vignette in which a patient (“Sarah”) disclosed physical violence from her partner (“Danny”) to a GP or practice nurse. She also described his controlling behaviour towards their three children aged seven, five and two years. The vignette allowed for exploration of clinicians’ views on responding to DVA and child safeguarding even where their own experience was limited. Additional questions eliciting clinicians’ responses in the event that DVA was disclosed are detailed in Table 2.

Interviews were audio-recorded with consent, transcribed verbatim, loaded into qualitative data analysis software (NVivo) and analysed thematically.¹⁷ A coding frame was developed by the multi-disciplinary team from the literature, and concepts which emerged during data collection, and following recommendations developed through discussions with two panels of professional and service user experts. The analysis reported here focused on perspectives of barriers and facilitators of engagement with child victims and adult perpetrators who were patients of the practice, not the adult victims disclosing DVA. Clinician and practice variables (Table 3) are reported where they correspond to visible differences in perspectives on engagement with other family members.

Results

In response to the vignette and questions about their own practice, clinicians provided their perspectives on talking with other family members. They talked about children (aged 2-18 years) and abusive partners in families experiencing DVA. Their perspectives revealed considerable variation in their practice and attitudes towards the two groups.

Children

Five of the 47 respondents who discussed engaging with children in families experiencing DVA, said they routinely would seek to talk to children directly. These five female clinicians (four GPs and one NP) were based in relatively affluent areas with higher levels of DVA. Seventeen respondents said they might seek to directly engage with children in some circumstances. Of these 17, five GPs noted this would be *'quite a way down the line'* (GP38) after talking to other professionals; six GPs said this would depend on whether an opportunity arose. Twenty-five respondents (17 GPs, 2 NP and 6PN) would not seek to engage directly with children to assess them, to elicit information from them or to directly support them:

'[if you ask children about domestic violence] you're making this accusation about so and so...I think that [talking to the mother is] how you kind of assess the... impact on the kids.

(GP19)

'Probably wouldn't actually go and say engage with the children... probably wouldn't proactively...might... put a code in their notes'

(GP29)

Nine qualified their answers during the interview to say that if a parent brought a child to be examined or a child disclosed experience of DVA, they would naturally pick up on this.

Over half of those who discussed the issue (18/29) said they would never see children alone, while eleven said that they might ask parents to leave the room so they could talk to the child alone. One GP outlined an approach to achieving this:

'Would you mind if I just had a word with them [your child] on my own for a few minutes? Just to explore whether there are any issues that they... wanted to talk about that they didn't feel comfortable to raise in front of mum or dad.'

(GP34)

Another GP (GP17) described the importance of being led by a child's wishes in this regard.

There were concerns regarding competence related to both children's competence as informants and clinicians' competence as communicators. Five GPs and two PNs made clear distinctions between children's competence at different ages (which varied from 3 to 16 years). There was no age above which clinicians consistently agreed it would be appropriate to talk to children about DVA; some were hesitant even about talking with teenagers.

Although most interviewees had received child protection training, seven clinicians had concerns about their ability to make themselves understood saying *'I don't have the skills'* (GP26). Talking about DVA was seen as particularly difficult, even for those who had skills in discussing sensitive issues:

'I talk to children a lot about their parents dying and things. And I find that a lot easier funnily enough than talking to them about violence.'

(GP03)

Fear of misunderstandings was evident with three clinicians concerned that children could *'twist things that adults say'* (GP10) and that children could potentially divulge to

perpetrators that DVA had been discussed. Surprisingly, three of six interviewees with safeguarding lead responsibilities and six of nine who had received specialist DVA training said they would not talk to children either because they would not see it as their role to do so, or for fear of asking leading questions.

Four GPs saw talking to children as something they would leave '*for Social Services*' (GP40) or saw it as the role of '*the safeguarding team*' (GP11) or the police; four PNs saw this as a GP rather than PN responsibility. GPs who would not proactively engage with children tended to have less experience of patients experiencing DVA. They were less likely to consult a health visitor, social services or school nurse or make a child protection referral.

Abusive fathers

Of the 46 respondents who discussed this issue, 12 (7GPs; 1NP; 4PNs) would not attempt to raise the issue unless abusive partners (usually referred to by clinicians as fathers or male partners) raised it themselves. Sixteen (14 GPs; 1NP; 1PN) said they would attempt to broach related issues (alcohol, anger and possibly violence) but that they would be aware of the need not to break confidentiality or increase risk. Eleven (9 GPs; 2NPs) would proactively ask the victim for consent or direction about whether to raise the issue with a perpetrator. Seven GPs said they would confront the perpetrator about DVA. These GPs tended to be older (>45 years), proportionately more were male, and three had received no training on DVA (not even via a child protection course).

For the 12 GPs and nurses who would not attempt to raise the issue of DVA unless perpetrators raised it, safety for the victim and children was the key concern; they perceived potential risks that engagement with perpetrators might pose to families:

'whilst I'm understanding of the need to help support and get treatment for perpetrators where possible, I would be very concerned about increasing the risk to these, to the children and adults...it may escalate problems' (GP36)

The seven who would confront the perpetrator indicated no awareness of the risk posed to families. Three of them assumed that if their practice received official written notification of DVA from another agency, the abusive partner would already know about allegations or might as well know from the GP as anyone else.

In contrast to their diffidence in respect of talking with children, interviewees' concern for their own competence regarding talking to perpetrators was markedly absent. Only one PN felt she was not competent to do this and seven GPs appeared confident that they had the appropriate skills to work effectively with couples, noting that they would seek to see both victim and perpetrator together if possible.

'it'd be nice to have them, you know, both in as a couple to talk about it, listening to his... take on things.'

(GP20)

This couple centred approach tended to come from GPs with little or no experience of DVA cases and more years in practice.

Key differences in clinicians' relationships with children and perpetrators

The extent of clinicians' readiness to engage with other family members (both children and adult perpetrators) related to similar issues: opportunity; concerns about potential consequences and risks and responsibilities regarding consent and confidentiality. However, perceptions of other family members as competent informants, as patients, and established

relationships, emerged as key differences in their attitudes towards engaging with children when compared to perpetrators.

Abusive fathers were perceived as competent informants: some GPs would engage to *'see if there are ways that we can engage Dad to find out Dad's perspective on this'* (GP21) or noted that *'there are always two sides to any story'* (PN10). Perpetrators were also seen as active service users, able to engage with advice, behaviour change and support with DVA related health problems (such as alcohol use and mental health concerns). Recognition of children as competent patients in their own right appeared to be limited. Rather, non-abusive parents or other professional adults were identified as informants about children. When engagement was envisaged with children, they tended to be conceptualised as passive informants who might not even know the reason for the consultation, a GP may just *'look for ... signs of physical abuse that [the parent] may not have noticed'* (GP22). Children were conceptualised as lacking any direct access to health services:

'you couldn't phone a child and talk to them, you know, ... you could maybe say [to a parent] do you mind if I speak with them on their own?'

(GP09)

Some GPs reflected extensively on the needs of perpetrators, as illustrated by this GP who reflects here on the needs of Danny, the father in the vignette:

'You could have a situation where a man has been violent towards a woman and feels really bad about it and, and doesn't know why he got that angry and needs some help in controlling his anger and...he's your patient...so, maybe he needs some input?'

(GP42)

Although 11 clinicians said they would never or only in exceptional circumstances see children in relation to their experience of DVA, none suggested that perpetrators should never

be seen at the surgery about DVA related issues. One GP had to correct himself to even concede that children are patients in principle:

'Well probably not [talk to the] children because they're not ...[pause]... well they are patients'.

(GP29)

In line with previous research⁹, existing relationships were consistently described as significant to working with perpetrators:

'if you've got a relationship with the man already then it makes it more likely that they'll come in.'

(GP13)

In contrast, only one GP suggested that that existing relationships could enable proactive and direct engagement with children. Lack of time was repeatedly cited as creating difficulties in establishing relationships with children. In contrast, lack of time to engage with perpetrators was not mentioned.

Those few clinicians who were prepared to engage directly with children argued that offering opportunities to see the doctor could facilitate active patient-hood and give children *'the sense that it's okay to come and talk to you about anything that worries them.'* (GP21). Two female GPs described providing children with direct support, rather than simply assessing and referring on to children's social services: they listened to children over time and would assist them to access specialist services.

Discussion

We found low levels of GP and nurse proactive engagement directly with children experiencing DVA and our study suggests that a focus on adults¹² extends to include a tendency towards working with the abusive partner, when s/he is a known patient in the practice, rather than with children. This trend may have relevance for family physicians in other countries as the invisibility of children in general practice has been noted elsewhere¹⁰ and adult patients experiencing DVA have suggested that family doctors should provide children with follow-up support if they too are patients of the practice.¹⁴

Strengths of our study include the relatively large number and wide spread of the practices and interviewees involved, compared with previous qualitative studies,^{13, 14} enabling thematic saturation. Its limitations include a vignette that did not incorporate older children. However, clinicians were asked to identify differences in their approach to teenagers (Table 2).

Although some adult service users contributed to analysis, a further limitation is the absence of children's perspectives on how and when clinicians engage directly with them.

The study is consistent with previous research where GPs were found not to engage directly with children¹² and indicates the need to improve opportunities for children experiencing DVA to communicate directly with general practice clinicians. The actual and proposed practice of most clinicians interviewed would fall short of expectations outlined in English General Medical Council guidelines¹⁸ on child safeguarding. These apply to all children including those in families experiencing DVA. They state that doctors working with children and young people have a duty to listen and talk directly to them; to make sure they know who they can go to for help; to seek consent for information sharing from those children with capacity; and, regardless of capacity, to take account of children's wishes when making judgements about their best interests. Previous research indicates that direct communication with children is facilitated by proactive child focused communication skills.⁶ This study

suggests that engaging directly with children experiencing DVA relies on recognising them as patients, offering them opportunities to see clinicians on their own, and establishing ongoing relationships with clinicians.

Internationally,⁴ lack of training is a barrier to family physicians recognising and responding appropriately to child maltreatment. While training may be a means of improving family physician competence and confidence in working with families experiencing DVA, it is important that training is appropriate and fit for purpose. This study found that child protection training and lead roles did not necessarily coincide with greater confidence in working directly with children exposed to DVA. Indeed, current training may exacerbate fears about talking to children without highlighting the potential risks involved when engaging with DVA perpetrators. The impact of different forms of training could be explored in health systems where paediatricians, with more focused training and experience of child communication, are the first point of contact.

Clinicians' gender and professional role together with local deprivation, and level of DVA service provision, may be barriers to engagement with children. The only clinicians who said they would routinely engage with children experiencing DVA were female GPs in more affluent areas with higher levels of specialist DVA service provision. The link between low levels of specialist DVA services and low levels of direct engagement with children underlines the importance of redressing the lack of service availability,¹⁹ especially as children have called for community-based services.²⁰ Some respondents argued that they lacked the time to engage directly with children, but many saw themselves as able to find the time to engage with adult perpetrators and couples together, despite the risks associated with this.¹² If more clinicians, including male practitioners and nurses, are to direct their time

towards working effectively with children this will also require supportive practice environments which challenge gendered and role based constraints on practice.

Conclusion

As stated in UK guidance and the United Nations Convention on the Rights of the Child (1989), children should be viewed as competent to express views in relation to their health and support needs, regardless of whether they are deemed to have capacity to make decisions. Training must therefore be designed to encourage appropriate direct engagement with children experiencing DVA, rather than feeding cultures of fear, child invisibility or avoidance. This could be enabled by supportive practice environments and more widespread provision of specialist DVA services.

Declarations

Ethics. This research received ethical approval from the University of Bristol, Faculty of Medicine and Dentistry's Ethics Committee and relevant Primary Care Trusts.

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Conflict of interest. None.

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Table 1 – General practice clinicians telephone interviewed for RESPONDS study in 2013

Demographic details of research participants		GPs	Nurses
Gender	Male	17	
	Female	25	12
Age Range (years)	21-34	8	2
	35-44	11	
	45-54	15	8
	55-64	5	1
	Not Known	3	1
Experience managing DVA (No. of cases) ²⁰	More than five	5	0
	A few	13	1
	One	0	2
	None	18	8
	None, but aware of case at surgery	6	1
Experience of DVA training	Specialised DVA training	6	0

Table 2 - Questions used in RESPONDS telephone interviews regarding clinicians' perspectives on talking to other family members when DVA is disclosed by a parent

Interview Questions Regarding Responding to disclosure of DV in families
How much background information would you try to get?
Would you check their parental status?
Would you ask about the impact on their children?
Would you seek to talk to the partner/ children about the DV?
Are there any differences according to age e.g adolescents vs. children? Would you seek to talk to the children alone?
Regarding patient confidentiality, what sort of concerns do situations involving domestic violence and children raise if any, and how do you respond to these?
What sort of patient safety concerns do these situations raise if any, and how do you respond to these safety issues?

Table 3 – Variables explored in REPONDS study interviews on clinicians’ perspectives on engagement with child victims and adult perpetrators who are patients of the practice

Elements	Variables potentially impacting on barriers to and facilitators of direct engagement
Clinician demographics	Age Gender Numbers of years in practice,
Clinician experience	Experience in DVA case management Specialist training (DV and safeguarding) Professional roles
Clinician attitudes	Perceptions of age Perceptions of childhood Perceptions of risk and confidentiality
Practice Profiles	Size Location (higher or lower levels of specialist DVA service provision) Socio-economic composition