

In conversation with health visitors and women, discussing domestic abuse. A reflexive analysis.

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Abstract

Introduction: Domestic abuse is a pervasive form of violence affecting one in four women in the UK, with health visitors playing a key role in supporting mothers and safeguarding children. This study explores the perspectives of health visitors and mothers, examining the nature of professional support and its impact within universal health visiting services.

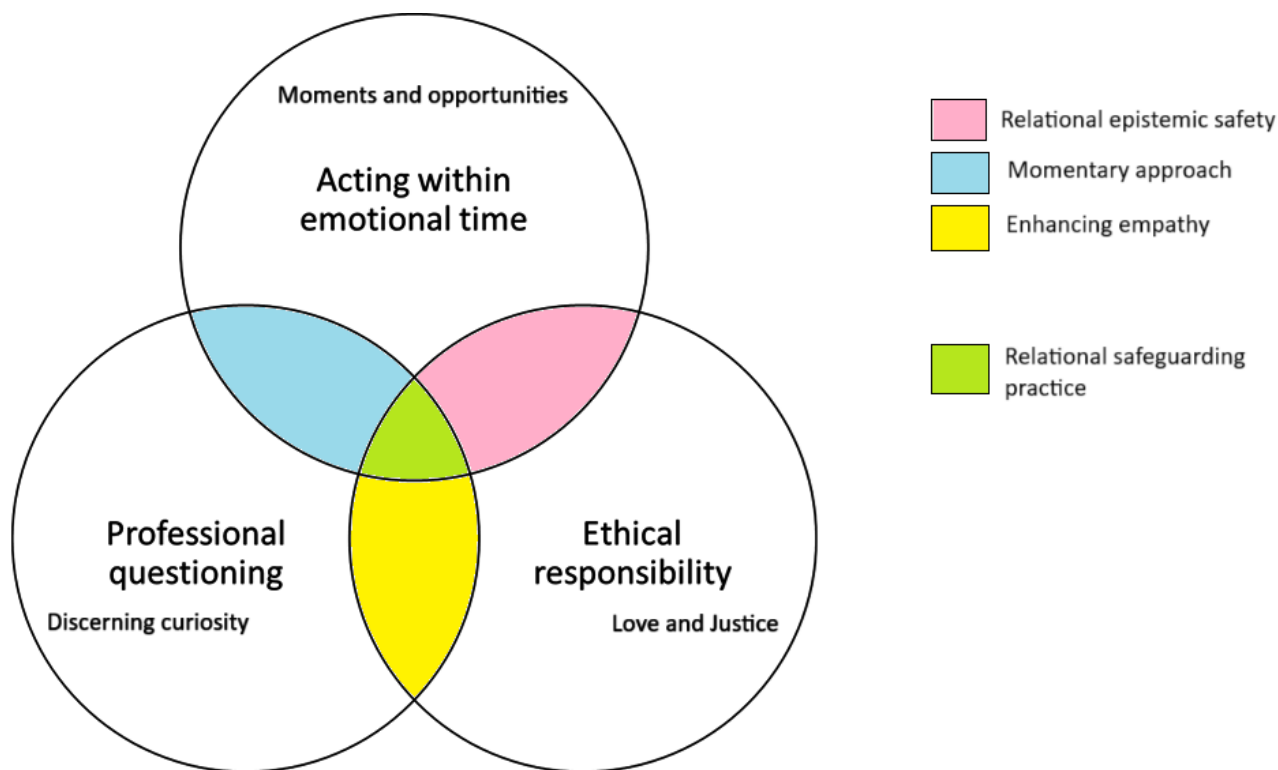
Study aim: to seek opportunities to progress and improve health visiting practice when supporting families experiencing domestic abuse. This is formed through the achievement of three key objectives.

1. Exploring the wider implications and perspectives of domestic abuse,
2. Exploring the broader perceptions of health visiting support,
3. Exploring the perceptions of achievable/wanted outcomes.

Methodology: A qualitative, feminist-informed approach was used, with semi-structured interviews conducted with 15 practicing health visitors and 13 mothers who had experienced domestic abuse. Data were analysed using reflexive thematic analysis, ensuring an authentic representation of lived experiences.

Findings: Three themes emerged: *Discerning Curiosity* – Health visitors and mothers navigated uncertainty, balancing professional inquiry with evolving understandings of abuse. *Love and Justice* – Relational care and trust were central to supportive health visitor–mother interactions. *Moments and Opportunities* – The timing of interventions influenced disclosure and access to support.

Discussion: The synthesis of the data presents intersecting considerations that result in relational practice through epistemic notions, taking a momentary approach, and finally enhancing empathy.



The study reinforces the use of reflexivity in health visiting and research and enhances the role it plays within professional competency. The study identifies how epistemic injustice affects health visitors, particularly in domestic abuse, and shows how mother's experiences are often dismissed. The study emphasises the need for health visitors to unlearn biases within a safe and nurturing environment of practice. Furthermore, the issue of responsabilisation is considered, adding an additional layer placed on health visitors as well as the deep moral and emotional weight felt.

Conclusion: This study underscores the importance of relational, well-timed interventions, offering insights to enhance policy, practice, and professional development in health visiting

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Authors' declaration: This thesis is the result of my own work and has not previously been submitted for any other degree at Staffordshire University or another institution.

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Signed:

A handwritten signature in black ink, appearing to read 'Katharine Codd', written over a horizontal line.

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Abbreviations

BMA	British Medical Association
CIN	Child in Need
CPP	Child Protection Plan
DASH	Domestic abuse, stalking and honour-based violence
DA	Domestic abuse
DH	Department of Health
DV	Domestic violence
DVA	Domestic violence and abuse
FSW	Family support worker
FGM	Female genital mutilation
FNP	Family nurse partnership
GBV	Gender based violence
HBV	Honour based violence
HV	Health visitor
IPV	Intimate partner violence
MARAC	Multi agency risk assessment conference

MASH	Multi agency safeguarding hub
NMC	Nursing and Midwifery Council
SCPHN	Specialist community public health nurse
VAW	Violence against women
VAWG	Violence against women and girls

Chapter 1. Introduction

This chapter begins by outlining the context and focus of the study, it will do so by providing information relating to domestic abuse (DA) and health visiting practice. The pertinent definitions that are cited within professional guidance will here be expanded, as well as placing the phenomenon of DA within the experience of mothering, and specifically health visiting support. Ethical considerations of wider registration and practice will be briefly outlined and specifically positioned within personal reflections. The aims of the study will be detailed, as well as providing an outline of chapters succeeding this introduction.

1.1 Context of the study

1.1.1 Present situation

The United Nations (2004) defined DA as being,

“A pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviours that frighten, intimidate, terrorise, manipulate, hurt, humiliate, blame, injure, or wound someone.”

The Home Office (2021) detailed definitions of abusive behaviours as physical or sexual, violent or threatening, controlling or coercive, economic, psychological or emotional. The Domestic Abuse Act (HM Government, 2021) stated abusive behaviours could be between parties who are *personally connected* to one another; furthermore, any reference to a victim of DA includes

reference to a child who “Sees or hears, or experiences the effects of, the abuse” (section 3, Domestic Abuse Act, 2021).

DA is categorised as abusive behaviours with different terms often used, including intimate partner violence, domestic violence, couple violence, or intimate terrorism. The term DA is adopted within this thesis to keep with the UK context of practice and legislation, however when citing others work within the subject, the terminology used within their research will be adopted but done so with the acknowledgement of the broader terms that can define the phenomenon. DA is part of a wider continuum of abusive behaviour known as violence against women (VAW) or gender-based violence (GBV) (UN Women, 2024), such violence and abuse also incorporate female genital mutilation (FGM) and honour-based violence (HBV). Both issues are complex and dynamic in nature and understanding, and as such require specific attention from practitioners, policy makers, and researchers. Definitions and terminology are important because acts of violence need to be recognised by third parties, friends, family, professionals, or policy makers (NSPCC, 2023). Without recognition there is open space for misunderstanding (McKie, 2005). Definitions, like those used here, should be broad enough to encompass context, and be inclusive of individuals with lived experience. A structuralist approach to definition enables the focus to flow from the individual to the context (Walle and Dahl, 2020). However, definitions are not finite, being socially, historically, and culturally constructed (McKie, 2005), and to understand and practice within definitions is to do so with the understanding that what we define domestic violence and abuse to be today, may change tomorrow.

The Domestic Abuse Act (2021) moved forward with the term DA, incorporating all forms including violent, psychological, financial, sexual, and emotional abuse. This bill also

encompasses consideration of some aspects of child abuse. The term DA is widely used within other policy and practice documents including 'Responding to domestic abuse: a resource for health professionals' (Department of Health and Social Care, 2017), with both the Royal College of Nursing and British Medical Association titling their policy documents 'Domestic abuse' (RCN, 2017. BMA, 2014), as well as CAADA (Co-ordinated action against domestic abuse) and national data gathering systems using the term DA (Office for National Statistics).

1.1.2 DA and women

"Men are afraid that women will laugh at them. Women are afraid that men will kill them."

Margaret Atwood (1982)

Preventing violence against women and girls (VAWG) is acknowledged to be of high importance on a global scale. Sustaining innovative and systematic programs that cover the social ecology of people's lives are essential to challenging the gender-power imbalance (Michau et al. 2014).

Addressing VAWG requires community-based approaches that draw on the political and social structures delivering legislation and initiative through education, healthcare, and local settings. As well as enacting laws to criminalise violent behaviours, continued and robust educational programs that focus on gender equality, healthy relationships and respect are required (Lombard and McMillan, 2013). The root cause is both complex and interconnected, and empowering girls and women can only be achieved through challenging cultural norms and disadvantage.

DA remains a pervasive public health and safeguarding concern. Globally, around one in three women will experience physical and/or sexual violence by an intimate partner in their lifetime

(WHO, 2021). Within England and Wales alone, 1.6 million women and 712,000 men reported experiencing DA in the year ending March 2024 (ONS, 2024), yet fewer than one in four incidents are ever brought to the attention of the police (NCDV, 2024). The impact extends beyond adult relationships: one in five children in the UK are thought to live in households where DA is present (NSPCC, 2019), and pregnancy itself is recognised as a time when abuse may be triggered or exacerbated (NHS, 2023).

As a health visitor, these figures are not just numbers on a page but lived realities I have encountered in homes. They serve as a stark reminder that DA is not rare or hidden somewhere else—it is present in the everyday work of community practice, shaping the lives of women, children and families I have had the privilege to walk alongside.

1.1.3 DA and child safeguarding

DA and child safeguarding are closely interlinked, with research demonstrating that the presence of one often indicates the likelihood of the other (Hester and Westmarland, 2005).

National reviews of serious case data highlight the severity of this connection, with DA contributing to over half of cases where children died or came to significant harm (Brandon et al., 2020; Dickens et al., 2022). Early childhood, particularly under the age of one, and periods of family separation have been identified as key risk factors (Department of Health, 2013).

Despite policy advances, DA continues to be insufficiently recognised as a public health issue (Ofsted, 2017).

Children's lived experiences of DA often go unheard, with professionals relying on adults as proxies rather than capturing the child's own perspective (Callaghan, Alexander & Fellin, 2016;

Lewis et al., 2018). While interventions frequently centre on protecting children, they must also account for the broader family dynamics and the supportive role of the primary caregiver, often the mother.

This study recognises the significance of safeguarding in DA practice, but a fuller exploration of the theoretical and empirical evidence relating to children's experiences, intergenerational transmission, and health visiting responses is provided in Chapter 2.

1.1.4 Health visiting service

Health visitors work as part of the health workforce in the UK delivering the Healthy Child Programme (Department of Health, 2009) to give every child the best start in life by reviewing, assessing, intervening and supporting child development, physical and mental health, and finally social needs and safeguarding (Institute of Health Visiting, 2021). Following qualification, health visitors register as specialist community public health nurses (SCPHN) on part 3 of the NMC register and deliver service provision to families with pre-school aged children (0-5 years). Health visitors play a pivotal role in identifying and advocating for individuals experiencing DA (Department of Health, 2013). The unique leadership role within universal health services is further amplified through collaboration with other agencies (Cowley et al. 2013).

Comprehensive support is only achieved through the pooling of expert knowledge and resources. Assessment of DA is fundamental, and as such health visitors are guided to ask at every opportunity, known as 'routine enquiry' (Department of Health and Social Care, 2013).

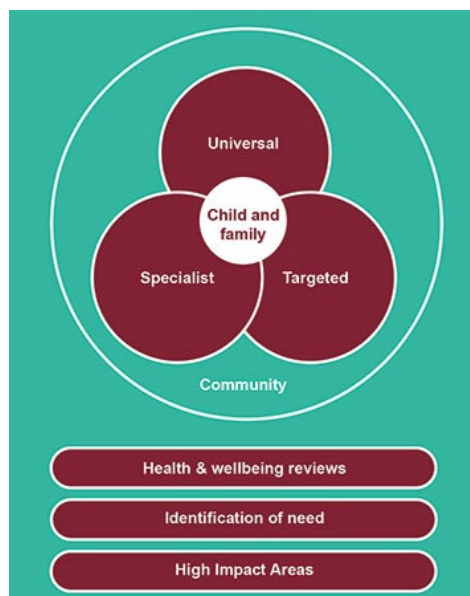


Figure 1.1. *Universal in reach, personalised in response model*. (Public Health England, 2021), illustrates the core elements of need-led health visiting. The service level of provision is determined through health and wellbeing reviews, identification of individual needs, and delivery of the high impact areas.

For this study and thesis ‘specialist’ is called universal plus, and ‘targeted’ is partnership plus. Universal health visiting is offered to all families and children within the UK. Dependent upon nation, this universal offer provides core contacts to meet the six high impact areas, and include supporting; the transition to parenthood, maternal and family mental health, breastfeeding, healthy weight and nutrition, wellbeing and development, as well as improving health literacy (Public Health England, 2021). Specialist or universal plus service would incorporate the universal offer as well as specialist referral or expert knowledge on a need-led basis. For example, this may include working with family support to deliver an early help plan. Targeted or partnership plus service would incorporate the universal offer as well as high need expert support, for example statutory agencies including children’s social care and probation. Consideration of further social care intervention, as dictated by the Children Act (1989, 2004), provides legal framing relating to obligations and risk, and is often involved when delivering a targeted service that involves multi-agency working (see Working Together to Safeguard Children, HM Government, 2018, 2023).

1.1.5 Health visiting and DA

Health visitors play a central role in supporting families to improve health outcomes and reduce inequalities (NICE, 2014). Positioned at the heart of community child health and development (Department of Health, 2010), they are uniquely placed to recognise and respond to DA.

Building therapeutic, trusting relationships has been shown to be key to enabling disclosure and intervention (Bobby, 2020). Compassionate, child-focused practice underpins the four domains of health visiting, supported by specialist public health knowledge of the social determinants of health (NMC, 2004).

Despite this pivotal role, DA has historically been framed as a private matter, limiting the professional response (Patrick & Jackson, 2021). Although national guidance urges health visitors to approach families with cultural competence and to enquire routinely about DA (Department of Health, 2013), barriers remain. Lack of confidence, uncertainty about which interventions to implement, and assumptions of similarity between cases all continue to hinder effective responses (Sundborg et al., 2012; Allard, 2013). Research further highlights that non-disclosure often arises not from a reluctance to share, but because professionals fail to ask the right questions (Cowley & Frost, 2006).

Routine enquiry, awareness-raising, and collaborative working with other agencies are therefore essential to ensure services are responsive to the needs of families (Smith & Horne, 2012). Given the prevalence of DA, it is a common feature of health visiting practice. Yet each situation is unique, requiring recognition of complexity, nuance, and the individual needs of families. This study builds on the growing body of work emphasising the importance of health

visitors' recognition and response (Bradbury-Jones, Appleton & Watts, 2016; Jack et al., 2017; Okenwa et al., 2024), and Chapter 2 will explore these issues more fully within the theoretical and empirical literature

1.2 Ethics of care

1.2.1 Professional regulations

Nursing research is undertaken to improve and/or develop new interventions or practices that benefit individuals, groups and communities (Geilling et al. 2021). To ensure such, ethical approval is often required to ensure safety and standards of practice. As this study recruited participants through NHS organisations, NHS ethical approval was sought and given through the Health Research Agency (HRA) process (IRAS number 317873). However, as Geilling and colleagues (2021) postulate, it would be naïve to conclude that such approval is enough to ensure practices are undertaken. For this reason, professional regulations are also adhered to and upheld to ensure the safety and respect of participants, as well as maintaining a responsible stance of data and study endeavour.

As an NMC registrant, upholding the Code (NMC, 2015) is weaved throughout this study, relating to the key aspects of prioritising people, ensuring effective practice, preservation of safety, and the promotion of trust and professionalism. Building upon these core principles, the influencing spheres of practice that promote human rights, community health, and autonomous, transformative practice (Figure 1.3) are fundamental to all stages of this study.

Spheres of influence	Specialist community public health nurse core standards of proficiency for health visitors
Sphere A	Autonomous specialist community public health nursing practice
Sphere B	Transforming specialist community public health nursing practice: evidence, research, evaluation and translation
Sphere C	Promoting human rights and addressing inequalities: assessment, surveillance and intervention
Sphere D	Population health: enabling, supporting and improving health outcomes of people across the life course
Sphere E	Advancing public health services and promoting healthy places, environments and cultures
Sphere F	Leading and collaborating; from investment to action and dissemination

Figure 1.2 SCPHN core standards. Nursing and Midwifery Council, 2022.

1.2.2 Indeterminacy

Indeterminacy as MacFarlane (2020) considers, is indecision, or vagueness of knowledge.

Underpinned by discourse, ambiguity or perception of intention is integral to measuring the margin of error for perspective and information sharing (MacFarlane, 2020). However, for this consideration indeterminacy within healthcare represents the judgement and ‘private’ knowledge available to professionals to make decisions (Jamous & Peloille, 1970 in Traynor, Boland and Buus, 2010). What Traynor et al. (2010) study found was that nurses’ decision-making skills were weighed between indeterminacy and workload. Nurses account for the everyday nuance of discourse and experience (Traynor et al. 2010) and in fact, mobilise such through contradiction (Clancy, 2024). What Clancy (2024) concluded was that nurses navigate the contradictory and inconsistent through the margins of knowingness, tangibility and time.

This study prioritises the foundational ethical positioning as detailed by the Code (NMC, 2015), applying it to the indeterminate nature of collaborating (practice and research) with individuals. Outcomes cannot be pre-determined and therefore aims are applied. This study sits within the context for which it exists, and hopeful in transferability for positive change and

practice support, are done in so with the appreciation of my own intention. The determinacy of this research aligns with practice legislation that is supported through the following HM Governmental (UK) frameworks; Working Together to Safeguard Children (2023), The Children Act (1989, 2004), The Equality Act (2010), The Domestic Abuse Act (2021), Children's Social Care National Framework (2023), and international guidance of The United Nations Convention on the Rights of Children (UN, 1991).

1.3 Reflections

I have worked as a health visitor for 10 years, prior to this I have worked in both acute and community settings within nursing and midwifery. Throughout my clinical career I have worked alongside many individuals experiencing DA (known, and as research suggests for many, it remained unknown to me). The literature presented in this thesis has gained scholarly recognition through established academic discourse, which, as Franklin-Phipps (2017) suggests, legitimises itself. The intelligible and inquiring nature of the positioning of this study requires the backdrop of such scholarly work, however the acknowledgment of experience provides reasoning.

What I have known for much of my career is the difficulty in entering conversations that are often emotional, personal, and fueled by fear. Specifically relating to DA, I worked with a small number of families in which DA played a fundamental part in their experience, and in such many challenges arose that questioned my practice and personal perspective.

What I have noticed is how assumption forms much of the way colleagues form questioning and curiosity relating to discussions they have. Similarly, relationships with mothers and wider

family members experiencing challenges have often resulted in a struggle to provide a thriving outcome for all, due to the multiplicities experienced.

What has struck me is the way differing perspectives held between health visitors and mothers' impact not only the outcome of support, but also the perception of who they are. To address this the study aims to speak with both groups about their experiences, in their own words, to enable insight. Upon reviewing the current literature base of information, I noticed that there were gaps in the exploration of perspectives held by both groups relating to perceived support.

Fundamentally I recognise myself as a researcher and clinician with lived experience, I do not deny my own belief system, however, identify them as ever-changing and fluid at times. My journey is reflected upon throughout the thesis. Utilising mindful practices focused on emotions and thoughts helps attune the mind to the present. On allowing thought and feelings to organically evolve required time, space, journalling, talking with others, and physical movement.

What I was yesterday is different from today and will change again tomorrow. I do not wish to know it all. I wish to learn, unlearn, re-learn and progress.

I am a health visitor. I have had the privilege to sit on many sofas, floors, beds and shared spaces, to speak with those at their most vulnerable. These moments I try to never take for granted. I have been a girl, a woman, a mother, and a wife. At times I have struggled with each of these labels. I have viewed life differently through each of these lenses, experiencing all the socialisation that such bring. I am an enthusiast, an enquirer, a question-asker, and a storyteller, and so for the purpose of this task, this makes me a researcher. What can you as a

reader, participant, professional expect? Us to ask, and us to tell. Your story, Their story, My story. Together in sharing we learn, we move, and we grow.

1.4 Focus of the study

This study draws from clinical experiences, personal interest, and current literature to explore perspectives of DA within the working relationship between health visitors and mothers. The study aims to draw upon insights from professional and service users to consider current service delivery and practice within universal and universal plus provision.

1.4.1 Research aim

The aim of the study was to,

- seek opportunities to progress and improve health visiting practice when supporting families experiencing DA.

To achieve this aim, objectives through further exploration of the perspectives of health visitors and mothers/women who are experiencing DA (during service provision), relate to:

1. Exploring the wider implications and perspectives of DA,
2. Exploring the broader perceptions of health visiting support,
3. Exploring the perceptions of achievable/wanted outcomes.

1.5 Positioning of the study

This study will add to the growing literature exploring DA within service provision. Important and influential work has helped to direct and determine service provision both within

safeguarding and public health. This study will specifically address the issues relating to health visiting support through the insightful perspectives of the professional and mother (in the experience of DA). Recent reviews have concisely explored issues relating to home visiting nurses' (global profession) experiences of working with families experiencing DA (Adams, Hooker and Taft, 2022. Vanderbury et al. 2010. Bender, 2015), with the most recent systematic review of literature pertaining to both health visitor and mother experiences within the context completed over 10 years ago (Eynon et al. 2012).

From the outset researcher alignment for this study is explicit. For this study there are some clear standpoints to be made.

1. This study will gain perspectives of health visitors working within the UK. Health visitors are regulated by the Nursing Midwifery Council (NMC) and have achieved registration following an accredited post graduate qualification. To complete the Specialist Community Public Health Nurse (SCPHN) training, individuals must already hold registration with the NMC within a branch of nursing or midwifery. Similar models of practice are seen globally, however for the purpose of this study the perspectives and practices identified will be related to the current UK field, however comparison and policy undertaken in similar roles globally will be considered.
2. This study will explore the perspectives of mothers. For this study mothers will be self-identified within the voluntary recruitment process. There is no explicit link between biological sex and gender within the recruitment process, however, when considering the socialisation of mothers and women, some biological facts will be drawn upon and referenced appropriately. The terms women and mothers will be used interchangeably

throughout the thesis to reflect the terminology used within the evidence base or used to reflect the self-identity of the data set.

3. The study focuses on mothers with experience of DA and acknowledges the intersecting oppressions and stereotypes at play for such a group. Not intending to deny father's and/or male's experience of DA, the multiplex of motherhood illuminates DA with the full complexity of theory and political power necessary. Furthermore, it does not wish to reduce the experience to singular events of outburst or incident. Research into gender symmetrical perpetration will be signposted, however the linear experiences suggested within such negates to fully conceptualise agency and rationalisation.
4. This study, and discussions to follow do so within the universal health visiting service delivery. Safeguarding is everybody's responsibility, and child protection systems sit within (see Working Together to Safeguard Children document, HM Government, 2023). Acknowledged, is that safeguarding is woven within supportive intentions delivered by health visitors. Child protection, being part of safeguarding, is initiated by concern or risk of harm, and often interventions deviate within this arena. Most health visitors, as this study demonstrates, have and continue to work with families deemed at risk within child protection, and work alongside statutory agencies when concerns are at their highest. Yet for this study, the aims are to unpick the universal experiences of health visitors and mothers who may, or may not, have exposure to child protection interventions. The insights drawn from this study cannot and will not be objectified to sit within serious risk of harm, yet are presented within the nuance and fluctuation of DA experience. Important to note, that when there is professional or personal concerns

of child safeguarding, conversation and individual perspective of outcome alone are not deemed appropriate nor effective to ensure a child's (or adults) protection and/or safety.

1.6 Outline of the thesis

This chapter has provided the context to the thesis, detailing some of the key legislative definitions applicable to health visiting practice, DA and broader violence against women. Rationale has been provided through personal reflection and practice. The research aims have been stated and the outline of the subsequent chapters provided.

Chapter 2 embarks upon a narrative review of literature pertinent to the study aims, exploring the current evidence relating to DA theories and models, as well as how such impacts the health visiting role. There is a plethora of studies relating to DA, and the experiences of women and mothers, as well as the perspectives of health visitors working within this safeguarding practice. However, there are few studies that combine the perspectives of both mothers and health visitors within the analysis.

Chapter 3 provides the theoretical and philosophical underpinning of the study. Methodological concepts are detailed and explored to provide a backdrop for the methods undertaken to achieve the research aims. Within the chapter, specific issues within the study protocol are discussed as well as ethical considerations and participation.

Chapter 4 sets the scene for the processes undertaken to generate meaning within the conversations held with both data sets. The reflexive process of analysis will be detailed to provide an insight into the linear tasks undertaken throughout. Themes produced from the

analysis will be detailed here and will enable the reader to move into the analysis findings with a clear story relating to the application of theme to address each research aim.

Chapter 5 introduces the research analysis findings relating to the health visitor data set. The application of the themes is discussed within the data set, as well as providing reflexive accounts from myself. The findings are presented within three sub-chapters addressing specifically each objective. Direct participant quotes will be interweaved to illuminate meaning.

Chapter 6 provides the analysis findings for the women participating in the study. The outline of the chapter will mirror that used in the previous chapter, to present findings addressing each research objective. Akin to chapter 5, direct quotes will be analysed and considered alongside researcher subjectivity to provide consideration. Both analysis chapters will draw upon previous research to support or challenge current postulation and practice.

Chapter 7 presents discussion points specifically focusing on health visiting service provision. This chapter will explore the findings of the study that related to theoretical, conceptual and practical implications. It is here that unique considerations and frameworks will be presented, alongside adapted current practice models to progress universal and universal plus support. Limitations and strategies undertaken will be provided.

Finally, chapter 8 will provide specific contributions to knowledge and practice, as well as considering future study conception.

Appendices will contain the study protocol specifics, including ethical approval, as well as participant transcripts. Reflective accounts will be detailed relating to analysis systems undertaken, as well as the themes and codes concisely presented.

1.7 Concluding thoughts

This chapter has provided the context for the study, as well as important definitions and practice competencies to consider. The research aims and positioning of the key study specifics have been detailed to enable an informed appreciation of the phenomenon of DA, health visiting practice, and how the two intertwine. The reader should be clear upon the focus of the study, and the thesis outline. A narrative literature review will now begin to explore the areas pertaining to the DA perspective within health visiting provision. The evidence-base for this study will be presented, debated and placed within the current theoretical frameworks and practice-based policies.

Chapter 2. Literature Review

2.1 Introduction

This chapter will contain a narrative review of the literature pertaining to the experiences of women and health visitors within the context of DA. The broader perspectives of DA will first be explored using both feminist and socio-ecological models found within practice. Considering the context of this study, it is notable that much of the current research base surrounds barriers, stereotypes, and assumption within the discourse of DA and families. Throughout this chapter, the reader will be signposted to the expert voices through citation. This chapter will lay the foundation for nuanced exploration of perspectives between health visitors and women, moreover with an examination of impactful issues scaffolding such.

2.1.1 A narrative review

A narrative review was selected for this study because it allows the integration of a diverse and heterogeneous body of literature spanning theoretical, empirical, and practice-based sources. Given the multi-layered nature of DA—encompassing gendered social structures, intersectional experiences, professional practice frameworks, and lived experience—an approach was required that could accommodate complexity, context, and critique. Unlike systematic reviews, which apply rigid inclusion criteria to answer a narrowly defined research question, a narrative review facilitates a more interpretive synthesis (Green et al. 2006). This permits the weaving together of multiple disciplinary perspectives, critical feminist analysis, and professional insights that would otherwise be excluded in a strictly systematic process. Moreover, a narrative review supports the iterative development of thematic connections across disparate sources, aligning

with the study's epistemological stance of exploring meaning and context rather than producing a purely aggregative summary of findings. This choice ensures the review not only summarises existing knowledge, but also interrogates prevailing assumptions and highlights underexplored dimensions—particularly the dual perspectives of women and health visitors in the context of DA.

For this thesis and study, the term DA is used as it is pertinent to current UK legislation, practice documents, and relatable to wider societal understandings. Furthermore, the use of words victim-survivor and abuser-perpetrator will be used interchangeably, this will reflect the current legislation, as well as narrative from lived experience. Any direct correlations with gender will be specifically highlighted, as well as other societal dynamics associated with experience.

During the iterative stages of the literature search a scoping review strategy was undertaken to highlight any similar/pertinent literature specific to this study aim. The primary scope mapped the field of interest, as determined by Arkey and O'Malley (2005) and provided early contextualisation of the data (see appendix). Searches were conducted on CINAHL, Nursing and Allied Health, PsychINFO, ScienceDirect and COCHRANE. Excluded from the searches were publications over 10 years old (before 2014) and not in the English Language. The search terms used (*"domestic abuse" OR "domestic violence" OR "family violence" OR "intimate partner violence"*) AND (*health visitor OR specialist community public health nurs* OR child health nurs* OR public health nurs* OR child and family nurs*) AND (*women OR mothers*). Following this title and abstract review took place as well as previous searches considered, and reviewing references lists; From this search there was one study that examined perspectives of both health visitors and women in the experience of DA (Eynon et al. 2012). It became clear that

there was an identified gap for further exploration of both perspectives. The second stage of the literature search broadened to capture work that focused on one or the other of the perspectives, as well as areas within wider safeguarding systems. This narrative review, unlike the primary scope, did not strictly adhere to limits of inclusion, rather as Cronin et al (2008) considers, the primary purpose is to provide a comprehensive background, and to make sense of literature (Byrne, 2016).

While these search terms and inclusion criteria were intentionally defined to ensure coverage of the most directly relevant literature, the adoption of a narrative review approach meant that this initial search strategy was treated as a foundation rather than a strict boundary. Focus of inclusion remained on experience and role (Cronin et al. 2008), and therefore some older empirical studies that provided useful historical perspective but were no longer reflective of current policy or practice were excluded. The narrative review's flexibility allowed for the incorporation of diverse and contextually relevant sources identified outside of the predefined search parameters—such as seminal feminist theoretical works, key policy documents, and grey literature—where these contributed meaningfully to the conceptual and empirical framing of the topic. This ensured methodological rigour in the early identification of core literature, while also retaining the breadth and adaptability that are central to narrative synthesis (Cronin et al. 2008. Green et al. 2006). In this way, the search strategy provided structure without constraining the interpretive scope necessary for exploring the complexity and intersectionality of DA in health visiting practice.

It is here that the scrutiny of evidence begins.

The literature continues to reflect debate and controversy, especially when examining experiential data on violence perpetration and the multifaceted intersections explored within feminist frameworks. I do not dispute that both men and women perpetrate abuse, and both can also become victim-survivor of such crime. However, for the purpose of this study, and as the statistics demonstrate, DA, like most violent crime, is an overwhelmingly male perpetrated phenomenon, with women more likely to experience it as a victim-survivor. Rather than exploring; *is it women?* It will move in the direction of *why is it women?* From a woman's gaze. Evidence will be drawn upon as concepts are explained. However, a deeper quest into the contextual actualities of the phenomenon are signposted for the reader to explore as part of their own interest. This study will examine DA through the perspectives of both a health visitor and a woman. This does not discount the men who work tirelessly to support individuals. However, within the professional sphere of health visiting, as with those who are more likely to be a victim of DA, both are overwhelmingly women.

Beginning with conceptual models of DA through feminist and ecological lens, the literature review will delve into the interrogation of literature pertaining to mothering and health visiting practice within the context of DA. Once the exploration of the current literature field is completed, the positioning of this study will be apparent in its illumination of the phenomenon of DA within health visiting practice, as well as the impact a lack of supportive measures can have on professionals, families and children.

2.2 Theoretical feminist conceptions of DA

2.2.1 Phenomenon

Feminist perspectives of DA recognised the issue not as an individual or family one, but as a societal problem (Weaver, 2001). Seminal theorists Dobash and Dobash (1979) described the division of two key roles within a heterosexual relationship in which there was abuse; female-victim and male-perpetrator. These roles were legitimised by the socially accepted oppression of women by the patriarchy. Fundamentally DA is a gender issue and can only be understood when gender is the central factor within the analysis (DeKeseredy and Dragiewicz, 2007, Anderson, 1997, Johnson, 2006). Feminist theorists conclude that men are expected, trained and encouraged to dominate women, and women in turn remain submissive (David and Brannon, 1976). Many academics argue that the very nature of abuse within an intimate relationship lies within the sphere of violence against women, and patriarchal issues within society (Winstok, 2013).

Within the family paradigm, DA needs to be examined and understood in terms of why some family members translate conflict and anger into abuse to resolve such feelings (Lawson, 2012). Burkitt (2008) drew association between changing social roles and gender roles, with such expectations on these roles developing within the family paradigm; for example, the role of the care giver being typically female, and the worker typically male. Lawson (2012) argued that violence continued to be associated with masculinity, and as the role of men became more 'female' it was inevitable that frustrations could erupt in such a way. Collins (2015) assumes that gender has profound differences in the way men and women think, particularly how

women's everyday has become alienated and objectified by the experiences of men. However, Brown and Stone (2016) argue this is but a result of the gender stereotype blueprint placed on us all from the moment we are born. Thus, the subtle influence from birth affects the way we think and act (Schmitt, Branscombe and Kappen, 2003). Interestingly Pratto *et al.* (2000) found that men were more favourable to equality than women, regardless of the context. The patriarchy inevitably, does harm to both women *and* men (George and Stith, 2014).

2.2.2 Intersectionality

Changing perceptions of relationships, acceptability of unmarried co-habiting, and recognition of LGBTQ+ people, have altered the previous homogenous study of male/female relationships. Intersectionality harnesses the prism of understanding that DA cannot be explained solely through a gendered lens. Razaghi *et al* (2022) argue that violence perpetrated by a person(s) to another within an intimate relationship is rooted within the cultural context in which individuals live. This claim supported preceding evidence suggesting that cultural practice, gender roles, and social norms, normalise violence against women due to patriarchal ideas (Marshall and Furr, 2010). Mills (2003) was critical of the simplistic concept that DA is the result of patriarchy. First and foremost, they acknowledged that DA was not exclusive to heterosexual relationships (Mills, 2003), and furthermore, DA within LGBT relationships cannot be simply categorised as 'same-sex' DA due to the nuances and spectrum of gender and identity (Donovan and Barnes, 2019). If such a concept is utilised (heterosexual and/or homosexual), then the appropriateness of state intervention is warranted in each case; In recognising the woman as human and embracing empowerment as a tool - state intervention cannot be applied universally and at the same timely intervals (Russell *et al.* 2022). However, as DeKeresedy (2011) concludes, and as

this theoretical positioning supports, acknowledging that women can also be violent and abusive does not discount the patriarchy or oppression of women. Recognising that not all victims are women, does not mean the phenomenon of DA is not a violence against women social issue.

Nationally, Caucasian women were more likely to experience and report DA (ONS, 2021). Nevertheless, such statistics cannot be taken at face value when considering non-reporting rates, and issues relating to cultural norms and institutional racism within the criminal justice system. Moreover, intersectionality provides an understanding that women exist within many guises, shaped by culture and race (Crenshaw, 1989. DeFelice and Diller, 2019). Walter-Brice *et al.* (2012) study noted the internalisation of DA experience due to the individual's own expectation of what a relationship should be, or the systems that failed them. Their gender and (for this study) disability placed them in a double jeopardy position (Walter-Brice *et al.* 2012). Intersecting experiences are unrecognised or misunderstood, yet imposing systems dominate within life (Clements, Clare and Ezelle, 1995). Consistent with the work of Crenshaw (1989, 1991), this study emphasises that discrimination experienced by women must be critically examined to ensure it does not obscure or diminish the broader spectrum of gender-based experiences. This is particularly relevant to universal health visiting practice, which, while often centred around parenthood, must not be limited by or isolated from other intersecting social categories. The principle of intersectional gender-power analysis was identified as core to intervention-based programmes in tackling violence against women (Michau *et al.* 2014). If we are going to tackle this, we must acknowledge and discern every part of women's lives. The polarisation of our politics, ideologies and society is placing *us* all within a box. The opposite of

polarisation is the recognition that we all share similar experiences and stories. Recognising the intersection of gender, families, and violence results in the propriety of women, additionally, adding mothering into the sphere embeds the idealised notion of nurture and love across most cultures (McKie, 2005). The interactions of the socioeconomic, cultural and class identity of women are significant, particularly in relation to DA (Skafida, Morrison and Devaney, 2022). Understanding how different dimensions of disadvantage overlap and interlock, highlights the significance of not being one OR the other, but that women can so often be many (Crenshaw, 1989). Furthermore, experiencing the intersecting layers of oppression in being a woman, being income poor, being young, culturally 'othered' and misunderstood, compounds disadvantage and increases the risk of exposure to DA (Skafida, Morrison and Devaney, 2022).

2.2.3 Theory into practice

Winstok (2013) asks us, is the context of DA essential? Well, yes if we are considering violence to be related to sexism, but no if we are purely examining it from a theory of violence. It would appear both arguments, either those posed by feminists, or those presented by violence theorists (see Dutton, 2006. Murray, 2006. George and Stith, 2014, Johnson, 2006. Straus, 2015) are dealing in different realities. Myhill and Hohl (2016) concluded that evidence of situational violence was prevalent within both sex perpetration, however coercion and control were highly gendered, being unilateral attempts to deconstruct identity within the gender dynamic (Myhill and Hohl, 2016. Stark, 2007). Stark (2007) argues that coercion and control are gendered in construction, delivery, and consequences. Be that as it may, the societal attitudes of general submission expected of women regarding their domesticity, mothering, sexualisation and place in community, compounds the gendered enactment of DA (Stark, 2009). This thesis does not

claim it is *all men*, however, evidence suggests a highly gendered analysis of DA within all areas, and therefore within perpetration it is highly likely to *be men*.

2.3 Feminist frameworks of DA

Frameworks have implications upon practice as they guide the wider conversation surrounding intervening systems. There are many practice frameworks and intervention theories that are underpinned by feminist concepts; they will now be briefly discussed.

2.3.1 Cycle of Violence

Proposed by Walker (1979), they aimed to explain why and how women stayed in abusive relationships. Acknowledged as often predictable (Ali and Naylor, 2013), the cycle considered the abuser's emotional frustration that builds resulting in an 'explosion' or act of violence, then to be quickly followed by a period of 'honeymoon' (Walker, 1979). This period was not defined by time, as tension could quickly build again, or an abusive-free period that could be maintained for longer, sometimes including pleas for forgiveness and acknowledgement by the abuser. Ali and Naylor (2013) criticised this theory as being simplistic in recognising an act of violence being the result of building tension or frustration. If this were the case, then other areas of the abuser's life would be affected, including friendships and employment.

Furthermore, with nuanced consideration of experience, pattern of abuse, and the recognition of coercion and control (Stark, 2007), this framework appears objective in nature looking at one-off events or incidents. Similar staged thinking has been used more recently to underpin violence. Monckton-Smith (2020) argues to remove victim blame we must ensure behavioural change is held by men, not women. Progressive work examining the events and behaviours

preceding intimate partner homicide (IPH) noted that the majority of cases occurred in heterosexual relationships and 82% of the victims were women (United Nations Office of Drugs and Crime, 2018). A stage-model (figure 2.4) explained perpetrator behaviours, that *can* result in murder (Monckton-Smith, 2020). Such markers can prove useful in practice, with room for context; however much of the picture preceding IPH, as well as DA is hidden and therefore the ‘former’ events are only known and discovered following incident or disclosure.

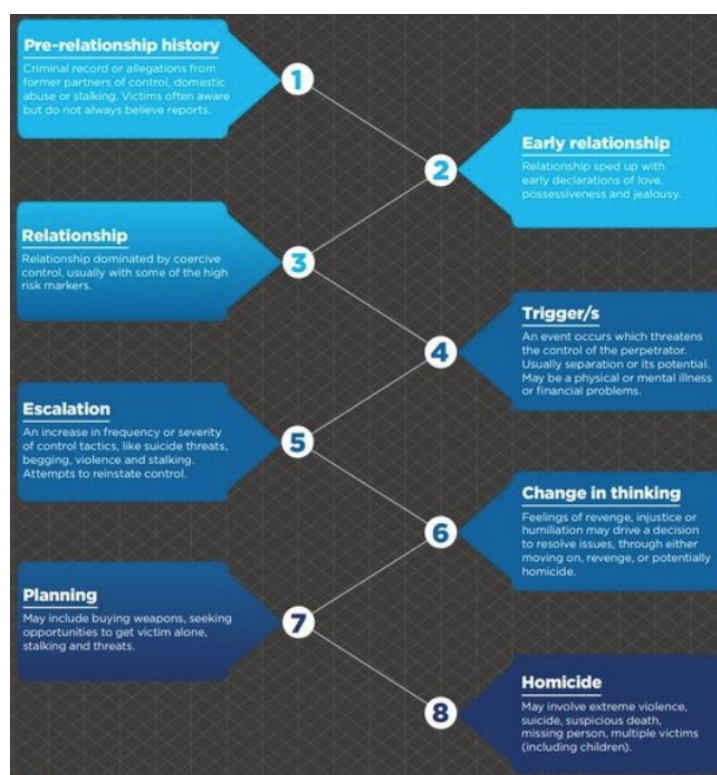


Figure 2.1. Homicide timeline

(Monckton-Smith, 2020).

An eight-stage model outlining the typical escalation of coercive control and risk factors leading to intimate partner homicide, used as a tool for recognising patterns of abuse.

2.3.2 Learned Helplessness

This concept was first explored during the 1960's by Seligman and colleagues and detailed the psychological impact continued experiences of abuse had on the woman's ability to perceive stress and success. This concept supported Walker's development of the cycle of violence in acknowledging that if women did not believe they could leave, violence itself was the cycle to

be broken (Walker, 1979). However, this state of helplessness, based on Seligman and Maier (1967) laboratory experiments of exposing controlled groups of dogs to repeated electric shocks, fails to recognise the pattern of behaviour, as well as considering the social reasons for a woman not leaving including parental alienation, economic instability, societal and community pressures (Naved *et al.* 2006. Ali and Naylor, 2013).

2.3.3 Battered women syndrome

As previously coined by feminist scholars in the 1970's, Walker (1979) postulated that women remained in a cycle of violence and perceived that, due to similar effects of post traumatic distress, they simply could not leave. The concept was used in early 21st century policy reform when considering the psychological state of women that retaliate and become violent themselves (Ali and Naylor, 2013). This has been recently documented in high profile cases of women experiencing long periods of DA resulting in the manslaughter/murder of the male perpetrator.

2.3.4 Power and control

Violence is used to control (Dobash and Dobash, 1979), and as Ali and Naylor (2013) noted, power imbalance equates to relationship imbalance. The Duluth model (1982) has been adapted and supported within practice over subsequent years. Specifically, the '*Wheel of Power and Control*' (figure 5) identifies gender-based violence as a primary concern within DA and captures the constellation of abuses experienced by women (Gondolf, 2007). However, it has been argued by family violence theorists that such a model is an example of the "*practices endemic to the gender paradigm*" (Dutton and Corvo, 2007 pg 658). Is the selective avoidance

of female violence by practitioners a barrier to disclosure for women? Routine enquiry is universal and undertaken without bias. So, in doing so health visitors and practitioners alike must open themselves up to the consideration of any abusive dynamic. Considering the relationship held within conversation, when the ontological perspective is narrowed, so does the enquiry and therefore disclosure (Dutton and Corvo, 2007).



Figure 2.2. Duluth (1982) *The Wheel of Power and Control*

A visual model depicting the forms of coercive and controlling behaviours used by perpetrators to establish and maintain power within abusive relationships.

The ideological awareness of the dominance of men is widely acknowledged and underpins much seminal feminist thinking. Concepts of power and control men hold within the private and public spheres (Dobash and Dobash, 1979. Winstok, 2013) renders the use of such in the domestic home as both acceptable and beneficial.

2.4 Social and ecological perspectives of DA

The three underpinning principles of health visiting are; valuing and caring for individuals on their own terms, acknowledging the intersecting factors that impact people's lives, and creating healthy environments (Cowley *et al.* 2013. Fanner, Whittaker and Cowley, 2022.) Health visiting practice navigates within socio-ecological perspectives, and therefore it is important to acknowledge such relating to DA. Previous research has demonstrated the use of ecological sensitivity and feminism within frameworks of DA (Pio and Moore, 2022), as well as understanding attitudes within various cultural contexts of DA (Ahmed, 2004. Ali *et al.* 2011. Anitha, 2010. Emery, Jordan and Chui, 2019. Gill, 2004). The diversity of populations cannot be overlooked, and ensuring cultural sensitivity is applied to individuals is essential to capture the essence of intersectional feminism (Crenshaw, 1989. Collins, 1990. and Yuval-Davis, 2006). The context of this study is within families, and the very reason for health visitors' presence is that more than one generation is involved.

2.4.1 Social need

Meyer (2022) acknowledged the complexity of addressing social needs, as well as the belief from some health professionals that Westernised healthcare should not be responsible for dealing with the social drivers to inequality. Adapting a life-course theoretical approach to healthcare systems accepts that people are intertwined with others, both past and future generations (World Health Organization, 2020); the health and well-being of one depends on the interactions with another. Acting early to prevent and impact social inequalities can improve the health of people(s) (World Health Organization, 2015). Life course theory perspective, as postulated by its pioneer, Glen Elder Jr (1998) notes that people, during historic

moments, create new pathways of culture and meaning, or seemingly by individuals who move through life transitions, including that of parenthood (Salinas-Miranda *et al.* 2017). As Purkey *et al.* (2022) explains; categorising a life course theory considers timing, trajectory and/or impactful event.

Health visiting principles recognise such concepts through the searching for health needs, and facilitating health enhancing environments (Cowley and Frost, 2006). An example of the application of such perspective within practice is the use of motivational interviewing. The use of this technique has been applied by health visitors as an effective tool to explore behaviour change, as well as subsequently exploring the difficulties that may arise for that individual to overcome (Hirdle and Vaughan, 2016. The Health Foundation Inspiring Improvement, 2011). Pertinent to health visiting practice, it is based on the principle of reciprocity (Hirdle and Vaughan, 2016), considered essential to relationship building within practice when promoting healthy lifestyles (Fanner *et al.* 2022). The use of motivational interviewing has been proposed for victim-survivors of IPV/DA (Anonymous, 2010), specifically noting that motivation for change is harnessed within the context of the relationship (Rollnick, 2008).

2.4.2 Social learning theory

Social learning theory has been used to explore issues relating to intergenerational DA (Copp *et al.* 2019). Studies have concluded that one of the strongest predictive factors of experiencing DA within a person's own adult relationship, is their exposure to such as a child (Fehringer and Hindin, 2009. SaferLives, 2017. Temple *et al.* 2013). Arkers (1998) note that the probability of engaging in criminal behaviour increases "*associated and.... relatively more exposed in-person*

or symbolically to salient criminal/deviant models...” (p50). Arkers (1998) as postulated by Cochran *et al.* (2017) expands that social learning theory is dependent on concepts including definitions, associations, reinforcements and imitation. All concepts are within a person’s own evaluative judgement but scaffolded by the normative behaviours and dimensions of in-person exposure (Cochran *et al.* 2017). Two efforts to examine couple violence; *Intergenerational transmission theory* (Straus *et al.* 1980) and *male peer support theory* (DeKeseredy and Schwartz, 1993); The former suggests that experiencing violence as a child may result in violence or victimisation as an adult. The latter explains violence through the stress perpetuated by societal patriarchy developing alongside relationships where men seek support from male social groups (gangs, sports) that legitimise patriarchal ideas of women. Both are limited in theory and evidence, basing concepts on heterosexual relationships only, and undermining societal attitudes (Sellers, Cochran and Winfree, 2017). Furthermore, both cannot account for the fact that perpetration of violence is not undertaken by all men, nor is it experienced in adulthood by all children witnessing such.

2.4.3 Ecological consideration

Fulu and Miedema (2015) argued that globalisation is highly gendered and not all the benefits of movement are mutually received. Globalising an integrated model focusing on violence against women is important to harness the understanding of continued movement of people (Fulu and Miedema, 2015). Aboagye *et al.* (2021) examined intimate personal violence in correlation to wider social conflict. They noted that when there is social unrest, conflict or political uncertainty, social-protection systems deteriorate. The patriarchal make-up within Westernised society in which predominately white, privileged men are the law makers within

the land, produces an undercurrent of values and expectations that continue to satisfy and reinforce their status (Ozaki and Otis, 2017). Studies (Nanny, 2017. McCloskey *et al*, 2016.) have highlighted the social norms, and acceptability of violence and abuse within a relationship, perpetrated by the man. These two studies took place in the global south, where it could be argued, hegemonic masculinity is common, with families reflecting patriarchal ideology (Nanny, 2017). Such patriarchal views were upheld by all family members, male and female, when questioned. It was noted that urbanisation and increasing educational attainment had a direct impact on IPV, with both partners less likely to uphold overarching acceptable views of partner violence (McCloskey *et al*. 2016). Furthermore, in communities where relationship breakdown and divorce held less stigma, IPV was lower (Fulu and Miedema, 2015). However, such male dominant societies as used in these samples were noted to have little impact on the rates of female violence (Straus, 2004).

2.5 Women's lives and DA

Heise (1998) proposed that one could not discount the evidence of DA being a gendered issue, whilst also acknowledging gender-symmetry perpetration and situational violence, and therefore postulated an ecological framework (see figure 3) for contextualising the etiology of gender-based violence. An ecological model as proposed by Sacannapieco and Connell-Carrick (2005) positioned the mother experiencing DA as a victim-survivor within the wider context. Stewart (2021) supported the ideologies existing within the macrosystem of gender norm formation, discrimination, and family role expectation, as having an influence over mothers. Mothering is a social construct that blankets women to ensure that the welfare of their children is placed before their own, thus rendering them unseen (Stewart, 2021. Buchanan *et al*. 2015).

Straus (2004) concluded that male dominant societies are violent in general, being both male and female perpetrated. Bi-directional violence between the sexes was evident, and gender symmetry in the perpetration of partner violence is well documented (Straus, 2004).

Furthermore, if feminist emphasis dominates the discourse without consideration of other social or individual factors, how can one explain why some men abuse women while others do not? (Heise, 1998).

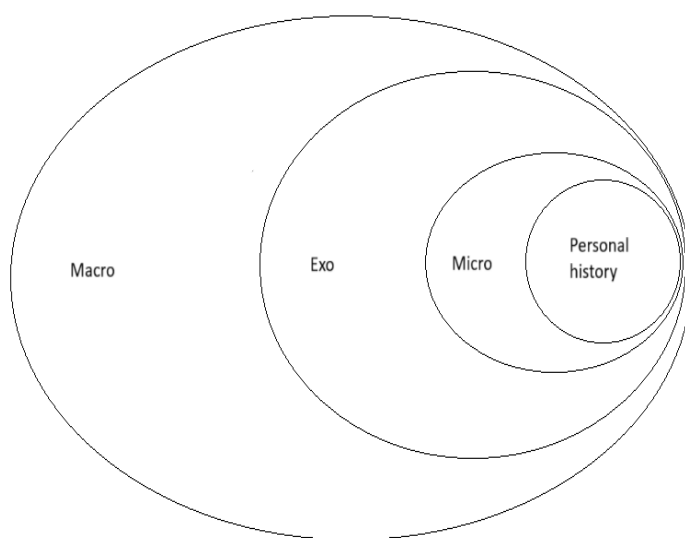


Figure 2.3 Heise (1998) Adaptation of Belsky (1980) model. An ecological framework illustrating how individual, relational, community, and societal factors interact to influence violence against women.

Personal history

- Witnessing violence as a child
- Being abused as a child
- Absent or rejecting father

Microsystem

- Male dominance in the family
- Male control of wealth in the family
- Use of alcohol
- Martial/verbal conflict

Exosystem

- Low socioeconomic status and/or unemployment
- Isolation of women and family
- Delinquent peer associations

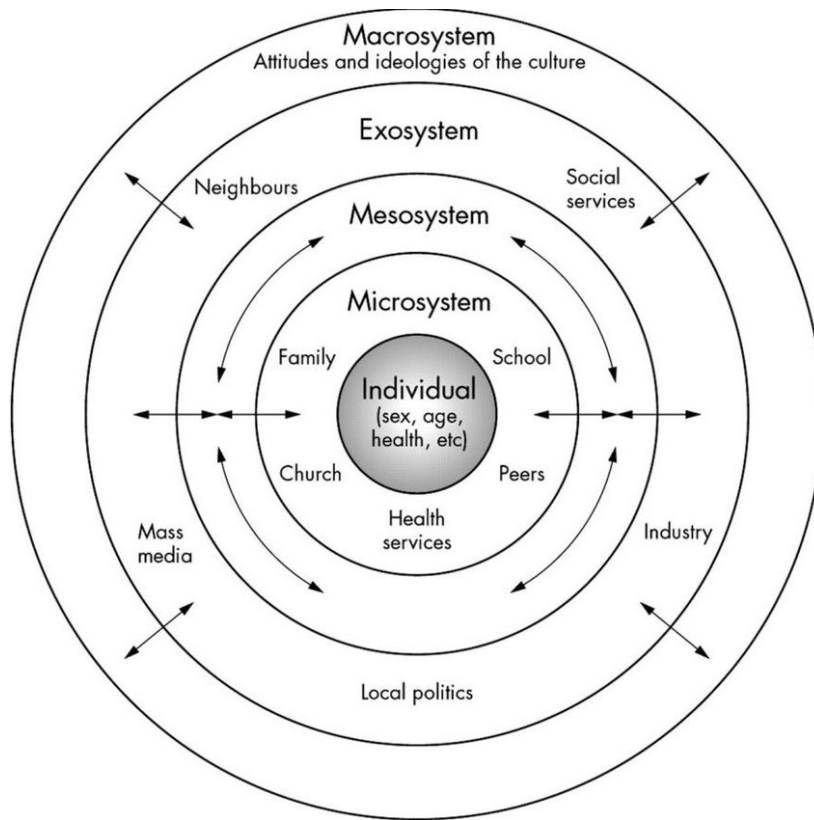
Macrosystem

- Male entitlement and/or ownership of women
- Masculinity linked to aggression and dominance
- Rigid gender roles
- Acceptance of interpersonal violence
- Acceptance of physical chastisement

Heise (1998) noted the criticism of such a multi-systems model being simplistic but emphasised the use of this framework as a heuristic tool for organising the existing research base. Kennedy and Kirman's (2023) review of the literature pertaining to abused mothers encapsulated the opinion of '*failure to protect*' regarding safeguarding their children. They further analysed the work undertaken by Sacannapiecp and Carrick (2005) in which they focused on child maltreatment. Utilising an ecological model like that proposed by Heise (1998) and supported by Maher *et al.* (2021) and Damant *et al.* (2008) work, all acknowledged the power dynamic situated at the macrosystem of professional intervention, in which responsibility and failure were common responses to women in domestic abusive relationships. Damant and colleagues (2008) went further to discuss the oppression experienced by women on many levels by the patriarchal systems governing politics, healthcare, and social care. Within such a construct women could not break free from the control and expectation placed upon them (Buchanan, 2015). These feminist researchers noted the application of perspective to human ecology, not discounting either, but overlapping both to highlight the multiple layers of oppression experienced through the life course.

Figure 2.4.

Bronfenbrenner (1979).
Urie Bronfenbrenner's seminal work postulating an ecological systems theory (1979) puts forward the explanation of the influence of the social environment on individuals.



The overarching acknowledgement of culture on all systems is recognised in many feminist theories (Crenshaw, 1989. Hill Collins, 1990). Examining women within their socio-ecological framework enables one to conceptualise and understand the diversities and intersections at play (Hasselle *et al.* 2020). This study (Hasselle *et al.* 2020) recognises the multidimensional theoretical framework of the social and ecological understanding of an individual.

Bronfenbrenner (1979) postulated that the environment was nestled within external structures, *“like a set of Russian dolls”* (p.2). Furthermore, such a framework captures multiple layers of influence including the intrapersonal, interpersonal, and external (Sallis, Owen and Fisher. 2008). This model has been adopted by many public health initiatives (Yakubovich, *et al.* 2018), including its application of VAWG (World Health Organization, 2008). Utilising a socio-ecological

model captures the many intersecting influences on women. Particularly the mesosystems that exist between the microsystem of the individual and the exosystem of the external demonstrating the power and influence of individuals, organisations and political structures relating to patriarchy and oppression.

2.6 Perspectives of mothers experiencing DA

Studies suggest that mothers are more vulnerable to DA due to economic dependence, social isolation, and compounded responsibility for the child (Holt, 2015). Barriers to seeking help have been widely explored in terms of fear of reprisal (Thiara & Harrison, 2016), stigma and shame (Överlien & Aas, 2016), lack of economic dependence (Yakubovich et al. 2018), and concern relating to statutory involvement with children (Lapierre, 2010). Unpicking such barriers requires a deeper understanding of the arguments surrounding each compounding factor.

2.6.1 Impact

The direct negative impact of DA on the pregnant woman and foetus has been well evidenced; the increased risk of premature labour, poor neonatal health outcomes including congenital anomalies, and low birth weight (Kady *et al.* 2005. Kaye *et al.* 2006. Martin-de-las-Heras *et al.* 2019). Increased cortisol production due to stresses experienced in pregnancy can have further detrimental physiological effects on both mother and unborn (Hansen, Lou and Olsen. 2000. Nimby *et al.* 1999. Zhang *et al.* 2013). Furthermore, the documented correlation between poor mental health, dependency on alcohol and drugs, as well as detrimental impact to relationships can further increase the risk of comorbidity and psychological disorders (Ogden et al. 2022.

Mehr et al. 2023). Extensive work exists examining the immediate and lasting impact of DA on women and children, physiologically, socially, and within their internalised sense of self (Orr et al. 2022. Maxwell et al. 2018. Martin-de-las-Heras et al. 2019).

2.6.2 Coercion and control

Coercive control is the ‘golden thread’ weaved through DA (Myhill and Hohl, 2016), in nearly 85% of DA incidents reported to the police in the year ending March 2024, non-physical behaviour was present (ONS, 2025). However, DA is often portrayed within the media as being violent and extreme, rather than the often subtle and psychological. Such portrayal dehumanises perpetrators as monsters and evil, in doing this the blame of the abuse is then moved from the perpetrator to the victim (Rollero, 2019). The ‘othering’ of perpetrators makes them appear an anomaly, or someone with easily recognisable evil traits, and so if we can all see it, why can’t the victim? They can. It is not an inability to recognise the everyday, but the constant and ever-changing risk ‘vs’ harm assessment each undertakes. Evidence suggests a person increases risk of serious harm and/or death after they have left abusive partner (Monckton-Smith, Williams and Mullane, 2014). Furthermore, reports of homicide indicate that coercive and controlling behaviours are more prevalent in the time running up to the fatal event, rather than violent acts (Monckton Smith, Williams and Mullane, 2014. Dobash and Dobash, 2015).

Coercion and controlling behaviour (CCB) were introduced into Section 76 of the Serious Crime Act 2015. CCB is recognised as a crime and thus perpetrators can be charged and prosecuted against (Home Office, 2022). However, CCB is examined over a period, considering evidence,

personal narrative, and patterns of events. Conflictingly, crimes brought under the Domestic Abuse Act (2021) are often viewed within the single event in which they occurred (ie. A violent assault). The void between the experience of DA and the objectivity of the criminal justice system is apparent. The typical pattern of violence becomes invisible by segregating out single acts of violence. This fails to recognise the whole reality for those that experience it (Stark, 2013). Moreover, within a family paradigm the acceptability of the courts to allow access between the abusive parent and child(ren) highlights the disparity of thought between leaving and staying through an intentionally 'legal' form of contact and control. In addition, *incidents*, or *discrete events*, of DA were noted, and repeated as many as 13 times per document in Russell and colleagues (2022) analysis of local authority child safeguarding legislation. This is a clear example of the mischaracterisation of DA in failing to name it as patterns of experience (Russell *et al.* 2022). If we cannot agree where the lines are drawn between abusive behaviour and the agency that person holds over other aspects of their life, then how can we expect the decision between staying and leaving to be so easily carried out for the individual?

2.6.3 A professional view

Astbury, Shephaerd and Cheyne (2017) noted that 'complexity of family life' could get in the way of clarity. I wonder about the term's 'complexity' or 'complicated' or 'multiplicity'. Are these terms, so often used within healthcare provision and social care, problematic? Hood (2018) described complex situations as being those that bring about unexpected behaviours or reactions that are difficult to place within the context, he goes on to consider that unexpectedness is experienced within the interactions and dynamic of the relationship (in this case with social care professionals). The focus lies within the relationship dynamic between

service users and professionals; the connected and supportive nature of the relationship is dependent on this dynamic (Brown, 2021). When one considers the importance of empowerment and acknowledgement when working with victim-survivors of DA, to unbalance the power by attributing a term such as 'complex' more often provided by the professional, is to create barriers in the primary endeavour. So often encountered within working relationships are the perceived and actual inputs and outputs, such are described within systems theory (*Bowens Family Systems Theory* see Keller and Noone, 2019). Peckover and Golding (2017) attributed this term with the input from different professionals with differing agendas and understanding of the issue. As so often seen within families experiencing DA, there are often other factors at play; for example, parental mental health factors, substance misuse, which in turn create many focuses for attention (Peckover and Golding, 2017). It is these multiple layers of focus and agenda that create complexity (Peckover and Golding, 2017. Stanley and Humphries, 2014). So, in fact, do the complexities arise from the professionals rather than the families themselves? Is multiagency working complex? Could it be that families have a multiplicity of needs, and we create complexity through analysis and solution? Moreover, as Clancy (2024) concludes, nurses assume complexity, but do not take a reductionist stance of siloing. Within health visiting, the therapeutic intervention derives from the practitioner – service user encounter, yet confusion arises when complexity is defined by the intervention and thus leads to a presumptive prescribed response (Clancy, 2024). When taking the stance of indeterminacy, applying the term complexity renders any intention foretold. Here in lies the tension between professional intuition and systems, and it is the art of health visiting that navigates across the silos, rather than creating them.

The term *empowerment* is utilised across many different disciplines and therefore the meaning can become changeable (Bond-Taylor, 2014). Considering the theoretical underpinnings of power and thus empowerment firstly questions whether it is finite; something given/deliverable and then taken/received (Bond-Taylor, 2014). The debate surrounding the influence of the self (Kuokkanen and Leino-Kilpi, 2000. Thompson, 2007), available resources (Bartle *et al.* 2002. Lister, 2004. Knol and van Linge, 2009), and culture (Bradbury-Jones *et al.* 2008. Foucault, 1980) relating to empowerment can be viewed through different critical sociological and psychological theories. Bond-Taylor (2014) appears to concede that the line between empowerment and responsibilisation becomes blurred when considering strategies undertaken within communities with complex families. As Featherstone, Morris and White (2014) reflect that little is known about families with complexities or facing adversity, and thus 'caricatures' are created to fit the narrative of policymakers and interventionists.

Russell and colleagues (2022) in their analysis of current safeguarding policy noted that in only 10% of UK local authority documents examined, the term racism was included when discussing contributing factor and/or impact. Starker was the absence of the terms sexism, patriarchy, ageism, homophobia, transphobia in all the 59 policies analysed. Is this a clear example of uninformed or improper evidenced policy in practice, when the theory base globally is clear, and all distinctive systems feed into the pervasive nature of DA? Moreover, by failing to acknowledge the broader social and cultural systems that shape the ecological model we all inhabit, an 'incident' or 'event' appears to arise in isolation. This lack of recognition for upstream public health and sociological factors renders the phenomenon seemingly unpreventable.

2.6.4 Mothering and blame

Research exploring *blame*, and the attribution of such by organisations and professionals working with families experiencing DA, specifically focusing on *mothering* is not new (Douglas and Walsh, 2010. Goodmark, 2010. Arnall and Stewart, 2021. McKie, 2005). Evidence suggests a compounding sense of self-blame felt by mothers who have been victims of DA (Crawford *et al.* 2009).

When considering the ontology of systems working within child protection, they appear to have differing perspectives. The criminal justice system within most of the Westernised world comes from a perspective that an individual is responsible and accountable for their actions (Arnall and Stewart, 2021). Furthermore, parental responsibility is defined within section 3(1) of the Children Act (1989) as being,

“All rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property.”

Being the only legal definition of parental responsibility, legal cases relating to family court proceedings have detailed how such is used within a safeguarding perspective. The parent/guardian’s responsibility is to secure the welfare of their child without the need for court to redefine or restrict (Black, Cleary and Prest, 2023). The acknowledgement of children as victims if they are connected to, or bear witness to, DA (HM Government, 2021) has reinforced the requirement of protection from parents and/or statutory services. Within child protection services the ontological perspective is centred around the safety of the child (Arnall and Stewart, 2021). Protecting the child from abuse and the trauma resulting from such

requires those with parental responsibility to demonstrate their ability to safeguard the child. Research (Humphreys and Absler, 2011. Lapierre, 2008. Douglas and Walsh, 2010. Arnall and Stewart, 2021. Archer-Kuhn and DeVilliers, 2019) across Europe, North America, and Australia, suggests that responsibility to safeguard children from risk is overwhelmingly placed on the mother, regardless of the abuse the mother herself may have had, or continue to experience (Ferguson *et al.* 2020). Yet the de-gendering nature of policy fails to account for the attitudes held (Hearn and McKie, 2010). Lapierre (2008) recognised this move away from centralising gender and power in policy and study within family violence. Furthermore, de-gendering policy asserts that men and women (in this instance, heterosexual relationships) hold equal amounts of power. For McKie (2005), implying such equitability is problematic as it fails to recognise inequality within employment, domestic labour, care, leisure time and income. McCarry's (2009) research captured the contradictions young people held regarding gender equality within relationships, and as such how these exacerbated acts of violence within relationships. Fundamentally, failing to address ideologies surrounding gender equality creates an ambivalence of acceptance and justification. Additionally, inequality within the power dynamic of the couple is then not matched by the over-arching responsibility the woman has on the safety of children, particularly relating to welfare and development. This often involved a notion of *middle-class optimal parenting*, as discussed by Gillies (2007), explored the presumptions often placed on families regarding finance, social support, and wider marginalisation. For Bunting, Webb and Shannon (2015), implied assumptions within social policy and practice needed to be explicitly extrapolated, respecting the differing mothering practices through open

discussion, paved the way to sustainable understanding. Shame is internalised when we imagine how others see us (Wilkinson and Pickett, 2009).

The discourse encompassing mothering positions children at the centre of women's world and promotes selflessness that simply does not apply to the discourse surrounding fathering (Douglas and Walsh, 2010). Furthermore, the woman being responsible for the DA, additionally and specifically relating to safeguarding the child(ren), results in a persistence on the focus of mothering in child protection (Featherstone and Peckover, 2007. Hester, 2011). Buchanan and colleagues (2015) note that mother blame was a recognisable construct for adults who had experienced and lived with DA as children. Blame, shame and guilt are all too common emotions experienced by mothers, but not father's (Lapierre, 2010. Stewart, 2020), not exclusive to, but generally, the female within the parenting dynamic comes off worse (Winstok, 2013). A feminist perspective explains this through patriarchy, oppression, and expectation (Dobash and Dobash, 1979. Winstok, 2013. DeKeseredy, 2010). This focus perpetuates an interventional construct that centre's the victim-survivor (CQC *et al.* 2017), negating the attention to the abusing parent (Strega *et al.* 2008). There is growing scrutiny on fathers who perpetrate abuse, and their capacity to parent, and how such abuse continues within child-contact arrangement (Heward-Belle *et al.* 2019. Hester and Westmarland, 2006). The societal and cultural implications of responsibility on women begin before childbirth. Antenatal care within the first core contact from the health visiting service, as stipulated by the Department of Health (2013) and Every Child Matters document (Department of Education, 2009) details the importance of conversations that impact the mother and unborn. Wild (2023) in their study exploring the experiences of mothers victimised through DA, noted the awareness of

preconceived expectations placed on them as women with children, conditioned with a sense of nurture and care. Crucially, Wild (2023) reports the cycle of self-blame that exists within internalised conversations, reinforced by the implied focus that women should be protecting their children from the person who is abusing them. Many of the women within Wild (2023) study were encouraged by social care, if not mandated, that they should attend courses, programmes and interventions that explore the impact of DA (Russell *et al.* 2022).

Goffman, in the 1960's, postulated stigma as a social construction; much of sociologist's ideas of stigma, both conceptualised and experienced, have been built on this perspective (Kleinman and Hall-Clifford, 2009). Recent thought has built upon Goffman's works on stigma but now recognises the multiple layers of discrimination faced by groups. Tyler (2018) discusses how this reconceptualisation within the critical dialogue of oppression dehumanises whole groups through stigma and stereotype. Aranda *et al.* (2023) recent review of the literature noted three groups, the *stigmatiser* (the 'normal'), the *supporter* (the wise), and the *stigmatised* (the target). They concluded a prominent consideration was the relational perspective within stigma, they focused on the 'audience', neither the *stigmatiser* or *stigmatised*, and it was these relationships that could influence re-stigmatisation or acceptance (Aranda *et al.* 2023). If stigma is nestled within the nexus of social interaction, then the stigma itself is assigned by those with power (the normal, the wise and the audience) (Kvåle and Murdoc, 2022). Consensus within the literature is that stigma is subjective, and context driven by those that apply and support (Aranda *et al.* 2023); however, Devers *et al.* (2009) concluded that these attitudes in themselves objectified sanctions on individuals that influence economics, employment, healthcare and education. An interaction between two people may seem isolated, but its impact often extends

outward—like ripples in a pond—affecting those who witness it and potentially fostering oppression and feelings of shame.

Azzopardi, Alaggia and Fallon (2018) noted motherhood to be both glorified and condemned simultaneously, and regardless of feminist scholarly achievements and activism, mother-blame existed within the professional context of responsibility regarding child safeguarding (Azzopardi, 2015). If mothers are the ‘life-givers’ and primary caregivers, when children come to harm, witness patterns of abuse, or experience adverse events, the finger is overwhelmingly pointed at the mother, in failing (Azzopardi *et al.* 2018). The unreasonable and unachievable social expectations of being a *good* mother does not consider the cultural variations of mothering (Bunting, Webb and Shannon, 2015). Moreover, the insidious strategies undertaken by perpetrators will often deliberately disrupt or play on the notion of ‘good mothering’ (Azzopardi *et al.* 2018). If we consider the layered exertion of power and control encapsulating women’s lives within the macrosystem, to then consider the mother to have failed, or have responsibility over the actions of perpetrators seems to concede that women somehow have some control over their situation (Henry, 2020).

Rowland (1997) explored the gendered nature of power in relation to family, power to *do* and power *within*, enrich experience. To empower families and children should begin with centralising women; understanding how they may use their power, and what the demands on women with power have (Bond-Taylor, 2015). As detailed above, it can be difficult to differentiate and separate the mother and child, whether this is desired on an individual, professional or system level. Many radical feminists believe that the woman should be centred; if she is protected, then so too will the child (Damant *et al.* 2008). The acknowledgement of

harm to children through DA is now recognised in law and within the mass of literature exploring childhood experiences (Øverlien and Hydén, 2009. Radford and Harne, 2008. Brandon *et al.* 2020). Haight *et al.* (2007) and Wendt *et al.* (2015) agree that the strongest mitigating factor in protecting the child from adverse effects of DA is a sustaining relationship with the mother. Rather than debating separation, a more progressive approach is to focus on both the mother and child by strengthening support and interventions that empower and nurture their relationship. (Buchanan, 2015).

The growing qualitative literature exploring women's experiences of DA and service intervention, has enabled a deeper analysis of current healthcare practices (Bacchus *et al.* 2003. Pratt-Eriksson *et al.* 2014). Hearing the experiences of others enables an empathetic understanding of experience and the often complex and complicated decisive moments that impact the desired outcome. However, acknowledging the decision of another when it is opposed to our own perspective is difficult, particularly when considering child safeguarding and moral judgements of acceptable behaviour. Prosman, Wong and Lagro-Janssen (2013) study examined why women did not seek professional support. Denial, shame, and self-blame were all contributing 'self' emotions that played a part in their refusal or decision to not seek support when in a domestically abusive relationship (Prosman *et al.* 2013). Lazenbatt and colleagues (2005) explored the negative stereotypes associated with women in abusive relationships, with general societal assumptions transferable into the nursing community, regardless of job role or service user (Kim and Motsei, 2002). A health professionals' decision to enquire about DA, or the support provided to women was directly impacted by their own

personal views and assumptions relating to DA, judgements on outcome, and stereotyping of the woman individually (Lazenbatt *et al.* 2005).

2.7 Perspectives of health visitors addressing DA

2.7.1 The sanctuary of home

Home is both pertinent to health visiting practice (Brooks and Rafferty, 2010), and to women and girls. The notion of home, and the movement and activity surrounding home has long been discussed and debated within feminism and underpinning much of capitalistic propaganda. The conversation around domesticity, women's liberation from the home, and social independence were discussed during the early 20th century (*A room of one's own*, Virginia Woolf, 1929, and Rose Macaulay, 1881-1958). The notion that women should be grounded in their interest and expertise within domestic work was the heteronormative expectation (MacDonald, 2020), and much perpetuated in the 21st century. The changes inflicted during the global COVID-19 pandemic and the policy to 'stay at home' worked to conceal much of the gender-based violence occurring within this sphere, as well as reaffirming the capitalist stance that home is a place of safety (Boyce Kay, 2020). Interestingly, generational shifts of what home *is* are apparent. A study examining the paradigm shifts through childhood studies suggests that the physicality of a space (house), is of less relevance to children, rather the emotional loaded *home* is described through affective relationships (James and Prout, 2015). Many children no longer relate the term *home* to a place, but rather *home is* a relational connection (Ellsworth-Krebs, Reid and Hunter, 2015). If this be the case, is the space of family important? I argue it is. Generational shifts of philosophical paradigms continue to change how individuals view and

react with reality. However, from a viewpoint of basic need (shelter, food) and vulnerability (protection), families and children are nurtured in spaces that for the purpose of this study and within wider community practice, are accepted as being *home*.

Health visiting or home visiting practice has been an undertaking for the last 150 years. There are examples of work undertaken by women entering the home, and supporting families, in the UK, North America, Europe and Australia. Brooks and Rafferty (2010) specifically examined the roles undertaken by women preceding and then following first wave feminism (early 20th century). Their insightful inquiry exposed the ambiguous role of health visiting that sat between the reforming situation of women and families, and the surveillant work undertaken to uphold the capitalistic views of the patriarchy. Rather than such a divergence from surveillance/interference to holistic lifting of the lexicon, in-fact, the boundary of political motivation has moved further into the home as time has gone on (Noble, 2023. Zuboff, 2019). Schoeman (1984) postulated the philosophical discussion of privacy as a right *in and of* itself, essential to human development and social functioning. However, what matters is how people understand the construct of privacy, and when does another factor, such as welfare and safety overbear the maintenance of privacy (Friedman *et al.* 2006). Moreover, moral judgements and behaviours are often based on the power imbalance within the status-quo (Wikan, 2002), if those perpetrating aggression know that immoral behaviour no longer stands up to the upholding of privacy, would it eventually cease? The home has become an open playing field, those that dwell inside are *the watched*, and those that enquire are *the watcher* (Friedman *et al.* 2006). The proverbial expression of privacy most notably concluded by Sir Edward Coke in 1604 in which he stated “...*the house of everyone is to him as his castle and fortress as well for*

defence against inquiry and violence, as for his repose..." This is all well said but what about when those that dwell inside the castle (the fortress as the woman) live in fear and submission?

When directly applied to public health crisis', including that of DA, this study, and that of many would highlight that such issues cannot remain behind the closed front door. When DA is exposed or feared, the home should, and often does, become *invaded* by health visitors and other third-party agencies (Peckover, 2013). Peckover (2013) further identified that DA was no longer on the fringes of health visiting practice but had centralised itself at the core of safeguarding. An issue to be discussed and explored with every family, in every home.

However, consider the sanctuary of *home*. Is privacy safety? Should the sanctuary of home be regarded as private? Friedman *et al* (2006) explored the literature that suggest moral harm increases in sensitivity when the location and severity of harm are intertwined; if you're likely to be harmed in a location you know, your injury (physical/emotional/psychological/financial) becomes greater. For this reason, the very place we need to ask about safety and DA is in the realm of where the injury has the potential to be most profound: the home.

The divergence between sex and gender within policy and legislation cannot and should not be overlooked within the sphere of home and family. The Equality Act, 2010 (HM Government) protects the characteristics of sex and uses terms purporting to gender (woman/man), yet interestingly Hearn and McKie's (2010) work identified that much practice within health and social care is aimed at women. A claim supported by Cuthill and Johnston (2019) that policy does not support the gendered practice often delivered. Maternity and early childhood support navigates around the birthing female and child. Hearn and McKie (2010) argue this dominant

focus within the realms of safeguarding adverts the gaze on women and safety, rather than on men and violence. If privacy and self-autonomy are defined over the access to spaces, personal information, and history, does much of this female dominated policy within health and social care leave women lacking in privacy and haven of home?

From the stance of the family, and specifically the woman and child, a comparative review (Hearn and McKie, 2010) of DA in Finland and Scotland examined the statistics and gender-based policy of assaults between men and women. In all studies, women were overwhelming more likely to be assaulted in the home, and more men were assaulted outside the home (Hearn and McKie, 2010). The safest place for men is directly contrasted with the least safe place for women; the home (Edwards, 1989). From an early age many infants and children are taught the ontological basis of security and safety existing within the home. For those children who go onto experience DA standpoint becomes fragile. The privacy of home reinforces the notion that analysis and solutions are formulated at an individual and familial level; however, such practice falls short when there are constant barrages of media swollen with violence, in the name of securing family life (McKie, 2005)

Consider this with the reality of *home* for the health visitor. Central to constructing the therapeutic relationship between families and health visitors is the home, and the health visitor being an invited guest into another person's space. However, the unavoidable and necessary conversations that occur between all families and health visitors, including those around DA and safeguarding can undoubtedly create tension (Cuthill and Johnston, 2019). If we acknowledge the fragile and nuanced sense of safety within the home, we must also accept

that conversations about DA—particularly those that risk destabilising that safety—may not occur as openly or honestly as intended. Cuthill and Johnston (2019) questioned whether conversations about DA would become more objective by moving them into the clinical space, to remove the tension and reality of home, and hence make them easier and more likely to occur.

2.7.2 Safeguarding

Safeguarding is a vital part of the health visiting role, and wider specialist community public health nurse training. Competent and effective safeguarding, particularly regarding advocacy of vulnerable groups, including children, requires a high level of emotional intelligence, and expert evidence-based knowledge (Department of Health, 2011). The use of these skills is essential for appropriate escalation, ongoing discussion, or multiagency collaboration; however, issues such as practitioner confidence (Bradbury-Jones *et al.* 2015. 2016.), ethical dilemma (Greenway *et al.* 2013), and experience (Seal, 2013. Eynon *et al.* 2012) all impact on the effectiveness of risk assessment. To enhance the efficacy of risk assessment, a holistic approach is required that incorporates cultural competence (Gunn, 2016), strengths-based approaches that are victim focus (Sullivan *et al.* 2018), and specialist training (Perryman and Appleton, 2016). Yet, as Robinson *et al.* (2009) reports, risk assessment is often generalised, particularly in relation to DA victimisation that is positioned in favour of the heterosexual female.

Health Visitors are in a good position to ensure the child has a voice; with the specific, holistic assessments they undertake (Brandon *et al.* 2020). Humphreys and Bradbury-Jones (2015) editorial summarised the key themes from journal publications. They noted that DA will often be

viewed as an attack on the mother-child relationship, with practice crucially consisting of both strengthening the mother-baby relationship, as well as safeguarding the child. The two factors should not be viewed as a dichotomy of intervention, but both akin to one another, and intertwined. However, in highly emotive situations such as working with DA, tensions can arise when professionals experience conflicting feelings toward mothers who do not follow their advice (Lewis et al., 2018). As a result, the balance between supporting the mother-baby relationship and prioritising safeguarding can become distorted.

Health and social care support prioritise child protection intervention, and ensure it is everyone's responsibility to report concerns (Department of Education, 2018). Literature also supports the notion that women living in domestically abusive relationships prioritised and constantly re-evaluated the safety of their children (Pratt-Eriksson *et al.* 2014. Buchanan *et al.* 2015. Haight *et al.* 2007). Strategies employed to ensure a child's safety ranged from making sure they were in bed at certain times before an abuser came home, calling upon others to care for the child when the woman felt tension rising, maintaining routine in taking beatings, and recognising that often she and her children were safer staying (Monckton-Smith, 2014. Stark, 2008. Kennedy and Kirman, 2023). Women reported a sense that professionals often presumed that they simply had not considered how to keep their own children safe (Pratt-Eriksson *et al.* 2014. Buchanan *et al.* 2015). Fostering a strengths-based approach as proposed by van Tol *et al.* (2023) and underpinning through problem-based support (Bacchi, 2009) as well as through empowerment (Russell *et al.* 2022), enriches the mother-child relationship and overwhelming safeguards both.

2.7.3 Enquiry

The acknowledgement that you are a victim of any crime is largely based on the premise of belief and confirmation of your experience from another. Belonging and acceptance is the reciprocal 'contract' between one party and another (Brown, 2017). A fracture within this two-way juncture disarms the ability to process and progress. ...*Will I be believed if I tell them?*

Public driven policy has gained momentum in North America, UK and Australia following several high-profile cases of assault and murder by known perpetrators (Fitz-Gibbon and Walklate, 2017). Victim-focused laws, such as Clare's Law (following the death of Clare Wood) highlight the shift of bringing the victim into the focus of the criminal justice system (Fitz-Gibbon and Walklate, 2017). However, as Duggan (2012) suggests the increased likelihood of criminalisation does not necessarily make any potential or actual victim of DA anymore safe, nor does it provide safety and security for women.

When considering previous perpetration, history, and public awareness of perpetration within homes and communities, Fitz-Gibbon and Walklate (2017) provide a thought-provoking moment - is it 'right to know' or 'right to ask'? What are the rights of the woman and practitioner to know, in relation to the risk? Lambert *et al.* (2003) commentary identified the consequential perspective; the right to know and then act is based purely on the consequence of *such*. Within a moral stance it is the ability to do the greatest good at the lowest cost. If the consequence of disclosure results in an increased possibility of harm, why disclose? The second, deontological perspective is duty-based: good follows from a duty or principle (Lambert *et al.* 2003). Kass (2001) identified that public health initiatives take a societal approach of protecting and promoting health, whilst minimising threats to health through collective actions. The

deontological approach to public health emerged from the principles of beneficence, non-maleficence, respect, and justice (Lambert *et al.* 2003). Kriebel and colleagues (2001) argue prevention and the probability of risk, which includes the concept of ignorance, is present within policy. Lambert *et al.* (2003) concludes that the ethical principle of prevention reflects the spectrum of risk in relation to what is known, what may be known, and what we choose not to know (the unknown through ignorance). Integrating health visiting practice with ethical principles, especially in the context of DA, is rarely straightforward. The barriers to enquiry and the various forms of action following disclosure have been, and continue to be, the subject of ongoing exploration.

The barriers have been researched by professionals and academics alike, regarding confidence (Cowley *et al.* 2013. Perryman, 2024), education (Kafi *et al.* 2018. Bradbury-Jones and Broadhurst, 2015), attitudes and stigma (Bradbury-Jones and Taylor, 2013. Jack *et al.* 2021), hesitancy in action (Heron, Eisma and Browne, 2020) and cultural/intersectionality issues (Sarsby, 2016. Femi-Ajoa, Kendal and Lovell, 2020. Bradbury-Jones *et al.* 2015). Furthermore, the deontological context of doing good alongside the consequential consideration of knowing and acting can sometimes render the health visitor in an ethical dilemma, for which they are aware of the objective truths, or pitfalls, of the criminal justice system. The reality of increasing the risk of harm from the perpetrator, as well as the safeguarding systems churning through case-after-case, leaves one grappling with the ethical dilemma of right to know, right to ask, and right to act.

Dennis (2014) identified the levels of intervention provided by health visitors. Primary prevention involved the engagement within the community to advocate for

oppressed/marginalised groups and uphold the four principles contained in health visiting practice. Routine enquiry is noted to be held within the secondary preventative model put forward by Dennis (2014). Routine enquiry is the basis for early identification (Working Together to Safeguard Children, HM Government 2018. Cowley et al. 2013), and subsequent actions cannot be undertaken without the initial request. However, although routine enquiry is likely to increase disclosure, there is no evidence of subsequent interventions (Ramsey *et al.* 2002). Cowley and colleagues (2013) stipulated that a single enquiry or assessment did not help to accurately identify safeguarding issues, and repeated contact and enquiry was best practice. The experiences of professionals and victims of DA cannot be neatly compartmentalised, as everyone's thoughts and actions are shaped by their unique perspective within the context of the present situation; it can adapt and change minute by minute (Keiski *et al.* (2016). Bacchus *et al.* 2016). Evidence was drawn from other vulnerability assessment tools used within health visiting practice that were largely disregarded, and instead professional judgement and continued collaboration were noted to improve outcomes. Interestingly, such frameworks may hinder disclosure due to their objective, linear approach to enquiry (Cowley *et al.* 2013). However, research (Hester and West-Marland, 2005) undertaken to support the 'Suffolk Framework' issued to tackle DA approaches, noted that as health visitors became more proficient in enquiry, disclosures increased, even though participants stated they asked fewer women. Analysis was drawn from the fact that this framework facilitated the understanding of DA better and moved the practitioner away from victim-blaming (Hester and West-Marland, 2005). Yet, recognising the hesitancy to routinely enquire cannot be overlooked, the weight of

emotional labour experienced by professionals is acknowledged (Perryman, 2024) and thus enabling interventions to support such are the area requiring attention.

Bacchus *et al.* (2016) study found women felt more comfortable discussing their experiences of DA with a home visitor when perceived professional barriers were removed and felt more comfortable with someone they could relate to; indicating homophily enhances the likelihood of disclosure. However, trust is a process that needs to be established over a timely relationship, even more so for those who have suffered abuse and therefore a true account of disclosure cannot always be guaranteed from one home visit (Gilson, 2003). Bacchus *et al.* (2016) study was conducted in the USA. However, results were highly anticipated to be transferable to the UK and other Westernised countries offering continuing home visits, quoting both NICE and the Department of Health and Social Care guidance that promotes postnatal care as being an opportunity for early intervention. However, this study sampled women already part of an established domestic violence programme, and thus receiving enhanced support from the universal service offer. Results from the study indicated a largely positive reaction to home visitors enquiring about DA. Women found enhanced visits that were directly designed to support with issues relating to DA were helpful, as well as enhancing their self-esteem and awareness of services available. UK guidance informs professionals to take the opportunity of any contact to screen for DA, and if disclosed offer additional universal plus services (Department of Health, 2009). One could therefore argue that research collected from participants already receiving enhanced DA support cannot reflect true enquiry carried out on a universal level. Conversely a meta-analysis carried out by Gene *et al.* (2006) concluded abused women were more comfortable with indirect questioning from healthcare professionals that

they knew, and therefore enquiry is associated with the context of the contact. Healthcare professionals continue to direct questions about DA to those only perceived to have signs and symptoms of DA (Bradbury-Jones and Taylor, 2013) with many victims wishing to hide the abuse from professionals (Bradbury-Jones *et al.* 2011). Some research (Catallo, 2006) has been conducted into the nature in which enquiry by healthcare professionals takes place; specifically women wished enquiry to be asked in a sensitive and confident manner that was not rushed, and many women who were in abusive relationships wanted to be asked about the abuse on numerous occasions (Catallo, 2006). Furthermore, within the compassionate grounds desired, women wanted verbal confirmation that what they had/were experiencing was unacceptable from the professional (Gene *et al.* 2006). Ensuring sensitivity and safety is paramount. With each visit listen, assess, act, and document (Department of Health, 2013).

2.7.4 To assess and act

Effective risk assessment within DA situations is essential to mitigate harm and ensure safety. To consider the importance of risk, and planning around such, there needs to be an assumption made relating to the political and social climate. The Conservative free-market of the late 20th century held the mindset of individual ownership and mobility within the social sphere. The neo-liberal ideology, as Culpritt (1999) noted, enabled the disadvantaged individual to be an 'active' agent within their own outcome. The disadvantaged and complex families discussed earlier were no longer passive with little accountability, rather viewed as constructors of their own destiny (Culpritt, 1999). The turn of the 21st century and New Labour brought about ideas of small community and influence that focused on universalised considerations of risk (Featherstone *et al.* 2014). Risk and readiness were both key drivers for the rationale in the

Allen Report delivered to explore early interventional work within early childhood (Allen Report, Cabinet Office, 2011). Gadd (2012) cited Campbell (1993) as enriching and calling for more consideration into the relationship between masculinity, heterosexuality, politics and violence. The emerging evidence identified the correlation between ideals of society and domestic violence and abuse (Gadd, 2012). The further shift into localised services and inclusion of third party and charity organisations as part of the ‘Big Society’ model, came down to the small print: budgets directly pulled into local government during the early 2010’s (Gadd, 2012) suffered the wrath from ongoing financial crisis’ particularly impacting children’s services (Higgs, 2011). Considering the political landscape, societal views, and statistics of DA, it would appear belief in deterrent and justice measures is wavering (Shermen *et al.* 1991. Gadd, 2012. Johnson, 2007. Horstman *et al.* 2021). Interestingly, Horstman and colleagues’ (2021) exploration of public perceptions of sentencing in DA cases changed as DA moved within the scope of being a public health issue, rather than solely a criminal justice issue. This study highlighted the overwhelming importance of community education within DA (Horstman *et al.* 2021). Moreover, Gavin and Kruis (2022) identified a correlation between the acceptance of violence within intimate relationships and the likelihood of perpetrating such violence. Based on the evidence discussed, an emphasis on risk assessment alone can feel like a drop in the ocean when broader, systemic ‘top-down’ approaches aligned with societal and political frameworks are urgently needed. Nonetheless, health visitors are on the front line, working with families facing adversity, hardship, and crisis—making robust and effective planning not only warranted, but essential (Department of Health, 2011).

Assessment of risk (Department of Health's (2013) is undertaken through conversations (Every Child Programme, Department of Education, 2009). Utilising clinical judgement, and/or the completion of the DASH risk assessment (Richards, 2009-2023) can enable appropriate decision making relating to statutory involvement. Objective measurements are often undertaken within assessment, requiring binary answers; however, like many conversations undertaken between health visitors and parents, the DASH begins with an individualised perspective question of *Are you frightened?* Risk, as determined by Robinson *et al.* (2009) is based on knowledge reported by the victim. Furthermore, its reasoning being threefold; to enhance the safety of the victim, prevent the escalation and thus resource implications on the criminal justice system, and finally to share information with other agencies (Robinson *et al.* 2009). If deemed appropriate, risk assessments can also lead to further discussions within a multiagency team formulating in a MARAC assessment (MARAC, 2003). Robinson and colleagues (2009) analysis of risk assessment tools within DA, supported the significant association between risk and fear, moreover, the perception of fear is an accurate predictor for future victimisation (Robinson, 2006, 2007).

Risk assessment has been explored previously within the literature, with King (2016) noting that a health visitor's decision making was often weighed on the support available at the time, rather than the level of need. What's more, decisions made relating to assessment are time and again in contention when the consideration of objective, medicalised assessments are applied to subjective life experiences that are dependent on resource (King, 2016). Prior to this study, Appleton and Cowley (2008) noted the principles of assessment within health visiting were multifactorial, complex in nature, and prioritised dependent upon individual practitioners. The concept of fact and observation relating to risk, and the work of Ahmed (2004) as cited in King's

study, considers the issue of emotions at play, and the reshaping of practice. The pivotal concepts of connection and relationship building that are central to health visiting assessment (Cowley and Frost, 2006. Appleton and Cowley, 2008) are highly influenced by the individual and collective emotions held by health visitors (Taylor, Smith and Taylor, 2016). What Taylor and colleague's (2016) study highlighted was the hidden labour felt by health visitors when working with families experiencing safeguarding issues. However, what became difficult to distinguish was the influence of such on assessments made within this arena, comparative to the lack of health visiting specific research, and the changing blueprint of health visiting caught between support and surveillance (Taylor *et al.* 2016).

Crucially, with DA risk assessment, one can never remove all risk due to the unpredictability of perpetrator and victim behaviour, circumstance, and external influence; therefore, comprehensive and collaborative reassessment is required. Effective assessment demands both the mitigation of risk, as well as empowerment through support.

2.7.5 Barriers

Research has explored the barriers faced by public health nurses in dealing with DA (Bradbury-Jones and Taylor, 2013. Saletti-Cuesta, Aizenberg and Ricci-Cabello, 2018. McGarry, Hussain and Watts, 2019). Different professional hurdles have been presented; however, it would appear there is a culmination of reasons as to why health visitors do not always address issues of DA. This study will not focus on the barriers, as the reader is signposted to such literature that addresses such. However, in seeking to explore the effectiveness of interventions, it would be detrimental to the enquiry if such barriers were not acknowledged and understood. In the

pursuit of knowledge, embracing the intersubjective notion of reality, that truth is both objectively defined as well as subjectively experienced, provides a research stance leading into theoretical frameworks of phenomena (Savin-Baden and Howell Major, 2013). Barriers experienced by health visitors are shared across the profession, with the reality in which practice occurs; being formed through interactions with people, activities, and shared goals. Furthermore, health visiting practice is grounded in subjective encounters (Sarsby, 2016).

Bradbury-Jones and Taylor (2013) directly addressed nurses' responses to DA in terms of abjection. Health visitors are identified as key professionals to address DA due to the contact nature with new parents (Department of Health, 2013). However, the daily *horror* of DA in its description, motivation and outcome, can elicit a psychological defence experienced by health professionals. Daily experiences form part of the professional world view, nonetheless, reminding ourselves that abusive relationships transgress social boundaries of acceptability, causes one to remember that such behaviour is not inevitable or *ok*. Abjection within this context is where the professional subconsciously rejects the possibility of DA to protect themselves from vicarious trauma. In failing to address any issues, the professional renders themselves unable to formulate appropriate responses and/or input interventions (Bradbury-Jones and Taylor, 2013). Conscious fear of identifying and acknowledging DA can be driven by lack of experience and training (Saletti-Cuesta *et al.* 2018. McGarry *et al.* 2019). Sarsby (2016) addressed health visiting practice when working with black and ethnic minority communities experiencing DA. Their exploration uncovered both the feelings of fear in offending individuals if their relationships were questioned, as well as the notion of powerlessness, and being overwhelmed to appropriately support individual. The importance of emotional intelligence of

listening, having empathy and self-awareness were identified as key skills for professionals dealing with DA (Millar, Davaney and Butler, 2018). They (Millar, Davaney and Butler, 2018) concluded that service providers must endeavour to move from being objectively task orientated, to exercising emotional intelligence. This was noted to be of distinct importance when professional groups were highly gendered. Patrick and Jackson (2021) concluded nurses' responses to abuse, particularly violence against women, to be inadequate. They argued that the medical paternalism of abuse took precedence over the holistic model of community nursing, with the nurse becoming both the dominator of the woman, and the dominated by the medical profession. However, Henderson (2001) found that community nurses are more willing to address DA with women, resulting in disclosure, due to the nature of the visit being likely to be undertaken within the home. Bacchus *et al.* (2003) supported this claim that women found GP's and hospital staff less helpful than health visitors in responding to DA. Furthermore, women recounted that forming a trusting relationship with health visitors enabled disclosure (Litherland, 2012. Papas *et al.* 2023). Cowley *et al* (2013) noted that the social model of health utilised within health visiting practice permitted the professional to pick up on social problems.

2.7.6 Radical empathy

If relationships, including those between mothers and health visitors are constructed and bound through discourse, then an issue can no longer be seen as *yours*, but must be seen as *ours*. Reflexivity will be discussed within the proceeding chapter; however, one cannot consider and discuss human ecology without noting the importance of reflexivity. Displaying empathy is the ability to adopt a subjective perspective of another individual, not only reacting to an emotional state, but understanding it (Eggum *et al.* 2011. Decety *et al.* 2015). Radical empathy

requires impact and consideration of vulnerability from one to another, it relies on the relational component, that recognition and impact is not solely placed on one, but distributed between the two (Jordan and Schwartz, 2018). Consider;

I see you, I hear you in your pain, and I will begin to consider how I may play into your pain.

What is it about how I get to exist in the world that impacts how you get to exist in the world?

Black feminism engages in the movement of radical empathy, promoting us to consider the oppressions experienced by others that we have, in some way, had a part in. Givens (2021) encourages leaders to not just know about someone's experience but deeply share their pain to understand it and promote change. Being deeply profound and transformative, it delves into an approach to understand and connect. Mejia, Balangoy and Katoch (2022) auto ethnographical work invited the reader to consider how white fragility may permeate with feelings of entitlement, within the context presented of racial inequality experienced by healthcare workers during the COVID-19 pandemic. They spoke directly, acknowledging the powerful narrative of lived experience 'jolting' the comfort of the white reader. Their radical imagining of care being demonstrated in the ability to learn from experience, citing Collins (2002) of the ability to turn care work into "resistant knowledge projects" (p.159). Radical empathy demands active engagement with someone else's experiences, emotions, and perspectives, regardless of difference (Eggum *et al.* 2011). Critics argue that one can never truly see an experience through the eyes of another, because what we are fundamentally shifts the reality of experience for each one of us; similarity and difference neither unites nor fixates our position (Wilkinson and Kitzinger, 2013). However, Yost and Chmielewski's (2013) research demonstrates that an outsider (researcher) position can shift to become an insider (participant) position. What

happens when one's story infiltrates our own? Wilkinson and Kitzinger's (2013) commentary on Chmielewski and Yost's feminist work explores the strategies of managing the insider/outsider pursuit. The concepts of minimising or maximising personal experience within research can be enlisted to present either a positivist, objectifiable position of external reality within the former, or an auto ethnological approach to centralise the unidirectional flow of experience (see Ellis and Bochner, 2000) within the latter. Further concepts include utilising insider experience, often to gain access to groups, as a relatability factor (Fish and Wilkinson, 2003. Clarke, Kitzinger and Potter, 2004). Finally incorporating one's own experience or perception, Wilkinson and Kitzinger (2013) postulate this as a move often enlisted by feminists to progress towards a more egalitarian position. It would appear with positionality and reflexivity, as with radical empathy, active engagement is fundamental.

Radical empathy extends beyond intrapersonal positionality, it demands a move into policymaking, decision-making, and collaboration (Givens, 2021). The foundations of practice that are scaffolded by radical empathy become the antidote to societal rifts and problems. Allowing someone else's story to infiltrate our own is to begin to imagine the life they live and hence begin to dismantle the barriers of prejudice and bias. To share in stories engenders a sense of humanity that is, in its essence, collective. By recognising humanity in DA experiences, the chasm between conflicting ideologies of DA becomes narrowed. This is where the health visitor must sit. Between the academic literature of the psychological, sociological, and biological debate, and the real human experience impacting the now. This is where constructive dialogue is paved, fostering the groundwork for individualised and societal change. The journey

is not devoid of challenges, confronting one's biases, acknowledging privilege, and a willingness to be vulnerable and engage in uncomfortable conversation, is required.

2.8 Gaps in literature

As presented within recent literature, there is growing focus on the experience of DA for mothers (Arnull and Stewart, 2021. Cort and Cline, 2017. Moulding, Buchanan and Wendt, 2015), the mother-child dynamic (Smith et al. 2015. Damant et al. 2008. Morgan 2020), and health visitors (Tandon et al. 2008. Taylor et al. 2013. Bradbury-Jones, Appleton and Watts, 2016). A systematic review of mother and health visitor perceptions of support revealed inconsistencies within enquiry, as well as barriers relating to disclosure, and thus intervention application (Eynon et al. 2012). The misalignment of perceptions relating to support desired and offered continues to present practitioners and academics challenges to improving services (Moseley 2017. Bradbury-Jones and Keeling, 2020. McCarry, Radford and Baker, 2021). Often the perceptions and experiences of mothers have been captured within the broader insight of child safeguarding services, more often focus upon child protection and social care.

Recent calls to integrate health visitors within research and on-going study (Baldwin, Jackson and Gilroy, 2024. NMC, 2022), are shining a light on the few health visitor voices within the dearth of healthcare research and academia. Notably, influence and awareness of behaviours that impact outcome were noted within Rose and colleagues (2021) research exploring study recruitment. The confidence and capability of practitioners increases when there is discussion and reflection around perceptions of support. Drawing together the perspectives of both practitioner and service user enables deep exploration of what is done, and what considered

improvements are needed. Capturing the perspectives of both the health visitor and the mother when discussing DA support will enable a meaningful analysis of perception, service and outcome. It is this area the study will situate.

Collectively, this review has revealed several notable gaps in the existing literature. First, there is a scarcity of studies that examine the perspectives of both health visitors and women concurrently, despite the interdependent nature of their experiences in DA contexts. Second, while feminist and socio-ecological frameworks are well-established, there remains limited integration of these theoretical lenses with empirical accounts from UK health visiting practice, particularly in relation to the operationalisation of safeguarding and empowerment. Third, research often isolates either professional practice or lived experience, with few works addressing the relational and systemic interplay between the two. These gaps underscore the need for empirical inquiry that bridges theory and practice, foregrounds women's and practitioners' voices equally, and situates their experiences within broader cultural, policy, and service delivery contexts. The subsequent empirical work in this thesis is designed to address these gaps directly.

2.9 Concluding thoughts

This chapter has introduced issues relating to DA, and specifically to women and mothers. The debate of concepts underpinning DA has been discussed, and specific frameworks considered. Women and mothers are at the heart of this study. Over 98% of health visitors are women (iHV, 2020). The biological difference of female sex and the gendered construct of *woman* are

acknowledged. For this study to identify as a woman is to understand the socialisation of such, and the oppressions experienced. DA is gender-based violence.

Conceptualising the implicating factors of womanhood, motherhood, and responsibility within an experience of DA, enables a critical lens to understand the prioritises of support and intervention pertinent to all. This study seeks to explore how health visiting support is considered and understood by professionals and mothers when DA is experienced within a universal service provision. This study does not position itself to solve or fix the issues of DA. As detailed above, the insidious and consuming phenomenon requires a multi-dimensional systems approach in both theory and practice. However, this study aims to illuminate the experience of both service users and professionals to provide meaningful debate as to what is wanted and/or appropriate.

This narrative review has provided new insights by drawing together feminist theory, socio-ecological frameworks, and contemporary health visiting practice to illuminate the intersection between mother's lived experienced and professional perspective. The review has highlighted the disconnect between safeguarding policy and the reality of coercive control, as well as gendered blame, and the emotional labour of health visiting. Integrating the differing concepts paves the way for a strength-based approach.

The thesis will now progress onto exploring and discussing the methodological approaches considered within this research study process. The underpinning concepts will provide a backdrop to the specific methods employed in the endeavour to explore the study aim.

Chapter 3. Methodology

3.1 Introduction

This chapter will detail the methodological underpinnings of the proposed study. It will present the methodological framework, emphasising feminist methodology and the role of reflexivity within meaning making. The critical appraisal of qualitative methodologies will form a debate that outlines the direction of the study. The chapter will discuss the concepts considered and progress the reader into the subsequent chapter examining themes and study protocol.

The ideas, methodological foundations, and methods used to explore reality in this study are shaped by researcher subjectivity. The use of the first person (“I”) is intentional and consistent throughout the thesis. The narrative moves fluidly between engagement with existing literature and the researcher’s own voice, reflecting the reflexive nature of this inquiry. I do not position myself as separate from the study; rather, we are inextricably connected. To omit my presence or avoid self-identification within the thesis would be to misunderstand the core of this reflexive approach.

Reflexivity as a core component involves a continuous interrogation of the researcher's own positionality. This chapter will focus on *what*, *why* and *how*. To position myself within philosophical concepts and ideas, I will provide rationale for what I’m doing, and why it is meaningful. As you read and critique the words presented on the pages, I invite you to consider the *what* and the *why* of meaning, and how it impacts you and those around you.

3.2 Theoretical foundations

3.2.1 Positionality and paradigms

Nursing education embraces and encourages positionality within research. It allows a depth of self-awareness that evolves through personal reflection relating to how one engages with others in diverse communities (McKinley *et al.* 2022). It recognises that knowledge is contextual and partial, it is tethered to an individual's beliefs, values and experiences (Rushton, 2023. Gamm, 2022). Jafar (2018) supports the awareness of positionality and standpoint within research from the 'get go', and rather than undermine, it gives clear boundaries to the validity of the work. The study aligns itself with the theoretical approaches of subjectivity and reflexivity within a feminist framework. Key to creating research direction is the awareness of the researchers own philosophical position (Coleman, 2019). The position proposed within this chapter provides the backdrop to the research aims that explore the experience of DA through a standpoint theory of understanding.

Exploring this study through narration of experience, the creation of meaning and truths will flourish. Contextually the study is positioned within the dynamic held between health visitors and mothers and therefore drawing upon philosophical approaches within the profession is acknowledged. Co-produced and integrated methods are becoming common place particularly within health research; however, the underpinning approaches of each party (public and health) sit in different conceptions of understanding (Madden and Speed, 2017). Yet, as Callon (1999) argues, both do not have to compete, rather can be synergistic and reciprocal. The knowledge and conceptualisation of phenomena fluctuate in both groups, yet correlate and

correspond in power share (Hickey, Richards and Sheehy, 2018. Green and Johns, 2019). This study seeks to explore standpoint of perspective from both groups and unpick the conceptualisation of DA within the context, and how such relate or contradict.

What reality *is* refers to the complex network of relationships, practices and systems that shape human interaction. Bhaskar (1987, 1989) argued social structure was a necessary condition, but agency in turn was necessary for the reproduction and transformation of social architecture.

Fundamentally, what must it be about the world itself that makes knowledge possible?

Considering DA, the reality of *it* is compromised by complex overlapping layers, each causality is distinctive but plays a part in the interacting whole (Matthews, 2009). When perspective and experiences drive reality, considering some to hold more power or weight than others acknowledge an epistemic elitist position. Parr (2015) states a critical stance would believe some accounts of violence to be better than others. The depth of the world is positioned within the mechanisms and powers that generate events, and thus constitute experience (Sayer, 2000). Positioning reality dependent from constructs (Parr, 2015) and accounts can therefore be deemed successful and unsuccessful to produce reliable knowledge (Sayer, 2000). A feminist perspective values the voice of the individual, whilst examining the power dynamics held by the varying systems intersecting and impacting experience (hooks, 2000. Collins, 2000, Crenshaw, 1989). The focus on making sense and valuing insight acknowledges the ontological question of *what* DA is, but rather seeks new knowledge, and does not consume with a quest to deny or correct reality. One can never define the underlying controlling nature of the physical, sexual, psychological, financial or coercive nature of violence, as separate from those that experience it.

Experience and 'truths' of a phenomenon are highly impacted on physicality, emotional and psychological effect, and behavioural pattern. If reality is independent to what we think, with social theories enhancing this intransitive dimension, then it is important to consider that such theories are flawed and limited (Coleman, 2019). Furthermore, McGhee and Grant (2017) state that it is impossible for researchers to remain neutral within the context of the phenomenon, as we all understand the world through our experiences, history, narratives and culture. Herein lies whether the researcher-practitioner understands the phenomenon of DA and violence as having objective truths that can be hypothesised and tested against current practice. And, if so, can any new information gained through study produce new health visiting practices? Furthermore, as Brown (2020) states, to understand that things have not always been this way, is to apply critical judgement to that which has gone before, that exists in the present and seeks potential for change. It is argued that the perspective of truths provided by those with experience provides insight into what is known and understood, and therefore proposal for progression.

The social world is made by people (Berger and Luckmann, 1979), and people have enculturated the natural world and given it meaning (Hiebert, 2016). The meaning of a relationship and coming together of two people is no longer based solely on reproduction (within particular the Western world), nor is there the gravitas of religious influence on the relationship. Fowers and colleagues (2016) evaluated relationship 'flourishing' scales and reviewed the literature field that examined coupling. They noted that relationships often developed within the sense of togetherness, as well as self-awareness (Fowers *et al.* 2016). No

longer at the centre of togetherness is procreation, but a shared goal of commitment to giving and meaning within, that recognises personal expressiveness (Fowers *et al.* 2016).

Anthropologists continue to investigate the differences between gender, sex and sexuality (DuBois and Shattuck-Heidorn, 2020). DuBois and Shattuck-Heidorn (2020) and Markowitz (2001) argue that much of the understanding of *masculine* and *feminine* constructs were considered through the lens of colonialism and white supremacy. Feminism has remained critical of binary differentiation between sex and gender to counter a biological determinist argument (Mikkola, 2008). Indeed, French philosopher Simone de Beauvoir (1949) noted the *becoming* of a woman, rather than the innate birth of one. Considering the roots of gender entangled within the masculine and feminine (Mikkola, 2008), gendered roles have evolved (first wave feminism and Westernised women moving into the workforce), and new knowledge has been discovered through observation and experience (Talja, Tuominen and Savolainen, 2004). Talja and colleagues (2004) noted that social influences directly impact the relationship between the individual and the world. Akin to childhood development as understood in health visiting, Piaget's stages of cognitive development (1936) were underpinned by the principle that humans cannot be given information and expected to immediately understand it; they construct and build through experiences.

Constructing the world, as Talja, Tuominen and Savolainen (2004) noted it to be, was achieved with the emphasis on conversations, through which the self and world as experienced, are articulated. Boundaries of knowledge are set by conversations, categorising and bringing phenomena into sight (Talja, Tuominen and Savolainen, 2004) yet regulated through self-resilience and self-surveillance: a clear example of power operating 'from below' (Foucault,

1980). However, if knowledge is discovered through experience and overtime, then the discourse that defines it can re-evolve and change also. If neither can ever be consistent and stagnate (Talja, Tuominen and Savolanien, 2004), then with a view of subjectivity, the researcher can acknowledge and underpin practice and study in both camps.

If DA means different things to different people; in context, in acceptance, in understanding, as I believe to be the case, I steer my focus from the ontological statements surrounding it.

However, to consider women as 'bodies' of which language and power embeds, denies the voices of the oppressed to be heard and resistance considered (Harstock, 1990. Fraser, 1989).

3.2.2 Reflexivity and knowingness

Reflexivity is implicitly weaved throughout this research and study undertaking, so much so, having a defined section seemed counterintuitive to the fundamental workings of qualitative methodologies. However, explicitly, and intentionally exploring reflexivity gives it the power it deserves. Throughout this study and thesis journey, questions prompting reflexivity will be asked. These will be clearly demonstrated within the text, data collection methods, and analysis. Also discreetly, within every single day spent undertaking this task, within every thought and consideration, I will ask questions. Subtly, asking questions has been weaved through my development within the personal and professional sphere. Maslow's hierarchy of needs (Maslow, 1943, 1954) demonstrates the self-actualisation as being the pinnacle of what we can be or achieve. It would appear naïve to argue that qualitative methods do not objectify individuals as I argue there to be many realities for which we all build our assumptions, beliefs, and bias upon. Qualitative methods serve the investigator, and due to the flexibility within

design, methods are adaptable to fit with an inductive inquiry (Cadena-Iñiguez *et al.* 2017). Arnall and Stewart (2021) argue that social care practitioners recognise individuals within an objective understanding. However, these realities are situated within the context and time for which they occurred. Covey (2004) argues that everything heard is filtered through our own paradigm, often serving to fit the response or reaction, rather than the understanding. To overcome this, a critical lens and scrutiny is required to challenge our world view, and how such impacts on our ability to support, intervene, and research. Choreographing a study encapsulates three issues; researcher assumptions regarding knowledge production, researcher positionality and power within the research, and techniques undertaken to ensure quality (Day, 2012). Considering such, Pedersen (2008) and Reissman (2008) discuss how the researcher selects both the included and excluded perceptions of reality that are consistent with their epistemological foundation.

Reflexivity and time allow us all to harness new perceptions of the reality we once knew, the reality we know now, and the expectation of what new experiences are to come. Hofmann and Barker (2017) noted the use of *reflection* and *reflexivity* being interchangeably used within health research. Reflection, whilst a necessary component for reflexivity, is noted to be the self-exploration of one's own role, and reflexivity within practice is the critical stance of self-awareness of the impact you have on the role (Etherington, 2004). Willig (2013) further defined reflexivity within research as being personal and epistemological, either concerned with thoughts, feelings, and values, or with the research question and methods. As a practitioner and researcher both areas of reflexivity are important and mutually benefit one another.

Reflexive practice in research accepts the bidirectional relationship between cause and effect and recognises the forces within the socialisation of structures (Hofmann and Barker, 2017). Burns *et al.* (2012) identify that reflexivity allows researchers to participate as observers but that they need to navigate the middle ground of insider and outsider. The insider position suggests that the researcher should acknowledge their professional understanding and status around a subject area close to them, and recognise the social advantages that allows (Burns *et al.* 2012). It is useful to gain access to hard-to-reach groups to acknowledge such concepts of commonality, protectiveness, and binary positioning, to gain credibility. Subjectively identifying with the participants, whether through gender, profession, ethnicity, or other signifier is not a new concept, and can be traced back to much of the seminal feminist research carried out in the 1970's (Malpass, Sales and Feder, 2016). However, the researcher is also an outsider to that group no matter how hard they try to enculturate themselves (Malpass, Sales and Feder, 2016). It is postulated by some authors that there is a lack of consideration of how identity enculturation accompanies the boundary crossing process by researchers and, that this results in a lack of reflexivity around the subject area (Hung and Victor-Chen 2007). It is acknowledged that all research is subjective and ideologically driven allowing for bias within the study (Polit and Beck 2006). Imperatively, before and during the research process, preconceived viewpoints of the researcher are raised and analysed. However, in the knowledge that statistically some of the health visitors supporting families who are experiencing DA will have been/are experiencing abuse themselves, the insider/outsider debate has never been explored specifically in relation to interventions employed (Malpass, Sales and Feder, 2016). Alvesson and Skoldberg (2000) cite the notion of reflexivity, suggesting that open discussion and exploration of the researchers'

bias upon the study will authenticate the findings. The use of reflexivity not only serves to increase the researchers' self-awareness but also it guides the research process (Rolfe 2006). Gaining a richer understanding of the phenomenon hopes to formulate more questions, not answers, and in doing so moves the discussion forward (Coleman, 2019).

Engaging in problem-based solutions, such as those within health visiting, requires a commitment to 'self-problematisation'. Bletsas and Beasley in their conversations with Carol Bacchi (2012) expose that the basis to understanding a problem is reflected in the probing of unexamined assumptions. Such assumptions may be explicit or implicit in nature, held by systems, communities, and individuals alike. In doing so, attention can be paid to the knowledge that underpins such. Bacchi (2009) stated that what *we* propose to do about a problem only reveals what *we* think is problematic. Innovation and creativity are moving problem *solution* to problem *representation*. With this consideration, underpinning feminist standpoint theory concepts of insight provided by those with experience, the representation of DA support between health visitor and woman becomes apparent. Acknowledging the power held by the professional within this relationship is done so by hearing stories separately, and exploration of experience within the context of position held. However, not being blind to the power struggle, and in providing meaning from both groups, captures the relationship in practice.

3.3 Epistemological positioning

3.3.1 Feminist Methodology

Conceding that it is obvious what 'feminism' means is challenged by Delmar (2001). Within this text, there is a generalisation that feminism recognises the oppressions faced due to sex and gender, and change is required within the social and political order. However, to conclude that feminism is an objective or agreed concept fails to understand the many perspectives within feminism (Delmar, 2001). One cannot reduce feminism or feminist thinking in a definable box, feminism, rather challenges the patriarchal ways of doing and thinking (Pateman and Gross, 2013). What is postulated is that women become both the subject and the object, not in terms of male thinking or doing, but in their own undertaking (Pateman and Gross, 2013). A focus does not sit on 'women's issues', but in how all aspects are considered, thought about, and acted upon (Pateman and Gross, 2013). Identifying feminism, is as Baumgardner (2011) states, a useful tool when thinking about a chronology, however, recognising a reflexivity and fluidity within perspectives of feminism enables a critical think on limitations and progress (Evans and Chamberlain, 2015). Bringing together perspectives that are committed to identifying and eradicating sexism is focal (Evans and Chamberlain, 2015. Donchin and Purdy, 1999), yet, remaining purely reactive within an anti-sexist stance does not allow for space for creativity within the current norms of thinking and doing (Pateman and Gross, 2013). Perhaps at its heart is the dismantling of unjust power dynamics that exist to oppress and suppress.

"What would happen if one woman told the truth about her life? The world would split open."

(Muriel Rukeyser, 1949. p168)

A commonality within feminist thinking is the exploration of oppression and inequality through the issues of power, dominance, and gender (hooks, 1989. Sprague, 2016). Feminist research and theory draw upon these insights relating to oppressed groups, particularly women, and places them at the centre of research (Willsher and Goel, 2017). The feminist epistemologist Kathleen Lennon (1997) argued that all knowledge is situated knowledge. Ashton and McKenna (2020) argued that this stance was concerned with justification, rather than facts, and the two could come apart and be examined separately and thus deviate from traditional scientific conceptions of knowledge. A single truth is not the only truth, nor is there a hierarchy of truth (vanWormer, 2009). The approach to be undertaken from an epistemological and methodological stance views a narrative of experience within the social reality it exists in as truth (Swigonski, 2004).

3.3.2 Principles in feminist research

Recognition of power dynamics

Concepts of power relationships, patriarchy and knowledge production are central to feminist theory. The long-standing structures that enlist a positivist, empirical stance of academia (Danvers, 2018), health and medicine (Patrick and Jackson, 2021) are pushed back on by reflexivity and reciprocity. It is the reflexive nature of this study that I first and foremost acknowledge my position and assumptions. Recognising the equality of knowledge held by myself and participants enables power sharing (Green and Johns, 2019). To encapsulate this, the study facilitates the voice of the participant through in-depth conversations that are contextually positioned by the study but led by the participant in their own understanding and

experience. Knowledge is not harvested, but instead those involved create a new understanding of what *it* is (Johnston and MacDougall, 2021). Rather than gatekeeping knowledge to *my* understanding of experience and health visiting practices undertaken, I wish to hear from those at both ends of service delivery; the importance of listening with empathy and respect. Sandra Harding (1987) in her seminal book, declared that feminist research must view experiences through the lens of women, provide for women in intention and outcome, and finally engage in researcher reflexivity. Feminist research should go beyond, and centralise power (Hesse-Biber, 2007); what is said matters, and this will be illuminated within the analysis of direct narration. Feminist theory attempts to deconstruct oppression, through exploration of women's experiences and voices (Green, 2012), and furthermore it tackles the 'invisibility' of women within society (Pritchard, 2005). As has been suggested mothers can feel ignored and invisible to practitioners and those deemed with power (Aston et al. 2021), as well health visitors describing their experience as being 'street-level' and led by those above, rather than leading in what is done (Hughes and Condon, 2016). However, Sprague (2016) draws criticism at the simplification of power within research. Simply pronouncing the researcher holds the microphone to allow the participant to speak neglects to account for the power held at different stages within the study (voluntary participants hold more power during the pre-interview stages than pre-selection or during interviews). Furthermore, as Skinner (2005) demonstrated, being mindful of how participant selection may privilege or enhance researcher ability and career, demonstrates elitist mindset within the dynamic (Sprague, 2016). An awareness of insider advantage and disadvantage is further considered within the dynamics of this study design. Previous studies have accounted for the issues surrounding insider social

order (See Glucksmann, 1994), in that hegemonic discourses can prevent exploration of experience. Pertinent to this study, is the researcher connections enabled through insider knowledge (being a woman and practising health visitor). Being held to norms within the social order (Zavella, 1996) can prevent obstacles in participant discourse, but furthermore misinterpretation of the understanding of *insider* or *outside* can create the biggest obstacle (Sprague, 2016). Simply describing myself as a health visitor is not enough to justify expectation of shared power; multiple dominations shape experience (hooks, 1981. Collins, 2000). Therefore, this study promotes an enhanced empathy due to commonality (Sprague, 2016) rather than expectation of knowing.

Intersectionality

Feminist methodologies recognise that gender intersects with race, class, sexuality, and other identities that shape lived experience. Harnois (2013) argues that feminist research is achieved by *how* the research is undertaken, acknowledging multiple approaches; such is evident in intersectionality studies that have interweaved with examination of DA (MacKenzie *et al.* 2015). Liberal feminist discourse previously discounted various identity categories, including race, sexuality, culture as 'non-entities' that required no further specialisation within the violence against women debate (Crenshaw, 1991). Crenshaw further argued that to ignore difference *within* a group was to contribute to tension "*among a group*" (Crenshaw, 1991. pg 1242). Prior to the birth of intersectionality feminism, feminist thinking failed to see how racism and sexism impacted on the debate. The commitment to intersectionality acknowledges the multiple layers, and complexity of oppressions that add to inequality (Skafida *et al.* 2021). To practise within the sphere of 21st century health visiting is to acknowledge the movement of families in

terms demographics. Perhaps a clear translation of such is the mandated status of 'new to area' or 'new to country' contacts that health visitors deliver; the service recognises the changes and fluidity of what a community is or will be. Addressing inequalities and human rights (NMC, 2022) demonstrate the proficiency foundations of equality, diversity and inclusion. However, in broader maternity terms the increase of maternal mortality is two-fold for Asian women, and alarmingly five times more likely for black women (MBRRACE report, 2019). The results are complex in reasoning (Gunn, 2016) and cannot be simply proposed due to ethnicity alone; however, practice and principles must endeavour to encapsulate respect, social norms and behaviours (Campinha-Bacote, 2002. Gunn, 2016). This study translates an intersectional approach through the dissemination of recruitment into those mothers with experience of DA, rather than placing further stipulation on demographic. Furthermore, acknowledging my own will and endeavour to hear voices of women that intersect with many other demographics influences mindset (Hesse-Biber, 2012. Crenshaw, 1989) and study direction.

Valuing subjective knowledge

Feminist research recognises the narratives and lived experience as valid sources of knowledge. Feminist standpoint theory emerged in the 1970's and 80's, it was positioned as an epistemological and methodological perspective in which experiences of women and the socio-political landscape met (Harding, 2004). Standpoint theory encompasses the notion that the only way of knowing a socially constructed world, is knowing it from within. Positioning myself within the peer groups and supportive spaces women with lived experience navigated, was embedded throughout the study. However, Medina (2012) argued that those who are not

oppressed can achieve epistemic advantage through collaboration. An emphasis of co-creation and collaboration is weaved within the iterative stages of the study proposal, as well as the in-depth interview technique. The specific and broader conversations held in these DA supportive spaces (refuge residency and community groups) were not necessarily intended to produce participation in recruitment, but to listen and learn; to shape the study from the perspective of those who knew. If all knowledge is situated within context, then reflecting on such knowledge generated through experience can become an epistemological privileged standpoint (Ashton and McKenna, 2020). Fundamentally, the epistemic privilege of those working within DA support, and those with lived experience was initially sought to discuss the study design. The input shaped recruitment strategies as well as methodological choices.

Feminist standpoint theory argues the traditional androcentric perspectives often neglects the viewpoint of women and marginalised groups (Harding, 2004). Knowledge gained through social oppression is powerful (Ashton and McKenna, 2020), the literature field details the shame and stigma associated with mothers experiencing DA (see Crawford, Liebling-Kalifani and Hill, 2009. Moulding, Buchanan and Wendt, 2015) and thus their insight cannot be replaced nor substituted in gaining perspective. Furthermore, those who are oppressed are less committed and more resistant to the assumptions embedded within justificatory resources applied to practices (Harstock, 1983. Ashton and McKenna, 2020). Marxist historical materialism bases a notion of economic exchange and social relation being experienced differently by the oppressed and the oppressor (Mitchell, 2004). These different experiences cannot be viewed through the same lens. Feminist standpoint theory builds on this concept of experience standpoint and applies such to gender oppression, and the multiple intersecting dimensions of

experience. Campbell (2015) makes claim that social setting does not determine, but shapes insight. The central idea is that individuals can reflect on their experiences and thus turn them into an epistemically privileged standpoint (Ashton and McKenna, 2020). The recruitment of women was undertaken after a period of researcher integration within their spaces. Women, due to their historical and social positioning, offer insights that challenge the often-dominant narratives to provide a more nuanced understanding of various phenomena (Ashton and McKenna, 2020).

Feminist standpoint theory goes above examining the perspectives of certain women but appreciates their views within the socio-political space (Bohrman *et al.* 2017). Feminist standpoint theory does not require groups to be the same, but allows for different intersectionality (Collins, 2004) if general experience is similar. Standpoint theory enables those in power to be challenged (Medina-Minton, 2019), for the purpose of this study, those in power will be the health visiting systems and professionals that dictate supportive direction. Harding (1997) suggests that feminist standpoint theory offers multiple-knowing positions, grounded in experience. It strays from the notion of the 'knower' being someone with power and in authority. Smith (1990) criticises early feminist standpoint theory thinking, and later Kokushkin (2014) agrees that the standpoint of women is in constant opposition to the standpoint of knowers/those in power. Such binary stances of understanding become conflicted when taking into consideration the discussion surrounding gender and sex, and broader intersectionality's. Can women's experiences be grouped together? Smith (2005) argues that the origins of feminist standpoint theory outlined in the early 1990's have progressed into the methods applied, and that collective experiences of women can no longer be applied to represent them

as a group. Collins (2000) discussed black feminism meeting standpoint theory, and how the ethic of caring, emotionality, empathy, and expressiveness, are contained within a personal viewpoint. Combining individuality and appreciation of self that encompasses health visiting practice is translated within a standpoint approach. It is a standpoint concept, with its consideration of power and privilege of lived experience that will be encapsulated by the undertaking of the study.

Ethical engagement and care

Feminist research prioritises ethical practice of collaboration, and avoids practices that may exploit, or further oppress groups (Sprague, 2016). Neoliberal, consumerist approaches often seen within health research prioritise the professional or system (Green and Johns, 2019). It was therefore paramount that this study enabled an ethical engagement with stakeholders and participants that valued input that shaped and informed, rather than simply fulfilling an objective requirement. Feminist theories relating to care, explore and seek to understand the responsibilities and relationships of individuals (Green, 2012). Feminist theory is politically positioned; focused on gender, reflexive within process, and transformative in action (Gutafson, 2000), it furthermore illuminates the inequality of *masculine* and *feminine* traits within nursing (Green, 2012). Notably, Pincha Baduge and colleagues (2024) systematic review noted the prevailing femininity of care proved a significant obstacle for women in their career progression of nursing. The overwhelm of female health visiting workforce, and men within senior nursing roles (World Health Organization, 2019) supports the fact that the perception of submissive care associated with femininity is not an obstacle for male nurses (Gauci et al. 2023) therefore, nursing must be concerned with dominance and oppression. Care is relational and interested in

connection and relatability, and to impose such, as akin to health visiting practice, the connection between the researcher, participant, and key informants is centralised. The divide of power imbalance between caregiver and caretaker is implicit, with a risk of women, as the oppressed, remaining in a passive role (Westergren, Edin, and Christianson, 2021). The process of this study is woman centred in approach and practical terms, the overwhelm likelihood of women imparting knowledge or influencing this study is for-set, with myself as the researcher, and both data sets. However, it is important to simply not advance a statement of ethics by reducing the study down to its *woman-ness*. Ethics and care examine the relational and rights aspects of approach and doing.

Feminists call into question the universality of rights arguing that women's morality differs (Caswell and Cifor, 2016), with Jagger (1992) arguing that the notion of rights being privileged over relationships was failing women. Caswell and Cifor (2016) postulate a feminist perspective of care that does not concede moral assumption broadly but examines context and connection through the webs of responsibility. They further argued caution over reducing women to their biological defacto of carer, rather than focus on the socialisation of womanhood in which all relationships were viewed as contextual and emotional. Fundamental to this design, within the acknowledgement of DA, sits the additional layers of responsibility for both mothers and health visitors: safeguarding. The neo-liberalist stance of personal freedoms in a market economy, agency over decisions, and autonomy, are simply ideologies driven through a male lens that often deflects the reality of privatisation, economic and natural disaster and chronic underfunding that women bare the brunt of (Caswell and Cifor, 2016). If law and criminal justice hold us accountable to the state in an objective and universal entity, then the need for

feminist human rights conversation and policy is required to enable understanding and interrogation of the integrating structures of injustice within morality, care, and labour.

As demonstrated within this chapter the intrinsic link between health visiting practice and qualitative underpinnings appears obvious when recognised. However, health visiting is part of the wider nursing and midwifery family notably recognised within NMC registration status and requirement. Yet this 'family' of practitioners is part of the wider spectrum of health and medicine practised within Westernised society. Whether I dispute the objective and positivist stance of universal truth, I cannot deny the influence of such over practice, support, and intervention. Health visiting is built on the foundations of universal access to delivery of care, as is the wider National Health Service. However, this study, as I believe health visiting practice also to be, is about understanding and recognising experience: past, present, and future (Orbanic, 1999). Thus, adapting the '*what next*' of care through reflexivity, acknowledgement of multiple realities, and utility of approach, becomes meaningful (Mackey, 2005. Orbanic, 1999). As Orbanic (1999) explains care to be in response to the perception of meaning, and how meaningfulness and caring are intertwined, and each exist through the other. The concept of care in research extends beyond compliance with ethical guidelines, but embodies the profound responsibility toward subjects, communities, and wider social ramifications of inquiry (London, 2022). Furthermore, London (2022) moves to postulate research enterprise to go beyond focusing on the singular, but broaden its research to wider communities, bridging the gap between the basic interest of the social community, the wider societal institutions, and the endeavour to safeguard.

Feminist ethics of care is concerned with relationality and interdependence (Kittay, 2020). Its focus is to ensure care remains in the public domain (Tronto, 1993), and this cannot be achieved without examining the political landscape (O’Riordan *et al.* 2023. Loughnane and Edwards, 2022). Loughnane and Edwards (2022) analysis of care concluded it to be; as being a *value*, as being *relational*, and as a *practice*. Himmelweit (2008) argues in their paper presented to the United Nations, that inequality in care exists within the distribution (not based on need); on production, and on available resource. They argued that as capital gains continued to rise and inequality gaps increased within the labour market, the determination of care responsibility held by women would perpetuate (Himmelweit, 2008). Further noted were the terms and conditions of maternity leave being directly linked to the gender inequality within resource production prospects (Himmelweit, 2008). Previous studies support the conclusion that women continue to carry the burden of unpaid care within the domestic sphere (Boyer *et al.* 2017. Henriques, 2020). Furthermore, Caroline Criado Perez’s book *Invisible Women* (2019) thrust the issue into the wider public conversation in which the data gap of inequality was highlighted, particularly within the sphere of care. Concluding, MacLeavy (2020) postulated that the neoliberal marketplace leaves little room for the concept, practice, and work of care to move into the public debate, and whilst this remains, the burden will fall to women. They further highlighted the illumination of the issue brought about by the COVID-19 pandemic in which drastic changes in delivery and undertaking of labour markets occurred, but domestic care fell further into the hands of those within the home (MacLeavy, 2020). Feminist academics and activists are calling for a thrust of a rethinking of care, and the requirement for leaders to view the ethics of care through a feminist lens (Tronto, 1993. O’Riordan *et al.* 2023. Loughnane and

Edwards, 2022. Kittay, 2020. Held, 2006). The changes in working patterns, increased use of artificial intelligence and technology (MacLeavy, 2020), changing dis/ability of populations (Himmelweit, 2008), and globalisation (Fulu and Medema, 2015), require a rethink of the political landscape when considering care.

As both a practitioner and a researcher, this study encapsulates care in its approach and positionality. Inquiry into phenomena through the realities of those who experience it is the focus of this piece. Undertaking such a task requires an intentional, considered, and passionate approach to ensure the care and safety of all those involved. As Downes and colleagues (2014) note, the lack of evidence coming from the voices of women and children victimised through abuse and violence is compounded by their engagement as being from vulnerable groups who require further protections in research (Bredal, Stefansen and Bjørnholt, 2024). Ensuring those with lived experience remain key stakeholders and peer reviewers, is key to ethical engagement (Downes et al. 2014).

3.3.3 Feminist health visiting practice.

Feminist researchers MacKenzie, Dodds and Rogers (2014) explored differing concepts of vulnerability positioned as dependency-driven (see Kittay, 1999), political, or morally motivated (see MacIntyre, 1999). Notably they positioned vulnerability as an inherent human condition. Within their work, as explained by Jämterud (2022), vulnerability was considered in terms of pathogenesis, relational, and inherent in nature (based on autonomy). To consider relational vulnerability is to acknowledge barriers to autonomous choices made in life with one's own belief system and values (MacKenzie *et al.* 2014). However, a holistic approach does not reduce

an individual to their 'parts' (in biology or definite terms). If vulnerability is a broad-church of different elements, when dealing with so called 'vulnerability' within a service provision approach, one must understand what is meant by the term. Crucially, a person's autonomy should be regarded and understood within the cultural and social system and considering the intersubjectivity of the self (MacKenzie and Stoljar, 2000. Käll and Zeiler, 2014). It is, as Jämterud (2022) notes, that decisions are made within the social context, and to understand relations one must first unpick the relational power and oppression that lies within a person's autonomy. Health visitors demonstrate the relational aspects of support as part of the demonstration of health creation that is individualised. If there is inequality, how can we deem any decision ethically autonomous in nature? Through a co-informed and co-produced understanding of what something is. This study is not driven by the desire to produce specific frameworks and outcomes, but rather to understand.

Interdependence of the human condition has been previously explored (Kittay, 2020. Held, 2006. Barnes, 2012). The ongoing mutuality of those that receive care also provide care, and those that provide care are within the nature of care delivery itself (Kittay, 2020). The fluidity of the prism between provider, receiver, and care work is further amplified through feminist ethics of care (O'Riordan *et al.* 2023). The core principles of *change*, *containment*, and *reciprocity* are situated within the practice of health visiting (Douglas, 2010. Douglas and Johnson, 2019). Such is demonstrated within the data collection methods and reflexive nature of methodology; the ability to change direction within the context that acknowledges the power of knowing. Both within practice and research, reciprocity is undertaken to address the power relationship, whether this is between the parent-infant, parent-professional, or

participant-researcher. Reciprocity is the process of developing interactions that are in tune with one another based on respect and connection (Douglas and Ginty, 2001). Within feminist research, the researcher is encouraged to acknowledge their own social standing, political ideals, and philosophical stance, and that this may impact the research at any stage (Hesse-Biber, 2014). In acknowledging such, the feminist researcher can utilise reflexivity and reciprocity by considering the research questions and potential outcomes in terms of benefit (Johnston and MacDougall, 2021). Undoubtedly the researcher will gain some benefit from the research, in the better understanding of a phenomenon, or in this case, the completion of a thesis. By recognising this, the researcher can begin to shape the study and put in place aspects that demonstrate reciprocity through the ethics of informed consent and allow participants an opportunity to reflect on any potential benefit or disadvantage they may experience. This enables the dynamic process within feminist research of co-production and mutual respect.

Maternity care ethics are argued to be rooted in medicalisation and in terms of safety (Salter *et al.* 2021. Clesse *et al.* 2018). However, feminist researchers (Newnham and Kirkham, 2019) argue such a basis of 'bioethics' becomes difficult to translate into the relationship held in practice. Maintaining reciprocal relationships cannot happen within the underpinnings of such patriarchal assumptions held within paternalism (Buchanan *et al.* 2022). Feminist principles are central to health visiting practice, nurturing a trusting relationship between parents and professionals that is strengths-based and produces positive outcomes. This is demonstrated by Song (2012) in their study. Women's recovery from domestic violence and abuse was facilitated by the very nature of the relationship they had with a key professional (Song, 2012). However, health visiting practice, like any healthcare intervention, cannot be purely placed within the

post-modern, social constructionist world of subjectivity and feminism. The ecology in which the Westernised healthcare system exists is such that practice is governed through law, policy and procedure, and is done so through standardised operating procedures, audit and legislation. Such is not up for interpretation or perception of experience. Something is either achieved or not achieved, the *what* that is undertaken and the *what* that is the outcome. So, what is the *what*? Barnes (2012) argues that feminist care demands responses that enable social justice. Feminist care is political at its essence, demanding consideration of power with the relational landscape (O’Riordan *et al.* 2023). Tronto’s (1993) early work considered that the segregation of care into the domestic and private sphere, would perpetuate a crisis in the powerlessness felt by people, and othering from the political marketplace. What is required is a centralised approach to care within political discourse (Tronto, 1993. Ward, Ray and Tanner, 2020). A positivist stance encourages medicalisation, and a paternalist relationship of task orientated intervention; whether it is providing clear safe-sleeping guidance to a new parent that is static and not up for interpretation, or the understanding of an action, interaction or experience within an intimate relationship that moves from safe and appropriate, to unsafe and unlawful. The law and legislation in many circumstances requires professionals to use their knowledge to make such clear distinction, therefore we cannot fully move away, or claim practice does not still enlist such a philosophical stance. But what about the area of experience between the safe and the unsafe, between the law and the unlawful, and between moral acceptability and unacceptability? Suddenly practice has moved into the undefinable, the unquantifiable. When we move into this place, we must enlist skills of subjectivity and

understanding. Such can only be achieved through connection, empathy and shared experience... a space in which health visitors excel. Or do we?

The salutogenic practice of health visiting, that is both understanding of person ecology, and person valuing (Cowley *et al.* 2013), recognises individual stories that are both complex and diverse. Vasiliou *et al.* (2013) identified that community nurses practice with cultural competence. They stated that recognising cultural diversity was more than globalisation and immigration, but encompassed cultural knowledge, sensitivity, and awareness. Regardless of homogeneity within a population, we are indeed, all very culturally different. Both the most recent triennial reports into the serious case reviews for children (Brandon *et al.* 2020) and adults (Preston-Shoots *et al.* 2020), identified that key cultural information within safeguarding cases continued to be missed, overlooked or not considered (Child safeguarding review practice panel, 2021). Bywaters *et al.* (2016) identified the problematic evidence base within the analysis of many serious case reviews involving abuse. Their report noted the strong link between family dynamic and culture, and the chances of children experiencing abuse. However, there continues to be a lack of joined up thinking and analysis within practice. Health visiting, and wider public health is a meritocracy collective, of those in power holding merit within their professional achievement, rather than experience of vulnerabilities or safeguarding issues (Viana and Silva, 2018). Srinivas (2021) argues that foregrounding human dignity, regardless of position or merit advances the collective societal goals of health promotion and reduction of inequality. Furthermore, they state that the more an individual or group has power and influence, the more they need to listen and learn. Srinivas (2021) moves on to discuss academia within the public health arena, however the message is translatable to public health practice; in

that the more the aspiration of equity and justice, then the sharper the scrutiny of one's own community, and the various '*isms*' (sexism, colonialism, racism) that impact upon practice and guidance.

Lived experience and health visiting

The compatibility between social work and feminist standpoint theory has been researched and evidenced (Keeling and van Wormer, 2012. Harding, 2008. van Wormer, 2009. Ashton and McKenna, 2020), however there has been little demonstration of its application within community nursing, and specifically health visiting. The presented evidence on feminist standpoint is not directly addressed within health visiting academia. Positions are explicit and implicit in reflexivity and recognition of the individual; however, they exist within the male dominant medicalised discourse of need and health prevention. As Ardill (2013) asserts feminist standpoint theory addresses the researchers own privilege in relation to those they research and furthermore legitimises lived experience when there is no vested interest (Eagleton, 2003). The underpinning philosophy of health visiting as Fanner and colleagues (2022) proports to be social justice, however, as Ardill (2013) argues such liberal frameworks are produced and driven by market ideology. As their work noted, often well-meaning scholars will make careers out of being self-appointed experts to the detriment of those with lived experience (Ardill, 2013). This criticism, although in this case relating to colonialism of indigenous populations, captures the essence of standpoint theory, and what I believe, health visiting does not fully consider. Understanding the role of public health surveillance and child protection within health visiting

does leave one wondering how feminist standpoint theory can be fully immersed in practice. However, the gap in critical thought of its conceptual underpinning still appears limited.

Feminist standpoint theory values the perspective of women experiencing DA above all others (Bohrman *et al.* 2017). The lived experiences of marginalised women are often overlooked by those in dominant groups. Dominant groups included those that benefit from the paternalistic assumptions made within healthcare. It is questionable if there is consideration of the benevolent interventions that women are encouraged, or directed to engage with, and how such oppress further under a new controlling structure (Campbell, 2015). What is it truly like to live a life experiencing DA? Can only the individual fully conceptualise the practice of power they experience? Or, can victims become so suppressed within the control they are unable to articulate and advocate without an outsider view? Those in power need to collaborate with communities. Fourie (2011) discussed *transformative innovation*, in which communities need to be completely at one with the research process, rather than as by-standers dipping in and out. This study enlisted informal discussions with practitioners as to its direction and goal, as well as drawing on personal reflections surrounding DA. The recruitment in its design will enlist the integration of the researcher into previous groups unknown to myself. Harnessing and building trusting relationships with facilitators of DA support, and women themselves is hoped, result in participation. Importantly this immersion will enable an organic evolution of the design in real time. Health visiting philosophy is underpinned by an integrated framework that focuses on health promotion, and within safeguarding building community connections and supporting families (Institute of Health Visiting, 2022). Fundamental to the study design was engagement talks with stakeholders at the planning stage. Individual practitioner experience was used to

direct the research proposal. In addition, conversations with health visiting staff, service users, and third-party organisations enabled the formulation of the study aims. These connections with individuals, and the support delivered will remain at the focus of this study.

A richer and deeper understanding of public health issues comes from the fair distribution of common advantage and common burden: a true philosophy of public health is the dream of justice and fairness (Gostin and Powers, 2006). Using considerations utilised within standpoint theory will enable positive social change, as well as providing another view of requirement and need from those who are not in power (Kokushkin, 2014).

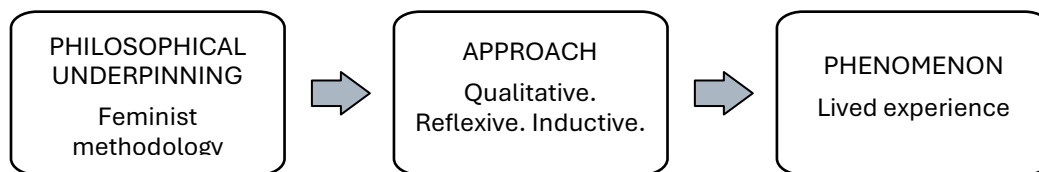


Figure 3.1 The philosophical processes of this study. This ensure the voice of those with experience are heard and give meaning to current practices and potential progress.

3.4 This Feminist research process

The feminist research journey is often non-linear, and reflexive throughout. Qualitative methods allow for the exploration of lived experience in depth, and commonly the use of ethnographic fieldwork, interview, focus group and narrative analysis are applied. For this study the use of interviews and reflexive thematic analysis were chosen as they centre the participants' voices and consider the power dynamic operating within the processes of discussion.

Figure 3.2. This qualitative study process



Aligning purpose, process, and context within a study ensures a convincing account of real-world questions (Thorne, 2016. Adam, Hooker and Taft, 2023). Ensuring epistemological integrity is essential to the exploration of lived experience, as well as how such is demonstrated related to the *knowingness* of the researcher as a practitioner, and the reflexivity undertaken throughout the whole process. Many of the attitudinal practices required within qualitative research are present within health visiting philosophy and principle (see figure 3.3).

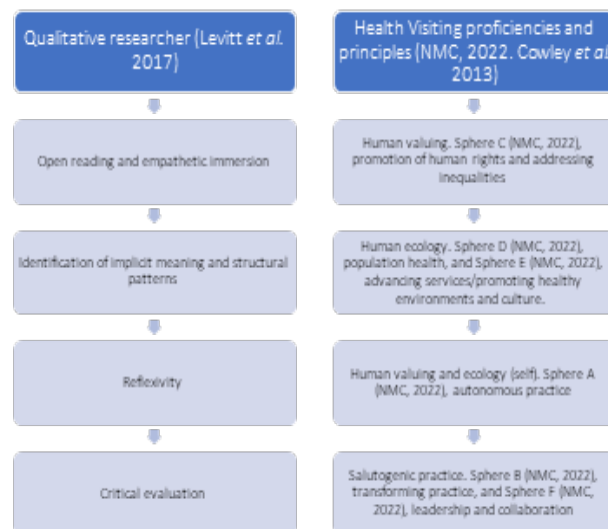


Figure 3.3. Comparison between health visiting proficiencies and qualitative approaches.

The synergy of the relationship between researcher, study goals and study design are fundamental within the application and consideration of qualitative research (Levitt *et al.* 2017). Levitt *et al.* (2017) positioned the concepts of *fidelity* and *utility* central to ensuring integrity within qualitative research. *Fidelity* being the recognition of my own perspective and experiences, and how I understand and consider such within this methodological underpinning of study design. Such a concept is pertinent within health visiting practice. Praxis requires recognition, understanding, and application of one's own *knowing* in practice (Rafii *et al.* 2022). Such a complex package of care provided within the philosophical principles of health visiting (Cowley *et al.* 2013) requires a sophisticated understanding of how the practitioner can consciously and unconsciously influence delivery of care (Rafii *et al.* 2022). As a health visitor and researcher, the immersion of practice allows for a deep reflexive account of what is known and done, a praxis as Carr and Kemmis' (1986) note, that needs continued focus. Furthermore, nuanced and abstract interpretations of nursing praxis consider the art of forming relationships of compassion, in which both the practitioner and receiver sit in their questioning and response (Enzman-Hines and Gaughan, 2017). Rather than fidelity being used as a model for implementation or effectiveness, within qualitative considerations, fidelity is rather a process of undertaking (Rafii *et al.* 2022), with the researcher being transparent about their influence and perspective within data collection and analysis (Levitt *et al.* 2017). I suggest this to be transferable to conversational practice undertaken within health visiting. To be 'salutogenic' in practice, considerate of human ecology, and creative (Cowley *et al.* 2013), this can only be undertaken with an awareness of self and the power one holds within working relationships. Tracy (2010) posited criteria for ensuring validity within qualitative study, which I again believe

to resonate within the conversations undertaken within health visiting practice. Ensuring worthy topic, rich rigor, sincerity of intention and analysis, and credibility that is recognised within reflexivity (Day, 2012), resonance and significance of contribution, ethics of application and care, can then be indulged within meaningful coherence (Tracy, 2010), both in practice and consideration. However, as Denzin (2008) noted, it is important to remember that created criteria only exist within the author's paradigm, yet markers of quality can be applied by qualitative researchers across all paradigms (Tracy, 2010).

3.4.1 Sampling and recruitment

When considering sampling, Dixon-Woods and colleagues (2006) detailed the concept of candidacy for vulnerable groups. Their synthesis of the literature, being specifically applied to accessibility to healthcare, is an important consideration for this study. The synthetic construct of candidacy is constantly defined and redefined through the service provider's perceptions of health, as well as the prioritises of health services. Acknowledging that health services are based upon normative assumptions is along a similar thread of recognising the privilege held by researchers in relation to participant eligibility. Dixon-Woods et al. (2006) remind us that utility is not a measure of equity.

The focal question and identified area (see figure 2.9), centre the health visitor and mothers' experience of DA within the working relationship. This study will unpick the dynamics of what happened, perceptions of why things happened, and seek insight into the desires and outcomes from both parties all within the context of DA being a reality for the mother and her child(ren). In seeking understanding from a working relationship, both parties within were requested to

participate. Purposeful sampling will occur with the total sample population consisting of heterogeneous groups including health visitors, and women/mothers. There will be the shared experienced of the working relationship, however, the differing perspectives will be sourced through the differing groups. Both sample groups are information-rich with a deep understanding of the phenomenon within the constraints of the working relationship (Patton, 2015).

Generally, within qualitative research the size of the sample tends to be smaller than that of quantitative research due to the in-depth enquiry, and sufficient sample sizes within heterogeneous populations have been suggested as being between 14-20 people (Immy and Holloway, 2017). Larger sample sizes have been deemed unnecessary and can furthermore lead to the loss of unique and specific experiences of the phenomenon (Todres and Galvin, 2006).

Within the protocol design submitted to organisations a sample set of 15 health visitors was proposed, this was deemed sufficient within the time constraints of the study and considering workload for individual health visiting teams. In the quest for meaning, like support within practice, considering experience from one individual cannot be applied to the masses. Health visiting proficiencies are specifically detailed to be proportionate and undertaken with an understanding of the individual (NMC, 2022). Evidence of experience of DA informs us time, history, context, and impact are different for individuals, the nature of the insidious pattern of behaviour demands we hear the individual experience (Pratt-Eriksson, Bergbom and Lyckhage, 2014). Unlike other methodologies, reflexive thematic analysis (RTA) can be applied to smaller sets, as well as alongside other methodologies to create hybrid analysis techniques (see Ronkainen et al. 2016).

The epistemological stance of feminist standpoint theory ensures that voice is given to those with lived experience; the feminist perspective will focus on the experience of the woman who is dealing with DA within her family dynamic. For this reason, women only will be sampled through service user involvement. The health visiting profession overwhelmingly employs females, which is reflected within statistics relating to other community and public health nursing roles. It is foreseen that the total sample of health visitors will be entirely, or a high majority female also, however male health visitors will not be excluded from the study as they will give valuable insight into the role through a gendered lens.

Table – Study eligibility criteria.

Inclusion criteria	Exclusion criteria
<u>Professionals</u> Practising health visitors with active SCPHN qualification in England Experience working with families who have disclosed DA or have supported a family following a DA incident over anytime period since qualification.	<u>Professionals</u> Outside the professional qualification (inc. student health visitors) No experience of working with families experiencing DA
<u>Service users</u> Women/mothers Over 18 years in age	<u>Service users</u> Men/fathers Under the age of 18 years No children and/or children school age

At least one child pre-school age, and in receipt of support from the health visiting service	No disclosed experiences, and/or incidents of DA
Experienced DA in any capacity under the Domestic Abuse Act (2021) definition	Not attended a third-party DA intervention programme
Engagement, and completion, in a third-party domestic abuse intervention programme	Insufficient use of the English language to prevent providing informed consent and undertaking of interviews.
Sufficient use of the English language to read and sign informed consent, and take part in spoken English language interviews	

The invitation to recruitment was envisioned as being autonomous with care and safety of participants centralised. This was particularly important given the potential harms an inquiry such as this could cause to participants when discussing DA (Bredal, Stefansen and Bjørnholt, 2024). However, ensuring these voices are heard prevents the concern of vulnerability and potential harm acting as a barrier to recruitment (Downes et al. 2014). Rather than a focus on persuasion to participate, the study information will activate an individual's desire to participate due to personal benefits of retelling their experience and enabling agency (Bredal et al. 2024). As Salter (2012) considered, a re-validation of experience will drive the benefits of participation. The reflexive stance of recruitment and data collection recognises that the meaning to those who hear and listen can be different from those that speak, and therefore, not everything can always be categorised. Theoretical sampling and data saturation, although

commonplace in other qualitative methods (including grounded theory) (Braun and Clarke, 2020) will not dictate the close of study. Rather the benefit to validate experience will allow for those who wish to take part to do within the open recruitment period.

Informed consent and participant autonomy

The priority of autonomy and dignity of participants is fundamental to feminist research. As Kraft et al (2021) explore, demonstrating respect for people within research encompasses the obligation to individual rights, needs, feelings and interest. Furthermore, such a demonstration from the outset enables the building of trust between the researcher and participant (Dave et al. 2018). However, as Elander, Beach and Haywood (2011) note, the experience of respect is subjective and therefore it is necessary researchers understand the behaviours that demonstrate such (Kraft et al. 2021). From their study (Kraft et al. 2021), most participants noted inclusion within the design to be of importance within respect. To encapsulate such the reflexivity throughout this study has considered both my own practice, historical and more recent conversations with colleagues, as well as immersion into spaces that support women through their experience of DA. To ensure interview questions direct the study to achieve the study aims, careful discussions took place to allow for potential participants to consider how their perspectives could be explored.

All potential participants were provided with written study information prior to deciding whether to take part in the study. Within this study information, the intention of the researcher was detailed in seeking their perspective within the key elements of the Code of Practice (Nursing and Midwifery Council, 2018). Furthermore, the NMC code (2018) positions evidence-based practice to be essential to the awareness, accessibility, availability, and interventions

employed by registrants (Whiffen, Barnes and Henshaw, 2024). By therefore acknowledging my registration and adherence to such stipulations, my own positionality is implicitly stated for those that have awareness of such (fellow registrants). Yet I do not expect all potential participants to have an awareness of the NMC code fundamentals and because of this a brief snippet of my current practice is provided to give context. As well as this, an explicit admission of respecting participants' needs and wishes throughout the study by stating their ability to remove themselves from the study if they wish, and abstaining from answering any questions should they wish. A clear comment is also given within the information informing them that their taking part does not affect any element of the support they are receiving in terms of universal care, specialist intervention, or employment terms and conditions. Due to my own registration and safeguarding obligation, it is made clear within the information that if any safety concerns are discussed for which I feel there is risk towards individuals and/or people, these will be discussed and escalated accordingly. By providing such information it is hoped the transparency of the study endeavour is provided without any concern of ulterior motive.

3.5 Consideration of methods

Ankney and Leonelli (2024) conclude that qualitative methods are being increasingly utilised within research. The utility of qualitative methods provides a nuanced understanding, knowledge production, and meaning (Ankney and Leonelli, 2024). Qualitative inquiry provides a rich understanding through exploration, often navigated within complex realities (Renjith et al. 2021). Qualitative design approaches emphasise and encourage interpretation and nuance (Sprague, 2016), undertaking interviews with intense focus on detail enables such. It is a contraindication to provide marginalised groups with the opportunity to speak, but only speak

of the things that another wishes to hear about (Gatenby and Humphries, 2000). To enable those with the insight to speak of their experience, a reflexive perspective was used throughout, as well as intentional discussions with key stakeholders. Qualitative methods are often utilised within nursing research as they encapsulate the recognition of care and meaning, both often pose a question and recruit accordingly. Reflexivity is encouraged with the researcher's evolving understanding reflecting the hermeneutic circle of co-creation (Mackey, 2005).

The undertaking of qualitative research involves often systematic considerations which have been applied to this study. Such as exemplified by Ankney and Leonelli (2024) mirror the stages undertaken within this study; 1) Identification of focal question, 2) representation of a gap or area of development, 3) Choice of location or population, 4) Planning and undertaking of empirical study, and finally, 5) analysis and interpretation of data. Figure 2.9 demonstrates the specific points relating to this process. The theoretical approaches applied with thematic analysis (TA) offer the focus on patterns of meaning, with flexibility being informed through feminist philosophy. Such a use of TA within a feminist approach is exemplified in Hayfield, Clarke and Halliwell's (2014) study by giving voice to women whilst locating experiences through meaning.

3.5.1 Reflexive thematic analysis

Reflexive thematic analysis (RTA) is positioned by Braun and Clark (2022) as not only a method of making sense of data, but also as a conceptional process for undertaking study design and doing. Thematic analysis (TA) has been detailed to have three characteristics in concept;

flexibility, procedures for coding and themes, and coding that manifests through meaning (Braun and Clark, 2022). This 'spectrum' of analysis is not always explicit (Carter and Little, 2007), however TA is not supposed to be one method, one way of doing it (Fugard and Potts, 2020). Rather it is applied with the underpinning research values (Braun and Clark, 2022) of owning one's own perspective and meaning. Feminist approaches are fundamentally critical of the androcentric processes that have historically left out marginalised voices (Hawkey and Ussher, 2022), the utility and flexibility of RTA enables a fresh approach to exploring study design, interpretation and analysis. Braun and Clark distinguish between TA through the methods taken relating to coding; code reliability, or the use of a codebook. Like TA in analytical approach, is qualitative content analysis (QCA) (Schreier, 2012), yet the difference lies in the emphasis of researcher bias within QCA, and therefore the use of multiple coders (see Schreier, 2012. Burla *et al.* 2008). Such an explanation of a method applied aligns with post-positivist assumptions (Braun and Clarke, 2020). Similar again to TA is interpretive phenomenological approaches (IPA) (Smith, 2019), IPA usage (see Smith *et al.* 2009. Spiers and Riley, 2019) is described as fundamental human practice (Braun and Clarke, 2020). Noted to be semantic and latent in its search for overt and interpreted meaning, language is seen to reflect and communicate what people feel, with emergent themes developed for each individual transcript (Braun and Clarke, 2020). However, criticism lies in the neglect of the social context or world view within the analyses (Larkin *et al.* 2011), yet Spiers and Riley (2019) developed a study that enlisted both TA and IPA analyses, and concluded they worked well together, however they did recognise the usage of IPA within smaller data sets. The iterative stages of this study design included the consideration of different methodologies, including grounded theory and

interpretative phenomenology; both recognise subjectivity within realities. The post-positivist ontological underpinning of phenomenological approaches (Urcia, 2021) that recognised reality being independent from one's mind ruled out its use.

For this study, *reflexive* thematic analysis (RTA) is the school of direction to be applied. Bryne's (2022) concluding points note that RTA can never be fully one thing, or another thing. Noting thematic analysis (TA) to be typically constructivist (Frith and Gleeson, 2004) in epistemological terms, and inductively driven through data, the codes developed are reflective of the data, yet open to the representation of meaning (Bryne, 2022). RTA as described by Braun and Clark (2022) prioritises the values of the qualitative paradigms, however Bryne (2022) argues that theoretically, no approach can be exclusively linked to an epistemology, as themes can never be fully data driven, as such only evolved through a study design proposed by the researcher with pre-conceived views and experience. It is certainly true of this study, the drive to explore the perspective and perception of DA has built through years of health visiting practice and intrigue into the phenomenon. I did not enter this study blind, nor without the acknowledgement of my own pre-conceived ideas and direction.

Braun and Clark's (2006) inaugural thematic analysis (TA) will give foundation to the analytical process, however data analysis within the study will adhere to their contemporary approach of reflexive thematic analysis (RTA) (Braun and Clarke, 2019, 2022). It is hoped that the study will focus on the working relationship between health visitor and woman, exploring the support delivered, and how both felt during and afterwards. The reflexive approach to TA represents the researcher's own interpretation of patterns across the data set, furthermore, as a

registered health visitor, I will act as an insider' and be able to place situations within the working context.

Generally, data collection and analysis should continue until no new themes/codes emerge (Bryman, 2013), yet Van Rijnsoever (2013) writes that sample size is often implicit. There is a consensus in the literature that sampling in qualitative research should continue until saturation is reached or ceasing collection of data until all categories are exhausted (Endacott, 2005). Braun and Clarke (2022) argue that the theoretical concept of data saturation within meaningful qualitative methods is closely linked with grounded theory approaches. Knowledge is generated and constructed, and therefore as Mason (2010) details, there is always potential for new understanding. Knowing when to cease data collection is better understood in relation to meaning sufficiency, and therefore saturation is not conducive with RTA (Braun and Clarke, 2022).

The process of coding is flexible and evolves organically (Braun and Clark, 2019), themes are not predefined but rather produced through identification of commonality within codes (Byrne, 2022). RTA encourages subjectivity, and reflexivity under the constructionism paradigm for which the understanding of feminism being socially constructed and understood sits. Analysis will be adapted from Braun and Clark's 6-phased analysis (2019) -

- Familiarisation of the data
- Generate initial codes
- Generate themes
- Review potential themes
- Define and name the themes

- Produce a report

As an insider within the profession, sitting myself within the context of DA practice, sat comfortably with me. The early stages of considering methods, and how such would align with the study aims. Recognising the intimate, and at times delicate conversations held between women and health visitors that are not prescriptive in timing, direction, nor fluidity, would therefore be difficult to capture through observation. Rather, for this study aim, to seek perspectives and perceptions required an insight captured through narration that focuses on the content of stories, from phrases to long stretches of talk (ESRC National Centre for Research Methods, 2008), and the promise of hope and change (Denzin, 2004).

Interviews

The study will aim to seek further perspective of health visitors and women who have experienced DA, engaging in conversations about the support provided by the health visiting service. Giving both an opportunity to share their lived experiences about the support provided, contextual events, and collaboration, it is expected to provide further insight into individual experience and seek improvements to service provision. Using a feminist methodology to explore the phenomenon of DA, it will give voice to those with experience and seek to explore the power dynamics *within* their experience. The narrative method acts as a storytelling of experience to the researcher (Renjith et al. 2021). Combining data from both professionals delivering the support, and clients receiving the support would provide invaluable insight. Data collection is primarily achieved through interviews, but the use of journals, photographs and

reflections prove contributory (Renjith et al. 2021), however, for this study image or photo illustration was not utilised.

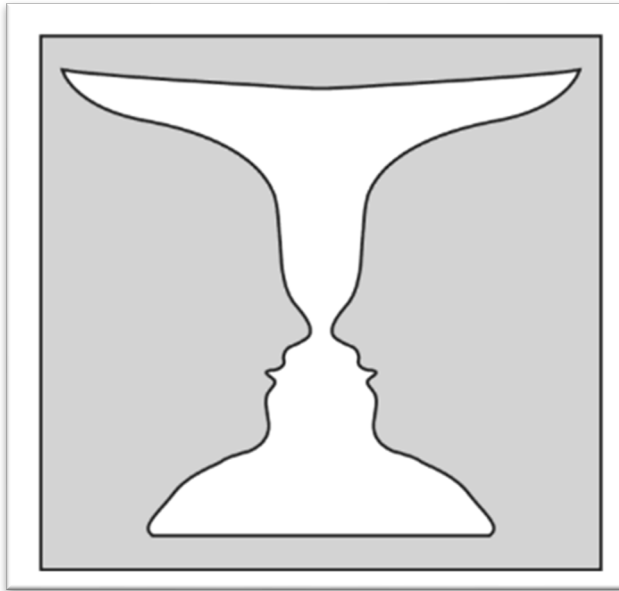


Figure 3.4.

This diagram as presented in Kvale and Brinkmann's book (2009) beautifully illustrates the conversation and *inter-change* between both individuals within an interview. The *inter-view* is a joint venture into the experience, that is nuanced and individualised to their story. The shape of the chalice is recognised, but the detailing is yet to be filled.

Interviews are best suited to provide in-depth and rich insight into lived experience (Renjith et al. 2021). Furthermore, interviews allow the researcher to explore unique insights held by individual participants (McGrath, Palmgren and Liljedahl, 2019). The interview allows the researcher an insight into the perspective held by the participant of a phenomenon, rather than seeking a generalised understanding of large groups (McGrath, Palmgren and Liljedahl, 2019) and often employed when researching marginalised groups (Reeves et al. 2015). The interviews were built around research aims that navigated perspectives of wider implications relating to DA involving family and gender dynamics, perceptions of health visiting support, and considerations of the achievable and/or wanted outcomes. The use of interviews aligns with

the methodology of this study to illuminate experience through participant insights and narratives (Wolf et al. 2024), and furthermore this method provided a direct lens into the world view of those recruited (Kvale and Brinkmann, 2009). Wishing to know about another person's world, you are best to talk to them (Figure 3.11, Kvale and Brinkmann, 2009). Like interviews, focus groups are a powerful method for exploring experience (Morgan, 1998), however often used for generating collective views (Gill et al. 2008). During the iterative stages of study design, a focus group was used to broadly discuss the study aims and lived experience of mothers attending a DA peer support intervention. The insightful discussions provided feedback as well as providing direction and encouragement to continue. Yet, it was also noted that there was some unease, or hesitancy in discussing certain areas of experience with others in the group, a similar conclusion noted by Gill and colleagues (2008). Moreover, with the importance of moderation during a focus group (Morgan, 1998), at times the difficulty to direct voices away from uncomfortable areas noted for others was apparent. Useful in terms of reflection and highlighting the privilege of experience in storytelling, interviews solely were employed to research the study aims.

3.5.2 Reflexivity in practice

The researcher is an active agent in consideration, interpretation, and analysis of data (Bryne, 2022) and therefore having a safe place to capture thoughts and reflections was fundamental to this process (Braun and Clark, 2022). Conceiving and accepting of wonder as Franklin-Phipps (2017) noted, the confusion in *doing* and *not doing* at times, and loss in direction, is the acknowledgment of wishing to find a way back. For this study, demonstrating credibility was founded in epistemological arguments presented within this chapter, to credibly fit within the

study process and analysis (Tobin and Begley, 2004. Bradbury-Jones, 2007). Advocating for reflexivity within the whole process (Bradbury-Jones, 2007. Braun and Clarke, 2022) can be captured through journalling. Such practice provides an opportunity for scrutiny and transparency (Polit and Beck, 2004). The purpose of a journal was to record *what* and *how* I saw, heard and thought about things, and continuing to ask myself reflective questions enabled this. Both a benefit and barrier, was the flexibility in conceptual analysis of this method of RTA (Trainer and Bundon, 2021). However, maintaining a journal provided a space to explore frustrations, and troubleshoot options to overcome. The flexibility and creativity captured within RTA can create wonderment as to the direction and processing of data and provides a platform for profound meaning production (Braun and Clark, 2022). The researcher reflections are captured alongside the transcripts during each stage of analysis (see appendix). Capturing reflections was considered within the use of computerised analytical tools, including NVivo. However, it was decided that a deeply reflexive approach was better suited to me using journalling and Microsoft Word documents with annotations at each stage.

3.6 Ethical considerations and rigor

3.6.1 Collaboration and co-creation

Rather than passive subjects, participants were involved as active agents within the process. Researcher engagement within participant spaces was crucial to building meaningful relationships prior to recruitment. Ongoing personal interactions enable inclusive and transparent environments within the study intention, as well as increasing perceived demonstrations of respect (Kraft et al. 2021). Such enabled potential participants and key

stakeholders to discuss the study, as well as explore broader concepts that were pertinent to themselves. Harnessing a perception and intention to collaboratively construct a study design enables the root to knowledge production to come from those with insight (Bohrman *et al.* 2017), as well as developing trust of participants when taking part in research (Dickert *et al.* 2018). Once data collection began, semi-structured interviews were employed as they allowed some specific questions to be asked to enable the participants to feel at ease and give demographic information. Following this they were asked to share experiences in an organic style of back and forth that reflected everyday conversation of exploration (Braun and Clark, 2022). Their discussions enabled the creation of the questions to uncover truth and meaning. Such inclusion enables empirical research to shift the normative thinking into a progressive model of co-creation and community inclusion (Kraft *et al.* 2021. Dave *et al.* 2018). Within a healthcare context, ensuring rigorous investigation incorporates the collaboration between researcher, service user, and health professional (Whiffen, Barnes and Henshaw, 2024). However, as Whiffen and colleagues (2024) acknowledge the triangulation between the three is not 'water-tight' in terms of evidenced practice. This study hopes to give voice to those with experience with an endeavour to progress practice and support. Under the guise of evidenced-based practice, the design is undertaken with the merits of collaboration. However, ensuring study transparency also adheres to the possibility of results that may not achieve meaning that is subjectively comfortable to read in terms of practice intervention, or support perception. Conversely, by undertaking conversations with those with experience in either victim/perpetrator insight, registrant practice, or stakeholder support, reflected potential questions that could allow for careful consideration of likely truth in terms of practice

possibilities and/or adaptations (McGrath, Palmgren and Liljedahl, 2019). The value of this study lies in highlighting that not all so-called 'evidence-based practice' is fully supported by research. Often, seemingly positive results are prioritised to align with practical constraints such as resource availability, time pressures, and specific settings (Every-Palmer & Howick, 2014).

3.6.2 Addressing power imbalances

Striving to reduce power imbalance between researchers and participants is key to feminist methods. Yet what we believe to be evidence-based does not always equate to truth (Whiffen, Barnes and Henshaw, 2024). A critical lens allows for the debate of truths uncovered, and with this in mind, I cannot undertake this study with the explicit achievement of 'uncovering the truth!' The power held by me as the researcher cannot be completely mitigated, however effort and procedure can be undertaken to reduce such within the constraints of this study. Efforts were made in this study to maintain non-hierarchical relationships by conducting interviews in spaces that were comfortable and neutral to participants. Participant voices are prioritised in the methods and analysis, with a continuous awareness of researcher assumption and meaning throughout. Addressing power dimensions used within interview methods is necessary, and considering the implications of undertaking such a task for participants is a consideration (Nimmon and Stenfors-Hayes 2016. McGrath, Palmgren and Liljedahl, 2019). This study, in the fulfillment of a PhD, attempted to ensure any request to engagement could be adhered to. However, capturing the voices of all willing to tell was restricted to those who speak the English language only, and other amenities to provide comfort to participants could not always be considered due to financial constraint. Reflections upon such will be later explored, however the acknowledgement addresses the power imbalance the researcher holds.

3.7 Concluding thoughts

This chapter has detailed the journey of thought and consideration of the different philosophical paradigms and views to establish the backdrop of practice, and research intention of this study. As previously mentioned, the intention of my own positionality, or this study, is not to discount or shatter the beliefs held by others. The presentation of the philosophical paradigms that underpin DA at a local, national, and international stage are themselves debated and contentious at best. Feminist theories privilege those with experience, acknowledge an ethics of care from the outset, and consider the power dynamics held within concepts of gender, race, dis/ability, economic status, and class, striving to want better. This study wants better.

Health visiting practice since the early construction in the 19th century finds itself in a weighty dynamic held between surveillance and support. How can ill health be prevented and healthy lifestyles promoted, as required by clinical governance frameworks, while also recognising individual differences in stories and experiences, and embracing the concept of the holistic self in every encounter? Furthermore, nested within this dynamic are the values, histories and culture held by the health visitor themselves: The prism of public health initiative, individualised experience, and self-identity.

A limitation of feminist research is the tension between scholarly rigor and activism, striking the balance between credibility, in academic terms, and being politically engaged is essential. Moreover, whilst reflexivity acknowledges research bias, it does not completely mitigate

researcher subjectivity. However, this study acknowledges such and offers a nuanced and contextualised understanding of DA within the health visiting service.

Reflexive thematic analysis (RTA) in its methodological approach accepts different paradigms and methods but rather focuses on utility. At its core, researcher subjectivity is a tool, and to generate meaning is an art, not a science. I, as a health visitor, am privileged to be exposed to others in their vulnerability, and within the reciprocal nature of the relationship, I expose my own vulnerability. Incorporating this notion of exposure and relational vulnerability is webbed throughout RTA. In its approach of narrative storytelling, as a researcher I want to hear other's insight. I want to learn from them, just as I learn every day in practice. Learning and knowing are never over, RTA understands this and embraces the ever-changing, ever-deepening understanding of life experience.

In demonstrating my own understanding of the methodological approaches, the proceeding chapter will set the scene for the systematic analysis undertaken, and the themes produced from the data gathered. Specific details of design protocol can be located within the appendix and may prove useful reading following this chapter. It is the endeavour of this chapter that the reader now has an appreciation of methodology that can enable analysis of the phenomenon of DA experienced during health visiting service provision.

Chapter 4 – Setting the scene

4.1 Overview of recruitment

Health visitor

In total 15 practicing health visitors were recruited into the study. The recruitment of health visitors was facilitated by two NHS trusts and within professional research forum spaces. The two NHS sites were in different geographical localities in England, recruiting 12 health visitors. The final three health visitors were recruited through research forums and were working in Scotland (n=1), South-East England (n=1) and finally Northwest England (n=1).

Unsurprisingly all the health visitors were women, with 13 identifying as White-British/Scottish, and two identifying as British Asian. The working experience ranged from 12months to 18 years.

Service users/mothers

The participation of mothers was achieved through the recruitment within refuge and support group spaces. Intensive engagement through conversations took place with individuals with expertise within DA support, as well as group discussions with mothers currently in receipt of third-party support or live-in accommodation. 13 mothers were successfully recruited into the study. All the mothers had experienced DA during a period whilst parenting a pre-school aged child and therefore in receipt of health visiting service. Some of the women who agreed to contribute to this study were living in refuge with, and some without their children, with all engaging in various DA support. The context of DA in perceived severity or longevity was not explicitly explored within this study due to limitations of time and endeavour. Some of the

women were still living, or in a relationship with their perpetrator, and some no longer in a relationship with them.

Seven of the mothers identified as white-British, two British-Black Caribbean, one British-Black African and two Pakistani, and one British Pakistani. All the women spoke and understood English. Their children varied in aged between six months and 13 years.

4.2 Introduction to the findings

Chapter 5 will present the findings from health visitors, and chapter 6 will present the findings from mothers that address each research objective to fulfil the aim.

1. Exploring the wider implications and perspectives of DA,
2. Exploring the broader perceptions of health visiting support,
3. Exploring the perceptions of achievable/wanted outcomes. 

During these chapters and the proceeding discussion chapter, when presenting findings pertinent to the data sets the term *health visitor* or *professional* will be used. These terms may be interchangeable but will represent the same data set, the different terms may be used to reflect the participants own identification of self or may be appropriate for the context of the presented argument. It is noted that some of the health visitors may at some point themselves have experienced DA in their personal lives. However, for the purpose of this study the health visitors are discussing DA within their professional remit. When the term *women/woman* is used this will directly reflect the other data set of mothers participating. Within the findings and subsequent discussion, the terms *woman* and *mother* will be used interchangeably but will

represent the same data set. The use of both terms may be done to reflect the participants own identity of self, or maybe appropriate within the context of the argument presented.

The following chapters will be presented utilising each research objective as a heading. The transcripts taken from the health visitors and women were analysed using Reflexive Thematic Analysis (RTA) as presented by Braun and Clarke (2022). Each transcript has been analysed using the six staged approach to produce meaning through familiarisation, coding, generation of theme, review and development of theme, refining and defining of theme, and finally reporting of theme. The systematic approach undertaken for each stage of analysis, built and generated findings. The interpretation of data will centre the theoretical underpinnings of feminist and reflexive methodologies. The themes produced from the data are overarching and cross over with the themes produced from the other data. Having the same themes, but differing in perspective from each involved, the interpretation within the context of first health visitor and then woman will illuminate the perception of each. The themes produced will be presented as sub-headings within each aim. The formulation of themes, sub-themes, and codes relating to health visitors and mothers will be provided within the appendix. The findings are taken from the voices of those contributing to this study with researcher meaning generated, and the presentation of such will reflect this.

The presentation of the findings will be descriptive, substantive and comparative. Findings will be supported by direct quotations from the participants, as well being placed within the literature field, allowing for considerations of practice. Considering RTA as a theoretical methodology, researcher reflexivity and subjectivity is encouraged throughout the data collection process. This study recognises that women's stories are not merely anecdotes but

represent real-world testimony (Jenkinson et al. 2017. Rich, 2021), with this in mind, “*extracts provide foundational validation for analytical claim*” (Braun and Clarke, 2022. P.131).

4.3 Overview of methodological approach

4.3.1 Reflexivity in analysis

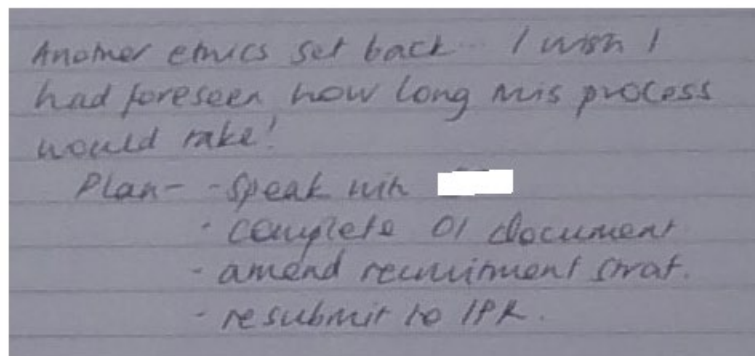
Reflexivity is a core component to qualitative study designs, and as the name suggests, is fundamental to reflexive thematic analysis. Within RTA, not only is reflexivity reflecting upon the research process, but also the researcher role; a critical interrogation of what, how and why, we do (Braun and Clarke, 2022). Termed “*positivism creep*” (Braun and Clarke, 2022, p.7), utilising tools within qualitative paradigms requires the avoidance of positivist-empirical objective valuing and bias in search of a definite truth. Essentially to mitigate bias through avoidance does not harness the value of reflexivity of acknowledgement, one must be comfortable with uncertainty; akin to practice within the context of child safeguarding is the ambiguous nature of its occurrence, presentation (NSPCC, 2023), and outcome (Dickens et al. 2024). Furthermore, maintaining reflexivity throughout (in research and practice) enables a transparency in terms of consideration, action and inaction, as well as a focus on quality (Silver and Lewins, 2014).

Personal reflexivity and journalling

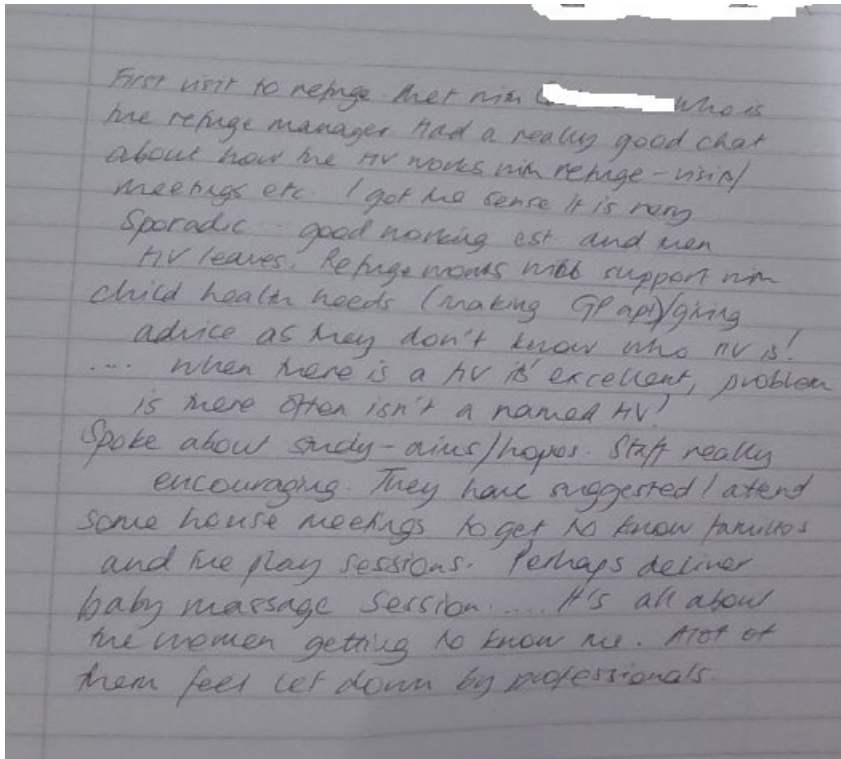
Journalling that contained my own emotions and subjective perspectives was a deliberate undertaking throughout the study process. I ensured I maintained a reflexive journal that had entries every 1-2 weeks dependent upon the stage of the study, with some entries a daily occurrence when key developments happened. As undertaken by Bradbury-Jones (2007) the

reflexive journals were subject to the analysis stages detailed by Braun and Clarke (2022).

Previous literature has explored the use of journalling and presented the direct analysis and processes undertaken within researcher subjectivity (Bradbury-Jones, 2007). As proposed by Braun and Clark (2022), there is no ratified system or procedure for keeping a reflexive journal alongside a qualitative study, rather it should enable reflections and integrations that could easily have been overlooked. For this study, the journals maintained their chronological ordering to encapsulate my own progression and development as a novice researcher, as well as being captured surrounding each participant. The reflexive comments can be seen in the primary stages of analysis within the familiarisation of the data. Other journal entries, as seen here capture a plan, as well as wistful thinking.



Many of the journal notes were handwritten (other than the internal questions demonstrated



on the early transcript analysis). This

was a personal preference as it

enabled a speed writing process,

preventing fear or bias from

prohibiting honest reflections that

may have been somewhat enabled

by my slower use of computer text.

As intersectional proponents have

situated (Crenshaw, 1989, 1991),

and black feminists argued (Love,

2016), researcher subjectivity is not simply a process to make one feel better, acknowledging

personal stance does not therefore mitigate from any future criticism. It can, and should be,

discomfiting and change-making (Braun and Clarke, 2022).

The extracts displayed here demonstrate the reflective moments, seemingly positive and

negative. They also allow for curious hindsight and consideration in conceiving how things could

have been done differently.

Good day!
 Had a phone call from [redacted]
 and [redacted] and [redacted] will speak
 with me. They will do the consent
 form tomorrow. Apparently [redacted]
 may also agree to be interviewed.
 ... snowball effect. After all this
 time I ~~am~~ no longer am a
 threat. The key to recruiting is
time I owe them time!

I'm sure they don't like me!!
 I feel like I have nothing to offer.
 What happens if I can't recruit
 any women!?!? I need
 their voice and insight this
 is what it's all about! Ah!

Inductive or deductive

A consideration when producing the study design, and subsequent commencement of data collection and analysis, was reflecting upon the endeavour of the data. Thus, being *inductive*, meaning driven from the data, or being *deductive*, researcher or theory driven. As an insider (a healthcare professional within the healthcare research), the assumptions built through experience could inhibit the interrogation of data as it may be taken for granted due to routines or behaviours that have been seen previously before (Morse, 2010). With this in mind, blending an *inductive* and *deductive* approach to the analysis is achievable and rational (Braun and Clarke, 2022). The feminist frameworks of practice, and theories relating to mothering and DA, impact professional outcome, and have driven this study design. Chapter 3 explores the methodological underpinnings of this study, and indeed RTA is appropriate as it is theory driven, yet flexible within its utility (Braun and Clarke, 2022). Examples of blended TA approaches within healthcare research have been explored (see Fereday and Muir-Cochrane, 2006), however, this researcher does not use an 'a priori' framework to fit meaning, but acknowledges the theory driven foundations of insider practice and knowing. However, as

Braun and Clarke (2022) themselves acknowledge *inductive* approaches can be achieved by insiders when the strive is to understand experience and perspective. Therefore, stipulating a largely *inductive* orientation in which data drives meaning, yet acknowledges the presence of insider knowledge and practice frameworks, is appropriate.

4.3.2 Theme development process

The approach of reflexivity was threaded throughout the study, however there were processes adhered to when undertaking reflexive thematic analysis (see Braun and Clarke, 2022); familiarisation, coding, generation of themes, review and development of themes, refining-defining-naming themes, reporting of themes. The stages for each transcript are provided within the appendix to demonstrate the systematic steps undertaken to produce the themes and analysis, as well as linearity of the process preventing barriers to moving to next stages (Silver and Lewins, 2014). Yet as Braun and Clarke (2022) and Silver and Lewins (2014) identify steps can be undone or redone at various times within the analysis.

Familiarisation

The preliminary stage of analysis involves the immersion and critical engagement within the data (Braun and Clarke, 2022). Reflexive questions were asked during the reading and reviewing of the transcripts including *‘what does this data mean?’*, *‘how do I feel when reading this data?’*, *‘what assumptions am I making whilst reading?’* and finally, *‘what appears important to the participant?’* This stage involved re-reading the transcripts and listening to the audio recordings and then returning to the transcript again after some time (between 1-6 weeks). Reflective comments were captured alongside the transcript during the early stages of

immersion. An advantage of being an insider (practising health visitor with lived experience) enabled the skill of analytical sensibility; the interpretation of the data that goes beyond and critically considers it within the current literature field (Braun and Clarke, 2013).

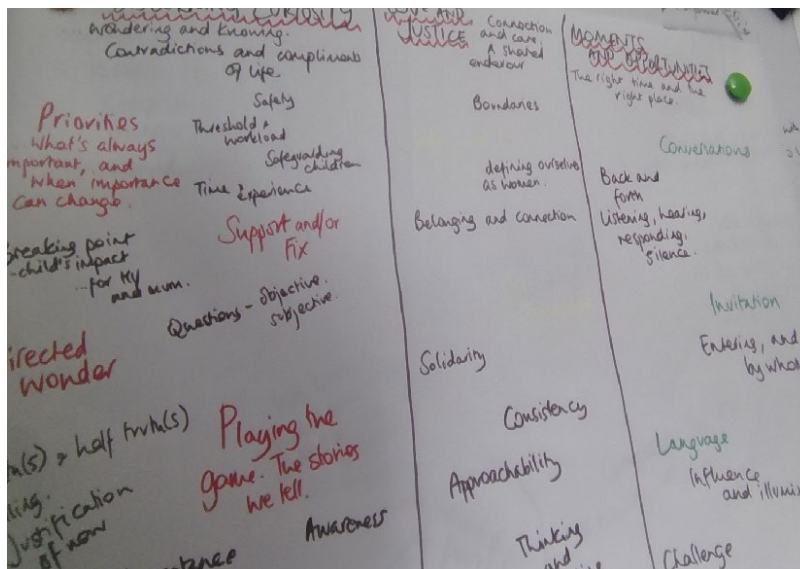
Coding

The codes produced in this stage of analysis acted as building blocks and springboards to produce themes (Braun and Clarke, 2022. Bryne, 2022). Like the reflexivity noted within the familiarisation stage, considering researcher subjectivity is important in capturing what is reflected within the code; assumption, worldview, meaning? *Coding* was the process undertaken to explore the patterns within the data and was conducted over a number of weeks following the familiarisation of all data. The *code* was attached to a particular segment of data, and then a *code label* or *tag* given to the segment of data. It was paramount in this stage to maintain researcher focus on coding, rather than the temptation to begin generating themes. The codes themselves were a combination of descriptive summaries, or terms to give meaning to the data, engaging in curiosity (Trainor and Bundon, 2021). Maintaining a rigorous process of coding that ensured engagement (Braun and Clarke, 2022), reduced the likelihood of researcher pre-determination as noted by Morse (2010), with data cherry picked to fit predefined ideas. Systematically reviewing and reading the transcripts time and again maintained rigour, yet the struggle lay in deciding to move to the next stage of analysis, as meaning is non-exhaustive (Braun and Clarke, 2022). As a single coder, the progression onto the next stage was considered through reflection and multiple reviews of the data, and viewing the codes to ensure that they summarised the diversity of meaning held within the transcript (Terry et al. 2017). The single coder, as in this research, is commonplace within RTA as it warrants subjectivity as a strength

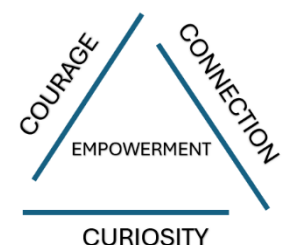
and prevents the loss of meaning when more than one coder facilitates the process (Braun and Clarke, 2022).

Generation of themes

The generation, review and refining of themes were most timely, and at times, frustrating. The processes undertaken within the following stages of the analysis were often unpicked, undone, or dismissed. Rather than considering themes to emerge from the data, the generation and production of themes is not a singular process but is fluid within movement across the theme development stages (Braun and Clarke, 2019). It was the essence of RTA in its creativity and interpretation that created the frustrations held within this process of analysis (Trainor Bundon, 2020). 'Theme mapping' as suggested by Braun and Clarke was utilised within the generation of themes and beginning formation of sub-themes.



Early generation of themes began to generate meaning, however, when moving to a deeper level of engagement with the data in the subsequent stages, the themes did not reflect the boundaries for which



meaningful insight could sit and therefore, were changed.

Review and development of themes

Reviewing the themes asked many reflective questions '*does this theme capture the story?*' '*Is there too much going on within this theme? Where is the boundary?*' Notably this stage began to produce an overall story that provided meaning. As seen above, themes and sub-themes were mapped and developed, however preventing themes from losing depth was an important consideration through potential dilution (Braun and Clarke, 2022. Trainor and Bundon, 2020). As noted from the coding stage, there were codes not captured within themes, this was consciously undertaken, as the process of RTA does not intend to capture *everything* within the data, rather the process of development can grow as I moved through the analysis.

Refining, defining and naming themes

Three themes were produced from the data, as negotiations were considered to manipulate their meaning. Braun and Clarke (2022) suggest that the focus should not be on the number of themes, but rather on ensuring that each theme is developed with sufficient depth and quality. They caution against generating too many themes, as this may compromise the ability to fully do each one justice. At this stage, the focus shifted from the participant's voice in generating the data to the researcher's interpretive voice, which constructed the story produced from the dataset. During this stage, each theme was developed around a central idea, acknowledging that it could not encapsulate all things within every context. It was during this stage that the themes overarched across both data sets, that the central ideas and arguments within the experiences were centralised. Growing closer to the transcripts was fundamental again here (Braun and Clarke, 2022). It was at this stage to consider whether the themes captured through

patterns of meaning represented the data itself, the field of health visiting practice, and the broader context of DA and mothering.

Figure 4.1 An early refinement of themes. This diagram demonstrates the positioning of codes within the early generation of themes. It was during this stage of the analysis that the themes changed. Time and reflection were spent here as there was an eagerness to hold onto the themes generated early on in the process. However, as Braun and Clarke (2022) themselves warn, themes that do not have clear boundaries relinquish depth and quality.

	CODES		SUB-CODES		
<u>CURIOSITY</u>	Awareness/Perspective				
			Domestic abuse within society		
			Self-awareness		
			Stereotyping		
			Expectations		
				Minimising behaviour	
				Normalisation	
			Impact		
				Voice of the child	
<u>COURAGE</u>	Empathy/Emancipatory role				
			Belief		
			Listening		
			Empowerment		
			Courage		
	Multiplicities				
			Context		
			Family history		
			DA experienced as a child		
	Confidence/Experience				
			Curiosity		
<u>CONNECTEDNESS</u>	Conversations				
			Disclosure		
			Routine enquiry		
			Openness		
			Invite		
			Healthy relationships		
			Information sharing		
	Wellbeing		Fear		
			Shame		
			Woman		
			Health visitor		
	Instinct		Gut feeling		
			red flags		
			Truth		
	Family dynamic		Dad's/men		
			Family roles		
			Gender		
	Safeguarding		Safety		
			Child protection		
			Threshold/intervention		

DISCERNING CURIOSITY. Wondering and <u>knowing</u> , how things can contradict and compliment at the same time.					LOVE AND JUSTICE, connection and care					MOMENTS AND OPPORTUNITIES			
Power and Priorities	Safety	Acceptance		Humanity in the home	Multiplicities of life	Embrace	Moving between awareness, understanding and empowerment	To sit alongside	My values, your values, our values	Managing and changing	Accountability	Help and support	Weight of the past
Acceptance	Safety of home	Protection	Priorities	Team working	Individualised	Children	Gut instinct	Wonder	Privacy	Knowing	Truth(s)	Questions	Planning
					Containment	Boundary	Listen with humility	Solidarity	Approachability	Safe	Connection	Honesty	Who am I?
					Consistency	Help and isolation	Shame	Martyrdom	Love/hate	See me	Vulnerability	Transcendence	Belonging
					Anger	Empathy	Respect	Blame	Stuck	Fuel	Fear	Breaking point	Pattern of abuse
										Protection	Team working	Responsibility	Blind
										Simplicity	The systems	Time	'That's it?'
										Opportunities	Breakdown		

Figure 4.2 The final themes; refined with some ideas surrounding the generation of sub-themes.

What proceeded this process was the re-familisation of the data and movement of subthemes to ensure that the analysis reflected the transcripts and data held within.

Reporting

What sets RTA apart from other methods of analysis is that reporting is part of the process and is not undertaken once the analysis and themes are complete (Braun and Clarke, 2022). It is at this stage of the process that the academic presentation of the reflexive notes, journals, and theme mapping described within the previous stages. At this point, the rich, contextualised meaning is presented to make recommendations for theoretically informed rationale within practice within

the discussions. The reporting style captures the voice of the participant whilst expanding on the meaningful insight of researcher subjectivity.

4.4 Introducing the themes

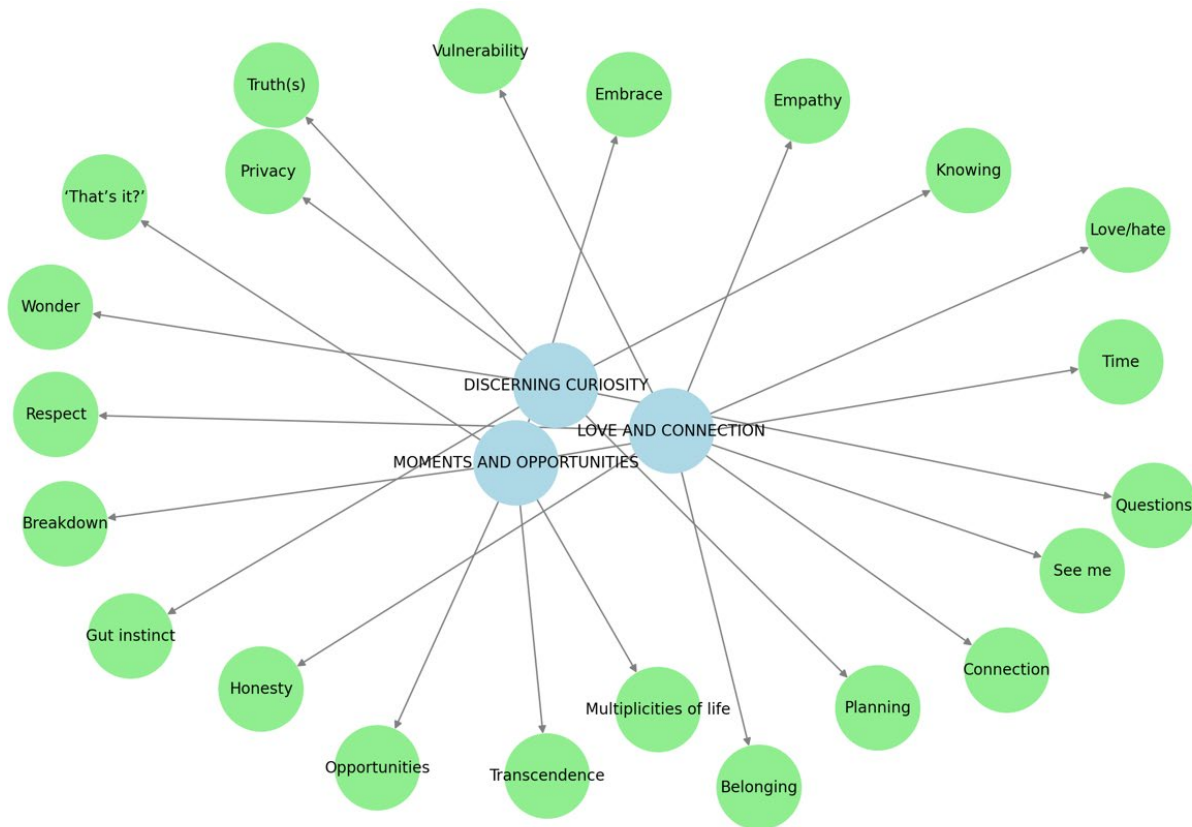


Figure 4.3. Mapping of themes

4.4.1 Theme One: Discerning Curiosity

The first theme, *Discerning Curiosity*, encapsulates the paradoxical nature of knowledge and perception within the dynamic relationship between women and health visitors. The interplay of contradiction and complementarity characterises the fluidity of experience, shaping the evolving narratives of both parties. This complexity reflects broader sociological tensions, such

as those highlighted by Settersten and Gannon (2005), where agency and structure intersect to produce nuanced realities.

Throughout the analysis, it became evident that power dynamics fluctuated depending on the storyteller, the listener, and the interpretative lens applied. The constant flux of knowledge—what is said, what is meant, and what is inferred—underscored the subjective construction of truth. As Lykes and Távara (2020) articulate, knowledge production is neither a direct representation of community understanding nor a solely authored interpretation; rather, it exists as a "third voice" that emerges in relational encounters.

This theme foregrounds the act of inquiry—driven by curiosity, shaped by conscientiousness, and dependent on tenacity and impartiality. The exchange of narratives necessitates an equilibrium between questioning and responding, where both participants engage in meaning-making. A health visitor may not fully inhabit the world of the woman she supports, but through proximity, presence, and active listening, she can grasp its contours.

Sub-Themes

- **Priorities:** This sub-theme reflects the shifting thresholds of concern—workload, children, and safety—affecting both health visitors and mothers. Decisions were often made at critical junctures, particularly where children were implicated in DA scenarios. The prioritisation of safety was deeply intertwined with personal histories and systemic influences.
- **To Support and/or Fix:** Health visitors operate within the duality of statutory obligations and holistic support. The medical model emphasises safeguarding, yet effective

intervention demands time, humility, and relational depth. Mothers' awareness of services, and how they navigate them, further complicates these interactions.

- **Directed Wonder:** Inquiry is not arbitrary—it is guided by institutional mandates and individual discretion. Both health visitors and mothers engage in discerning questioning, influencing the trajectory of support and decision-making.
- **Truth(s) and Half-Truth(s):** Retelling experiences often involves negotiation between absolute truth and contextual necessity. Women and health visitors constructed narratives that justified their present realities, sometimes as a means of protection. The retrospective framing of past events influenced both understanding and intervention.
- **The Humanity of Home:** The home as a private domain held dual meanings—sanctuary and site of manipulation. Within the home, relationships unfolded with layers of blame, shame, and internalised thought. Health visitors navigated these tensions, striving to foster trust while mitigating risks.

4.4.2 Theme Two: Love and Justice—Connection and Care

This theme illuminates the human need for meaning, belonging, and connection. Embedded in health visiting practice is a social justice imperative, whereby professional interventions intersect with deeply personal relationships. The challenge lies in reconciling professional detachment with the emotional depth inherent in supporting women affected by DA.

Reflecting on the nature of these interactions raised critical questions: *Can professional engagement be rooted in love and care? Does acknowledging emotional connection challenge*

the clinical rigidity of healthcare models? Despite these tensions, love and justice emerged as guiding principles, shaping the relational dynamics between health visitors and mothers.

Sub-Themes:

- **Who Am I?:** This sub-theme explores radical empathy and self-awareness. Participants reflected on their roles and how these roles shaped their perceptions and actions. The quest for connection—whether in dyads, families, or communities—was a recurring motif.
- **To Sit Alongside:** Solidarity and consistent presence characterised this sub-theme. Participants exhibited awareness of each other’s struggles, balancing involvement with respectful distance.
- **To Embrace Another:** Transcendence in relational encounters was evident in acts of going above and beyond, often for the sake of children. This sub-theme revealed participants’ desire to see and be seen, fostering intentional connections based on respect and understanding.
- **Language and Discourse:** The words used to describe and discuss DA carried significant weight. Language framed narratives, shaped perceptions, and either reinforced or challenged dominant discourses. The legislative landscape and cultural context influenced these discursive practices, shaping how individuals and institutions responded to DA.

4.4.3 Theme Three: Moments and Opportunities

This theme explores how individuals retrospectively construct meaning from past experiences, particularly within the context of DA. Health visitors and mothers alike engaged in deep reflection, often reconsidering actions and decisions in hindsight. The weight of these moments was palpable, underscoring the enduring emotional and cognitive impact of DA.

Sub-Themes:

- **Invitations to Talk:** Conversations were shaped by power dynamics and safety considerations. Health visitors often employed structured yet open-ended questioning, allowing women to navigate disclosure at their own pace.
- **Outcomes and Actions:** Fear, both personal and professional, influenced decision-making. The emotional labor involved in child protection work has been well-documented (Winter et al., 2018; Cook, 2020), with subjective interpretations of risk impacting assessments and interventions (Ingram, 2015).
- **Managing and Changing:** Moments of realisation—whether of stagnation or transformation—were pivotal. Participants articulated feelings of being "stuck" or "blinded" by circumstances yet also recognised moments of agency that allowed for change.
- **The Power of Language:** The choice of words, and the significance assigned to them, shaped experiences and interventions. Language mediated reflection, influencing both internal processing and external communication.

4.4.4 The Interplay of Themes: Fluidity in Experience

The themes of *Discerning Curiosity*, *Love and Justice*, and *Moments and Opportunities* do not exist in isolation; rather, they intersect dynamically, illustrating the fluid relationship between health visitors and mothers. *Discerning Curiosity* establishes the foundation for engagement, where inquiry and perception shape relational dynamics. *Love and Justice* introduces the emotional and ethical dimensions of care, emphasising the human need for connection within professional interactions. Finally, *Moments and Opportunities* highlight the retrospective and prospective dimensions of experience, where individuals make sense of their past while envisioning possible futures.

At key junctions, these themes intertwine:

- *Curiosity and Connection:* Inquiry-driven interactions necessitate empathy and ethical responsibility. Health visitors navigate the tension between professional detachment and relational warmth, shaping how women disclose and process their experiences.
- *Love and Meaning-Making:* The emotional labour of care extends beyond duty, embedding relationships within broader social and moral frameworks. Recognising and embracing another's humanity disrupts rigid professional boundaries, fostering authentic engagement.
- *Reflection and Agency:* The moments of realisation within *Moments and Opportunities* are informed by the relational groundwork established in *Love and Justice* and the questioning embedded in *Discerning Curiosity*. Through reflection, individuals reconstruct their narratives, influencing future actions.

This intricate interplay underscores the depth of experience shared between health visitors and mothers. Their encounters, shaped by power, emotion, and perception, resist linear categorisation. Instead, they reveal a complex, ever-shifting landscape of understanding, support, and transformation.

4.5 Concluding thoughts

Following from this finding's introduction, the words of the participants will give insight into research aims and questions. Their words are what is important, and through researcher subjectivity meaning is produced. The thesis will now move into the chapters in which the findings are presented within each data set (health visitor and service user), addressing each research aim. As noted by Braun and Clarke (2022) themselves, presenting findings separate from analysis does not reflect the on-going reflexive nature of RTA, therefore the data set chapters will provide a report of meaning alongside researcher reflections.

The overarching themes will provide a structure to the sub-chapters, and direct quotations used. The direct quotes will give rationale for the researcher subjectivity within the meaningful reflections. The researchers voice will bracket the participants, the presentation of such demonstrates the underpinning approach of feminism, as well as methodological concepts of reflectivity.

Following from the two findings chapters, a discussion will be presented to illuminate the meaningful conversations with the data set and produce theoretical and practical implications for health visiting when working with mothers experiencing DA.

Chapter 5 - Health visitor analysis of the findings

This chapter will report the findings taken from the health visitor data set. The chapter is split into three sub-chapters with each addressing a research aim. In each sub-chapter the findings will be presented within the key themes generated from the data, this is achieved through further analysis of sub-themes and codes. Direct quotations are presented to situate the participants voice with researcher exploration discussed around each to give meaning.

The findings presented within the themes do not capture everything discussed within the transcripts yet have been specifically chosen to give example of how the participant voice had generated meaningful analysis when considering each of the research aims. Some of the conversations explored relate to domestic abuse within statutory involvement, the concepts derived from these are meaningful to the wider service delivery, however done so in mind of the focus of this study situating with a universal – universal plus model. The discussions surrounding implications to practice in chapter 7 will align with the focus.

Each sub-chapter will present some concluding thoughts relating to the research objective addressed. Following from this chapter, the proceeding chapter will present the findings taken from the mother data set with the same chapter structure.

5.1 Addressing objective 1. Exploring the wider implications and perspectives of DA

This section will explore the findings relating to the first objective of the study for health visitors,

- To explore the wider implications and perspectives of health visitors when discussing DA.

Within the conversations with health visitors, the positioning of perspective was either directly explored within their professional practice or personal thought, or through longer discussions surrounding specific families. What transpired with each health visitor was their deep-rooted reflexive thoughts and their own critical understanding of working with individual families.

5.1.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Priorities

Reckoning with the threshold of what abuse is and defining such both personally and legislatively appears changeable.

“Ohh, but my understanding of everything has come on, like child protection. But everything changes as well. You know, new legislation we've got now, like that non-fatal strangulation is now a criminal offence and you can get a custodial sentence for it. Which is really good, but you know, a few years ago I wouldn't even have thought about asking somebody about that.” (HV5)

The recognition of areas surrounding knowingness relating to abuse is understood and therefore encompasses a sense of wonder relating to the unknown, or simply what is considered acceptable in terms of legality that may not be so in the future.

Here the health visitor considers the threshold of acceptability of DA and distinguishes between levels. It raises a consideration that threshold is not solely based on service stipulation or capacity but is weighted on the phenomenon or concern itself. When one considers the cultural norms and gendered expectations surrounding family, how can a universal consensus be reached?

"I don't think acceptance is the right word, but I think that there's kind of like a low level of domestic abuse that is kind of accepted by professionals and multi-agencies and it's kind of left there a little bit." (HV6)

Playing the game with the stories we tell.

Health visitors postulated their own truth(s) when it came to unpicking the epistemological understanding of DA, how they came to know it, understand it, and conceptualise it. As well as hoping for better, the data set also explored their perspectives of why DA continued to be a scourge on families.

"...the reason it's getting worse is that women used to be in the kitchen and looking after the children, but now they've stopped doing it, we want equality, rightly so, but that's where it went wrong. Everyone is fighting back. Men used to get away with it, didn't they. It's just such a mess. I don't know what the answer is but I don't want it going back to women just being doormats though, and going back into the kitchen.

But that's what I think. That's what men want, isn't it? They just want that woman to sit at home whilst they go out and get drunk with a mate." (HV11)

This health visitor concedes that attitudes of men may reinforce violent and controlling behaviour, however, as Sudenkaarne, Browne and Kendal (2023) conclude that positioning men's status by women fulfilling their (men's) needs, is both outdated and unjust. Here the health visitor acknowledges that DA may have escalated since women moved 'out of the kitchen' and into the workplace, the answer is not to be found in rewinding the clock, perhaps the solution to perpetration is to be found within the perpetrators themselves. However,

acknowledging the existence of each of us within the embedding of social ideas and values, the following extract left me wondering if we go further than acknowledging and understanding, but also embedding constructs that don't initially sit comfortably with us. Here the health visitor is talking about the mother and her courage to disclose abuse yet, also placing the weight of the family dynamic on her shoulders; when a woman has a baby, she becomes a parent to the adults also. Does this quote embed the notion of burden on mothers to keep the family together? Or is this simply the acknowledgement of such? Can acceptance exist without reinforcement?

"You know they may feel disloyal, they've just had a baby with this person, so they're taking on all the responsibility of keeping the family together." (HV14)

Perhaps due to underpinning principles of social justice and lobbying policy makers, health visitors articulated their heightened awareness of how political structures and wider systems impacted day to day lives for communities. Health visiting as a politically engaged service is recognised within the transcripts; conceptualising the factors at play for families in which maintaining healthy relationships becomes difficult. DA as causative, but also as a response, to the intersectional experiences of 21st century life in the UK.

"So I think you could get a couple that have never experienced any kind of explosive domestic abuse, but life's hard and there are verbal arguments, and it builds to not arguments but verbal domestic abuse. When there's no money, the house is freezing, there's no food, and you've only got £20 left in the electric meter. That could make the happiest of couples you know, failing under the pressure, and obviously with the cost of living as it is now, the houses that I'm going

out to that are freezing, and I just keep my coat on because they're too cold. And then I document that the house is so cold. I will ask them if they're able to pay for heating. The rent has gone up, and obviously the rent comes before anything else. I will ask if they want a food bank referral, and sometimes they say yes, and sometimes they don't.

So, there is so much stress for these families. You could see how the stress impacts the relationship passed the point of normal arguments. You know we're at the coalface..." (HV14)

For women experiencing DA, a Scottish health visitor applauded her governments attempts to prioritise issues relating to VAWG. Indeed, Scotland accepted the gendered-basis of DA within legislation (Hearne and McKie, 2010) and such narrative supports governments in recognising gendered assumptions relating to inequality including care-work and lower income status (United Nations Development Reports, 2023). The awareness of the gendered nature of DA and the compounding inequalities experienced by women is recognised here, however, the health visitor reflects on whether the top-down approach is reaching women in homes.

"I think the Scottish Government have really prioritised violence against women and girls. So I think more and more bodies are becoming aware, you know, I think Scotland was the first country in the UK to make coercive control a criminal offence. So, I think it is something that they have really, really prioritised from a policy level, whether the actual policies are having an impact, filtering down to those individual women. At this point, I guess I don't know, but it feels like it's something as a society that we are trying to address. It's a positive thing, but I suppose it's those policies, you know, are they having a real impact on our communities? That is what you want to feel. You know, it's good to feel like ministers are recognising this, and want to do

something about it. But it's whether it's having a real impact on communities, that's when you're going to feel like this is great.” (HV10)

When considering a gendered lens of perpetration, health visitors highlighted their ability to conceptualise wider issues that were driven by the patriarchy. Interestingly understanding more nuanced understandings.

“I just think there is a toxic masculinity to them, and that they are just getting worse and I don't know as a society where that'll end... And I don't think anyone realises how bad it is. You know, they talk about it, like on social media and all that stuff, but it's literally awful and they get away with it and there's no consequences for them. And I think that's where the frustration probably lies about it all.” (HV11)

Harrington (2020) explores toxic masculinity and concludes that although providing a useful window into gender politics, using such as a basis of analysis is not enough. Interestingly, narrowing women's empowerment down to constructs within men's attitudes and practices, often umbrellaed by toxic masculinity, in fact does equality a disservice (Flemming, Lee and Dworkin, 2014). Rather positioning public health interventions that deemphasise hegemonic ideas is more successful (Flemming, Lee and Dworkin, 2014). However, reflecting upon the low expectation of father's to be 'present' within health visiting intervention was rooted in action. If we accept father's to be absent in terms of contact during universal provision, should there be surprise when they remain absent throughout additional support?

“I mean, these things are offered. These things are offered to the fathers and but it's almost like there's not really much of an expectation that that's gonna go anywhere, it's just like a token

thing to say. 'Well, we'll offer you this programme, but we know you probably aren't gonna come'."

You know it's very low expectations of men." (HV7)

Understanding that patriarchal ideals infiltrate into the mindset of both genders through generational and societal norms was conceived by the data set. Attitudes are apparent in systems across the spectrum of communities, and uphold the argument proposed by Hunnicutt (2009), that patriarchy is not the sole cause of violence against women. Health visitors recognise that men are many things and cannot be placed in a singular, much as the families for which they exist in. Here there is a critical insight into how patriarchal views impact men, families, women, regardless of perpetrator or victim.

"...whereby domestic abuse and how you talk about it, it doesn't always come down to the husband's behaviour, but often it can be about the in-laws. That's how they might treat that woman in their house because most often, the woman moves in with the paternal family and then she becomes isolated. Economically, financially, emotionally. Then they're afraid of the consequences, of leaving that house. That's even harder to bring out into the open." (HV4)

Here, the health visitor supports the overarching feature within communities and families that patriarchy accounts for the hierarchal positions taken, and thus the acceptable behaviours to negotiate within such. There was also an insight into the nuance of women's lives and the feminist movement. Recognising that women have benefitted from the economic advances in the last 50 years, and employment status that accompanies such, however, the expectation of motherhood that expects women to reproduce and maintain a home.

“So, women were in poverty, which is why the government came up with the family allowances. And that's where that came from. Women just had to put up with it. And I think, you know, the 70's came and the whole 'burn in the bra 'and that was all great because then women have got a voice and now, I think, the more affluent families and the diverse cultural families, there's a lot of shame involved in that. So women will find it really hard to admit.” (HV4)

Interesting and meaningful to outweigh shame, feminism has not fully empowered women, it may have perhaps placed more on their shoulders as one cannot discount the biological privilege *most* women hold in the ability to reproduce, birth, and feed infants. This quote demonstrates a lack of intersectional feminist endeavour; feminism works for *some* women.

From conversations with the data set it was clear that health visitors work alongside many cultures within communities. When questioned, health visitors would often define the area they work in by the socioeconomic status, as well as the ethnicity of families. When not directly asked, it was interesting that health visitors used these two demographics to summarise their community profile within the context of DA. Notably, when exploring culture and ethnic diversity, health visitors appeared to conclude that social norms, as well as power hierarchies were positioned as the reasoning behind DA. This raised an interesting point of whether such summary resulted in cultural awareness, or in sweeping assumptions.

“just thinking about the culture that they've come from and things like that... It just gives me an enhanced knowledge about that as well. And how the patriarchy plays into it, and in Poland that's an even, you know, greater prevalence kind of thing.” (HV10)

Taking into account the wider socialisation of patriarchal culture, this health visitor expanded to consider behaviours, not excusing them, to be a result within the socialisation of gendered roles.

“...the dad was very controlling, he was extremely territorial, he admitted he was.... and I said ‘what, like a dog...?’ because some dogs are, and he said ‘yeah’. He called his partner ‘My missus’. So, I spoke with him, she was very vulnerable high risk, and I spoke to him about it, and he knew it, but culturally for him it was normal... he was the patriarch, the male, it was a sense of ownership for him.” (HV9)

Embracing a cultural awareness requires an understanding of representation and how you may differ from those within the community. Reflecting on the privilege held by oneself was considered.

“...my ethnicity can be a barrier, they may think I don't understand. We need to bridge the gap in communities, representation, how do we empower these women in hard-to-reach groups?”
(HV3)

Mother blame has been explored (Azzopardi et al. 2018, Wild, 2023. Arnull and Stewart, 2021) within the recent literature. The consideration of blame corresponds with the placing of accountability. Brown (2017) explored the epistemological concept of blame and wrongdoing. Here they presented the arguments surrounding supposed blame-less wrongdoing. Perhaps unintentional, however, within the dataset the understanding of parental responsibility acknowledges intention within behavioural factors and therefore blame is issued. If it is seen, then surely, we must take responsibility for what is to come?

“I find that particular women will go and pick the same kind of relationships over and over again, so you know they'll bounce from one domestic abuse relationship to another and you think ohh, when will you learn, you know? They just seem to attract the same men that gaslight them or make them feel really lovely at first and then start...” (HV5)

There is a palpable, yet inexplicit position of blame placed on ‘*particular women*’. As much as we attempt to attribute blame to the perpetrator, or wrong doer, the victim bares some of the blame and responsibility. A quiet echo-chamber for the patriarchy.

There were pertinent moments of self-acknowledgement relating to responsabilisation weighted onto mothers, particularly those who are experiencing DA. Recognising something but feeling almost powerless surely demonstrates the weight of socialised norms.

“the dad was an alcoholic. A heavy drinker and physically abusive to his partner, and when we started working with them, it was very much the responsibility on her to do things like get the children to school and get sorted and all those kind of things (when she was in this sort of domestically abusive relationship with this perpetrator). And it was almost like I think as professionals, we probably do have those kind of ingrown gender norms as well. Like, it's her responsibility to be doing these things. The responsibility of her even with the fact that she was in an abusive relationship. And actually she had no self-esteem” (HV7)

Positioning their own understanding of DA was also highly weighted by individual histories and experience. Reflexive in nature, viewing the world through a constructionist lens encapsulates how we come to know. Some of the health visitors acknowledged their own personal experiences of DA. Profoundly, was the ability to recognise how experience did not remain in

the moment of happening but resurfaced and could sometimes be pliable in terms of weight for experiences to come.

"...looking back when my youngest child was little, I experienced it. And I remember my health visitor coming out to me. She was so posh, and she was at the new birth, and she said, you know, "have you ever experienced domestic abuse?", she just said it like that. As if she was asking if I wanted a biscuit with my cup of tea! And I remember thinking, all these years later, "if I did, I wouldn't tell you!" I remember that because I didn't have that connection with that one health visitor. And so, I always, that's always in my mind that." (HV14)

Unpicking the above narrative, one could draw many assumptions about experience relating to relationship connection, but what became illuminated was the memory and sense of feeling.

However, here reflections of assessment were made on a short retelling of a contact.

"I actually said, "you know, you're allowed to talk. Choose your own carpet. It's your house too..." and I got thrown out of the house... I got told to leave. So I said to my colleague, there's abuse going on and it turns out that it's been going on for years. So my gut feeling was just right with that one. Something's not right there...Why? She flipped out so much over the facts. Because I've touched a nerve..." (HV5)

One wonders whether an assumption of situation occurs because the alternative is less palatable. The request to leave by the family was purely based on the health visitor providing an objective truth to the individuals, or were they asked to leave because there was a sense of unempathetic or flippant questioning? Rather than debating whether comments were

appropriate, there were a means-to-an-end, as it turns out there was DA, and this re-telling becomes justification.

The detailing and awareness of multiple truths was apparent in the data. Both data sets retold versions of reality that impacted pertinent moments within the health visitor-mother relationship, often grounded within emotion and shared belonging. What produced, however, was the retelling of stories that often took turns away from the direction of truth that an individual had previously conceived. One health visitor spoke of her positive and consistent relationship with the whole family in which over time it construed that the mother was and had been experiencing DA.

"I mean, she disclosed to me that there had been a long history of emotional and financial abuse going on and it was only then that I looked back and thought "Oh my God, how did I not see it?"

That was a big shock to me because I thought having seen it every day, or most of the time whilst I'm at work..." (HV4)

Truth(s) was a code generated to highlight the many perceived realities at play for health visitors. The concept of various perspectives of feeling and meaning appeared to be understood by health visitors when applied to themselves and others.

"Before it was very obvious (domestic abuse), but maybe that's because my confidence in picking it up has changed, but now, it's more, I see, more coercive controlling behaviours, and the victims or the survivors aren't picking it up, and you need to bring it to their attention.

Without kind of, victimising them. So yeah, I'm seeing quite a lot of that now." (HV9)

This health visitor highlighted the changing understanding of DA, particularly regarding coercive control, and perhaps the mismatch of awareness in the professional sphere of understanding and recognising, versus the wider community consensus. It begged the question whether the improved legislation and awareness of coercion and control has resulted in DA being harder to self-identify as a victim?

Not only capturing the nuance of what it is, health visitors could also critically consider the viewpoints from others,

“Frustration that I'm struggling to get somebody's voice heard. And I, I suppose, frustration with the family when you know that there's so much going on for them and they're not in a place yet to do anything about it. I mean, I would never behave in a frustrated way with them, but there's that underlying frustration that life could be better for them if they would just brave enough to do something. And I totally get why they're not
But when they've actually disclosed, when there's something going on and they've been denying and denying, and the relief that actually they've been able to share that with you, and you can offer support.” (HV8)

Furthermore, considering how different realities impacted the perspective of experience.

“One person may think one thing and a separate person who experiences the same thing may feel it was a completely abusive situation where they had no control. Some people may say "fuck this" and kick them out, others can't, some may get on with their lives. But that's not every situation, everyone is different, and that, you know, if we don't believe people, it denies the coercive control and emotional control.” (HV5)

“Some women just feel like they can't say anything to keep up appearances. But I go and speak with colleagues, and I know that that woman is being abused, but she just won't tell me and I can't get to the bottom of it. We can't help everybody.” (HV5)

Truth(s) featured heavily within the data, however it was distinguished under the sub-theme of *acceptance* in terms of understanding and consideration. Through discussions, truth(s) organically opened into other codes within this sub-theme, such as knowing and awareness. Similar in placement relating to the wider theme, the codes remained separate as they distinguished between the understanding and application of knowledge. Truth(s) were further considered in relation to the wider service delivery, specifically how fathers could and/or should be acknowledged.

“They (organisations) are trying to make an effort and we always try, and you know all our letters say we want fathers to attend appointments if they can and stuff like that. But I just think it's very focused on mum, I haven't had loads of experience with same sex couples. So I can't really speak to that very extensively, but yeah. So just being heteronormative about it, it's tends to be very focused on the woman, but it's always wonderful when fathers are in the room and do want to be involved, and I always try to address them and include them but it doesn't come naturally, because we are so geared to mum and baby, above all else really....just historical I suppose.” (HV7)

Humanity held within the home

Embracing humanity is having the kindness and humility to accept that we may not know and emphasising attentive listening as well as an openness to conceive new undertakings (Isaacson,

2014). Considering the differing perspectives within the family enables a holistic picture. Health visitors consider the varying perspectives at play by all those involved; however, the issue of child safeguarding takes priority. Yet, as explored here, acknowledging a wholly child centred approach that fails to recognise the wider family often does not create the impetus to change.

“... if you're not focused on what the parents are doing or the situation in which those parents have become into parents, then you can't change anything, can you? It's a intergenerational cycle of behaviour. So, I struggle with that often because I think people lose sight or they don't even want sight of what the parents are doing because they've become so child centred. And it can't possibly be just about that child, because that child is not on its own. The child is influenced everyday 24 hours a day by parents. So, you can't separate the two” (HV4)

However, where does the stance of acknowledging the standpoint of parental experience sit, particularly when there is divergent understanding held about what the child recognises.

“...because as parents, you probably know already, they will say, “...well, they were in bed there asleep. They don't hear anything. They don't know what's going on...” So, I talk about the children's feelings. I explain that if she's anxious or if there's an atmosphere, or mum feels worried or scared, that child will pick up on the emotions that are going on in the home, even if they're asleep, they will. They might hear something. Hearing but not actually knowing what's going on can be more frightening for children than them actually seeing what's going. Their imagination will conjure all sorts. I think a lot of parents think, when their children are babies, they think it doesn't affect them.” (HV8)

Health visitors embrace a sense of victimhood for children that is evidenced through explicit behaviour and development expression but, also understand the implicit impact DA has on every sense, at different ages. There is a humble recognition of the voice of the child. Mothers' (as unpicked in the other findings chapter) will prioritise their child above all else in terms of safety and risk, the issue remains where we each draw the lines of safety and risk, and how such are perceived.

Directed wonder

Wonder about the wider experiences of DA relating to families is apparent in the literature and education of health visitors (Eynon et al. 2012. Litherland, 2012. Hudspeth et al. 2022). What further compounds the wonder is the acknowledgement that one cannot fully appreciate the multiplicities and differences in context until it is experienced as a professional.

“You can hear people talking about it, but I think until it happens to you, you don't understand the depths of it, and how complicated it is for in in each situation is very different, isn't it? So, I think although learning about how you can help them and how you know it affects them. What the services are out there that can also help with people, but the rest of it is definitely experiential. I don't think even looking back now you think, right, if each time I go to a different family with those kinds of needs. Then all that stuff that I've experienced definitely has a major impact on the way that I am as a professional. Opening books and going to presentations and workshops and things are all very well but until you experience it, I don't think you fully understand.” (HV4)

Offering universality within service provision enables health visitors to gaze within family and community life; health visitors recognise the multiple factors that are at play for families in the 21st century. The burden of deprivation and pressures on the external environment were frequently mentioned in the data set when considering compounding multiplicities relating to DA.

“So not having much of an income, housing tends to be a massive issues. I think housing and domestic abuse are the biggest issues for these families. Housing, there's a chronic shortage of it everywhere I think..... They aren't the sort of places you really want to bring children up in, and there tends to be quite a lot of crime, like violent crime, knife crime or drugs as well, a lot in the areas that I'm thinking of. And there's also a very high transient population in these areas.”

(HV7)

The meaningful considerations here acknowledge the priorities for families, in survival and basic need provision. When the day-to-day is difficult in terms of limited income to pay for bills, housing, food, does it become easier to see the path to unhealthy adult relationships that can turn into abusive ones? When unpicked further it pondered the question whether DA was cultural. Historical anthropologists and psychologists have considered culture in terms of observable trait, value based, and assumptive (Schein, 1990). The data set appear to draw generalised conclusions that either individual or collective behaviours can indeed be influenced by the organisational culture (see Oyserman and Lee, 2008 for deeper exploration) for which they sit, either within the home, or wider community. The lines of acceptability become unclear.

“Obviously, you know, I know that domestic abuse can happen in any setting regardless of affluence. But I think in certain families, I think there’s a culture of it. And a lot of people have grown up around it themselves, so they find it almost not acceptable, but a part of life really, that’s quite common. So I think there’s almost like a cultural sense, not necessarily like ethnicity.” (HV7)

Specifically relating to routine enquiry and questioning, universal application of questions including terms were considered. It appeared that practice differed dependent on the context and individuals involved. There was a consensus that probing about general experience was preferred, however utilising the term *domestic abuse* was important and was used to embark on conversations.

“I can understand set questions, you’re giving everyone the same opportunity to disclose information, but I’m very mindful, it may be the area I work in, but I can’t ask set questions, one person’s version of what domestic abuse is can be very different to another person’s. So, for me to ask ‘has there ever been any domestic violence? Any abuse?’ Most of the time, if not all of the time they will say no. But if I ask a mum ‘have you ever been scared of your partner?’ or ‘have you ever felt low and felt like they’re not listening to you, and you’re blamed for things?’ and then that opens up everything. And then you unpick it.” (HV9)

Opening the question up to a broader discussion around support and safety was retold by other health visitors, rather than specifically applying the term DA.

“...but I don't usually use them (words ‘domestic abuse’) when I’m talking about someone’s relationship. It would be ‘do you feel safe?’ or ‘do you feel threatened?’ You know, sort of along those lines, really.” (HV12)

Opening conversations with directed questions was applied within practice, and following from this wider exploration could begin. The effectiveness of routine enquiry questions is based on the answer given and the skill undertaken to explore subjectivity of how they/we come to know.

“So the way that we do that is using promotional guided questions to explore and talk about relationships. Not just about couple relationships, but about any relationships and so, obviously, we ask directly, have you had any relationships where it got really bad, or if there has been conflict where it's turned into violence. They may disclose when they have told me about social care involvement in the past, or we may get notifications from other professionals involved, and then it prompts us to enquire further what that might be.” (HV1)

Considering a back and forth within supportive conversations was further contradicted by health visitors recounting defined moments of ceiling capacity; when there is nothing left to do. Surely a demonstration of paternalism within medicine that acknowledges the limits of intervention and thus discharge.

“So it goes back through the system and the outcome is for the health visitor to review... So I was like, what? What am I gonna say? I mean, will she even engage? Because my colleague went out last year and had exactly the same situation and conversations. You go through, like, effectively your checklist.” (HV15)

What creates wonder is recognising the importance of conversation and therapeutic discussions. When one goes in with directed questions it can create barriers to openness.

"And I think if people go in with, like, right. "So, I'm here to do an antenatal, we're gonna talk about this, this, this and this..." and they don't give people the opportunity to have a conversation that could really be a barrier." (HV3)

Is wonderment within support asking questions with potentially, none, or a limited response? Posing a question that is allowed to rest and be considered. Here lies the *art* of health visiting; the undertaking of a task that has no definitive result, rather to provide moments that enable self-transformation, or encourage conclusions drawn individually (for parents).

"But trying to put them in their child's shoes and what it must feel like for their children is really important. And I think sometimes, just making them think about how their own child might be feeling and what they might be thinking.... You know, "I wonder what little Johnny thinks, or how he might be feeling when he is you and your partner shouting. You know, I wonder what he's thinking. What do you think?" And trying to get them to think about that sometimes, that is a little bit of a light bulb moment." (HV8)

Support or fix. Safe(ty)(guarding)

Entering conversations with a pre-conceived ceiling on what can be done, is diagnostic and symptom-based driven. However, the weight of safeguarding responsibility so often governed the preconceptions health visitors made prior to entering conversations. Holding the weight of safeguarding must, and does, have defined moments of statutory involvement that are

assessed through risk, regardless of conversation and experience. When asked about the stress experienced within safeguarding, one health visitor explained;

“Because it’s on you. Like, you have your safeguarding supervision and colleagues, but it’s just you. You weigh up the factors. To have someone else with those statutory powers to say ‘yeah, it’s fine..’ or ‘no, this is enough to worry us and we will assess...’ either, it’s not you making that call. Making the call is the stress.” (HV13)

The mitigating evidence of health visitors’ immersion within the story and *attempt* to give and take power was demonstration in their consistent involvement with families and becoming part of the story.

“...you feel like you know so much about the family, and the details of it, and you’ve built that relationship, which was very difficult to build, and then you kind of feel, ‘oh gosh, now I’ve got to pass that over to someone else, and give that responsibility to someone else.’ So that was quite a difficult experience as well, yeah.” (HV13)

5.1.2 Theme two. Love and Justice, connection and care.

Considering the differing perspectives within the data, health visitors spent time considering a reflective and empathetic view of ‘*what is life like for you?*’ Within this sub-theme sat the health visitor’s ability to sit alongside families and consider the different viewpoints with a variety of feelings including solidarity, anger, and frustration, yet with the awareness of histories and implementation of boundaries within relationships. To conceive the understanding that they would do the same thing as the other is doing, if they were them. To

enter such a viewpoint, concepts of radical empathy which harness reflecting upon our own preconceived bias and assumptions is required.

As with curiosity in terms of perspective, drawing on personal experiences enabled health visitors to recognise difficulties families, and specifically victims faced. With empathetic consideration health visitors embraced the whole situation rather than siloing certain elements.

"...because I know what it's like, I've been through it, I know how hard it is to actually tell an outsider, or someone that's not a family member, what's going on in your private life... It's really hard." (HV14)

Here the health visitor draws on their experience to understand that the journey of experience presents many challenges.

Sit alongside

To harness and then maintain an ability to hear stories and empathise, health visitors understood the need for consistency. Consistency not solely within case loading and management, but in hearing and creating stories with another. One health visitor described,

"I think we're now providing a different service to when I started and there's probably not as much opportunity to get to know the families, so they maybe don't feel as comfortable to divulge any information I feel in recent years, I don't feel like anyone has said. I'm not saying that I got disclosures all the time before, but I just think that maybe families felt more comfortable with me as a familiar practitioner. You know, seeing them more regularly, they saw me at clinic, they saw me for every single contact with each child. It's different now...I don't feel like there's that relationship built up as much now. (HV12)

Here the health visitor drew from an awareness of comfort in telling a story and listening to it. Rather than simply hearing the events, listening directed the way the other spoke.

What became striking from the data was the health visitor's ability to empathise with perpetrators. Considering perpetrators, recognising them in the narratives as fathers or men within the family, health visitors empathised with their situation and context.

"...But I often think that these (perpetrators), they've been let down at some point in their childhood." (HV6)

"If I look at my experience, perpetrators have always been through trauma themselves which has led to that aggressive control, having a need to control their fear... or, a sense of normality to controlling." (HV9)

Acknowledging another's experience and believing them underpinned much of the wider perspective's health visitors provided. The sense of solidarity felt in their experience and the affliction felt when another did not believe in the same way they did.

"It makes me cross. It makes me really cross that women are still not listened to, that they daren't tell the police that this is going on and has gone on for fear of what's gonna happen to them, and them not being believed. And these women aren't being believed." (HV5)

The sense of solidarity put simply in terms of reality,

"if we don't believe people it denies the coercive control and emotional control." (HV5)

Solidarity was reflected in the health visitor's recognition of the challenges faced by mother's experiencing DA, a feeling of being stuck due to compounding factors including social support,

finances, and housing. Such multiplicities could result in near impossible situations to navigate out of. Health visitors could be caught between the solidarity of the challenge and pushing for change to improve health and wellbeing for both mother and child(ren).

“Eventually, even though she didn't want to, because she wanted to get out of that house, she ended up going back because she felt like she didn't have any other option and she didn't wanna go into a refuge or anything like that and didn't wanna lose that support off her family, and even though they were abusive towards her and controlling her behaviour, she didn't wanna lose them. They're the only parents she's ever had, so it was very difficult for her really, to kind of break out of that, and leave them.” (HV13)

This health visitor recounted a woman who was experiencing DA from an ex-partner and her own parents. The words spoken here reflect the difficulty of her situation. An awareness of leaving “...all she's ever had...” The expectation held by outsiders of the woman to leave, is a task that would feel near impossible for us also.

Who am I?

There were moments of deep reflection held by the data set, particularly when relaying how they felt about DA, and the individuals involved. Taking the professional role out of their conception, for a moment at least.

“They go back to them and they've done horrific things and I think that's where I'm struggling as I've got older. To understand. Why would they? And I think that it is quite hard for me to grasp, because I don't want to feel like that, obviously. And I still have loads of compassion for them, and I still give them a lot of my time. But then I think I don't know where does it end?” (HV11)

5.1.3 Theme three. Moments and opportunities

Managing and changing

Exemplified within the narrative, the health visitor reflected upon the moments encountered by women during their experiences. Realising the breaking point of safety for women could be changeable and dependent on context, but enabled an open exploration.

"...they'll say "ohh nothing's happened" and then when you read the abuse reports, it's like he's got her up against the wall trying to strangle her or knife her or something. So you can use the report you have to read through it together with her. And then you can say, "well, how did you feel whilst he had you up against the wall? What was he doing with the knife?" And ask "you obviously were scared enough to call the police, so what was happening there?" That helps with getting through to them." (HV2)

The moments considered to be a breaking point for health visitor action (intervention, referral or signposting) were based on the children. Often these moments, even though shared in reasoning by mother and health visitor, were encountered at different times. Supposedly this is understandable due to the ontological understanding of what is happening. Being outside the home and looking in (metaphorically speaking) enables the observer to see the whole picture, yet those dwelling inside may find it difficult to conceive other's experiences. However, who knows best for the child? The parent? Or the professional who has little, if any, emotional connection?

"...she experienced high levels of domestic abuse and you know, her young child was kind of living with this and she didn't, this mum couldn't understand why we were worried really, and

why we're having these conversations and why we were having a child in need meeting. She didn't understand at all. She just kept saying she was OK, she didn't feel that it had an impact upon her. We've kind of turned it around a little bit for now. She's with a new partner ...

...we had a recent meeting just to kind of pull it altogether. But it was lovely cause I was able to say to this mum "I feel like you've turned things around. I feel like you've had a change of understanding," because just last year when I'd talked to her about that feeling that you'd get in the pit of your stomach, you know, when you hear someone shout and you feel a little bit unsure and that funny feeling. She now recognised that, and I said that's what your little girl has. She has that feeling. And she said "Why would I want my little girl to go see him (dad)? Because it's not good for her to hear all that shouting and arguing." (HV6)

Understanding and conceiving the wider implications of victims' actions were considered when understanding the factors at play for women,

"You know, she's told somebody, and thinking what the repercussions of that might be. Because quite often they will go back, won't they? And the fear of leaving but then going back, and what will happen then... not knowing what's going to happen to them...fear of the unknown in that way as well." (HV8)

Health visitors had an awareness of DA and particularly the barriers and psychological elements of staying and leaving women juggled with. Deeper, was the awareness of lived experience and how such impacted on the acceptance of fear felt within relationships. Health visitors articulated the cycle of fear and oppression experienced by both victims and perpetrators and how such held them in a state of control.

“So, what they think is a relationship, what they know, the fear of people, you know, the acceptance. That's their lot. And because they've got no self-esteem, they're vulnerable... and perpetrators recognise that.” (HV8)

Also capturing fear for personal safety, practice and conduct.

“I said, “listen, I personally don't feel safe in this situation with this argument ongoing”, you know, and that was a culmination of asking them to try and de-escalate and reminding them that there was a child in the flat. And yeah, I said, I don't feel safe being in here. And I'm going to have to leave.” (HV10)

“It's terrifying at times.” (HV15)

Here reflecting on a particular family, and supporting the mother,

“And at one point, she said, “...you know, you're the only person that's listening to me...” And I felt so mixed about that. How can I be the only person? It was just... It's harrowing, really.”

(HV15)

This health visitor considered the trusting relationship she had built with the mother yet conceded the sadness in knowing the reality of so many missed opportunities for others.

“That was just one person that we know about. I mean, how many other people, because there is a lot of disguise compliance. Or individuals never get the chance to say” (HV15)

A reflective moment captured by a health visitor was the consideration of a relationship moving into the space of being abusive. Unpicking the changes that may occur in families that can

initiate abusive behaviours was considered by the data set. Here discussing a case in which there was a disclosure within a seemingly functioning couple took the health visitor by surprise.

“And that it was really quite sad actually with that case, because essentially, I think they'd really just struggled about that adjustment from single, well, you know just people with no kids, to having kids and I think they were stunned.

His mental health had dipped and I think he was struggling with becoming a father, so we spoke a lot about services he could access. I think it was the stress of that transition.” (HV3)

The moment a couple moves from being supportive, healthy and functional, into the space of abuse needs to be considered. It begs the question, are abusive behaviours a maladaptation to life's inevitable challenges? And if they present, are we all vulnerable to perpetration and victimisation?

Language

The health visitors considered the general discourse surrounding attitudes of DA and specific incidents involving families. Taking the opportunity to challenge language used, notably within a professional context, was important to health visitors. Here this health visitor recounts their own moment to challenge perceptions of how we define DA, and how the words used inevitably impact perceived victim behaviour.

“Social care then became involved, and they said to me “...and so yeah, I've been talking to this family about, you know, their arguing with each other...” And I went to hang on a minute. I said I'm sorry, I just have to challenge the language you're using there because actually this perpetrator has assaulted this woman and calling it arguing between one and another is

undermining and minimising it.

Only the other day we had a meeting that somebody said, "Ohh yeah. Mum says she's, you know, she gives as good as she gets..." And I said no. Sorry I, I have to challenge that." (HV1)

To reflect

Taking moments to reflect is recognised in policy and practice within health visiting (see SCPHN proficiencies, NMC, 2022). The data set overwhelmingly discussed supervision in terms of reflection and seeking support rather than in a statutory requirement. One health visitor considered this to be congruent with time in practice.

"It comes with time and perhaps I think possibly when you first are newly qualified, those conversations may not come naturally if you've never been in a position about having to initiate difficult conversations. It's quite a skill, isn't it? It's something we have, trying to be able to read the room and see all the non-verbal communication, and that two-way conversation and developing that therapeutic relationship. I think in some respects it's a skill that you can't teach." (HV3)

However, later with this health visitor, there was acknowledgement of how time may desensitise a practitioner.

"I think it's really important as a practitioner you can get to a point where there is normalising of what's seen and experienced...Acceptable behaviour and you can become desensitised to it." (HV3)

The data set consisted of health visitors with practice ranging between 1 and 18 years, considering specialist community public health nursing is a post-registration qualification, the

breadth of experience working in community and acute settings was apparent. Each participant was asked whether they work with many families experiencing DA to which there was unanimous agreement of prevalence.

“I think when most people start health visiting, they realise how prevalent it is, more than you probably think beforehand...” (HV13)

Some of the data set noted the changes in their experience working with families due to changes within the service.

“I think we’re now providing a different service to when I started and there's probably not as much opportunity to get to know the families, so they maybe don't feel as comfortable to divulge any information. I certainly don't feel like people tell me about domestic abuse when I go to see them for the core contacts as frequently as I may have done.” (HV12)

‘On-the-ground’ practice is reflective of the wider political climate and direction of public health policy. From the turn of the 21st century with a focus on early intervention and integration (Department of Health, 2004. Peckover, 2013), to the financial cuts experienced in the last 15 years, the stretch is felt. Health visitors are aware of the impact decisions made within Westminster have on their practice and ability to deliver services to families. Moreover, with the importance of trust and relationship building within the intimate conversations between health visitors and mother’s if there is inconsistency, the endeavour to promote healthy relationships and reduce safeguarding concerns becomes futile.

5.1.4 Concluding thoughts relating to study objective one: *Perspectives and wider implications of DA.*

Interaction between themes

Health visitors demonstrated their consideration between the application of intervention and impact, alongside their own subjective reflections and world view. What connected the themes was the health visitor's ability to recognise the nuance within situations and consider others with empathy. However, the responsibility of safeguarding the child is viewed through the experience of the mother, and although awareness is present, the perspectives indicate that oppressive expectations often remain. The overwhelming interaction between the themes is the positioning of health visitors within their curiosity to probe and question, their empathy with the women, and their understanding and uptake of momentary opportunity. Health visitors appear to navigate their perspectives within each theme on a fine line of their knowingness and unknowingness, with an appreciation that too much concession into the knowing or unknowing may leave them in the dark completely. The findings here demonstrate the need for pathways that encapsulate both the understanding of safeguarding and impact, as well as the recognition of the self.

How themes fulfil the research aim

This section has detailed the considerations narrated by the health visiting data set following in-depth interviews exploring their perspectives of DA experienced by families. What became notable when exploring wider perspectives were how they are considered through deep consideration based on experience, either professionally or personally. The themes illuminate the nuances of *what*, *how* and *why* that are particularly pertinent to health visiting practice. The

deep sense of responsibility, how such is felt and enforced, seeps through the words spoken.

There is a rejection of binary definitions of DA, and rather the application of understanding of subjectivity and context within the time for which *it* exists. This is demonstrated by the health visitors considering patriarchal constructs of family, as well as how culture impacts understanding and awareness.

5.2 Addressing objective 2. Exploring the broader perceptions of support

This sub-chapter will explore the findings relating to the second objective of the study for health visitors,

- Exploring the differing perceptions of support and intervention provided from the health visitor.

Much of the discussions surrounding perceptions of support centred around individual previous practice and reflections. The conversations about support were often implicated by the challenges current services faced within the current political climate. There were recollections of past practices comparative to current ways of doing, as well as the changeable thresholds the service worked with.

5.2.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Priorities

Along the lines of sensing boundaries came considerations relating to the service, as well as another professional role's remit. Who does *what, when* and *how*? Working with statutory agencies particularly social care, had the largest conflicting opinion and experience.

"The difficulty and inconsistency with other services working together but not always sharing information. They kind of triage the families in their area and then by the time we go out, we've got limited information..." (HV14)

A historical review of health visiting practice acknowledged the confusion of the safeguarding role due to the misunderstanding of service responsibilities (Baldwin, 2012. Malone, 2000), and one wonders if much has changed since.

The service model (Public Health England, 2021) enabled a broad acceptance of boundary in terms of time. However, the nuances, of consistency and approachability have little direction (Institute of Health Visiting, 2021), considering prioritisation in terms of intervention intention limited through constraints of time. In this instance it appears that conversations surrounding the safeguarding of the child need to take priority.

“I could talk about the ACE's and then look at resources, but sometimes all you can do is just talk through the effect of the domestic abuse, and the effect on the child, there isn't time. What is the child's lived experience, you know, living in this environment, how is the child? There isn't time to go that deep, if that needs to be discussed, perhaps a different profession?” (HV2)

As highlighted here, the health visitor acknowledges the threshold of safeguarding, and boundary of health visiting offer, however there is a contradiction in terms of legislative policy that ensures safeguarding is not siloed to statutory services. If social care assessments deem situations to not meet thresholds of concern, does this mitigate individual health visitor concerns? Or are thresholds of safeguarding concern within the service based on staffing availability?

“Sometimes even if there is statutory involvement as there are safeguarding needs, due to staff shortages, we have to remember we are health professionals, and so if there's no identified health needs for this child we won't always be attending the meeting but will give a summary of

our last contact. In those situations where there just aren't enough staff, you hope the social worker is leading on the safeguarding aspects within the family. If then social services step back as they deem there aren't safeguarding concerns, then you can assess the rationale for on-going health visiting input. You just have to be very clear what the health visiting service can offer, what they will do, and what they will signpost to, remembering this is not a compulsory service."

(HV1)

The nuance of support thresholds is indeed confusing with the consideration of clear boundaries explored above, yet there is acknowledgement that if you wish to return following a contact, one can.

"Then you will you leave it open or maybe say "ohh I'll bob back in a couple of months" or something because our job you can do that, can't you? As long as you've made a reason for it."

(HV2)

When prioritising workload, professionals required information to make appropriate assessments based on *need* and *risk*, however when there is much to discuss what becomes the priority? Understanding, which is demonstrated by the data set, that disclosures and trust to enable conversations was not finite, and often took time, made it very difficult to prioritise with the awareness of not, or *maybe* not having all the information.

"...and you've got your little agenda in your head of things of what you're going to do, but then that can completely change the minute that you're in. It's hard to plan ahead. I think we have so many things that we have to achieve in a visit..." (HV10)

Support or fix. Safe(ty)(guarding)

This sub-theme was created to give meaning to the reflected conflict of priority the health visitor experienced when working with families. It produced a deeper meaning of wonder surrounding what intervention and/or support is. Is conversation and listening enough? Or does intervention have to produce an acknowledged and defined outcome?

Health visitors consider the threshold and boundaries of the role, yet when asked to consider this further, the lines between what constitutes public health and what does not, within the context of DA, becomes blurred. With DA featuring in over half of child serious case reviews (Brandon et al. 2020), and the evidence of other concerning factors at play, including mental health concerns and substance misuse (Skinner et al. 2021. Hewerd-Belle, 2023), it became difficult to define between health and non-health.

“if you've got a woman that's suffering domestic abuse, you can guarantee hand in hand there is gonna be maternal mental health issues, anxiety, low mood. Because one affects the other, and so and that's why I think health is so important because we cover that many things, we're the workforce that goes out from pregnancy right up to five years old. We're the only workforce really that knocks on the doors and gets the doors open for us, for such a length of time anyway.” (HV14)

Encompassing the supportive and surveillant nature of health visiting practice was implicitly weaved through much of the considerations relating to prioritisation by the data set.

Acknowledging the moments when the child took priority were ever present.

“But only that woman can decide. All you can do is support them, but you can’t make them decide whether now is the right time or not. But then of course, you have the priority of children in that scenario, so the mom may not feel it’s the right time or want to leave, but is it safe for the children? What’s the risk to the children if they get caught up in a conflict? Will they be hurt? Emotionally affected? Development impacted? How will it affect the child’s attachment to their parents??” (HV14)

Here the health visitor demonstrates the conflicting priorities and questions required when subjectively supporting families and objectively mitigating risk to children. Can one fully support when there is the hierarchy of safeguarding? Considering the priority of threshold relating to the objective level of intervention that is linear and systematic in nature is often weighted on the risk of harm to children, an example of how objective assessment is prioritised over subjective experience.

“...we will level up our service to Universal Partnership plus, so we assign that level of service to clients who are experienced in domestic abuse because of the impact known on the child.” (HV1)

The data set demonstrated the conflict between a task orientated, paternalistic model of fixing a problem, and the subjective, empathetic model of supporting. Could both exist at the same time? Or did one option render the other impotent? Here the health visitor reflected on the questions she asked herself during the wonder of priority of intervention and support. A mother who was doing everything she could to safeguard, yet the perpetrator continued to place her and the child at risk. When everything is done, what is there left to do?

"So it goes back through the system and the outcome is for the health visitor to review... So I was like, what? What am I gonna say? I mean, will she even engage? Because my colleague went out last year and had exactly the same situation and conversations." (HV15)

Health visitors recognise the importance of information to provide a holistic picture of the family. Practitioners could not appropriately work with individuals on experiential information alone. An essential part to the role was collating evidence to ensure discernment. When asked, one health visitor stated the importance.

"...even if it's just to give you an awareness that something's happening before you go in, and you can see on the record that something's there, then you can ask directly... "what did the police say when they came?". You know it's helpful in that way...." (HV2)

...there must be something triggered in her at that moment where she knows it isn't right, she isn't safe and this is so much more than an argument to make her call the police." (HV2)

Directed wonder

Entering support surrounding concerns, or potential risk had to be done so with an empathetic sense of wonder. Understanding the world view of another was important to beginning the journey of working together.

"...it's a really fine line of how to be supportive, because there's no point in going in if someone said to me "that's domestic abuse, what you're doing?! You need to get out with your baby"...Whoa, I'm not ready to hear that. That's not abuse. If they've been in a relationship where there's been lots of coercive, you know, domestic abuse, controlling things like that, you've got to really talk about healthy relationships." (HV3)

Considering above, this health visitor positioned their supportive interventions, in this case conversations from the basis of what a healthy relationship is, rather than focusing on concerns. Wondering where to begin the support, do we explore what it should look like, or where it may have become concerning?

Health visitors spoke of their 'gut instinct' or a sense of 'vibe' when working with families. Overwhelmingly the data set described such as a reality, and gave it weight when considering support offered. Never downplayed, rather exonerated as a truth that was fundamental to practice, it was often utilised in the observation and assessment period of working with families.

"Sometimes it's your intuition, that gut feeling and I trust my gut feeling." (HV5)

Following directly from this, asking this health visitor how their gut instinct has changed over the years,

"I think I can just tell when people are telling me truth... Yeah, I went to somebody the other week, a birth visit, and Dad wouldn't let the interpreter in. So, I'm like, 'OK. What's going on here?' and at the end of the visit, I have to say my gut feeling was telling me there's something not right, and we got to the end of the visit but I'm still gonna have to go back and ask more questions, because she just smiled her way through." (HV5)

This quote illuminates the decision to continue support based on the unobjectifiable sense of uncertainty. The courage to unpick the uncertainty further is the moment to decide they need to go back.

Playing the game with the stories we tell

Health visitors captured a knowingness in their understanding of how women will conceptualise their experience and undertake certain interaction and action.

“...there are mom’s who are clued up if you like, they’ve been through the system, and they know, maybe they won’t tell you as much because they understand how information is shared. So, they are fully aware that ‘...if I say too much to the health visitor, she’ll talk to the social worker and it gets escalated to child protection’, and they know that.” (HV14)

Interestingly, there appeared to be contradiction within the data set as to the role remit when working with families. Perhaps an inability to understand DA as a public health issue, some narratives exemplified the health visiting role to health only in terms of medical need and intervention.

“I often find, and I’m sure many health visitors do find, it easier when there’s multi agency involvement because we can be the specialist public health nurse, be a nurse-health visitor, rather than everything. You know sometimes when you go into a universal contact and there are potential issues or whatever, whether they’re struggling or anything, there’s a lot to take in on those and visits, there’s a lot of ground to cover to be able to recognize where the need is. And I find that I can do the health role, really well when there’s other agencies involved.” (HV12)

What are the boundaries to health visiting support and intervention? Do they exist? And if so, where do we draw the boundary lines?

Moments of wonder translated to working with both parents and/or victim and perpetrator.

Often positioning the mother as the victim and person most likely to engage with the service,

health visitors found working with fathers and/or perpetrators difficult in terms of limited interaction.

"...it's a battle and a lot of men don't see it necessarily as their domain, they'll leave the room when we visit. But you know, I think we're getting better at it, but it's still not what it should be. I think in terms of considering them as an equal parent. And especially if the relationship is not, you know, they're not together, it's very awkward to try and involve them. Which is probably another of the root causes, cause they can probably feel a bit locked out of the whole system really, that it's more about mum and baby, than it is about, you know, the parents as a whole."

(HV7)

Meaningful considerations were raised here. Considering health visiting support, how does the service include men when they are written out of it to begin with? Birth notifications, assumed legal responsibility prior to registration, caseloads... Much contain little acknowledgement of the father, with assumptions of them being 'added' prior to the intervention, rather than belonging and being within from the out-set.

Humanity held within the home

The exploration of the experience of children was positioned as challenging for health visitors, as so often they recognised the breakdown in personhood and identity that women felt, marred with guilt.

"But it's hard because you're trying to make a relationship with this person if you've not met them before, and you're gonna talk about how it has affected the children. How's this experience and distress that you're all going through affected the children?"

I think that's a challenge for us because you don't want to devastate and crush a person when they've already gone through all that.” (HV1)

Often discussions with parents about children, and the impact of experience on them, were positioned as challenging, needing to be undertaken with an awareness of humility. This was considered beneficial to relationship building, specifically within listening; To listen and not just hear, a deep understanding that their experience is theirs to be heard.

“I think it's really important that you, you know, present yourself as someone that's able to listen and that you go in there wanting to have more conversations with somebody, rather than going in there with your own agenda. Taylor more of a two-way conversation with people, cause I think having those skills to be able to build up to those sorts of conversations is a really good skill to developing that therapeutic relationship.” (HV3)

5.2.2 Theme two. Love and Justice, connection and care

Who am I?

Interestingly, health visitors often discussed their dynamic with families and women in terms of intimacy often found within ‘informal’ relationships, such as friendships.

“I think I do have those good skills and know how to be a good friend. In regard to, you know, domestic abuse and supporting families with that, I think I do a good job.” (HV3)

Reflexivity is weaved throughout health visiting culture (Cowley et al. 2014), considering what I believe and what I think is part of the radical empathy required to challenge assumptions. The code of *who am I?* applies to the individual and to the wider service. Defining the boundaries of ourselves and the service enables a truer connection with the families and agencies. However,

what may come into contention is the boundaries we set personally, comparative to the legislative and practice remits imposed upon professionals. Clarity here can empower oneself and others.

“It feels like you are carrying it, you feel the burden of that assessment in a way. But you have to be clear why we're involved, and when.” (HV1)

One health visitor explored their own perception of working with families before they had gained more experience within practice.

“I think some of your early experiences with these families are hard, you take it on so much, and each time you do get that bit where you take it home with you and it's about you, but then eventually you start to realise that it's not about you, it's about those poor problems, those poor women. But it does take a while. I think I have to admit that it was about me for a while, and each time you're in a sad situation, there is a part that thinks you know, you kind of let yourself feel a bit sorry for yourself because yeah, that shouldn't happen to you at work. You shouldn't have to experience that grief and that trauma can be big. But it's not about you. It's about them. But it does take a while to learn that.” (HV4)

Here, to embrace a radical sense of being and consideration of learning, unlearning, and re-learning; Capturing the notion of ‘orientation to practice’ as detailed by Cowley and colleagues (2014). In such, becoming immersed within the service helps to delineate attitudes and values to promote healthier outcomes for communities (Cowley et al. 2014).

Yet, regardless of experience the degradation of services and community togetherness would leave health visitors feeling isolated and doubtful of their care delivery.

"The longer I've worked in this job, it doesn't get easier, I think sometimes, you can start to overthink can't you, because of the changes going on, we've changed the way we work in the last few years because there's not the resources there, there's not the staff as much... and so you do every contact with a level of anxiety." (HV12)

Often doubt and worries were used as the reason for continued support. The idea of *not knowing* was anxiety inducing for some of the data set, and to alleviate such, timely contact with families was undertaken.

"...it was one where I'd constantly be like, right I need to check in with them, even though there might not have been anything that's specifically happened, they'd always be on my mind, so I'd want to check in with her. All this is a way of dealing with that uncertainty, maintain that level of contact to help your own worries about it all you know, you wanna keep an eye on, and just offer that extra support." (HV13)

However, the virtuous qualities of character and role remit could be drawn upon in the endeavour to support.

"I mean, I know that midwives obviously go in, but there's no workforce in the UK like health visitors that cover such, nearly a 5 and 1/2 year span, to have the ability to go out ad hoc. Knock on the door, and I think 9 times out of 10, you know, health visitors are tenacious. You know, if we don't get in the first time, we'll go back, we'll go back because we care about the clients and it's on our heads. We are the individuals that are tasked with seeing those children and making sure they're OK." (HV14)

Belonging and embrace

Health visitors acknowledged their own feelings and notably this played out in *how* and *why* they accessed supervision and support for themselves.

“You tick box it, you take the human out of it. That’s why I get so exhausted, it’s not a physical exhaustion, it’s that you have to give a lot to families to give that human approach to them, and you’re giving a piece of you away for it to be meaningful, and it has to be meaningful.” (HV9)

There was a sense of a culmination of both loss and hope within this quote. Work was truly undertaken with an awareness of the emotional toll it took yet was still delivered with meaning and intent. To give oneself could result in a greater sense of meaning.

A developmental approach to behaviour construction includes a myriad of influences through biological variables and previous experience (Carlson, Sroufe and Egeland, 2004). Health visitors themselves displayed their own construction of behaviour and delivery relating to previous experience; in this case where the health visitor herself was a service user.

“I remember my health visitor coming out to me. She was so posh, and she was at the new birth, and she said, you know, “have you ever experienced domestic abuse?”, she just said it like that. As if she was asking if I wanted a biscuit with my cup of tea! And I remember thinking, all these years later, “if I did, I wouldn’t tell you!” I remember that because I didn’t have that connection with that one health visitor.” (HV14)

The decision to harness belonging and connection with the mother was correlated with her own experiences of what, in her assumption, was not conducive.

Sit alongside

Having courage to support another is often do so with a conscious awareness of reality. A meaningful moment within the data set, was the acknowledgement of being in a place of *knowing* and trusting the information provided and presented. To build the connection is undertaken not only through solidarity, but by acknowledging that trust is not a definite, nor immediately given. It takes time with an appreciation of the *right to know*.

“So there's definitely a balance of then how you manage those situations and in how much do you know? How much do you need to know? Because that's trust. Definitely needs a trusting situation. Because even though I'm a professional she's not necessarily going to trust me to tell me the things that she knows that she doesn't wanna tell me. So yeah, that takes some time to build up that relationship with those women.” (HV4)

There were moments within the interviews in which health visitors simply placed themselves wholly within the supportive role of being there, alongside the mother in their reflections of practice.

“I sat with her while she phoned the non-emergency line and spoke to somebody.” (HV8)

“...we've got that time to sit down and listen, you can really get to the nitty gritty of it and you can hear their feelings, you can see how it's affecting them.” (HV5)

To hold space for another and validate their experience required time and encompassed listening. This health visitor almost enveloped the experience of the child through the recognition of the mother's experience. Would this be relevant in all situations; to understand the child's experience through a sense of solidarity with the mother?

“Because he has an effect on those kids that are in that house as well. So that's part of our job is hearing the voice of the child. How does that child feel if that mum's being controlled by that dad? So I think that's the difference really. We need to believe them, to see the child.” (HV5)

Simone de Beauvoir (1908-1986) stated the undertaking of motherhood places the woman with a God-like power in terms of life giving. However, as Beauvoir and other feminists acknowledge (Collins, 1994. Fromm, 2004), mothering is laden with biological and social oppression. As Arnall and Stewart (2021) suggest, the focus on the mother is linked with patriarchy, and responsibility for child welfare and safeguarding. Conversations held between mothers and health visitors were undertaken in solidarity and compassion for their situation, however the conversations also highlighted the health visitors' own bias. The back and forth of wishing to empathise with her, whilst also reminding herself it isn't acceptable.

“You know, she knows half the time that she's not safeguarding them. You know, she knows that. And I do try and sort of say that I understand they're the father of the children and it's a really difficult bond to break. And I always try and put across that I understand that that's how you feel. But you know children are in the middle. But I do get why they want to be with them. Because like I say, having children with a man is huge deal, no matter what the relationship is like. You have to understand...” (HV11)

The above quote demonstrates the intrinsic link between mothers and their children, however, by viewing the child's experience through solidarity with the mother do we perpetuate the overwhelm responsibility on the mother? The data set understood the necessity to talk alone

with women if there were concerns so to prevent escalation, however wonder about opening conversations to both parents (if present) were considered.

“Why don’t we talk to both parents about it? I mean I know about ensuring safety and the likelihood is if it’s happening it’s the male perpetrator and female victim, but we just direct the exploring questions to the woman.... But, in an ideal world, I would be able to go in on a first visit and talk to them both about healthy relationships, you know.” (HV14)

5.2.3 Theme three. Moments and opportunities

Conversation

Finding the moments to speak and/or listen were understood by health visitors. Often fleeting in time, grabbing the space to explore was undertaken with creativity.

“I could sense that there was something strange, I don't know what I could sense, but I could feel something. And the dad went upstairs at one point I lent forward and I just whispered to this mum, I just said "do you feel safe?" And she went "no", and then he came downstairs and we had to continue the visit. And during I had to kind of think like... what next, what next? What do I do? She's ready to talk.” (HV6)

“I will say "I better come back and see you in a couple of weeks. And if we want, we shall we go out for a walk with baby? Go for a stroll?" it's allowed me to have those conversations.” (HV3)

Taking the opportunity to speak with a parent was done so only when that individual was alone.

"If that person's there on their own, I will ask them outright. I'm not scared of asking the questions and saying, you know, is there anything going on that you want to talk to me about? because not everybody knows the language for domestic abuse..." (HV5)

However, with this in mind there would always be individuals who simply were never alone and therefore could not be spoken with.

"And I suppose that, you know, there are some families, where it's just never going to be possible to address it in a way that's safe, I suppose. [pause] ...Or we haven't found a way to do that." (HV7)

There was a salient pause within this narrative. A moment of wonder and sadness that was acknowledged by us both. The notion that for some an opportunity to speak freely was not feasible. Yet, the endeavour to broach relationships, or concerns was still apparent if the moment to explore them had not yet arisen.

"sometimes it might be that you park that in your head and think 'hmm, there's something not quite right here...but right now isn't the right time to address it.' I'm gonna revisit that at four weeks or six weeks." (HV14)

The entering of conversations appeared to be undertaken with a sense of honesty and awareness.

"I said to her, 'I know you don't trust professionals...I bet you've been let down in the past. I can't fix everything because that's not my role. I don't know you, but I know what's gone on, cause social care have told me. But I'm here to let you talk about it'..." (HV5)

Clarity was just as important to the moments within conversations, particularly within actions following disclosure.

"I would be very honest again with them and say, "...because you've told me this and you have got a young child or children, you know, I'm going to have to take this further..." I have had that experience where everything was sweetness and light up until that moment where you say that, and then they say "no, that's not why I told you." And then it gets quite hard because you have to explain that you have a duty of care." (HV7)

However, honesty seemed to come with its own boundaries. Here the honesty of perspective and awareness was delivered without a risk to safety.

"I'm very transparent, unless I feel it's going to put someone at risk of harm" (HV9)

The assumption that all health visitors take the moment to enter conversations cannot be taken for granted. This again reminds us of the fundamental difference of knowing and doing.

"So I said in my safeguarding supervision, I feel like we're stuck. It's a stuck point and I said I feel like I need to have, like, a challenging conversation." (HV15)

Acknowledged is the requirement on the health visitor to discuss and explore DA and relationships as stipulated within registration requirements (Nursing and Midwifery Council, 2022) and policy documentation (Department of Health, 2013. Department of Education, 2024). Interesting was the application of such discussions and the underpinning emotions related.

"I think sometimes you can get people that can for a better word, be a bit like pulling teeth with conversations, not really receptive." (HV3)

Above, the health visitor explained the difficulties in having conversations with families who had previous social care involvement; *“not really receptive”*. The hegemonic paternalistic model used within healthcare, underpinned through medicine, creates an environment that expects practitioners to ‘fix’ or ‘respond’ hurt experienced within a specific part (Libreros Piñeros, 2012. Barros et al. 2015). The over emphasis on diagnostic exploration within conversations enables the power imbalance to remain (Bryne, Happell and Reid-Searl, 2016), and in such, when the individuals are perceived as non-receptive this reinforces the paternalistic power held by healthcare professionals. This, as Bryne, Happell and Reid-Searl (2016) conclude is in contradiction to the recovery/trauma informed approaches so often encouraged within public health. The health visitor transcripts contained such contradiction in terms of support umbrellaed within paternalism.

“And I will open that conversation. I'll invite people in, or I'll say. ‘Listen, let me tell you, I've come here obviously to see how you are. And I know already about this situation, so you can talk about it with me and let's see how it's affected you.’” (HV1)

Invitation

The data set described how conversations often funnelled into direct questions and invitations. The topic broad in discussion yet narrow in direction.

“I might say well, how are things with him? How is your relationship now that you've had a baby and then specifically ask “Do you feel safe in your relationship?” But yeah, I would tend to lead into it like that, and quite often you can get an indicator of how things are feeling. Just kind of vibe-wise in terms of the support that woman's getting in the first place.” (HV7)

The moment to have a conversation initially appears to be open, however, the invitation is opened with moments that are laden in sexist views. The opportunity for an open conversation takes a reductionist turn in questioning.

"...You know, if you say domestic abuse, people always think of somebody punching them or hitting them or anything like that. So I ask questions like 'does your partner withhold money from you?' 'do they do anything to you that you don't like?' 'do they tell you off if you've not loaded the dishwasher properly?' or you know I ask sort of questions about housework and 'are you allowed to go out? Are you allowed to go see your friends?'" (HV5)

Compounded further by the moments to begin conversations, were the feelings underpinning the invitation itself. Considering how one recognises but attempts to limit the impact an emotion has on a question, involves reflexivity.

"It's never the nicest thing to bring up and it's probably something that I ask towards the end of the visit or the contact. I mean, we're used to asking all questions and discussing awkward things. But, you know, it does always feel quite uncomfortable to say it. And that probably does come across." (HV7)

This raised an interesting question; was the sense of allowing the dislike of the phenomenon itself (the abjection to abusive behaviours within a relationship), helpful to understanding?

Regardless, health visitors demonstrated an awareness of adjustment in questioning, understanding the necessity of routine enquiry, but requiring the adaptation of wording.

"So for me to ask 'has there ever been any domestic violence? Any abuse?' Most of the time, if not all of the time they will say no. But if I ask a mum 'have you ever been scared of your partner?' or 'have you ever felt low and felt like they're not listening to you, and you're blamed for things?' and then that opens up everything." (HV9)

Managing and changing

Accountability is inherently woven into practice through pre-registration education (See *The Code*, NMC, 2018). Contentious within explicit definition, accountability is overwhelmingly linked with responsibility in terms of identity, virtue and value-based beliefs, and action and behaviour (Bovens, 1998. Hayward and Blackmer, 2010). Dohmann (2009) makes an important statement that accountability reflects agency and free-will. Health visitors value the experience of reciprocal knowledge sharing yet understand the boundaries of accountability.

"I'm more able to let go of things and get people to take the responsibility themselves, rather than feeling like I need to do it for them or guide them or be there for a few visits...

...it's about empowering people. And it's funny because we've got some new starters in our team and I can see the way that they're visiting a bit more than they should, because they feel under confident, whereas I go, you don't really need to go again." (HV5)

Acknowledged, the link between accountability and experience/confidence. If the boundaries of accountability require support and confidence, does it reflect free-will? Health visitors believed women and had a desire to work alongside them and ensure their autonomy within decisions, whether this be to leave a relationship, or seek additional support. However, there

were moments within the transcripts that depicted the ceiling of what women wanted, the moments where the mother's opinion of action or plan no longer was as important.

"I was that worried that if she went back to that house, then, you know, she could be at risk...

...But I would, I would explain to them that even if they didn't consent, if I was that worried, I would have to do that referral." (HV8)

Fear, as previously noted within the first theme, meaningfully impacted the health visiting support. When asked, one health visitor discussed disclosure and gaining trust. Here, the health visitor acknowledged fear was attached to disclosure.

"I think you can only get that [trust] from when you have built that relationship up between the health visitor and the client...I think that only comes after a while. People would feel reluctant to divulge if they're not sure who you are, or you know, they've just met you for the first time, and that's the last time they're going to see you. So how can they feel safe to tell you, you may not be there again." (HV12)

The importance of consistency and building relationships with families, and how within the climate of fewer practitioners', women will often stay silent.

5.2.4 Concluding thoughts relating to study objective two: Perceptions of support

Interaction between themes

The meaningful considerations addressing this research aim highlight the conflict between surveillance/intervention and support/holistic approaches. As previously highlighted (Smith and Horne, 2012), the drive to define the health visiting role within these terms is not new. The

wonder for the data set navigated around the *how*. The health visitor's perception of support was clear within their own reflections of registration and accountability; however, wondering how to deliver and how to facilitate interventions were present. What became meaningful was the health visitors understanding and application of individualised care centred around need, yet the fear of binary rationale that is often provided within medicalised healthcare.

How themes fulfil the research aim

The three themes generated through the analysis and in fulfilment of the second research aim of exploring perceptions of support, lift the voices of those that deliver the service to consider what is undertaken and known to them. The juxtaposition between support and surveillant procedures is noted, and this supports the previous work by Hughes and Condon (2016) in which they noted health visitors were in negotiation between policy and practice. What is exposed further within the dataset is the disconnection within the service provision: the misalignment between what is done, and how it should be done, remains contentious.

5.3 Addressing objective 3. Exploring the perceptions of achievable/wanted outcomes

This sub-chapter will explore the findings relating to the third objective of the study for health visitors,

- Exploring the perception of achievable/wanted outcome from the health visitor.

This aim was personal. Much of the exploration surrounding outcomes derived through hope and despair. Health visitors considering their thoughts through experience and accountability.

5.3.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Humanity held within the home

Using the term 'perpetrator' and attributing the responsibility of hurt caused by perpetrators was noticeable within the transcripts.

"I want the ownership and responsibility to be aligned onto the perpetrator, because at the moment it's all on the mum." (HV9)

Considering the accountability in terms of perpetration was wanted, but often unachievable.

"And that is the main difficulty I think, is engaging with the perpetrator and switching that support over to them as well...making sure the perpetrator has a plan of what they need to do."

(HV13)

What followed this was what next. When plans are not achieved, what happens then?

"...it's reasonable to ask what are we having this plan for when the parents don't want to engage and there is no longer immediate risk? Do you escalate it if the parents don't turn up to

[core] groups if we feel the threshold is being met for looking at removing the child, or do we de-escalate?" (HV13)

As acknowledged above, health visitors are fully aware of dissonance in terms of action. Plans are only as good as the agreement and undertaking of action. If there is difference in wanted and realistic outcome, does one negate the other?

Outcomes were based on the breaking point of impact on the child. Regardless of acceptance or awareness, the safety of the child was the focus. As this health visitor explains, the theoretical working towards a similar goal of 'getting out', was not enough. Risk remained and therefore action was required.

"So, she was verbalising what she knew she had to do. But there was never any constructive movement forward, to getting out of that situation. So, yeah, there was a big risk there that she was putting the child at risk, although she was aware of the risk, she was maybe too vulnerable at times to safeguard herself." (HV13)

However, there were pensive moments of wonder when considering women and/or victims within the context. When considering contributing factors, the following health visitor recognises the perception in pattern of vulnerability some women may present time and again entering relationships with abusive people.

"...And it does seem that they just seem to go for the same one. When you turn up at the house and you think "ohh, no, what's going on again now? Not another one like that"." (HV2)

Following from this, one health visitor considers the expectation or desire from women and families. What was interesting was the framing of such in terms of *their need*. Bradshaw (In MacLachlan, 1972) postulated the taxonomy of need as *normative need, felt need, expressed need, and comparative need*. *Healthcare need*, as described by Asadi-Lari et al (2003), reflects the wider policy guidance and practice undertaken by professionals, so it would be little surprise that outcomes reflect the assumed or acknowledged needs of an individual. However, considering the placement of power, if one always has the need and the other always provides the requirement, how can the equity of relational back and forth be made.

“So they need professionals, they need the children's centre. They need the domestic abuse workers, they need the health visitors and the school nurses, they need the help, and for professionals to listen.” (HV5)

One health visitor reflected to have the sense of equality rippled into wider society.

*“But when you think about it, there's so many issues that predominantly affect women, really...
...it can feel that women are some kind of subset in society. You know I feel quite equal, but if you look deeper, subtly, it's still there. Are we actually equal?” (HV14)*

Playing the game with the stories we tell

Denouncing DA within any relationship was acknowledged within the data set. Rejecting any acceptable excuse for perpetration was explicit in the narratives and supports the wider evidence. Health visitors approached their responsibility in repeating such as acknowledging the service is not afraid to support the cause to tackle DA in talking.

"I think the key thing is letting them know that we're happy to have those conversations and I feel that's where we come from, and definitely in our team, we have open conversations. We're not scared about talking about it. I'll talk about it." (HV1)

When approaching the endeavour to talk about it, health visitors use the collective we. A shared goal. On individual contexts, striving for awareness and acceptance of the DA experienced by women was a consideration held by health visitors. However, what is contradictory in terms of knowing and truth(s) is how much health visitors perceive the level of awareness and acceptance.

"Sometimes you don't get an opportunity to be alone with the woman, that's the nature of the beast, the men are always there, and sometimes there are the obvious things with women that they don't or are afraid to engage with you because they fully understand the consequences of risk." (HV4)

...

"Often women don't understand that it's even a problem because they've grown up in that same situation. Parts of their self-esteem and self-worth is so low that they don't, or they don't want to see it. They don't want that it's something that they're going to have to change in their life..."

(HV4)

Acknowledging the nuance in truth of women's lives as demonstrated here, perhaps, is the goal. Trying to conceive the desire of awareness or acceptance is too far down the river? However, the desire for some health visitors was the acknowledgement of what had happened. One health visitor reflected on a woman for which an incident had occurred and there had been

statutory involvement yet the minimisation and seeming denial proved too hard to break. If one's own reality is indeed their own, if they deny an experience in terms of seriousness, how can we move forward?

"we've been told that this incident has happened and it's not uncommon for them to kind of be quite defensive about that. Like, "...it wasn't like that..." "They've misunderstood it. It was nowhere near as serious as that." "It's fine, you know, everything's fine now. It was just a heat of the moment." They know all-sorts of excuses why it wasn't as disturbing, as troubling, as it actually was. So that is quite hard when you get to that point of backtracking and it can be really hard" (HV7)

Perhaps what was hoped for was those that needed to know, knew.

"Social services involved, all that's out there, and everyone knows that. Easy." (HV4)

For all to know enabled an alignment of accountability of hurt, and thus safeguarding planning. Be this as it may, with the outing of truths, it also came with stigma and shame.

"...you don't wanna appear vulnerable. You don't wanna be another statistic. You don't want people feeling sorry for you. Don't want people talking about you. You don't want to be different from everyone else. You wanna feel like you're a lovely, happy shiny family, so you just carry on living that life." (HV4)

Considering personal experience, there was a moment in which a health visitor acknowledged other's reality to be understood through their own lens of truth. Apparent, the achievable outcome of reality of another is undertaken through our own history and culture. Once

entering a relationship, can health visitors distinguish between what they have known, and what another experiences?

"I've been in a situation where this has happened to me and didn't realise it was happening, and it took somebody else to point it out. After he left, my friend said "we all thought we were losing you." and I thought what do you mean? I changed, I disappeared. No one asked me, I've never been asked. If I'd been asked I probably would have said more, but its hard for someone to say that during the time. It's so hard to tell and ask, it's so emotive...because you can't stand up for yourself, you've let yourself down. That's why I believe them Because it's such a hard thing to admit to." (HV5)

Who's story are we engaging with? And at what time in their story? Apparent was the awareness of only what is told, and how this can change so quickly when more is disclosed. The experience of DA, even in hindsight, is never a finite reality. It changes in its form, its power held over the individual, and its lasting impact. Health visitors must consider that another's truth is only what they wish to share, and that they may feel they know someone, but rarely know it all.

"...and it must have been over a year after being in regular contact that she eventually revealed to me what it was like at home." (HV13)

Directed wonder

The strength of positive outcome appears largely proportional to the collaborative working within the wider multidisciplinary team. This health visitor wonders about the working practices

of other agencies. The directed, and intentional wonder is non-exhaustive regardless of who you are and who is alongside you, within the relationships (professional or family member).

“...it's just about talking to that person and saying, look, you know, this is the constraints that they are working with. I've spoken to other professionals before, and said, can you explain to me why this has happened or why this isn't happening? And then explaining it to the client, cause sometimes these other professionals use really long words, or legal terms they don't understand.” (HV5)

The outcome is based on implicit understanding of one another, rather than the explicit action between each other. To deliver the *art* of health visiting and enable change within another is the endeavour and, draws into the concepts of ‘Pathways to Empowerment’ as described by Wolf and Jonker (2020) as being driven through enhancing agency and self-direction.

“But when they've actually disclosed, when there's something going on and they've been denying and denying, and the relief that actually they've been able to share that with you..”
(HV8)

Support or fix. Safe(ty)(guarding)

Research and literature have long informed us of the increased threat and likelihood of escalation of violence when a victim leaves an abusive relationship (Monckton-Smith, 2020).

The changing of dynamic within the abusive relationship was noted within in this study, but also in recent literature. Hine et al. (2022) study examined data from third party agencies and DA services, for victims noted to have experienced some of the highest category risk DA, women were more likely to have tried to or left on at least one previous occasion. The movement of

staying and leaving, both emotional and physical is the overarch of much of the support provided between women and health visitors. The safety of staying in relation to violence escalation, as well as stability in terms of finances, and consistency of routine for children, is noted. However, this is tangibly close to the juxtaposition of safety in terms of emotional and physical harm to the woman and children, as well as the impact the experience of abuse has on childhood development. Health visitors considered the practical safety measures of removing victims from an abusive situation yet could expand the debate into the conflicting concerns relating to stability and consistency.

“So they'd gone into a refuge in ...(a different area), and the mum had text and said ‘we might only be here overnight’ and she (my colleague) was like, ‘why?’ And she said ‘because there isn't the space for us here.’ You know and she said to me ‘I don’t know if it’s a good thing or not, that they’ve gone. Cause you know, these children still haven’t got a secure and safe place’.” (HV15)

Perhaps, either conscious or unconscious in reckoning, the suppression of pertinent knowledge is at play? As Bradbury-Jones and Taylor (2013) propose, the concept of abjection in the recognition of DA for health visitors; realising that suppressing certain truths wholly negative to our emotional being may in fact create hermeneutical injustice (Fricker, 2016). A state of conscious or subconscious ignorance as Fricker (2016) argues, is not always a bad thing.

Interestingly what further compounded the contradiction in terms of safety, particularly for the health visitors was the heightened awareness of context relating to the DA, and how systems recognised the hierarchy for such. Previous experience and insight informed the health visitors of potential barriers or issues in accessing support and intervention. One health visitor

discussed their experience with a family, and how the lack of physical violence perpetrated, and the overwhelming experience of emotional, psychological and financial abuse may not be enough to secure safe refuge.

“We got them to move, but that was really difficult because I guess because those refuge places are for more life saving situations not life changing situations, I get that. But she in my eyes, she had the same right to be there as everybody else because she'd been experiencing this. Her only other options were to stay or be in a homeless B&B, and its damn squalor, living with all the drug users that live in the area.” (HV4)

Within this quote the health visitor acknowledged the situation as not being event-based on the premise of risk to life, rather they recognised the desperate need to leave. However, emergency housing is given to those in situations where life is at risk. It opened up reflections about how the experience of DA was weighted in wider systems. The see-saw contradictions within services that both recognise the detrimental impact ongoing control and abuse has on victims (adults and children), but that at service intervention level, threshold is not met to instigate change. There was a sense of both relief and frustration that health visitors recognise this, it bares little surprise as recent literature evidences the lack of progressive change within service intervention (Gear et al. 2021. Russell et al. 2021). Gear and colleagues (2021) within their review noted the fragmented, and culturally inappropriate services within DA, moreover, as Russell et al. (2021) postulated intervention threshold is often linear in assumption with future risk corresponding to the threshold at the time. Perhaps obvious to conclude, this mindset fails to address the overwhelming evidence that supports the concerning, and often violent intent within patterns of abuse (Monkton-Smith, 2020). Unpicking further is the gendered lens of context taken within

policy and thus safeguarding intervention; local safeguarding policies overwhelmingly use non-gendered language (England), with a minority taking a gendered stance to DA victimisation (3.4%), however what policies negate to identify is the perpetrator within safeguarding actions (Russell et al. 2021). By failing to explicitly address perpetration and recognition within such in the safeguarding context, it is no wonder that threshold implementation is driven by immediate risk to life. Health visitors recognise the life impacting effects on victims, notably mothers and children. Reflecting on individual situations in which women essentially weigh up the pro's and con's for leaving. Moreover, in the full awareness that things may in fact get harder when they leave the abuse.

“Well, they may recognise, but they just feel like there's no, there's no way out of it. You know, it might be financially, they're just thinking that it's just where they need to be at the moment when they've got such a young baby and maybe financially dependent on him. Or you know, alot of women know if they do leave these kinds of men, they'll end up in temporary accommodation and they could end up anywhere in the city and away from the support network they have and have to move the kids out of nursery. They just think this will have to do.” (HV10)

Self-safety was recognised by the data set. Reflexive in nature, health visitors gauge the importance of the self and embrace curiosity of others alongside of themselves. What translated in meaning from the data set was how safety of myself, and safety for them was weighed up.

“...the other day I went out to one, there's an unknown male in the kitchen. I don't know who he is. The grandma is in the living room, and the mom is saying to me ‘what's the reason for this visit?’ And I literally had to think on my feet and say why I went out....an ad-hoc visit. But then

she said she only recently seen the health visiting service for her child's development review, so I couldn't attach the visit onto that either. But I didn't know who this man is, and the grandma is, I didn't feel safe enough to talk about it. You don't always feel safe. I didn't feel comfortable..."

(HV14)

Here the health visitor acknowledged themselves within the context. Their rationalisation of safety in the moments were not wholly based on others (children/victims/perpetrators) but what felt inherently safe to them. It became a moment of realising practice can never be wholly altruistic. Reflections contemplated the contradiction in thoughts postulated by health visitors relating to risk, harm and choice. Recognising the lack of choice when experiencing DA equated to increased risk of harm, however, advocating for the child, who by societal, cognitive and biological reckoning had limited choice within decision-making was what was important. Recognising and agreeing the perils of DA and its insidious nature was not enough to mitigate advocating for the child.

"And at the end of the day, if the mum wasn't wanting to get out of that situation, it's kind of her choice at the end of the day, you know, she's an adult. She's capable of making decisions for herself. She has a level of choice as an adult. But when you've got a child, they don't have that choice. They are just growing up in that environment and that's where the difference lies really. But obviously within that, it's the parent that can make those positive choices for their child's wellbeing. But I guess it's difficult because it's all tied in together. And I mean you do build a relationship with the child, and with the parent as a health visitor, you're there for both, right?"

(HV13)

This quote reflects the contradiction in terms of *knowing* and *doing*, the world that exists in theory but can be different in application. The theory – practice gap within nursing is not a new concept, and previous work has explored this issue (Hauge, 2008. Scully, 2011). As Cowley and colleagues (2014) note the therapeutic notion of health visiting is at contention *“given health visitors’ usual focus upon primary prevention in the absence of existing disease”* (Cowley et al. 2014, p.21). The key components outlined within health visiting philosophy and approach (Cowley et al. 2015. Fanner, Whittaker and Cowley, 2022) consider this conflict, yet are based on the wider organisational remit of workforce. Unsurprising that the ability to support and deliver a ‘therapy of health visiting’ (Cody, 1999) is struggling within the current resource cuts and retention/recruitment issues within the profession (Institute of Health Visiting, 2021).

The health visitors were able to draw conclusions on past experiences of working with families from start to end, and how interventions, support and outcomes had evolved. Considering the power within prioritisation in terms of fixing *or* supporting situations within families was not far from the narratives. How the health visitor mitigated risk with humanity in terms of subjective reality, rather than deviating to the, perhaps, easier to implement, objective target was often explored. The awareness of families moving into risk thresholds and undertaking interventions that were short-term measurements to achievement and then move back to lesser concerns relating to risk and vice versa were highlighted. Reflected within the concerns of families re-referring into child protection services, the *‘revolving front door’* demonstrates a failure to make change long-lasting (Hood et al. 2016)

“That’s when you get severe high-risk domestic abuse, everyone gets involved, there is an action plan, it gets ticked off, professionals set back, you know things have been achieved, plan comes

to a close, and then hey, a month later a more significant event happens.... how do you change a lifestyle, change a person. You can't, you can't with such a short-term intervention plan."

(HV9)

Conceptualising health visiting practice within both a medical and health model involved contradictions in terms of support and surveillance. Considering the history of the profession, as explained by Malone (2000) and Smith and Horne (2012), and the requirement for an ecological understanding of practice (Rayner and Lang, 2012), community practices have never reached full potential due to complexities of modern life (Smith and Horne, 2012). There is a casual relationship noted between poverty and child abuse (Bywaters et al. 2016, 2018) and it can therefore be argued the complexities of life have the potential to impact practice to a greater severity.

5.3.2 Theme two. Love and Justice, connection and care

Sit alongside

"You know, you want people to be safe and have a good life." (HV2)

Previous academics have described nursing as *"human caring as an end in and of itself"* (Watson, 2018 p.7), however, as Bliss et al (2023) described the sense of advocacy within the public sphere is to mitigate threats through the goal of a collective future. It begs the question whether decisions made within risk and harm are truly to the benefit of other individuals or perhaps they are of mutual benefit. However, as one health visitor noted, the relationship between herself and the mother broke down following a referral of concern that was not in full

agreement. Empathetic considerations of desired outcome must be succeeded by the agreement of each other's expectations.

"I mean in the end I did end up making a (social care) referral because of the concerns, and these were the same concerns on the protection plan earlier, but it was really difficult because you know, I think the trust kind of broke down between us because she'd felt almost betrayed. That I'd found this out, and that I was acting on it, and I'd felt a little bit betrayed, really, that she hadn't been that honest with me, about the previous plan. It's really to not take things personally, but that can be really, really challenging when you think 'I just want to help you, but I can't because you're not being honest with me'." (HV7)

This narrative demonstrated the sense of betrayal and disappointment experienced by both. The desire for this health visitor was trust and honesty, but once this was rocked, further outcomes became difficult to achieve.

Coffelt et al. (2019) concluded that two of the three essential attributes for positive communication related to empathy; relating and translating. Utilising this concept, reflections were made to further unpick the concept of empathy within the data to illuminate a deeper meaning. Unravelling of empathy, demonstrated by Clarke and colleagues (2019), who made a distinction between cognitive, affective, and behavioural empathy. The data set captured a deep sense of solidarity, love and care through their empathetic opinions of all involved.

"...when you go to people's houses, you think 'why do I even bother because it's just pointless'. But you still do what you think is best, and that's the challenge of it, the hard part is excepting

that you're not gonna make their lives much better. Why am I bothering? Because no one else cares. But then I care. I want their lives to be different." (HV4)

However, empathy was demonstrated reflexively; Another person's experience is always positioned within our own perspective.

"I think we can't help having our own ideas about how families should behave and what they should do in certain circumstances. As empathetic as we are, we probably think "well surely you can just, you know, leave the relationship" (HV7)

Notably this was positioned in the understanding of intergenerational models of behaviour and experience; the power of influence on a young child's environment can pre-dispose their risk to lifelong encounters (Russell, Springfield and Greenfield, 2010. Symes et al. 2020). Here the health visitor went on to describe an encounter with another professional due to the homicide of a mother at the hands of her partner, and when asked how she felt.

"I felt real shame and sadness, that this has ruined his whole life and ended another. He will spend the most part of his life in jail because of the life that he experienced as a small child, and she (police officer) found that very odd. She said, "I don't understand". So, we have a police officer. Why don't you understand? I don't understand how you could not get it. Surely you have some educational insight into how people's behaviour is affected by their life experiences. He didn't do that on purpose. He didn't set out in life to do that to that woman...Those experiences, that's how that's evolved. And she didn't get it and I still have great empathy with those men who end up where they are through really through no fault of their own, because that's the saddest part, that they are victims, aren't they?" (HV4)

However, as exemplified by this health visitor, to sit alongside, one needs the time and resource to do so.

“You can't sit alongside a family when you've got a restriction in how many visits you can do.”

(HV1)

Sharing stories as advocates of social justice meant discussing the difficulties women faced regarding leaving an abusive partner.

“And so I remember I contacted the Council and the local MP in other ways I could think of to tell people how difficult people in these situations find it.” (HV4)

This statement, underpinned by health visiting philosophy (Fanner, Whittaker and Cowley, 2022. Cowley and Frost, 2006), makes sense of the translatory (Coffelt et al. 2019) and affective (Clarke et al. 2019) notions of empathy. The empathetic meaning of practice and reflection demonstrated by this health visitor, recognised herself within the context

Davis *et al* (2010) explored humility within the concept of other-orientedness. Not only as Davis and colleagues (2010) state, that one expresses emotions such as love and care to another, but they also are able to recognise their own authentic thoughts and bias. Moreover, Lehmann, Kluger and Tongeren (2018) noted ‘good listening’ increased humility, and thus virtuous outcome. Zinan (2021) explores the ‘Humility in Health Care model’ in relation to the patient-provider. Within this relationship, as Zinan proports, the provider considers themselves fallible and limited in knowledge, with an open willingness to learn and understand. Health visitors within this data acknowledged the wider issue of being aware of what they know may not be what is known to another.

For many of the health visitors, they spoke about the strive to give and receive. To give families as much as they could and more at times, was the desired outcome of change and thanks.

“...if I didn’t have passion, if I didn’t have that love I would be doing families a disservice... you invest in it, in them. I thrive on having the love to make the difference and want positive changes for those people, for those children.... If I knew the job was going to be like this, would I do it? But I need this... I need to make that difference for that one family, one family gets hit with that love then I’m happy, I will take the one. You may only get one thank you in a year, but that one thank you is a lot, it’s everything.” (HV9)

“...And that’s not what was gonna happen to her. I’m not gonna let it happen. Just not happening. So that was that was long daily calls to the domestic abuse helpline. Try and get into a refuge.” (HV4)

With an appreciation of challenges, health visitors acknowledged that sometimes the most desired outcome was to maintain consistency with a sense of solidarity with the woman. To sit alongside, and if nothing else to lighten the feeling of isolation and loneliness of their experience.

“And so I suppose for me maintaining that relationship with that woman and continuing to let her know that she’s got support, continuing to let her know, you know what her options are, continuing to safety plan. And just, just hold that space with her when you can.” (HV10)

Conceding that the desire of wanting the woman to leave her perpetrator for good, was a decision for her to make. Insightful reflections of reckoning were described. The universality of

support could be implemented, but for so many families, the strive to make healthy changes came from within.

"Maybe it's her, she has deep insight into it all, she gets it, but maybe it is the support. There is obviously a process they go through, it has to be right for them, they have to decide, they have to say "No, I've had enough" and it's as simple as that, they won't put up with it anymore, that's when they go, or ask for help. But they need to be empowered, because power to change is so lacking..." (HV11)

Belonging and embrace

Empowerment and self-belief were outcomes desired within the data. To enable a change in mindset that was encapsulated within being seen.

"...to empower that person to recognise it. That's what I want. And you know that they might not be ready to do anything about it. Sometimes, as long as they're feeling safe in terms of the children and you know, if it's not at the statutory level, then just a recognition and a feeling of empowerment." (HV12)

"But when you're low, you accept that behaviour, you don't expect anything more. I think the only way is showing women that they can have more... they don't have to be in these situations with these men." (HV11)

Perhaps giving someone the space to tell their story and be heard is enough.

"Sometimes I think they just want you to know, and have ideas about safety factors, because in reality I think it's really difficult because you can't just go..." (HV2)

Or, perhaps the outcome of being heard is all that can be offered? In the climate of limited resource and availability, how much more can we expect?

“...So I think at the beginning, they just want you to know, so that somebody knows. And then you talk it through, don't you? To say, well, what do you think? How do you feel? If they have three or four children is really difficult for them to go anywhere. I mean you can refer to social care and usually they would refer to the early help hub.” (HV2)

Some health visitors described how naming the DA was enough to enable deeper insight and potential change. To remove the normalisation of what their experience is, and to offer a moment to consider severity through naming.

“Is quite important for women to realise how significant that behaviour is, to really frame it for them. You know, because maybe it's been normalised for such a long time and you know, sometimes I think to hear that term (domestic abuse) is useful for them, for them to think, oh, OK, this is being taken seriously, and this is a thing...It's not me being paranoid. It's not me being weak. It's not, you know... all those things.” (HV10)

Acknowledging the hope for connection and belonging for the mother is perhaps obvious given that health visitors demonstrate a reflexive empathy that understands the impact of DA on victims. The standpoint of mothers is respected by health visitors.

“I think it makes you feel kind of quite privileged that they've opened up to you like that. Nice isn't the right word, but it can feel quite gratifying that they trust you enough to disclose, that you've got to that point in the relationship....

I guess it's a rewarding part of the relationship when people feel like they can do that, so yeah, it feels like you've kind of quite a special position. To be hearing that.” (HV7)

Many conversations with the data set, perhaps obvious given the subject - navigated around supervision and support they sort or received within their personal or professional lives.

Interestingly, health visitors discussed supervision as being formal and informal. However, what transpired through meaning was the robust nature of informal conversations resulting in belonging.

“Yea, so I think the informal supervision you get from your colleagues, you know where you might talk about it, you know, ‘...can I just tell you about this one?’ And to ask what they may have done is always helpful.” (HV12)

Furthermore, when health visitors are challenged to conceptualise what support means and is to them, it is often described as sharing with others. Is support context dependent? Or does the sense of giving and receiving support stagnate within connection?

“We could just ring them and have a debrief with them. My colleagues are brilliant. We all know that we can call each other at any point....I can also debrief at home, and chat it through, being able to share.” (HV8)

Furthermore, was the health visitors own professional development driven through women's stories and the empowering impact they had.

“Over the years, I've listened to women's stories and I've learnt a lot from it, so you can learn so much from listening to what they've been through and how they feel.” (HV1)

Who am I?

The relationship between health visitors and women was central throughout the data collection, often spoken about in transactional terms. Considering the boundaries implemented by the health visitor was highlighted in one transcript in which a mother was perceived to be over-dependent on the health visitor.

“...then it became almost the relationship between us - dependency. The dynamic was changed, and she became emotionally dependent on me. And that was really hard then to draw back from that relationship. So and then there was guilt I had about not being able to be there for her. She needed to become independent in her own right, so I'm not gonna do any favours by her being dependent on me and she's got everything she needs to know.” (HV4)

Engaging in solidarity with women and supporting families was the golden thread throughout conversations with the data set. Recognising the positive and desirable outcomes of such seemed obvious, but above the health visitor reflects on the negative elements of such an endeavour. Setting the terms of the connection health visitors make with women cannot be pre-defined, just as DA can be contextual and subjective, so too are the relationships. Having the courage and honesty with oneself to take the step back, and when to do so.

“I'm not your friend. I'm not her confident, I'm a professional. I was there to support her, to move on. And that's what I did. So I needed to stop answering phone calls and explained to her that that's not my role. This is not who I am. So that was really tough.” (HV4)

“Way back when, when you first become qualified, and realise pretty damn quickly that life is not about weighing babies. Where you realise that "ohh God yeah, but this is what it is really like. So I need to up my game and actually be brave...

...I can't wave the magic wand and make it better, so now I have to walk away from the situation knowing that she's just told me all this stuff. What am I gonna do with it?” (HV4)

Health visitors understand the wider implications of public health education that incorporate self-discovery and connection with others. Developing a sense of self from an early age is required to improve the way we treat one another.

“We seem to have come this far with everything else in life where people deserve the same rights as everyone to the whole LGBTQ thing that's going on. You would be arrested for being gay and all that, but now you know would be wrong to even use some terminology that we used in the 80s because now you know it's offensive, so we've come a long way with that, so surely, we can do more. We can achieve this to come out in the open so women learn from a very, very young age and then also boys, because the boys need to learn that too because it can be vice versa...” (HV4)

Yet, perhaps the greatest hope is one that sits within ourselves. One health visitor concluded feeling a sense of impact was the greatest hope. Unable to change every situation but having a sense of self-fulfilment.

“I've seen a difference it can make, and even those families where I thought it would change and get better and then it didn't, I tried my best. I have to be content with that, my limit to what I can do. The problem is you have to know a little bit about a lot of things.....” (HV9)

... if I didn't have passion, if I didn't have that love I would be doing families a disservice... you invest in it, in them. I thrive on having the love to make the difference and want positive changes for those people, for those children.... (HV9)

5.3.3 Theme three. Moments and opportunities

Conversations

Health visitors encouraged mothers to unpick their own understanding of how experiences may have, or may continue to impact their child's behaviour and emotion.

So you might have a gentle conversation to say, "well, you know, sometimes people, even children, feel tension. What do you think?" So you're having these gentle, careful conversations about that, about how it might have impacted the child. You're not gonna stand there and mouth off about statistics and how, you know. Well, evidence shows that, blah, blah blah blah. I'll be honest, I might do a little bit of that. I might do a bit of that because I think it's important to be transparent and to sort of say, look, this is how it affects children. But again, you've gotta be really careful.

You know, if children experience this, shouting and aggression, it can affect them in this way."

(HV1)

Here the health visitor demonstrates using the opportunity to explore discussions about the children with the mother. The health visitor discusses how such a conversation is initiated, and how they use the weight of statistics to influence. There is a moment of wonder as to how one undertakes such conversations, perhaps with the awareness of guilt such may induce.

"You can get easily side-tracked and because parents are stressed and anxious, you are containing them quite a bit. But if you're not experienced in directing a conversation and guiding the conversation, then you just get left, you know, listening to them, and actually your focus needs to be on that child at some point in that visit." (HV1)

"You set your stall out when you go in.... I'm here to look, to talk about, the child." (HV1)

Managing and changing

The experience of fear, and the acknowledgement of such, was heavily discussed by the data set in relation to outcome and actions taken. Acknowledging the fear is part of the bravery of asking. The fear exists in the moment of unknowing. Reckoning the reality with an inability to immediately act or fix negates the fear.

Discussing their perception of the fear experienced by others further compounded the outcome of support. Health visitors were armed with the awareness of what was to come (relating to resource and service availability).

"I think they're scared, I think they're absolutely petrified of repercussions. They're scared that social care are gonna get involved and take the kids, and they're scared that they are gonna lose the home, or maybe will disrupt their childrens lives. And you know, let's face it, often it is the woman that has to up and leave and, you know, go to a refuge." (HV6)

"...there must be something triggered in her at that moment where she knows it isn't right, she isn't safe and this is so much more than an argument to make her call the police." (HV2)

Negotiating the opportunity to implement a supportive package, or simply the opportunity to discuss further with the mother was recounted. The data set understood the importance of timely support, The Working Together to Safeguard Children framework (HM Government, 2018, 2023), as well as stipulations mandated within the Children Act (1989, 2004) state the importance of assessment, and interventions delivered at the right time for individuals and families. As Code (2006) concedes, locating and understanding the micro and macros systems at play for individuals within a moment becomes conceived similarly *“to the air we breathe”* (p.28). Accepting the changeable moments were closely emphasised by health visitors, and the fragility of opportunity.

“Yeah, they may call and quite often by the time social care get in touch with that person, that moment to speak to them has gone. Days could have gone past. That moment of disclosure because it’s bad, it’s bad and they need support and help, to then have to wait, the moment has gone. They’ve gone back to the family home and then they’ve been too frightened or too scared to do anything about it.” (HV8)

Again, the conflict within what policy dictates, and practice entails does not always allow for timely intervention. When health visitors hold information of disclosure or concern, and much of child safeguarding and wider intersecting issues including housing and finances can sit within other agencies, it becomes difficult to carry out interventions when there is a delay.

What further complicates the moment is the reliance on other services. The emphasis on multi-agency working is deemed necessary within policy (HM Government, 2018) and in practice (Cowley et al. 2013, Fanner, Whittaker and Cowley, 2022), however, accounting for the

approaches and processes does not make a simple referral into a service 'multi-agency working'. Effective public health initiatives are enabled through the process of availability, appropriateness, and accessibility (Levesque *et al.* (2013)), unpicking what is meant by multi-agency working is fundamental to those who partake in it. If different agencies are working with the same family, does this count? Or does a deep integration of approach enable such? However, how does this become a reality when there is a general acknowledgement of expertise, and a different understanding of priority within safeguarding (held between, and within, agencies)?

"Not all services have access to interpreters. Services have not always been available or difficult to get to. So particularly on a Friday afternoon, if you've got to make a referral to anybody that can be a bit of a struggle... And then you're worried because you've got that parent being in a situation possibly, you know over the weekend. Also getting a referral accepted can sometimes be difficult, but I feel that is definitely getting better. And that barrier of the person saying they'll accept help, or their readiness to accept support is limited. They maybe want the support whilst you're working with them, but then when you step back they stop." (HV8)

When working with other agencies - notably reflected by the data set when a threshold for concern is met - there was a meaningful insight that considered future planning. Here this health visitor explains a situation in which a child is on a child protection plan (Section 47, The Children Act, 1989) yet the parents are no longer engaging, but there have been no more reports of DA. They ask, *where to go from here?* With the awareness that the underlying issues have not been addressed, but there is no current concern, when do professionals step back?

“The problem is, like with this case I'm going to tomorrow, the chances are that it will not be on a child protection plan anymore because the actions aren't being worked towards. And since the plan started there haven't been any more reports of abuse, you know, the child is a current victim of abuse. You keep them on a plan forever just in case something happens, and obviously it doesn't sit well with anyone involved, but it's reasonable to ask what are we having this plan for when the parents don't want to engage and there is no longer immediate risk? Do you escalate it if the parents don't turn up to core groups if we feel the threshold is being met for looking at removing the child, or do we de-escalate?” (HV13)

Perhaps the most significant moment of consideration in terms of outcome is that you never know what is to come.

“And yeah, like I said, I'm not sure on the outcome of it all. I presume she's still there, but you always hope, don't you? ...that they've got out of there.” (HV13)

5.3.4 Concluding thoughts relating to study objective three: *Perceptions of achievable/wanted outcomes.*

Interaction between themes

The wanted and/or desired outcome was delivered through a personalised awareness that endeavoured to break through many of the structural layers of systems, professional regulation, and pre-determined intervention. Notions of empathy weaved throughout the data, however, enabling a radical sense of empathy, as Jordan and Schwartz (2018) consider to be the relational component of recognition and impact that is equally distributed, became near impossible. The difficulty in achieving the equity in distribution was the moral injustice inflicted

by another outside of the dynamic; the perpetrator, and the further subsequent victim; the child(ren). Objectifications of perpetration and childhood bore too much influence.

How themes fulfil the research aim

The themes presented within the fulfilment of the final research aim exploring the achievable and/or wanted outcomes present a meaningful interpretation of a medicalised approach to support. This aim drew into the work previously exposing vulnerability within care (Kittay, 2002) and Goodin's (1985) seminal work that considered the moral duty to protect those deemed vulnerable. What was insightful from the dataset was the interpretation of outcome related to *their* want, and that of the perceived *want/need* of the mother and/or child. Inconsistent with alignment between the two, health visitors found themselves debating and often conceding one for the gain of the other. A battle of *want VS need* defined within the health visitors' terms.

5.4 Concluding thoughts relating to HV findings addressing all three research objectives.

The findings generated from the health visitor data set have been presented addressing each of the three research objectives. During the stages of analysis, as detailed in chapter 4, the themes generated tell stories from the insights of health visitors, as well as perspectives relating to working with mothers experiencing DA. Overall conversations with the data set demonstrated the humanity and care delivered by the professionals. Notably, the moments in which health visitors shared their perspectives that did not align with current policies relating to VAWG, and influenced through stereotype or assumption, there was a strive to make things better. These postulations invoked a researcher curiosity to consider the impact of unlearning and re-learning in terms of our own history and culture when in contradiction to current practice. Can we ever

expect the two to align, and should they? If health visiting is an individualised approach to public health and reduction of inequality, do the personal experiences of those within service delivery matter? Yes. If an empathetic sensitivity is needed, one can never leave oneself at the door.

The following chapter will now present the analysis findings relating to the next data set, women with an experience of DA whilst under health visiting provision. As detailed in the previous chapter, the three themes overarch across the two data sets, and the research objectives remained unchanged. The findings will therefore be presented in the same manner as this chapter, however from the voice of the mother with meaningful insight illuminated by researcher subjectivity.

Chapter 6. Mothers' analysis of the findings

This chapter will present the findings from women who participated within the study. The women recruited were all mothers who had experienced some context of DA whilst in receipt of the health visiting service.

The women who participated in the study were recruited after engaging with specific DA support services. This approach aimed to reduce the risk of distress during conversations. Additionally, to meet ethical standards, participants were not recruited directly through their health visitors. Instead, they had already accessed support services and chose to participate voluntarily, without any impact on the services they received.

The findings presented here do not capture every conversation with the women; instead, they focus on the narratives exploring the research aims. Each research objective will be explored in a dedicated sub-chapter, within which the related themes will be discussed. The following chapter will then provide an in-depth discussion of the theoretical and practical implications drawn from these findings.

6.1 Addressing objective 1. Exploring the wider implications and perspectives of DA

This section will explore the findings relating to the first objective of the study for the data set of women,

- To explore the wider implications and perspectives of mothers when discussing DA.

For some of the women, experiences were retold as historical events in which they felt free from, for others the experiences were recent and/or they remained entangled within the lasting impact and implications in their physical, emotional, and psychological self. Some of the

women remained in relational contact with their perpetrator, and some had no contact with them. Some of the women were still in receipt of health visiting service provision, and some of the women had school aged children. The women were not asked to quantify their experiences with the health visiting service, nor were they asked to objectively recount their engagement as positive or negative, rather they were asked to expand on what happened, and thoughts of why, and how it occurred.

6.1.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Support and/or fix

When discussing the broader insight of experience with mothers, the data set articulated a sense of escalation in their perpetrator's behaviours. The awareness of escalation was clear for the women, and judgements or decisions were made quickly whether to call for help or do anything they could to deescalate what was sensed to come.

"It's like you're holding your breath.... It's knacker. She talked about that, about feeling safe, and what happened in the moment I called the police, and when I didn't feel safe. It was those moments I knew it was coming, I could feel it around him, like an air. I knew he was going to blow and start, it was me feeling the unsafety of it all." (SU4)

This insight demonstrates a mother's acute ability to draw upon her own interoception, as well as navigate a frightening situation to reduce harm. The wider perception held relating to a 'failure to protect' placed upon mothers within DA, and in the moments of minimising situations to enable de-escalation, exacerbates the narrative of mother blame (Moulding, Buchanan and

Wendt, 2015). Moreover, as this mother described above, her agency and decision-making ability were essential in knowingness. Failing to recognise the daily protective strategies undertaken (Stewart, 2021) by women feeds into the oppressive patriarchal structures for which mothers experience.

Playing the game. The stories we tell

‘Good’ or ‘bad’ mother narratives are present within the traditional dynamics of parenting in which selfless actions prioritising children and partners are weaved through the heteronormative typology of parenthood (Moulding, Buchanan and Wendt, 2015). Whereas there is a distinct lack of ‘good’ fathering discourse (Douglas and Walsh, 2010). The oppressions experienced at a macro, exo and individual systems level are felt by the data set and, are recognised within their communities. Social norms are powerful and indeed articulated.

“I know men who put up with pushy and mouthy girlfriends, but the real crap does seem to be done by the men. The women seem to have it worse, but what I mean, my sister, she’s had it, my friend’s.... My dad wasn’t really around and when he was he was vile... it’s everywhere, and everyone knows it is there, but it’s just one of those things you know. It’s life. But if someone says ‘this isn’t right, and you don’t have to put up with it’, you think ‘yeah, I don’t’ why do we put up with it? Because it’s normal, but it’s not normal. You know.” (SU4)

Participants discussed differing experiences relating to the ways in which DA presented; physical, financial, or controlling. What was interesting was a moment in which one mother appeared to recount the potential preference of one typology to another.

“...feeling like a prisoner all the time, it can be worse than getting punched in the face. At least when you get punched they feel bad for abit and they’re lovely. When they are just a control freak it never ends, there is no let up.” (SU6)

Humanity held within the home

Not explicitly defined, but implied was the recognition by both data sets of the power held by health visitors. Women conceded their own position within the relationship and added emotional weight to the narratives.

“...I would pick up the phone and I would say 'I'm sorry I've gone back'...” (SU1)

Almost as if the professional held emotional weight within the woman’s life that she had to acknowledge a wrongdoing on her part. On the surface it could appear the health visitor – mother relationship is equal in the back and forth, however the weight and power within the expectation is present.

All the women experienced abuse within their own home and therefore draws into question, regardless of the presence of the perpetrator(s), whether an individual can ever feel at ease or safe in the place such hurt, and fear exists? The data set discussed safety in relation to space, or home, rather than directly correlated to an individual.

“You know, when you are at home, where the domestic abuse is. Just that environment is scary by itself. You feel like you can't tell because you are in the house where the domestic abuse is, but if you're taken out of that environment, I think it's easier.” (SU2)

"I wasn't myself, I couldn't be. So no, how could I feel safe, if we were sat in the place I felt the worst? That was the saddest thing, my own home wasn't safe." (SU5)

Yet one participant spoke about how visitors coming into the home created protective peace, this supports the requirement for home visiting contacts.

"So, for me it meant having to be home, and the children be home, and my ex be at home. All the time. There was no escape, and no one coming. For me, seeing midwives and health visitors was always a protective thing, like he wouldn't kick off, or do anything whilst people were visiting. It was like time-off. So, because he knew no one was coming, he didn't have to manage his behaviour. He could trash things, tell you what to do, and be generally vile and it didn't matter because no one was coming." (SU7)

What this demonstrated was that the safety of home was in constant flux for the women. As unpredictable was their perpetrators behaviours, as was the sense of sanctuary at home. The ontological wonder of *home* is in contention, if home is determined by the physical walls of refuge, as well as a domain to connect with oneself and others (Barrie, 2011). When the former no longer exists, the latter becomes near impossible to flourish.

The data set spoke of the horrors they experienced within the home. The safe sanctuary being a fundamental right was, for these women, lost. When drawing upon the data set's perspectives in the context of the support they received, it is important to not lose sight of what they experienced. The insidious nature of control and abuse can never be undermined or forgotten when postulating how we can empower and support.

"I left last spring and the turning point, he was playing mind-games, like even making noises... he would open and close windows and doors downstairs, and make me think it was me, just dark. I was starting to find evidence that he was drugging me and sexually abusing me, and I found evidence of somebody getting through the bedroom window... so I think that's.... how... you know. So I couldn't do it, I didn't even feel safe going to sleep, so I couldn't do it, I had to leave." (SU9)

6.1.2 Theme two. Love and Justice, connection and care

Who am I?

Feelings of self-blame and shame were deeply woven into the women's experiences and their home lives, where their sense of personhood was often diminished by the constant control and abuse they endured. Survival often depended on masking their true selves. When asked about their home life, they frequently concealed the reality of their situation, shrouding the truth to protect themselves.

"Yeah, yeah, they asked, but I just lied. I just felt I couldn't open up. They asked... I was good at putting on a front. Which I knew I shouldn't have been doing..." (SU9)

Women internalised their own shame relating to the impact abuse had on their wellbeing.

"I've spoken to my doctor about it, but I don't want the label of it, I believe I have PTSD which is where my panic attacks have come from. My doctor has turned around and says that 'it's most likely you do have it in some kind of form with what you've been through', but I've said, 'let's just leave it at that'. I don't want it labelled or put on a record, and you know, I'm looked at differently." (SU1)

The compounded and sustained abuse left women feeling a loss of sense of self, and particularly the reinforcement that their abuser was 'right' and somehow, they were 'wrong'.

"And when everyone is abusing you, they make you feel that there's something wrong with you rather than with them, because there are three of them, and obviously 3 can't be wrong. Yeah.

So it took me a really long time to actually realise, you know, that's enough." (SU2)

Perceiving loss and shame because they couldn't live with their perpetrator.

"I felt like 'I'm a strong woman, I need to deal with this, I've got a small baby, I should be happy...' and just get on with daily life...." (SU3)

What was interesting in the conversation with this woman was her sense of shutting down emotions to preserve the 'resilient, strong self'. Considering that the perception of what is expected, is not only weighted how others see us, but also how we see ourselves.

"I could tell you about my past, what's happened, black and white, but I couldn't tell you how that made me feel... because then it opens up a can a worms. I feel it's a weakness, like I shouldn't get upset. I feel strong if I don't get upset." (SU3)

The data set drew on their experiences to showcase wider narratives relating to parenthood, and in particular mothering. That such is encased with love, and to be dealt with behind closed doors.

"To the outside world I'm a happy new mum. I cry in secrecy." (SU3)

Sit alongside

Women recognised the differences in practitioner agenda, role and approach, however, the sense of solidarity and being seen is transferable across the professions and can be used to promote areas of best practice.

Segal (2017) reports working with care in terms of shared responsibility underpins feminist solidarity. In Wickström et al (2021) paper, their conversation turns to *“responsiveness, recognition and a shared sense of vulnerability”* (p.8)

“I feel like a woman will understand a woman better than a man.” (SU2)

One woman mentions her experiences with a third party agency, the pertinence of feeling unseen and the lack of care was enough for her to draw lines across engaging with the service again. This view highlights the fundamental requirement to build connection with individuals and families through qualities that are centred around care and respect.

“I didn't want to get involved with them, to be honest. I felt they were really cold, and they didn't really care about me like a person. They cared about their paperwork.

I thought, no, I'm not gonna talk to them, so if I needed help, I'd talk to the refuge.” (SU2)

6.1.3 Theme three. Moments and opportunities

Conversations

Entering conversations was reflected upon within the data set, intentionally answering questions to deflect or require minimal further enquiry.

“That’s the thing isn’t it, asking is one thing, but it only becomes something if the person being asked wants to answer truthfully. For me, I just wasn’t wanting any more mix-up in my life, it was manageable as I say.” (SU7)

The experience of DA does not rest upon any potential disclosure, if someone says, ‘*all is well*’, one must consider that in fact all is *not* well. It was a meaningful juncture of back and forth of conversations, and how retelling could be wholly fictional. This woman goes onto expand the necessity, in her view, of maintaining such conversations even in the absent of truth telling.

“..help isn’t always asked for, or taken at that moment. But it’s still help I suppose. Nothing else, those times I was asked, yes I wasn’t honest, but it at least made me think ‘oh they know about it, cus they’re asking’. That’s powerful. Knowing that other people know something is wrong, if more people think it is, then you don’t feel like the only one. Like there are so so many women and people who experience it and live with it, but when it’s happening to you, you feel like the only person in the world. But when people talk about it, it reminds you.” (SU7)

Yet again an important reflection to concede that conversations are not structured around the interactions, but take on a deeper trajectory of morality, courageousness, and awareness.

Language

Broader conversations with the data set explored their agreement of the terms *domestic abuse* relating to their experience. Whether the terminology was instigated by the women themselves or by others, to be able to separate the abuse was helpful to recognise the impact.

"I dunno, maybe because of everything I have no issue labelling it, and I know what it is. I know it's not just hitting or physical, it's all the mind games as well. It's just part of the conversation I suppose." (SU5)

"I needed to hear that, I needed that label. As soon as she said it, it was hard to swallow, but I would never have called it that myself, I needed her to say it, everything had become the norm. Her saying that, and me doing the (intervention) program, that's when it came together, I saw it. I never thought it was domestic abuse or domestic violence, I just thought I had a bad partner." (SU1)

Yet, women noted an inability to segregate the abuse whilst they were living in it.

"...before my experience, I believed domestic abuse was just physical, because I'd never experienced it before, but being in my situation, it crept up on me throughout my pregnancy and with him as a tiny baby, it started slowly and built up." (SU3)

The data set reflects the continued use of the terminology *domestic abuse* when working with families. As Penttinen (2023) noted, those living with non-physical abuse often find it difficult to name and therefore identifying it provides validation to the individual's experience.

"Like I've used those words, and I've used them since my previous time working with social services, so I use them, and I think the social worker said them again to me. The nurse when I was at the midwife said it, because she read in on my notes.... I don't think she (health visitor) did though. She talked about being safe. When I saw her again she called it domestic abuse because that's what everyone was calling it, and I wanted him out, and that helped using the words then." (SU4)

The use of the terms '*domestic abuse*' is applicable and agreeable to women if the context allows such. This mother demonstrated that her openness to engage with the terminology allowed the continued use within discourses.

Managing and changing

Women articulated in detail the fear they experienced within their relationship. One woman explored how the isolated act or event of hurt was not the abusive element, rather the fear felt and the control encapsulating the abuse.

"You know I think perhaps the domestic abuse is all the stuff around the actual argument. So the minute you call behaviour controlling, or bringing on fear, that's when it is domestic abuse?"

(SU7)

For this woman, she spoke of how consciously managing behaviour would protect herself and the children from the fear experienced following an explosion.

"The fear came in the hours after an outburst, after him breaking something. The problem is when someone can break things and shout and obviously make you scared, you wonder where their on/off is. Like, why would you want to scare someone by going crazy? So the fear is in you wondering what next. And that's the thing you can't keep thinking 'what next, what next', because it's so tiring, so it is better to try and stop it reaching there. Particularly with kids, you can't be thinking, 'what if he strangles me in front of the kids', I even thought about what if he kills me... you know would he hide me, so the kids didn't see, would he do it at night, what would he tell the kids... all those things. You can't keep that up. I know some of the women here managed to keep that up for years and years, I couldn't do it. So you manage it to stop the fear I

suppose, not the actual thing. The actual thing that happens you can deal with, but you need to manage the behaviour to stop the fear.” (SU7)

This insight presented an interesting concept, not only how we understand the experience of DA to encroach on lives, but how we define and rationalise seemingly ‘accepting behaviours’ as maintaining safety. It posed an interesting moment of wonder; when are fear inducing behaviours acceptable and reasonable? It would seem the equilibrium of balance is the deciding factor. The dynamic of one knowing the dangers versus the unknowing, gives the behaviour reasonability and acceptability. Rather, as this woman’s insight provides, is an understanding of how when there is a balance of knowingness within the relationship, victims may manage and even acknowledge certain behaviours to prevent the escalation of unsafety and fear.

“She asked me if it had happened before, him pushing and shouting at me. I just told her, I told her he always had, we argued a lot, we always had. But I told her, I used to get in his face as well, but I didn’t anymore, not since I was near having the baby because he would always push back, and I got scared he would push me and I would fall. So I had stopped arguing back because he always took it to the next level.” (SU4)

Understanding *fear* in terms of anticipation and aftermath may be the defining moments of wonder, or simply capturing the epistemic locatedness within the experience. Perhaps rather than asking about the DA, ask about the fear... when it’s felt, and whether anything is done to mitigate it.

A code that developed during analysis of the transcripts was 'breaking point' and the shift such an event created in terms of changing, managing, or repositioning. One woman noted how her breaking point of calling the police resulted in a shift of awareness and openness; the freedom that presents us to no longer hide the truth. The nuances of what awareness could bring. Regardless of the action taken, the ability to talk.

"After that incident, I suppose because it was out there in the open, it was discussed more, in those appointments afterwards, and then again when my youngest two were born. It was like the secrecy and worry of it had all gone after that happened. Up until then, things weren't great, we weren't in a good relationship, it had been worrying me, but that was a time I was really scared (when I called the police) ...

...But it did feel good to talk about it, and I suppose know that I could talk about it, and it wasn't a subject that I had to avoid. I think for myself to know it wasn't just me, it wasn't in my head, and also for my husband to know that there were people I would turn to if it went back to how it was... you know, he couldn't get away with it. People were watching and asking." (SU10)

This study demonstrated the misalignment between health visitor's thoughts of minimisation surrounding the impact of DA on the child, and the women's awareness and protection of the child through careful management and containment of behaviours.

"It's difficult because I know health visitors are there for the children, I know they have to think about them first, and it's good they do, but with things like this, as a mum you so quickly feel like you are being told off abit, you know... I get why they have to say it, but sometimes you want to say back, 'you think I don't know this stuff? You think everything I have ever done has

not been to protect them?’ You know, all the times of managing, and just staying quiet, just letting him go off, it was so it was near me, not them you know.” (SU10)

This woman provided an insight into a particular event that resulted in the police being called. Within this conversation she explained how her personal moment of needing help was her perception of safety experience by the children. During previous escalation’s this woman had maintained the physical safety of her children by removing them or controlling the perpetrators behaviour through careful management. The moment of breaking and feeling unsafe was not dictated by her, but the moment her children became part of it. The delicate line held between the mother and child; once the fear seeps into the perceived reality of the child, mothers can no longer manage.

“we talked about the kids and where they were, the reason I called the police was because my eldest was there and screaming, that was the scary thing, he was scared. I couldn’t stop him because I think it would have made him (husband) worse, so I took the kids in the bedroom and called the police there. There has never been any issues with the children being unsafe at home, no way. I always kept them away from him (husband) when he would blow up. That was the thing, he crossed a line, in that moment when I called the police, I didn’t feel the kids were safe with him, and that was the thing. I can manage it, but I couldn’t let the children see that.”

(SU10)

Considering a rethink of the conversations held around children is pertinent. Deeper conversations about the perception of the child and how these influence the safety aspects put in place by mothers may be more fruitful.

“When my older child came to live with us, my perpetrator took it out on me. He didn’t like my other son, that was always a stress... and he (older child) mentioned a few things at school, and the school got involved, but I was happy for them to get involved, because at that point I knew, we needed help.... It was because of him (older child) I got myself out of there. I didn’t want him (child) to get more involved, I thought this can’t escalate, I can’t put up with this, I can’t let it affect him, him living in this environment.” (SU3)

A final meaningful contribution to this theme was the agency demonstrated by the women in their management and containment of behaviours and situations at home.

“I knew him breaking things wasn’t normal, it wasn’t good, but I don’t know, you just learn how to contain and manage it so well. I swear I could manage a hostage situation... you know, I know what to say, when to say it, when to keep quiet and stuff. I’m an expert. But I was OK at managing it.” (SU7)

It drew an insightful consideration of wonder relating to the ongoing selflessness mothers showed. This quote drew into the work of Moulding, Buchanan and Wendt (2015), and Crawford, Liebling-Kalifani and Hill (2009) who explored mother’s self-blame and resilience within their experiences of DA. Articulated by feminist academics (Stewart 2021, Arnull and Stewart, 2023. Sacannapieco and Connell-Carrick, 2005. Demant et al. 2005) are the oppressing structures women experience, exacerbated by the mothering narratives of blame, giving, and martyrdom (Moulding et al. 2015). Yet here we see a mother hone the skill of behaviour containment with disregard to herself to prevent escalation. Selflessness extends from the outward physical action but becomes an internal loss of self in regulation. To concede that

there are elements of passivity in victims experiences fundamentally fails to recognise the careful moments navigated by women. The narratives provided above give an insight into the protection of children, and how adults manage behaviours. What the data set exposes is the ability for both parties (abusers and victims) to maintain their agency.

6.1.4 Concluding thoughts relating to research objective one: *Perspectives and wider implications of DA.*

Interaction between themes

The interaction between the themes demonstrated the nuance of behaviour and emotion surrounding events and incidents. What translated from the conversations was that experience and perspective of DA was deeply personal and impactful through their endeavour to safeguard their child(ren). For the women, words mattered as it enabled the experience to exist as separate from their own sense of self. The most meaningful insight provided was the ability of mothers to navigate situations in a moment-by-moment event, the reactional ability of the women was powerful, and often lifesaving.

How themes fulfil the research aim

The themes address the research aim of exploring perspectives, through the deeply individual insight of DA. The analysis demonstrates the difficulty in universal application of definition, presentation, or implication of ontological aspects of DA. How we come to know, or how a phenomenon is experienced, is the central component to understanding.

6.2 Addressing objective 2. Exploring the broader perceptions of support

This sub-chapter will explore the findings relating to the second objective of the study for mothers,

- Exploring the differing perceptions of support and intervention provided from the women.

Throughout the interviews, mothers were asked about the health visiting support they received; however, the contextual positioning was retold by the women in their experience of what it was, rather than with defined delivery to ratified contacts. Purposefully within the interviews there was no explicit outline of service provision as detailed by policy, as there was a conceived understanding by the researcher that experience was individualised, and it was hoped perception was provided from their own perspective, rather than that of the service expectation.

6.2.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Priorities

Women considered awareness, when not explicitly explored.

“Maybe she knew, maybe that’s why she got someone to call me and help with the housing cause she knew. But if she knew, why didn’t she help? It’s stupid isn’t it, you don’t want to tell someone, but then you think they may know, and then you get mad because if they do know, they should do more, but you don’t want to talk about it. It’s a mad cycle.” (SU11)

This quote demonstrates the contradiction in what is thought and wanted, neither is definite, but fleeting in the moment. Yet, if it was helping, support felt justifiable.

“At the end of the day though, all I’m bothered about is if someone is doing anything to help my daughter and me that’s fine” (SU11)

Consistently within the data set, the priority of any supportive intervention should be directed at the children. Their centring was paramount to understanding and considering health visiting delivery.

“I know they’ve really helped with getting things done for my children” (SU10)

Having an acute sense of perceived priority, the data set recalled moments of conversation with the health visitor.

“But I know why she (the health visitor) came and it wasn’t for that, it was because I had a baby. She is there for the baby. So she did things for the baby and weighed her, and talked about all things like that, but she also listened to everything and she knew everything that was happening. She didn’t say ‘Oh that’s not to do with the baby....’ She heard everything. And there were many times we would talk about all other things.” (SU13)

Directed wonder

Both data sets demonstrated exceptional levels of resilience within their stories told, experiences lived, or decisions made. Ungar (2004) describes resilience as the outcome of negotiations between individuals and their environments in the endeavour of health, and moreover, that there was no hierarchical determination between risk and protection.

Wondering why questions were asked, openness and expectation were in contrast in varying detail.

“I know they are there for the baby, so they need to know things, like about the Dad and stuff, but I’m trying to move on and it can be hard to do that when you have to talk about things that have happened...”

“....but sometimes you need to talk about it all...” (SU12)

The conversation held with this woman demonstrated the contradiction in desire to talk about her experiences. To begin, she described how her desire to move on could be hindered by retelling her experience to different professionals. However, when she reflected upon her own openness to understand her perpetrator and their behaviour, she began to consider the need to talk about it. There were two considerations I noted when exploring this woman’s initial contradictions in shutting down talk and then willing it to happen. Firstly, her early dismissal statement of finding it hard to move on when one had to re-tell what was spoken of early in the conversation. Interestingly, and perhaps a clear reflection of the importance of trust in another and connection, her openness to storytelling became so, nearer the end of the interview. Perhaps a reflection of her wariness about me and my intention, or how explorative conversations themselves open consideration of wonder. Regardless of the reason behind, her contradiction is present, yet the nuance underpinning it draws in the concepts of connection. Supporting the notion of backwards and forwards, *giving* was important to women in developing trusting relationships,

“Someone lets you in and shows you a part of them then you give back abit. If I was working with someone, and believe I have with some professionals and they give you nothing, no piece of them, but then they expect you to open up then yeah, that ain’t gunna happen is it, not really.

It’s a two way thing. You trust me, and I trust you.” (SU6)

Here, a woman reflects on her desire for the health visitor to acknowledge the situation, regardless of whether she recognised such at the time. To be *told* the truth is sometimes what is wanted.

“I think if anything I would wish someone would have said 'you are in a domestic abuse relationship'. I couldn't see the wood for the trees, I was him.” (SU1)

This short quote further demonstrates the loss of self experienced within abusive relationships. When coercion and control are at such levels, it becomes nearly impossible to distinguish between what you are *made* to believe, and what *is* happening. This question could then be further pondered; whether such a lens of reality can be skewed in relationships where there is power imbalance, such as those held between women and professionals?

One woman reflected on telling professionals about her experience. Again, her dismissal in discussing DA with the health visitor was noted early in the interview; when asked if she wanted to talk with her health visitor after she left an abusive partner and home, she stated;

“I told them “I want to move on. I don't want to keep talking about it”.” (SU2)

What was noted during the familiarisation of this transcript was her objective desire to move on which occurred prior to any specific support and conversation with the professionals involved.

The meaning in this comment left me wondering whether empowerment enables not just an ability to re-tell, but bare witness to the experience outside of the bubble? As discussions continued, we moved onto her experiences of being in a refuge and attending DA programmes, and her subsequent relationships with health visitors following the birth of her second child;

“I wanted to talk more about it. I wanted to tell because I couldn't tell anyone about it for years.

And so I just wanted to let everything out. I wanted to tell everyone, “look what happened to me”, you know, and no one knew about it.

And then after I had, you know, the (intervention) programme, I felt like more at peace, and I didn't need to talk about it anymore. It doesn't matter. It's not really that important anymore.

It's doesn't affect me that much anymore.” (SU2)

Fix and/or support

Many of the participants within the data set were recruited through their engagement with specialist services, and some who had previously been supported by statutory intervention at a child protection level. Their stories spoke about the health visiting support offered prior, as well as following child protection assessments.

“She doesn't ask me direct questions, she knows why I'm here, but it's a general chat we have.

Like a catch up. She's the refuge health visitor so I suppose has extra training or something in it.

As I said earlier, help isn't always asked for, or taken at that moment. But it's still help I suppose.” (SU7)

Pertinent, was the reassurance in knowing someone was available to make judgements on potential future situations. The safety found in knowing another would, and could, scaffold your experience. Having a consistent named health visitor was reassuring as well as supportive.

"I know that she (health visitor) can answer questions, like with the baby, and that's good to know, and I'm happy with going to her..."

...I think if it was something I couldn't deal with, probably. Like her, I don't think I would just call up an office or anything." (SU12)

Furthermore, having an awareness of *knowing* enabled comfort in speaking openly for the women. It was out there, they already knew. It further increased their confidence in asking for what they needed.

"She asked me if I was comfortable telling her what had happened, what had led me to being there. I was happy to tell her, I was safe in the refuge. Everyone knew and it wasn't something to hide. The women wanted to feel strong there and that bit of their history didn't affect that anymore." (SU5)

Playing the game. The stories we tell

Maintaining agency within their planning was important to deciding when to seek support.

"I knew I needed out, so it wasn't like a new thing I was saying and I was scared. But I could say it straight because I wasn't scared of talking to her" (SU4)

Here, one woman recalled an encounter with a health visitor in which the awareness of knowing appeared mismatched for both. The summary of this contact was a skirting around a 'potential' issue with a 'potential' plan, but nothing identified.

"I didn't disclose everything, but I did say I was a little down and depressed, and that I wasn't getting on with my partner. I didn't disclose domestic abuse because I wasn't ready... maybe she picked up on that, and all she could do was give me some leaflets about domestic abuse... safety numbers. It was quite a little bundle, and I thought 'this is great, but now I have to hide these...'

So, they went from my baby bag into my top drawer next to my bed, but I was so scared he would see them and know I had spoken to someone and say what's been going on. But nothing was ever followed up after that..." (SU3)

Fundamentally one could assume missed opportunities to ensure that every contact counts (Public Health England, 2016), however when taken out of the theoretical basis, one could postulate many barriers as to why a deeper conversation did not take place. This quote demonstrates that any potential conversation about DA is reliant on the truth(s) known and unknown. This speaks to research undertaken by Bradbury-Jones and colleagues (2014) in which most health visitors agreed all women should be asked about DA, yet, ironically, there was also resistance to doing so. The truth of a situation is never the whole truth.

6.2.2 Theme two. Love and Justice, connection and care

Sit alongside

It became notable in the conversations with women that much of the desired and required support from the health visiting service took the form of solidarity. Whether implied, or explicitly physical in doing, sitting alongside women in their journey was fundamental.

“I said down the phone ‘I need help’, she didn’t try and keep me on the phone, she told me to come into the office, she sat with my whilst I called the police and women’s aid, and she stayed with me the whole time for 6 hours, she went on to take me to the police station...” (SU1)

Having no emotional ties allowed women to rest on the support without feeling they needed to give back. Again, the sense of solidarity underpinned with positive attitudes.

“I think early on she (health visitor) said ‘you can do this...’ I remember thinking ‘I can’t’ and just wondering how she could even say that. She only said it once early on, maybe she saw my reaction, and then we talked a lot how all this made me feel, how I felt awful. You know I didn’t believe her when she said I could do it, but her listening to me, she was the person I didn’t feel a burden too. I didn’t feel I was draining her. That sense supported me through abit” (SU13)

Apparent was the importance of connection and demonstration of care.

“I would say stick around, stick around for that cup of tea, be that friend because it is a lonely, dark world. And keep linking with other services, create an umbrella around that person.” (SU1)

Women valued being seen with consistency, approachability, and active listening. Upon considering the subjective and reflexive approach to health visiting philosophy that listens to stories, it would appear the data set echo such an emphasis in terms of support.

“Her focus was the children, but she was there. That’s what I remember the most, just a nice person who listened and was there.” (SU10)

The paternalistic medical standpoint of symptomology and ‘treatment’ simply is not appropriate for some, as this woman reflects.

“I feel like they just they asked it as, you know, just one of those questions... they don't really look you in the eyes and try to find out and see you. I know it depends on you, but they don't try to find if you're telling the truth or if you are scared. They just ask the question, just one of the questions as if they're just asking for your name.” (SU2)

Here this woman retells her experience with a health visitor asking the routine enquiry questions, she remembers the lack of listening with humility. When there is a perception of *having* to do something, rather than *wanting* to do something, it can affect the outcome. This woman discussed whether building a relationship with her health visitor (increased time with them) would impact whether she disclosed the abuse when asked. Her dismissal that this would change the outcome perhaps gives weight to the perception families have on the health visiting job role. How do health visitors care, and how do families know we care?

“I still really like her. But I don't think it's about the number of visits, because I think they just come to do their job. And although she's friendly, she's been talking, it still feels like a question-and-answer session. You're not having a cup of coffee with her, you know.” (SU2)

The same woman described her differing experiences with health visitors. Here she expands on how she came to trust and therefore share with the health visitor. The consistency of genuine asking in terms of care and wonder. This example demonstrates the requirement of trust in the opening of working relationships and how the connection is built.

“And when she asked, she actually meant her question. She asked in every session, and she'd look me in the eyes and she left the paper. She looked look at me and said “do you want to talk about anything? Is anything going on?” She didn't really read the question from the paper, she actually meant it when she asked the question. So after a couple of sessions where she asked me the same question, you know I thought, “OK, let's talk about it”.” (SU2)

Moreover, women appreciated the skill of listening and a health visitor's ability to connect with them. In a world of chaos, finding the commonality of day-to-day enables a sense of feeling at ease.

“I just told her what had happened. She was kind about it, you know, she smiled at me. She wasn't writing stuff down like the others. She was chatting with me about the baby and the kids aswell, just normal stuff, like what they were into and how busy it was in the morning getting everyone ready. She was just normal, she wasn't shocked, just normal.” (SU4)

Support from the health visitor was explored prior and during the periods of DA, but there was also retelling of support offered following DA and healing. A sense of solidarity that continues through stages of transition. Remaining with women on their journeys was important.

“I think after about 3 months we moved back home, so they wanted to check we were all OK I guess. It was nice that they really cared how things were, and how the children were.” (SU10)

Faust (2009) argued for a focus on *kindness in care* within healthcare that was more realistic and supportive. What the data set promoted was the empathetic environments peer support provided, as health visiting could not. Therefore, emphasising kindness in the perceived receipt of support was so important. To transcend above expectation was demonstrated here.

“She said she would see me every month, but her kindness.... She would drop formula off, or some baby clothes she said her colleagues had been donated. Her work was only a short walk, so we would go to the well baby clinic, she was sometimes there, or her colleagues. It was a place to go for us. She would text message me, and if I needed something, or was worried I called her.” (SU13)

Who Am I?

When discussing mother’s insights of the health visiting service, the data set determined approachability (as seen above) as important. Othering and stigma are well documented experiences for mothers working with services during DA (Hauge and Kiamanesh, 2020). The antithesis of shame is compassion (Brown, 2021), ideally experienced within, but not dismissing the sense felt by others is powerful. Here a mother recognised how compassionate conversations were laced with a visibility of togetherness; an example of commonality in parenthood but broadly demonstrating the power of shared experiences.

“But she talked about normal things and how like the mornings before school were hard, and she would find them hard as well with her own kids, like normal things, they don’t wanna get dressed and stuff. She was just normal with me.” (SU4)

Fundamentally,

“If I don’t like someone, I’m not going to tell them, why should I, if all they do is judge me?!”

(SU4)

One woman spoke of how her health visitor supported her in many ways other than directly addressing the DA. Within this situation, this woman had a family support worker who could address the impacts of DA, including a wellbeing programme and housing support. The health visitor took the lead with supporting other areas of parenting including feeding, allergy consideration and child development. All areas are universal within service delivery and are invaluable in enabling the woman to engage with her support worker.

“And with the health visitor she has been there to help with the baby, and let me know he is growing and things which is good, like she talks about ways I know he is growing and she tells me about things I can do to help with his brain growing, and you know I see all the things she would talk about, like if you smile and chat to the baby, he goo’s back and is talking to me, and like he watches me and he loves his grandad, he just knows us and things. She (health visitor) would talk about how I know he’s happy, and it’s looking at those things.” (SU12)

6.2.3 Theme three. Moments and opportunities

Language

When terminology and language was contextualised within the health visiting support, one participant explained how the terms *domestic abuse* weren’t ‘needed’ within the conversations, however within specific services they were helpful.

“I mean I didn’t need her, or anyone else to name it. I mean using the name domestic abuse helped when I was speaking to people who could get him out and help me, but just talking about how I was with it, I didn’t need her to say it” (SU4)

This demonstrates the individualised approach to the language and terminology health visitors use. Directly addressing a situation as DA may validate some in the moment of exploration (Penttinen, 2024), but health visitors must remain focused on the individual rather than discourse application that is presumptive.

Conversations

The data set recalled the conversations they had had with health visitors.

“The health visitor took the lead with the conversation, you know asking me things, and then constantly asking me what I wanted, what I think, I think I slowly got my confidence back. I wasn’t as stressed, I could breathe a little. You know, no one ever seem shocked, or like they were judging me, they weren’t even judging him. No one said a bad word, but just focused on help and what I wanted to do. Just the lifting of worry, that’s the best way I can describe it.”

(SU10)

As shown above, engaging in conversation requires intentionally guiding the dialogue while cultivating humility — speaking in a way the other person can truly hear. This approach allows for a natural, reciprocal exchange within the shared language.

Invitation

One woman reflected on her experience of being asked questions; The ‘invitation’ into a conversation was explicit but certainly implied a different application.

"She's just asking one of the questions that she has to ask. I remember she even said "I'm sorry about that, but I have to ask" And I felt like, 'OK, even if I want to tell you now, I'm not gonna tell you.'" (SU2)

This quote highlights the importance of asking considerate, reflexive questions that acknowledge assumptions unapologetically. In needing to say sorry for asking, it makes the responder feel a sense of shared guilt if they acknowledge an existence of the issue.

Women themselves provided opportunities to enter conversations. Perhaps more implied than explicitly requested, the invitation to begin was present within both data sets. However, as this woman recalled the response to her moment of opening was met with leaflets. Surely if ever there were physical barriers to continuing conversations, information about *other* services that may be more appropriate, are such.

"I disclosed that I wasn't happy with my home situation, but I was still a little bit secretive, and careful about who I told and what I said. But I disclosed enough to her that she felt I needed more support, and she gave me lots of leaflets." (SU3)

Highlighting the missed opportunities within the invitation to support were crucial within this woman's story. Of course, hindsight allows us to criticise the moments and we shall never know if capturing this opportunity would have changed the journey for this woman. However, what would have changed would be her sense of support and connection in a time of concern and fear.

"...that's why I felt let down in a way... I had given clues that I needed help, not in a direct way... you know, 'I need some help....' and you should pick up on that, as a professional.... I don't know

if, if my situation had have been worse and I'd have been being beaten up daily they should have picked up on that.” (SU3)

The meaning behind this quote is the importance of holistic observation skills. The ability to recognise and listen with the heart, mind, eyes, as well as the ears. The silent messages are the loudest ones to be heard. Yet, invitations to enter conversations would only be taken up if individuals are ready to discuss. Asking directly at different times may not produce truthful responses but may enable a reflection that can later be explored.

“Maybe she could have asked me more, and I probably would have said everything was fine, because I didn’t want to talk about it then, but maybe it would have made me think about it in a different way.... I don’t know.” (SU4)

6.2.4 Concluding thoughts relating to research objective two: *Perceptions of support.*

Interaction between themes

Perceptions of support were deeply personal and fluid in their application and requirement. Understanding the priority for health visitors being the child(ren) was acknowledged as well as embraced. Meeting health visitors in the prioritisation of the child(ren) was done so through solidarity and reflections of the self.

How themes fulfil the research aim

The data set spoke to the delicate application of health visiting intervention sat in-between an awareness of system management and individualised support. These findings demonstrate the awareness mothers have regarding the broad macro-level system approach that often ensures

objectifiable tasks, yet they recognise that barriers exist for practitioners in their delivery. Their empathetic awareness and approach to health visitors is present.

Undoubtably the insights shared within this chapter highlight the contradiction in opinion and experience of universal support. The findings overwhelmingly direct us to consider the importance of connection and understanding of the health visiting service.

6.3 Addressing objective 3. Exploring the perceptions of achievable/wanted outcomes

This sub-chapter will explore the findings relating to the third objective of the study for women,

- Exploring the perception of achievable/wanted outcome from the mother.

This sub-chapter will provide the mother's insight into the final research objective of exploring the achievable and/or wanted outcomes following their experience of domestic abuse. The perceptions captured within the transcripts detail the specific, contextual considerations of outcomes, as well as broader thoughts. Some of the insights provided by the women have been

given as absolutes within hindsight of what happened, others have been captured to explore their hopes of what is to come, or if things were done differently.

It was fundamental to capture the hopes and desires of women, as evidence suggests (McCarry, Baker and Radford, 2021. Jenkinson, Kruske and Kildea, 2017) their voice is often lost within safeguarding. Furthermore, once analysed alongside the health visitors' perceptions of the outcome, it presents an interesting intersection of hopes that are deemed achieved or simply wished for. The collaborative work between individuals and public health practitioners requires shared goals to enable achievable outcomes. To postulate current and potential practices, one must first hear what is wanted and why.

6.3.1 Theme one. Discerning curiosity. Wondering and knowing, how things can contradict and compliment at the same time.

Priorities

Fear was the bridging factor within both staying and leaving. For women, fear is a sense that sits with them daily.

"I got to a point, and I walked into a shop, and something triggered me, like a smell, or someone would say something that he would usually say... I would get heart palpitations... I had panic attacks. I started to recognise it was the abuse...." (SU3)

For some the sense of fear felt was hierarchical in its acute presentation, for others fear became a chronic unwelcome friend that was acknowledged and lived with.

“It hurt, it didn’t feel good, it made you feel shit, and that was what it was really. You know I’ve had so many fucked up things happen to me, but to me they’ve just happened, it’s like, whatever, next.” (SU6)

For the women who had experienced domestic abuse throughout their lives and deemed ‘repeat victim-survivors’, the sense of normalisation of not just the experience but the management of emotion was palpable. Hearing empowering moments filled the narratives with hope and justice, however the moments of listening to women describe their awareness of the abuse but caught in a process that was compounded by their own acceptance of the situation, was heartbreaking. Reflecting on the conversations shared between the women and myself, allowing my own contradictory thoughts and feelings towards women staying and leaving, became an organic state of flux. Weighing up the moments in which leaving may be possible, to then be compounded by the multiplicities of the family environment, held me in a state of epistemic wonder. The flux between fear and safety is known to me, and both data sets acknowledged the issues of power and control that compound either movement. Furthermore, recognising the patriarchal constraints of women that wield us to shape the category for which we are expected to sit within, supports this claim (Ficker, 2007). Moreover, leaving some perceived harmful things *unknown* and conceding that what matters is what we *need* to know, harnesses an epistemic co-operation (Townley, 2011).

Fear was also attributed to the unknown intentions services may have. One participant explored how her worry of not knowing what professionals would do with disclosures was enough to silence her. This is previously discussed, however, within this sub-theme it becomes pertinent to consider how services position their intention and priority from the outset. If

professionals work within a reductionist approach that focuses on event or disclosure to evaluate risk of harm, it becomes hard for service users to recognise any other priority (including supporting their wellbeing). Within this context, it is applied to social care, but transferable to health visiting services that need to recognise how their message of assessment is delivered and ensure experience is discussed more.

“You can’t help it, you worry because people will judge you and think you’re a bad mum. I’ve heard good and bad things about social services, like how they are with people, and I don’t know, but you worry. The worry is sometimes enough to make you not want to say” (SU11)

This woman further goes on to talk about trust and intention, and how there may be a need to please professionals with giving an answer that may align with their perceived priority.

“But with the health visitor, there is a part where you want to say the right thing, I don’t know, like do they work close with social services, but like they have that power more to tell other professionals’ stuff, but I do know they have to tell you what they’re doing first I guess. So for that, you care what they think, because they have the power to get people involved.” (SU11)

Again, a moment to reflect, as practitioners, how power is perceived and how it may inhibit the information needed to make appropriate supportive interventions.

Directed wonder

The data set spoke of the hopeful outcome of knowing where to go for future support.

Eradicating their previous experiences of loneliness and helplessness, self-resilience is found in knowing about resource availability and accessibility (Crawford, Liebling-Kalifani and Hill, 2009).

Having an answer for a potential *if* moment was important.

"I mean she told me she popped over once a month and anyone could come and see her who was at the refuge. Just a quick chat, weigh the children, ask questions, anything. That was so lovely to know, like another place of safety. She couldn't offer me anything at that moment, but just knowing she was there incase." (SU5)

A new reality was explored for the data set; many of the women embarking on a new journey at the time of interview. A sense of hope and new meaning was held with both trepidation and wonder, yet the positivity relating to their capability to parent and strive, was awe inspiring. Their previous experiences had birthed hopeful aspiration for future relationships, both intimate and with their children.

Support and/or fix

Reflecting upon what had gone before was done so with the wisdom of hindsight, yet when thinking if one would change anything, there was a consensus that what happened in the past could not be undone. Rather taking a supportive stance in whichever way that may be, but attempting to reduce an experience to something binary to be fixed was not possible.

"You know, don't fix it, just be there." (SU11)

There were profound moments of retelling in which this participant spoke of her own understanding of empowerment.

"You have to let someone find their own answers in their own lives you know? If someone else is doing it for them, then the person will never really get it. You know, this program talks about how they dominate and bully you, and stuff like that, and you go home, and sat on the bus it's running through your head, and then at night, you can be sat and you think about it, and you

realise that actually someone has written all about your experience without them meeting you and knowing you, and I don't know, for me, that's how I got it wasn't me at all, it was all about this behaviour, that you could write about. It didn't matter if it was me, or any other woman, there are just some messed up people that do these things. You can't change them, you can change yourself." (SU11)

As retold here, supporting self-empowerment is fundamental to change. Considering aspects of promotional guidance that inform and educate through understanding, goal-setting, and action planning were demonstrated in this woman's experience. However, as Arnold (2009) states, an enlightenment, restorative approach is perhaps one consideration; victims must know they're not to blame.

Playing the game. The stories we tell

For some women there was a deep sense of importance held within the honesty of reasoning and understanding. In acknowledging that, that did not mean they agree with everything professionals advised, or in turn feeling comfortable with others disagreeing with them, became fundamental to understanding one another better. Interestingly, given the context of discussing extremes of conflict within relationships, there was a recognition of how healthy conflict could enable a relationship to last and improve.

"Someone lets you in and shows you a part of them then you give back abit. If I was working with someone, and believe I have with some professionals and they give you nothing, no piece of them, but then they expect you to open up then yeah, that ain't gunna happen is it, not really.

It's a two way thing. You trust me, and I trust you." (SU6)

Demonstrating the back and forth of disagreement both shapes relationships and adds to the endeavour of forming healthy connections in the future; there is security to be found within respectable conflict.

The back and forth is also present in the understanding of the outcome, for the data set this was presented in terms of trust and time; both things earned and given, yet both essential.

“Help is that bridge from scared to safe. But you put trust into that helping person. They also need to give you time.” (SU7)

“I think give the person time, like, they need to tell you when they are ready, so go back. Go back and ask and do what you can do get them to trust you, talk to them, tell them they aren’t on their own, cus that’s the thing, it’s lonely. And then, don’t try and fix it, do what you can and get what help you can but get that you can’t sort it all.” (SU11)

“To listen is to sit with someone, and that takes times... The time is spent preparing for the next sometimes, because some things cannot change.” (SU13)

Humanity held within the home

Women recognised the role health visitors held and their responsibility towards the safety of children regarding assessment and planning. Mothers spoke of their frustration and defensiveness when health visitors questioned how children perceived the adult relationships. The responsibility weighed on the mother to safeguard children was apparent and supports much of the previous literature exploring mother-blame and responsibility for abusive behaviours (see Wild, 2023. Hauge and Kiamanesh, 2020. Arnall and Stewart, 2021).

“She talked about the kids hearing it, which I knew. That bit I got abit pissy with, because I didn’t want to be told about that... but I get she had to talk about them, that’s why she was there.” (SU4)

The same mother spoke of a previous conversation with statutory agencies in which she implied they simply assumed she wasn’t aware of the impact on her children.

“I told her that a social worker had come to the house with someone else and they had said I shouldn’t stay with him, it wasn’t good...I didn’t want her to tell me that. I knew it was shit, like as if she thought I liked it all and I was OK with the kids hearing his bullshit. I didn’t say that though, I just said ‘OK’.” (SU4)

Assumptions made regarding the acceptance of women of abusive behaviours, particularly women who experience DA with multiple partners, will often take the stance that they fail to recognise the impact on the children. Yet, what this quote highlights is that some women may in fact take a position of intentional unawareness when discussing with professionals, rather than speaking up. It became a moment in my own practice reckoning of wondering; how many mothers I presumed did not recognise the impact a behaviour or experience was having on their children? When they knew, but the implications to face this challenge were too difficult in terms of fear, for themselves, or for their children.

6.3.2 Theme two. Love and Justice; the care we share

Who am I?

Considering belonging and connection;

“The health visitor referred me to the freedom programme (domestic abuse intervention), they all knew each other, the doctor would call me and they were a great support. My home became a sanctuary again, I had space when we broke up to pick up the phone.” (SU1)

What became meaningful here was the concept of sanctuary; not purely weighted on the ending of an abusive relationship, but on the support offered from others: togetherness.

Moments of conversations with health visitors presented insight for women themselves to acknowledge a sense of safety that they had not yet realised or considered. Enabling an individual to reflect upon how they experience something can be profound in the smallest moment. Acknowledging that many victims may normalise a sense of un-safety or perhaps become ambivalent to what and how to feel, cannot be overlooked. An achievable outcome that can present a new lens of belonging, as narrated by this mother.

“She seemed to talk about safety more, like with the kids and them feeling safe, and with me, if I felt safe with him. I dunno, I’d never really thought if I felt safe, but I get it now. I’ve done the Freedom Program (intervention) and I know now, I understand, feeling safe with someone is so important, even if you don’t like them, if you feel safe it’s so important.” (SU4)

The data set spoke about martyrdom. Enabling another but diminishing yourself. Women wanted to be seen as an individual regardless of the parent-child-family dynamic.

“So, I was dealing with all that, and in a way worried and petrified you would take (child) away because I was with a bad man, because I was trying to make him happy, me and (child) happy and make professionals happy. Trying to cover it all up with sprinkles. Knowing now how transparent it was, there is a guilt.” (SU1)

"I think the thing that sticks out is when my daughter was born, the home visits. Me trying to put on a front, like everything was great." (SU9)

This woman captures the profound struggle of presenting a false sense of well-being, driven by the need to meet the expectations of others. A deep sense of selflessness, as Moulding and colleagues (2015) found, mothers will place the outcomes of their children and others above their own. Here the 'good mothering' narrative is explicit, laced with a sense of selflessness.

"The thing is, when you survive you just can't talk about it until you are ready can you? Well I couldn't. I pushed it down, because if I left it up I wouldn't have been able to be a good mum and function." (SU7)

Sit alongside

In understanding the need for us all, universally to feel a sense of connection and belonging, is argued to be the fundamental human endeavour (Brown, 2021). When considering the wanted outcome for the data set, feeling supported and cared for was essential. As Laitinen and Pessi (2014) note, the term solidarity is often used for a broader definition of mutual support. This woman encompasses the experience,

"Once it felt like someone cared, I felt so comfortable. And you know when someone actually cares about you, they truly care about you. You know it, you can feel it." (SU2)

Furthermore, as this mother explains, to be listened to with an open heart, recognising humanity and the individual, was important. The sense of disregard felt by some mothers inhibits the ability to belong and feel valued within situations, and therefore to enable moments of authentic storytelling were powerful.

"...she just listened and didn't give me funny looks, like she was judging. She just listened and then told me I'd done the right thing in calling the police. She talked about the kids and stuff as well, and she didn't make me feel like a shit mum. It happens with people sometimes, they make you feel like a crap mum who doesn't want good things for them." (SU4)

Interestingly, for some whether they are believed or not was not something explicitly strived for. Rather, engaging with support from someone who heard the whole story and didn't attempt to unpick someone else's lived experience. One woman recounted how support came by acknowledging the truth in her experience.

"...it's like if you are guna ask then believe that person. You know you can still think 'yeah, but I bet you're a shit...' but you can still believe what they've said. Especially if you want to help someone. That's the thing about the (intervention) program, they say it and talk and there is no question whether or not something happened, actually they don't even ask. It's just like you're here because it happened and we don't need to ask again or check." (SU6)

Truth, not only in the abusive encounters, but the intention of safety, enables hope and progress. Here this mother discusses how having a shared goal enabled openness.

"I knew that they just wanted me and my children to be safe and that was always the thing. I always knew that. I think because she always made me feel that, I was happy to be really open and talk through things, you know, there was no other agenda, they had no other plan.

Everything was very open." (SU10)

When exploring qualities of others that the women wanted, care and kindness were noted as important. In isolation with a perpetrator, maintaining a sense that there was much kindness, even from strangers was hopeful.

“So yeah, what I mean in needing people, is just having people be nice to you. I don’t know, maybe it sounds daft, but when the person at home makes you feel like an idiot, or ugly, having strangers be nice, or having people you know be caring, is so important.” (SU7)

One woman recounted how her ex-partner will still increase his abusive communication, but with the support of professionals she feels able to speak freely and put in place protective factors to prevent escalation. It is important to note that this is not her taking responsibility for the behaviour, but she is empowered through solidarity.

“...like they will ask “how’s it going?” like with him. And they know the set-up. They’ve never met him, or his mum. We had a bad time a month or so ago with agg, and my dad was here and told them that he had been calling and stuff. He hadn’t come round, he wouldn’t, but calls and messages, so they said I needed to block him else if it carried on they would have to escalate it, just for my safety. But I did, I don’t take it off him anymore. So yeah, we talk about it.” (SU12)

Her confidence in making decisions regarding when/if to tell, and how to navigate a response was powerful in the retelling. Empowering the individual, regardless of if others are not accountable for their actions and willing to change, enables the woman to feel able to continue to grow and parent.

6.3.3 Theme three. Moments and opportunities

Managing and changing

The perception of fear impacting the children has been mentioned, however the real moment in which the children become directly involved provided many of the women the impetus to seek help and/or leave. The moment is different for all, but what appeared consistent within the data set was the perceived reality for the child living *alongside it* to then living *in it*.

“So, when the social services got involved, it was because the abuse was affecting my child and that was why I decided enough, because they started abusing her as well. It was emotional abuse, not a physical.” (SU2)

Perhaps the most inexplicit desire, as discussed here, correlates to the health visitor’s awareness of accountability and perpetration. To be a victim, whether self-identified or not, to be ascribed whilst also having the expectation to make changes, draws into question how individuals are positioned in planning; how systems continue to perpetuate controlling interventions in the quest of beneficent support.

“It felt a lot at that point you know, feeling guilty, being the one to make the decision to go home, and still having to think about how we would manage. I mean he (husband) knew I think that I wouldn’t take it anymore, he knew anything else that would be it, so I felt OK about going home, but it was still me having to make the next steps, do the next thing, not him.” (SU10)

Not only was fear pertinent in the reliving of experience and storytelling of such, but fear was correlated with the outcome of service. The *desire* for what was to come could be easily matched by the *fear* of what not to come.

“...the fear if I don't leave this man... because they have you off everything, the worry, I'll take him, I will take you to court, I will kill you. And the professionals could take him, with the support of the police. You're stuck in the that, that man and them saying that, stuck in the middle, what do you do for the best?” (SU1)

The helplessness of the question asked, ‘*what do you do for the best?*’ The woman is caught between the perpetrator and professional, with little consideration of herself within the outcome.

Language

For desired outcome, there was a consensus that the use of relaxed language enabled women to share. Anxiety as depicted within discourse can impact engagement (Willis, Dodd and Palmero, 2013), it is important to evoke an ease to conversations with a consideration of the language used due to the strong correlation noted between approachability and trustworthiness (Willis, Dodd and Palmero, 2013).

“She sat down and just asked me, normally. No formal questions, just ‘are you happy to tell me...’ and off I went.” (SU5)

This quote drew considerations of what formal and informal language was, and how it could be interpreted within the power dynamic between mothers and professionals. Considering service user autonomy as a crucial outcome in its own entity, and as Veenker and Paans (2016) note such is a component within self-determination theories of health literacy and understanding.

Conversations

Capturing conversations within the retelling detailed how regardless of the issue dictating the discussion, or outcome to come, speaking with the health visitor was enabled by a supportive, non-judgmental stance.

“...the relationship broke down a couple times and I would pick up the phone and I would say 'I'm sorry I've gone back', but there was never anything aggressive, she was very supportive.”

(SU1)

Some of the data set wondered upon the conversations that had taken place, and perhaps if they could give some wisdom to health visitors beginning discussions with individuals. Relating to the when to have conversations, recognising the appropriateness of timing was important, and the first new baby visit may not be the most opportune moment.

“I guess when the midwife and health visitor come out first, when the baby is tiny, usually the Dad is gunna be there, he's off work. They shouldn't ask questions then, not at those times, be mindful if they think there is domestic abuse, don't question when he is there. If you think there might be, ask mum to come for a health check or something....” (SU3)

Moreover, there were moments when the women recognised that, despite the chaos and anxiety of their circumstances, they had created protected spaces around their parenting and their children — spaces they were reluctant to disrupt with conversations about DA. For example, having conversations that were about the new baby or child, were important for mothers.

“I mean, she didn’t ask much about him (ex-partner) and me, like how we were, or how it felt being with him, you know, those visits it was about the baby, and that was OK. In a way, I didn’t want him to ruin that either, you know, I didn’t want to talk about him.” (SU4)

The use of the word ‘ruin’ is striking, perhaps serving as a reminder of the idealised version of motherhood — one so revered that it becomes untouchable, placed within a protective sphere to shield it from harm. Supportive conversations help mothers preserve these moments of hope and aspiration.

6.3.4 Concluding thoughts relating to research objective three: *Achievable/wanted outcomes.*

Interaction between themes

It is the inexact, unquantifiable, and unobjective perceptions of outcome that interweave throughout the three themes. Overwhelmingly the data set spoke of outcomes that enabled their own growth and reimagining themselves again. There appeared little differentiation between wanted and achievable outcome as what felt tangible often just required time.

How themes fulfil the research aim

The themes speak to the powerful retelling each woman provided. What became apparent throughout the analysis was how outcomes were predominantly shaped by the supportive elements of health visiting practice that were not interventional based. Moreover, for this data set the outcomes were desired *and* achievable as they relied on a human connection surely available to us all when at a point of needing. However, the anguish was felt when the moments of connection could not be achieved due to constraints of availability. The woman’s

perception of fruitful outcome was that she was more than the experience, more than the sum of all the parts of her story.

6.4 Concluding thoughts relating to mother's findings addressing all three research objectives.

The transcripts were both illuminating and harrowing in equal measures. The women spoke of the inconceivable experiences they endured whilst continuing to parent. Their broader perspectives, perceptions of health visiting support, and explored outcomes, centred around their positioning of parenting. The findings from this data set support much of the previous literature that highlights the weight of blame and shame experienced within mothering.

Women were aware of resource restraints that often-limited choice and autonomy to make healthy and safe decisions. They sense the process of responsibilisation, often cited in the social sciences, in which responsibility is moved between the state onto individuals (Argüelles et al, 2017). Within this context through a feminist lens of ecology, it is noted that oppressing mothers to limit their ability and self-worth maintains a patriarchal governing, and it limits the consideration to instead examine how responsibility should and could be addressed within the wider macro and exo systems of society.

Both data sets spoke of prioritising the child(ren), for women this was demonstrated through the careful momentary consideration of what the child was witnessing and experiencing, as well as deep knowingness and connection with their child. Rather than presuming apathy or ambivalence, women were aware of how to manage their perpetrators behaviours, as well as professionals understanding with careful and intentional inaction and action, to maintain safety. If professionals endeavour to engage with women, they must acknowledge this

fundamental aspect of maintaining safety within the context for which they exist. With awareness and education within the wider conversation about coercion and control, it is still expected that mothers experiencing DA should do, and achieve more, than we know is possible at that moment.

The final chapter will take the analysis of both data sets and unpick further. Researcher reflexivity has been entwined within these chapters alongside the participant's voices to highlight meaning. From here, implications for theory and practice will now be explored to present models and pathways to evolve health visiting service provision. The analysis will be explored within the context of the current literature field to both support and highlight areas for further examination. The final chapter will also present the limitations of this study, and how interventions were employed to mitigate and prevent barriers to the research.

Chapter 7 - Discussion

7.1 Introduction

This chapter synthesises the two data set analyses to deepen the understanding of the working relationship between health visitors and mothers, highlighting implications for practice. This chapter will explore the unique contributions to knowledge produced from the data findings. Reflexive analysis explores the processes of unlearning, relearning, and gaining new insights to promote empowerment and advance professional practice. This chapter will address key elements, including a summary of the analysis, the extent to which the themes align with the research aims, and the theoretical, conceptual, and practical implications for health visiting. Additionally, it will discuss the study's limitations and future research considerations.

As established at the beginning of this thesis, the study is situated within the context of universal and/or universal-plus health visiting support (see Healthy Child Programme, Commissioning Report, Office for Health Improvement and Disparities, 2023; and Health Visiting Service Model, Public Health England, 2021). Health visitors work with families experiencing DA across a spectrum of severity related to child protection. Child protection assessments are conducted when significant risks of harm are identified (The Children Act, HM Government, 1989, 2004). In such cases, service provision escalates beyond the universal-plus level. When operating at this level of child protection, it is crucial that insights from this study are integrated into multi-agency planning and assessments that prioritise the child's voice and safety.

Many of the interviews with health visitors and mothers explored experiences that spanned the threshold from universal services to child protection. These insights provide meaningful considerations for improving service support. This chapter will also examine the role of participant insights and researcher subjectivity in shaping the implications for health visiting practice. While broader concepts contribute to working practices, this study aims to advance discussions specifically related to health visiting support. The evolving methodologies and techniques within violence against women (VAW) research have emphasised creative and inclusive research design (Johnson, Fisher, & Jaquier, 2015). Capturing diverse voices within communities enables nuanced understandings (Johnson et al., 2015; White et al., 2013) and fosters a sense of ownership over practice. Health visitors occupy a privileged position in recognising, exposing, and supporting families experiencing DA. The integration of research and practice encourages progressive ideas and service delivery (Baldwin, Jackson, & Gilroy, 2024), a key message underpinning this discussion.

7.2 Summary of analysis

7.2.1 The research aim

This study aimed to amplify the voice of the mothers and to empower their knowing, as well as the health visitor in their perception of working within DA. The narration provides an opportunity to ameliorate experience by providing the mothers and health visitors with an opportunity to be heard and make sense of what was done to consider progress. The research aim of the study was to,

- seek opportunities to progress and improve health visiting practice when supporting families experiencing DA.

To undertake the aim of the study a qualitative approach was applied through a feminist lens of enquiry using reflexive thematic analysis as both a methodological underpinning and an analytical method. In broader terms, the enquiry further explored the following objectives;

1. Exploring the wider implications and perspectives of DA,
2. Exploring the desired/achievable outcomes from the health visiting service within this context,
3. Exploring the perceptions on support and/or interventions provided.

Health Visitors' Perspectives on DA Support

Health visitors are uniquely positioned to provide support to mothers experiencing DA due to their role in early intervention and safeguarding. However, the study revealed that many health visitors feel underprepared and unsupported when addressing DA. Routine enquiry about DA is not uniformly implemented, often influenced by personal confidence, training disparities, and workplace policies. Additionally, health visitors face challenges in balancing their dual responsibilities of safeguarding and therapeutic intervention. Limited time, high caseloads, and bureaucratic constraints further impact their ability to provide continuous, meaningful support.

Mothers' Experiences of Health Visiting Services

Mothers' perspectives on the support provided by health visitors varied significantly. Some mothers reported positive interactions, where health visitors offered emotional support, signposted relevant services, and acted as advocates. Others, however, felt judged, dismissed,

or unsupported, particularly when their safety concerns were overshadowed by child protection considerations. A recurrent theme was fear of social services involvement, which deterred some mothers from disclosing abuse. Many mothers experienced coercive control, further limiting their ability to seek help independently. Their narratives underscored the importance of trust, empathy, and a non-judgmental approach in facilitating meaningful engagement.

The presentation of participants' voices has been fundamental in shaping and deriving meaning from the working relationships studied. This section brings together the themes produced through researcher subjectivity, offering deeper interpretive analysis. The analysis was positioned through the narratives provided by both data sets, utilising reflexive thematic analysis (RTA). Three key themes were produced, each overarching the findings from both data sets. These themes provided opportunities for storytelling, illuminating the voices of the participants while also contributing to the researcher's meaning-making.

The first theme, **Discerning Curiosity**, reflects the simultaneous contradictions and complementarities within participants' experiences. This theme encapsulates the fluctuating truths captured across both data sets, whether viewed through the lens of past experience, reflective wonderment, or the storytelling nature of interview responses. The theme underscores how truth navigates from an ontological concept to a subjective phenomenon, experienced differently by each individual. The analysis also highlights the researcher's positionality in relation to the subject matter and the discussions undertaken. The interplay between wonder and knowledge acknowledges the dynamic relationship between the

researcher and the participants, which evolved throughout the recruitment, data collection, and analysis phases. Feminist standpoint theory provided the conceptual framework for situating my wonder around participants' insights, emphasising their knowledge (Harding, 2004), while maintaining awareness that the dynamic of knowing would shift. The meaning-making was further influenced by how the truth and reality of participants' experiences were explored, particularly as new truths emerged with the privilege of hindsight. This theme ties into the progressive nature of public health interventions aimed at reducing inequalities (Marmot, 2010, 2020) and underscores the moral and epistemological rationale for practice interventions that encourage public involvement (Liabo et al., 2022). In the context of health visiting, this theme captures the ongoing approaches adopted within practice that balance universal expectations with individual rights and needs (Cowley, Whittaker, & Fanner, 2022).

The second theme, **Love and Justice: Connection and Care**, speaks to the intimate connections formed within the working relationships between mothers and health visitors. While acknowledging the power dynamics inherent in the mother–health visitor relationship, it becomes evident that mothers possess considerable power through their lived experiences, positioning health visitors as more passive agents at times. This dual power dynamic is particularly relevant in child protection and safeguarding contexts, where professionals often exert authority. However, the conversations highlighted that mothers, by virtue of their experiential knowledge, held significant power. Adib-Hajbaghery and Bolandian Bafghi (2020) noted the underexplored concept of love in nursing literature, while Watson (2003) emphasised that love in nursing manifests through shared humanity, particularly in moments of vulnerability, illness, or uncertainty. This study demonstrated how, in moments of despair,

focusing on humanity and belonging—rather than anger—became a crucial aspect of the relationship. Solidarity, in recognising another's humanity and reflecting upon one's own, fostered a sense of belonging for both health visitors and mothers. This theme, therefore, reflects a collective reckoning and recognition of shared human experience.

The final theme, **Moments and Opportunities**, reflects the evolving context of the working relationships between mothers and health visitors. This theme emerged from reflections on experiences that were not fully understood at the time they occurred but gained meaning upon retrospective reflection. It incorporates constructions of childhood, motherhood, and oppression, which are experienced individually but intersect with various social forces. The theme also provided a meaningful platform for exploring responsibility and accountability within the realm of child safeguarding. Further complexity arises from reflecting on how moral concepts—such as the juxtaposition of protection and hierarchy of need—shaped participants' stories of what was done and what might be done differently in future. This theme emphasises positivity, resilience, and hope embedded within both data sets, offering a hopeful narrative for the future. Unlike previous literature that focuses on lessons learned or barriers, this analysis provides an optimistic outlook, suggesting that progress is possible in shaping future interventions.

7.3 Addressing the research aim

This study contributes to the growing body of research on women's experiences of DA and mothering (Crawford, Liebling-Kalifani, & Hill, 2009; Moulding, Buchanan, & Wendt, 2015; Peckover, 2003). Previous research in health visiting has primarily focused on practitioners'

perspectives (Eynon et al., 2012; Bradbury-Jones, Appleton, & Watts, 2016; Peckover, 1998; Taylor et al., 2013). This study extends the existing literature by capturing the perspectives of both health visitors and mothers, thus illustrating the dynamic interplay between these groups within the context of DA support.

7.3.1 Research objective 1 – To explore the wider implications and perspectives of DA

The overarching themes derived from the data sets recognise both shared and conflicting perspectives, capturing the nuances in the mutual disagreements between health visitors and mothers. These themes reflect not only radical empathy but also the complexity of experience, which is rarely one-dimensional. The findings highlight that the dynamic nature of thought and action within their working relationship is fluid and context-dependent.

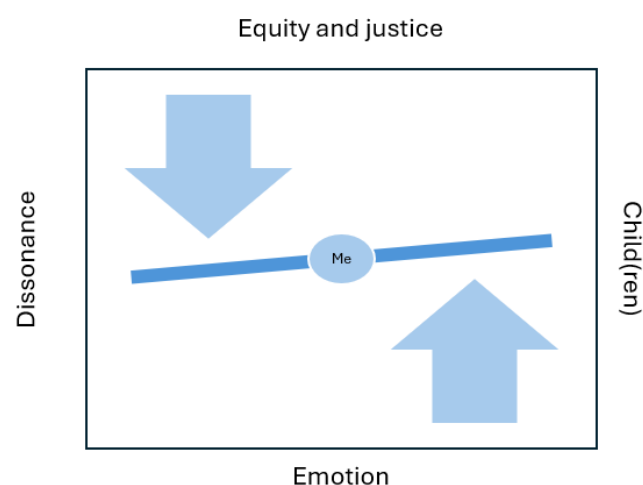


Figure 7.1. Dynamic relationship of themes.

The diagram illustrates a dynamic, oscillating relationship between the three key themes: discerning curiosity, love and justice, and moments and opportunities.

The central focus of this diagram is the concept of "me," representing the participant at the core of the experience, with the surrounding influences—including equity, justice, children, emotions, and dissonance—shaping their perceptions and actions. This depiction moves beyond the conventional notion of the "individual," instead emphasising the relational and

contextual factors that influence the participant's narrative. The findings are shaped by the stories shared by the participants, with meaning emerging from both my own analysis and the lived experiences of the mothers and health visitors.

The primary difference in perspective between the two groups stems from their positionality. Health visitors view DA through an ecological lens, considering the impact of culture, macro structures, and social support systems. This aligns with Heisse's (1998) work, which examined the interactions between individuals, groups, and policy. Health visitors conceptualise DA through a feminist lens, acknowledging the patriarchal influences on both the individual and the broader socio-legal systems, including the microsystem, exosystem, and macrosystem. Given the focus on ecological models in health visiting practice (Nursing and Midwifery Council, 2022), this approach allows health visitors to recognise the complex factors influencing health and well-being.

Health visitors' perspectives are shaped by their conceptualisation of DA, influenced by their individual views and a multi-method approach to understanding lived experiences. This perspective enables them to explore DA considerations, positioning them as ideally placed to support mothers. However, health visitors would benefit from adopting an epistemic safety model (see Figure 4 below) to support their enquiry. This approach would encourage health visitors to radically acknowledge their own perspectives, rather than refuting stereotypical conceptions of DA, thus fostering a more open and supportive dialogue.

Mothers, on the other hand, develop their perspectives from personal experiences of domestic abuse. Unlike health visitors, whose views are shaped by contextual factors, mothers'

conceptions of abuse are rooted in their sense of self. These women often demonstrate an acute awareness of the abuse they have endured and use various strategies to mitigate its harm. While feminist frameworks (Ali and Naylor, 2013) typically frame perpetrator behaviours within patriarchal oppression, the findings here emphasise the mothers' agency and their preventative approaches to abuse.

A notable distinction between the perspectives of health visitors and mothers lies in the degree to which the women recognise and accept abuse. Health visitors often view mothers as unaware of the abuse, especially when they move from one abusive relationship to another. However, the mothers in this study demonstrated a profound awareness of their situation. This finding suggests that health visitors should refrain from assuming that a lack of immediate requests for help indicates ignorance. Rather, the women may be strategically navigating their circumstances, often protecting themselves from the epistemic harm of being misunderstood or dismissed. This insight challenges the professional mindset of "abjection," which has been identified as a barrier to acknowledging certain phenomena (Bradbury-Jones and Taylor, 2013). By broadening this framework, we can better understand how professional assumptions may

prevent the recognition that women do indeed know the abuse they are experiencing.

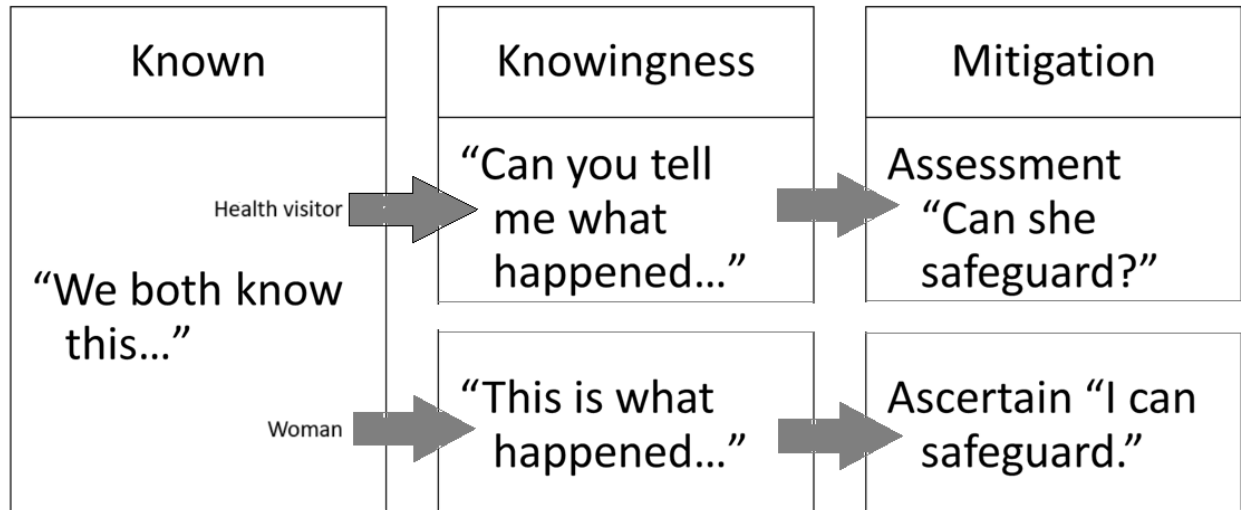


Figure 7.2. Dynamic of power influence. This diagram represents the dynamics of power influence within the perspectives of both groups. The health visitors acknowledge potential inequities, but as the findings suggest, the mothers are aware of the abuse and actively manage it. This discrepancy in perspectives on power and knowledge highlights the tension between the knowingness of experience (held by the mothers) and the protective mitigation of harm (advocated by health visitors).

Both groups reflect on the relational dynamics of DA, framing it as a complex, power-laden issue. They recognise the social construction of the woman as the victim, compounded by factors such as motherhood, physical vulnerability (particularly postnatally), and limited resources (e.g., employment and finances). These perspectives align with gender violence scholarship, which identifies multifaceted systems that impact women (DeKeseredy, 2006, 2008; Dobash and Dobash, 1979; Winstok, 2013; Stewart and Arnull, 2021). The findings reveal the layered nature of DA, illustrating how certain factors predict perpetration and others

constrain women's power. The reflections captured in this study invite a reconsideration of the dynamics of abuse within intimate relationships, suggesting that DA should not be viewed in hierarchical terms but as a pervasive and multifactorial phenomenon.

The fluctuating dynamics of power are crucial to understanding the perspectives held by both mothers and health visitors. These perspectives, informed by their respective experiences, underscore the importance of protecting one's own knowledge from epistemic harm. The findings of this study suggest that the ongoing interaction between the two groups—viewed through the lens of virtue and vice (Barker, Crerar, & Goetze, 2018)—provides important insights. Power dynamics do not shift only in moments of success; rather, the key issue is how inequality emerges through power imbalances, leading to both privilege and oppression. For health visitors, whose practice is rooted in social justice, the fear of harm and the necessity of mitigating risks are central to their role.

7.3.2 Research objective 2 – To explore the perception of health visiting support within DA (at universal/universal plus level)

Both data sets in this study explored participants' perspectives and perceptions, which were recounted through emotionally charged retellings of their experiences. The evidence documenting the emotional impact of DA on mothers (Moulding, Buchanan, & Wendt, 2015; Crawford, Liebling-Kalifani, & Hill, 2009; Hester & Radford, 2006) and their children (Thornton, 2014) is well-established. However, the emotional responses of health visitors working with DA cases remains largely underexplored.

The findings from the health visitors in this study align with the conclusions of Eynon et al. (2012), who emphasised that effective work with DA requires a nuanced understanding that is cultivated through dialogue—both speaking and listening. Spil (2007) found that victims benefit from a space where they can emotionally disclose their abuse without the immediate pressure of action or intervention. However, professionals often feel hesitant to inquire further, as they do not feel equipped to act, creating a significant paradox. This study's findings highlight that, while both sets of data acknowledged service intervention, the decision to act—whether to disclose or inquire—was frequently driven by fear (or lack thereof). The context varied across the data sets: mothers feared the social consequences, such as shame, blame, and the potential impact on their perceived parenting abilities, supporting findings from previous research (Moulding et al., 2015; Humphreys & Bradbury-Jones, 2015). Conversely, health visitors expressed their fears regarding accountability and safeguarding responsibilities, which were framed as ambiguous tasks (Humphreys & Bradbury-Jones, 2015).

The role of curiosity, or the lack thereof, emerged as a fundamental barrier to effective practice, as well as a crucial element in safeguarding children (Dickens et al., 2022; Brandon et al., 2020; HM Government, 2018, 2023). Cohen (2001), as referenced in the Lamming Report (2003), noted that following the death of Victoria Climbié, professionals were caught between “the dynamics of knowing and not knowing” (p. 9). They were passive witnesses to a horrifying tragedy—aware, yet unable or unwilling to act. This tragic case underscores the importance of curiosity in safeguarding practices and the dangers of its absence. To counter this, effective practice requires practitioners to step beyond institutional constraints to foster genuine curiosity (Braye et al., 2017). However, Muirden and Appleton (2022) observed that systemic

structures can inhibit curiosity and obstruct the construction of meaning from the available information. In this study, health visitors demonstrated a clear understanding and inclination to inquire further. However, their emotional responses—whether inhibiting or amplifying their actions—became a key factor influencing their ability to act. Achieving clarity and consistency in practicing curiosity would likely be facilitated by emotional regulation strategies and the provision of appropriate emotional support.

7.3.3 Research objective 3 – To explore the perception of achievable and/or wanted outcomes within DA experience (at universal/universal plus level)

The experiences of both service users and professionals are significantly shaped by the availability and accessibility of resources. As discussed by Gostin and Powers (2006) in their concept of ‘important goods in life’ (p. 1054), health is a fundamental aspect of well-being, intricately linked to a range of social determinants (World Health Organization, 2008). Social justice-driven interventions seek to empower individuals by ensuring an equitable distribution of benefits and burdens (Gostin & Powers, 2006). However, evidence underscores significant inequalities in resource availability and accessibility, particularly for women experiencing intimate partner violence (Papas, Hollingdrake & Currie, 2023). Additionally, the attitudes, biases, and tendencies to assign blame play a pivotal role in shaping the availability of supportive resources (Murray, Crowe & Overstreet, 2018; Moulding, Buchanan & Wendt, 2015). The mere existence of a service does not guarantee its effectiveness—key factors such as approachability, accessibility, acceptability, affordability, and appropriateness are essential (Levesque, Harris & Russell, 2013). This study reinforces the argument that objective implementation alone is insufficient for those who rely on these services.

“They asked it as... you know, just one of those questions... they don't really look you in the eyes and try to find out and see you” (SU2).

Health visitors acknowledged recent legislative changes but reported minimal shifts in their practices:

“So yes, the law might have changed, but what are we going to do for those children? Mum gets the Freedom programme, a referral to Woman’s Aid, but what do we offer the child?” (HV3).

Both data sets highlight a critical gap in application—whether in meaningful engagement or resource availability. Furthermore, this study raises a pivotal question: Do safe, effective, and person-centered outcomes arise from a proactive commitment to doing good, or are they simply a product of the fear of failure? In other words, is success defined by achieving the right outcome, or by avoiding mistakes?

The women’s testimonies underscored the need for more than professional engagement; they called for genuine, comprehensive support. Health visitors, however, were often constrained by the paternalistic structures of health and prevention frameworks. Both groups face systemic limitations: mothers experiencing DA are frequently subjected to patriarchal systems that limit their agency, while health visitors are primarily guided by the imperative to safeguard children. Recent legislative advancements, such as the Domestic Abuse Act (2021) and the Housing Act (1996), Sections 189 and 193 (Ministry of Housing, Communities & Local Government, 2018), represent important steps toward enhancing support. Additionally, Scotland’s adoption of gendered language in its definitions of DA acknowledges the disproportionate impact on women. However, in England, safeguarding frameworks such as *Working Together to Safeguard*

Children (HM Government, 2018, 2023), *The Laming Report* (2003), and the *Munro Review* (2011) focus predominantly on child welfare, thereby limiting health visitors' scope to address the broader harm experienced by mothers.

Arnull and Stewart (2021) critique the concept of 'mother blame,' highlighting ontological disparities in legal accountability. They argue that while individuals are held criminally responsible for their actions, recent DA policies imply that parents can be held liable for failing to prevent harm, resulting in an 'ontological slippage' (p. 115) that remains largely unexamined. The findings of this study align with this critique, emphasising the gap between what is achievable and what is desired. Addressing this issue requires continued discourse that interrogates and challenges the patriarchal norms that contribute to the shaming and blaming of mothers.

A key implication of this study pertains to the evolution of health visiting practice, particularly in fostering open and progressive discussions free from fear. Findings suggest that current practice is predominantly shaped by fear; therefore, initiating change begins with addressing this foundational concern. Thacker, Penhale, and Anka (2019) encourage practitioners to 'think the unthinkable' in child safeguarding. However, for health visitors, the challenge lies in addressing known risks in cases where child protection thresholds have not been met. This study advocates for a paradigm shift—toward proactive, supportive interventions that extend beyond immediate safeguarding concerns.

Key considerations from the analysis

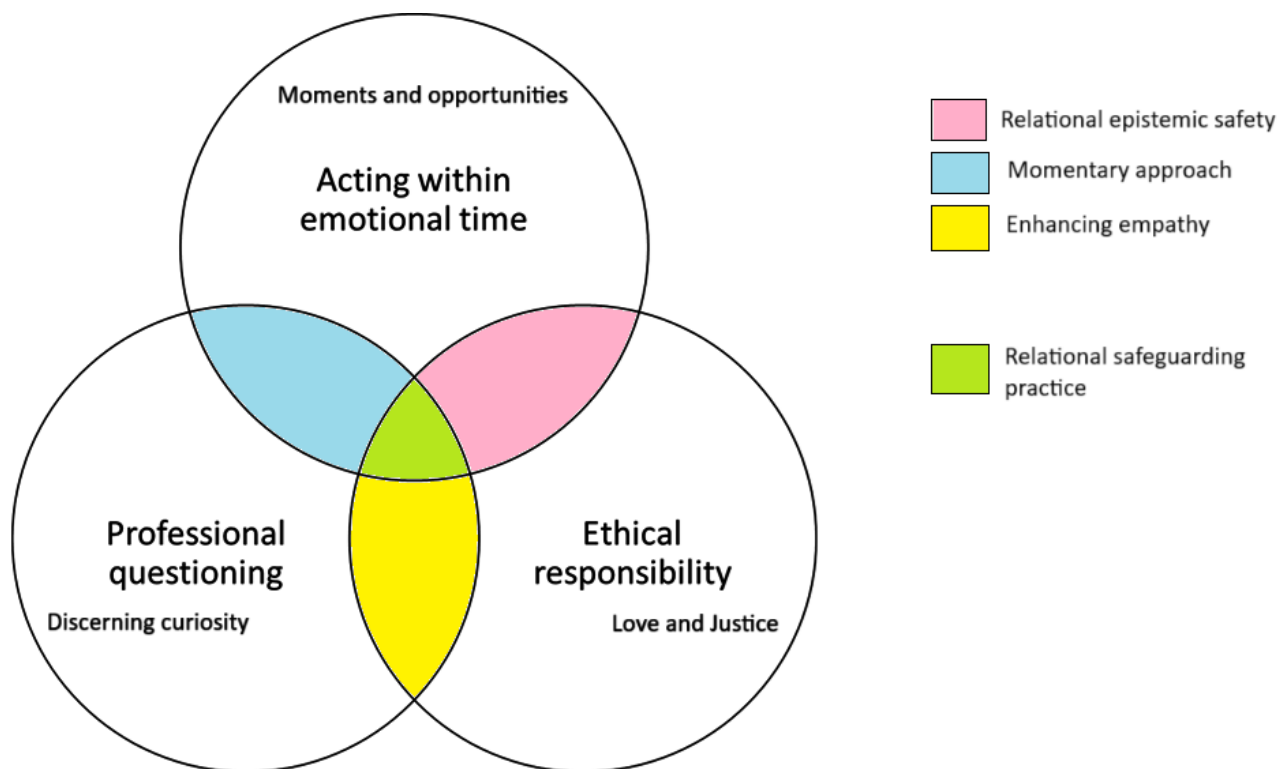


Figure 7.3. Key considerations. This diagram visually represents the three key themes emerging from both the health visitor and mother datasets: Discerning Curiosity, Love and Justice, and Moments and Opportunities.

By mapping these three themes in a Venn diagram, each segment can identify not just their unique characteristics, but also where they intersect. The central overlap reveals the shared essence of all three themes, which helps to formulate a unified, central concept that encompasses all perspectives: relational safeguarding (highlighted in green). This central area represents the convergence of these themes — a practice space grounded in mutual trust, meaning-making, growth, and reflexivity. Each coloured section highlights the contributions

made; The Relational epistemic safety model (Figure 7.4), The momentary approach (Figure 7.9), and the consideration of Enhancing empathy (Figure 7.11).

The diagram emphasises the relational and non-linear nature of safeguarding conversations, illustrating how practitioner enquiry, compassion, and responsiveness interact in real time to support women experiencing DA.

Pertaining to the fluidity between research and practice, the implications will now be explored.

7.4 Theoretical and conceptual implications

Qualitative inquiry has long been established within the literature surrounding health visiting research and child safeguarding. The findings from this study affirm the relevance of theoretical frameworks underpinning reflexive thematic analysis. Reflexivity is central to both health visiting practice and qualitative research, as explored in chapter 3 (figure 3.3 - adapted from Levitt et al., 2017, and the Nursing and Midwifery Council's Standards of Proficiency, 2022).

Previous research exploring perceptions within nursing, and more specifically within health visiting, predominantly employs qualitative methodologies, with thematic analysis being particularly prevalent (Tesfaye & Day, 2015; Brook & Salmon, 2017; Ashford, Ayres, & Olander, 2017; Tandon et al., 2008). This approach is also common in studies examining the perspectives of women experiencing DA (Showalter, Maguire-Jack, & McCloskey, 2022; Moulding, Buchanan, & Wendt, 2015). Additionally, national legislation often incorporates in-depth qualitative analyses to identify key themes that inform and improve practice (Dickens et al., 2022; Brandon et al., 2022; HM Government, 2023). This focus on understanding meaning through personal insight resonates with health visiting practice. The call for greater engagement of health visitors

in research (Baldwin, Jackson, & Gilroy, 2024) highlights the potential for incorporating subjective and reflexive inquiry that enhances the competencies and commitment of health visiting service delivery. Baldwin, Jackson, and Gilroy (2024) argue that research should not merely be an ancillary part of health visiting practice but rather an integral component of professional competency, embedded prior to qualification.

7.4.1 Feminism

Feminism challenges the universality of truth (MacKinnon, 1982), and the *art* of health visiting captures this. Delivering a universal service enables all to receive, however, practitioners understand the subjugated knowledge of motherhood, yet do not claim (as other academics have) that truth is absolute within individual standpoint (Ruddick, 2004). As Ruddick (2004) postulated in their essay on maternal thinking, *“justifications end in the commitments with which they begin.”* (p.165). This study demonstrates the nuance and rejection of dualistic approaches that would fail to recognise the prioritisation of children due to their vulnerability (Ruddick, 2004). The appreciation health visitors and mothers have for the unpredictability of family life in all its guises is clear, the contention however remains in the hierarchy of intention and threshold of risk. With person-valuing held in one hand and child safeguarding in the other, it is here conflict may arise for health visitors. Yet as Kennedy and Kirman (2023) postulate this ideology of separating mother and child may be counterintuitive, as maintaining positive attachment and bonds between the two parties is an effective protective factor to the impact and witnessing of harm (Wendt, Buchanan and Moulding, 2015). This study within the assessment of universal plus support, upholds this stance. Shattering the narratives of mother-

blame, health visitors must position themselves to support mothers as the findings present the essential protective moments undertaken by women to protect and reduce harm.

Where feminism and sociological traditions converge is a focus upon individualised characteristics and interpretations of knowledge (Rouse, 2004). Health visiting practice captures such, whilst driven through the political exosystem, to engage an ecological model of how individuals are shaped by, and in turn shape their environment (Sacannapieco and Carrick, 2005). Concepts of feminism call for a rethink and rejection of patriarchal ways of doing (Danvers, 2018a) and what is said, matters (Hesse-Biber, 2007). The intrinsic link between epistemic undoing captured in figure 7.14 (see below), and feminist standpoint, turns from what is known and has previously been done, and provides those with insight the platform to speak of experience. The theoretical implications of this study conclude that deeper consideration is required within the epistemological and ethical applications of enquiry and wonderment. Health visitors within this study competently recognised their proactive and reactive responses to safeguarding following information sharing, disclosure, or incident. Examining the patriarchal influences on mothers within their ecology enables a holistic examination of individual life that can invoke curiosity and context. Applying a feminist lens to consideration does not silo the mother within the family dynamic but rather, and fundamentally, feminism appreciates the requirement to rethink what has been previously done and consider new ways of conceiving and doing (Spivak, 1978. Gross, 2013).

7.4.2 Epistemic Injustice in Health Visiting and Safeguarding Practice

Epistemic injustice, as defined by Fricker (2007), occurs when individuals are marginalised through the denial of their knowledge or the misinterpretation of their experiences. In nursing, this concept has been explored by Fisher (2024), who emphasises that simply encouraging nurses to listen to patients is insufficient. Healthcare assumptions can disrupt the power dynamics that shape both hermeneutical and testimonial knowledge, further exposing the epistemic injustice (Carel & Kidd, 2017). The experience of testimonial injustice, particularly among women living with DA, creates significant barriers to disclosure (Warman, 2023). Such dynamics are evident in health visiting, especially in the context of child safeguarding. Professional curiosity, and the capacity to think the unthinkable (Thacker, Penhale, & Anka, 2019; Burton & Revell, 2018), is vital in amplifying the voice of the child (Brandon et al., 2020; Dickens et al., 2022). However, an overemphasis on professional interpretation can leave mothers vulnerable to epistemic injustice, rendering their testimonies overlooked or dismissed (Fricker, 2007).

Within safeguarding, the fear surrounding child protection (Littlechild, 2021) often amplifies professional voices, inadvertently sidelining the lived experiences of the mothers. Health visitors must balance the amplification of professional concerns with the recognition of the perspectives of those affected by the situation.

The findings from this study suggest that health visitors are mindful of the mother's voice while maintaining critical curiosity. However, they acknowledge that permitting epistemic injustice is a trade-off made to ensure the child's safety.

"...even if they didn't consent, if I was that worried, I would have to do that referral" (HV8)

The Complex Dynamics of Epistemic Prioritisation in Safeguarding

Health visitors face a complex decision-making process when it comes to processing epistemic claims. The fear surrounding the unknown in cases of DA leads to prioritisation of professional knowledge, even at the expense of the mother's voice. Health visitors are familiar with legislation and multi-agency frameworks but must apply theoretical curiosity to navigate the balance between the known and the unknown (Muirden & Appleton, 2022).

Empathetic awareness is essential in mitigating the unknown. Radical empathy, as defined by Díez-Goñi and Rodríguez-Díez (2017), goes beyond simple care or compassion. It involves critically reflecting on oneself from the perspective of the other, challenging reductive models of medicalisation (Kanagasabai et al. 2024). Within health visiting, this practice allows for a deeper understanding of the complexities of safeguarding, particularly in relation to DA. As Owens et al. (2024) argue, epistemic undoing in safeguarding ensures that professional assumptions do not overshadow the voices of children and mothers. This perspective encourages continuous moments of reflexivity, helping to identify and challenge entrenched assumptions.

Re-thinking Health Visiting Practice: The Need for un-learning

The findings suggest that health visitors may hold certain assumptions shaped by macro-systemic influences. These assumptions often manifest in statements like the following:

"That's what I think. That's what men want, isn't it? They just want that woman to sit at home whilst they go out and get drunk with a mate" (HV11)

"I find that particular women will go and pick the same kind of relationships over and over again, so you know they'll bounce from one domestic abuse relationship to another and you think ohh, when will you learn?" (HV5)

Such assumptions reflect a need for unlearning within health visiting, as described by Owens et al. (2024), who advocate for a "destabilisation of the status quo" (p. 15). The process of unlearning helps health visitors confront their own biases and reconsider preconceived notions about DA and its dynamics.

Figure 7.4. The Relational Epistemic Safety Model

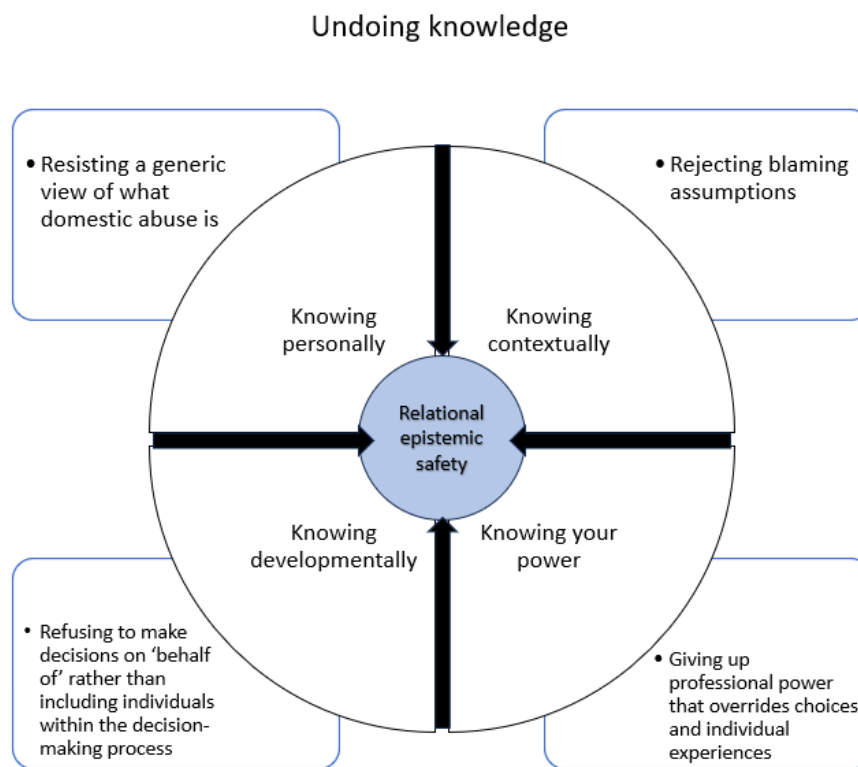


Figure 7.4 presents the "Relational Epistemic Safety Model" (Adapted from Owens, Walker, & Bradbury-Leather, 2024), which proposes a framework for

"undoing knowledge" within practice. The model is divided into four quadrants:

1. **Knowing Personally:** Building trusting relationships with mothers, which resists generic assumptions about DA.

2. **Knowing Contextually:** Rejecting blame-shifting assumptions and recognising the complexity of motherhood.
3. **Knowing Your Power:** Practicing reflexive empathy that acknowledges the power dynamics at play, empowering the individual.
4. **Knowing Developmentally:** Avoiding the infantilisation of mothers by engaging them in decisions that affect their lives, rather than making decisions on their behalf.

Engaging with these quadrants fosters epistemic safety, reduces fear of the unknown, and diminishes the dominance of professional knowledge in safeguarding practice.

7.4.3 Responsibilisation

The issue of responsibility within the context of safeguarding has long been debated within social care academia (Russell et al., 2022; Azzopardi et al., 2018; Wild, 2023; Arnull and Stewart, 2021) and has been explored by both data sets. However, within the health visiting literature, there has been little acknowledgment of such discourse. The concept of responsibilisation has been discussed extensively within criminology (Garland, 1996) and socio-political constructions (Hinds and Grabosky, 2008). Particularly within the context of the neo-liberalisation of countries such as the UK, North America, Australia, and Western Europe, where similar public health interventions are employed, the notion that the state is not solely responsible for the welfare of its individuals has emerged (Garland, 1996; Juhila, Raitakari, and Löfstrand, 2017). Growing literature presents this concept within healthcare, particularly regarding the shift of responsibility onto individuals for their own health. Holding individuals morally responsible for their health outcomes (Brown, 2013) through empowerment enables freedom and agency

(Hibbard and Greene, 2013); however, there are dangers in reframing social problems as individual ones (Ayo, 2012; Lupton, 2012). Wild's (2023) paper specifically addresses the responsibilisation of mothers who are victims of DA, highlighting the pervasive blame and the lack of perpetrator accountability discourse.

Numerous proposals and programmes have been approved by governments to ensure individual accountability through identified need, risk, or vulnerability (e.g., Freedom Programme, Triple P Parenting Programme, perpetrator programmes, mediation). These interventions are arguably understandable within universal public health campaigns that deliver targeted interventions in collaboration with individuals and communities. However, when applied to safeguarding vulnerable groups, including children, the shift of accountability and the reliance on self-identified need or responsibility becomes problematic. Care delivered specifically to mothers often neglects the diverse identities of women (Hanley et al., 2024) and, consequently, overlooks the intersecting factors that shape women's experiences. This study highlights the importance of understanding the concept of responsibilisation within health visiting theory when exploring DA more broadly. Shifting the responsibility for producing healthier outcomes from systems onto individual practitioners encapsulates the essence of responsibilisation and, contributes to the debate about reframing public health issues as individual problems rooted in morality and accountability (Ayo, 2012; Brown, 2013).

The recognition of victimisation and abuse within The Domestic Abuse Act (HM Government, 2021) and the delineation of agency responsibilities within the Working Together to Safeguard Children framework (HM Government, 2018, 2023) reflect the prioritisation of safeguarding in the legislative agenda. However, within practice analysis and critique, issues surrounding the

identification of need and transformative action persist, particularly regarding responsibility and accountability (Brandon et al., 2020; Bywaters et al., 2016; Skinner et al., 2021). This study demonstrates that supportive practice is often undertaken with a primary awareness of child safeguarding concerns. Individual professional decisions are made to mitigate such concerns, resulting in a profound sense of moral responsibility among practitioners. This shift represents the transfer of responsibility from wider systems to street-level practitioners, illuminating the emotional and ethical burden associated with safeguarding practice. Understanding responsibilisation in these terms does not absolve professionals of accountability for unsafe or ineffective practices, but rather contextualises the emotional weight experienced by practitioners.

Figure 7.5. Professional Responsibilisation

This diagram demonstrates the shift of responsibility from wider systems onto individual practitioners when delivering safeguarding support/interventions. Not



diminishing the registrant requirements enforcing safe and effective practice, rather considering the moral and emotional weight experiences by professionals at street-level delivery.

Reflective accounts demonstrate that the responsibility for safeguarding rarely falls on the shoulders of the perpetrator. A striking observation was the intense moral responsibility health visitors felt when supporting families. Their understanding of responsibility appeared deeply

rooted in moral and altruistic values. Perceived vulnerabilities, as identified by health visitors, were often linked to DA risk factors, consistent with social care literature that identifies the co-occurrence of violence, substance misuse, mental health challenges, and safeguarding concerns (Bywaters et al., 2016). Current demographic trends in the UK point to increased vulnerability due to deprivation and poverty (Marmot et al., 2021; Bywaters et al., 2016), highlighting the intersection of socio-economic factors and safeguarding challenges. As Gilson (2021) argues, vulnerability is not confined to specific groups but manifests differently depending on context (Rogers, MacKenzie, and Dodds, 2012). Gilson (2016) suggests that recognising these vulnerabilities fosters responsiveness, which, in this study, translates into health visitors' application of supportive measures.

The concept of “street-level bureaucrats,” as introduced by Lipsky (1980), aptly characterises the work of health visitors (Hughes and Condon, 2016). This framework describes practitioners who wield significant influence over individuals' lives through their intervention work yet simultaneously experience top-down pressures from wider health and political systems (Cuthill and Johnston, 2019). Care, as conceptualised by McLeod (2017), entails a responsibility “beyond the self and towards others” (p. 51). Tronto (2013) further articulates the notion of care as an affirmative responsibility that demands accountability from all members of society, preventing the privileged from abdicating responsibility. Both data sets analysed in this study reveal a conspicuous lack of affirmative responsibility on the part of perpetrators, whose ongoing involvement in parenting arrangements, often facilitated through family courts, further complicates the safeguarding landscape. Health visitors, in response, exhibited a practice of responsibility grounded in solidarity and care for parents and children alike.

Johnson (2003) contends that definitions of agency and self-determination are frequently rooted in liberal, privilege-centric assumptions of free will and independence. Johnson posits that individuals may either yield to or resist external power structures, sometimes achieving personal growth despite these constraints. The women and mothers interviewed for this study described making momentary, situationally informed decisions that prioritised their children. Conversely, health visitors' narratives often framed these decisions as indicative of mothers' passivity or unawareness of abuse, reflecting the professionals' own conceptualisations of free will and agency, which were often influenced by moral judgments. This observation underscores the need for greater awareness among health visitors regarding the complexities of agency, particularly within patriarchal systems that shape policy, culture, and societal norms. Both data sets highlight the systemic barriers women face when attempting to exit abusive situations, revealing a critical area for future professional training and practice development.

7.5 Practical implications for health visiting practice

7.5.1 The art of health visiting

Drawing from nursing scholars, the expressive nature of care within human experience is considered the *art of doing* (Porter, 2010. Weaver, 2021). Moreover, the processes that provide meaning and become transformative are where the art of nursing moves away from the empirical, scientific intervention (Weaver, 2021). The ability to stimulate dignity, autonomy and identity is an art form encouraged within healthcare; to recognise the individual with a past, present, and future (Lupton-Smith, 2023). Notably, the health visitors within this study demonstrated their ability to mold objective requirements into individualised considerations.

For example, when questioned about routine enquiry and terminology used within conversations with mothers, health visitors reflected upon the nuanced understanding of DA, and how specific words could not be universally applied when initiating discussions.

“It's just like asking how you're feeling, you know, asking about a relationship and do you feel safe and your relationship” (HV6)

“So I might say, you know, “how has it affected your relationship with your partner? You know, are you having any fallouts, you having any disagreements with anything?” And if they say, yeah, I'll say, you know, did that happen before? And so I try and then explore, depending on what they say.” (HV8)

What health visitors articulated was their ability to open and invite exploration. What this study demonstrates is that the intention to engage is fueled through an outcome. Health visiting provision is caught between the reductionist lens of medicalisation and the illogical notion of hope.



Figure 7.6. Blurring the boundaries. This diagram illustrates how health visiting is positioned between two opposing forces: the medicalised pursuit of

prevention, driven by fear of ill-health and inequality, and a supportive, empowering approach that promotes individual agency. The practice of health visiting lies in the moment-to-moment navigation between these competing pressures.

What health visitors competently achieve is the ability to centre conversations around the responses provided, maintaining an agency for mothers. The women explored their desire to be heard and seen by professionals regardless of the outcome of perpetration. The early conversations that are pivotal in gaining trust and connection must be led by the mother and begin through her agenda.

7.5.2 Considerations

The discourse within public health, particularly regarding the historical foundations of health visiting, highlights the duality of safeguarding practices: their surveillant nature (Smith & Horne, 2012) and their supportive function in promoting wellbeing and agency (Cuthill & Johnston, 2019). The findings from this study illuminate a dynamic interplay between the wellbeing of those involved—primarily children—and the simultaneous desire for visibility, support, autonomy, and accountability. The data reveal the nuanced interactions between health visitors and mothers, where approaches are perceived as both beneficial and intrusive.

The Visibility Paradox: Addressing DA

The challenge of unrecognised or unaddressed DA exacerbates what this study conceptualises as the 'ladder of disconnection' (Figure 7.7). The narratives of participants underscore that DA impacts not only survivors but also health visitors themselves. While the severity of these impacts may differ, they must be acknowledged in professional practice.

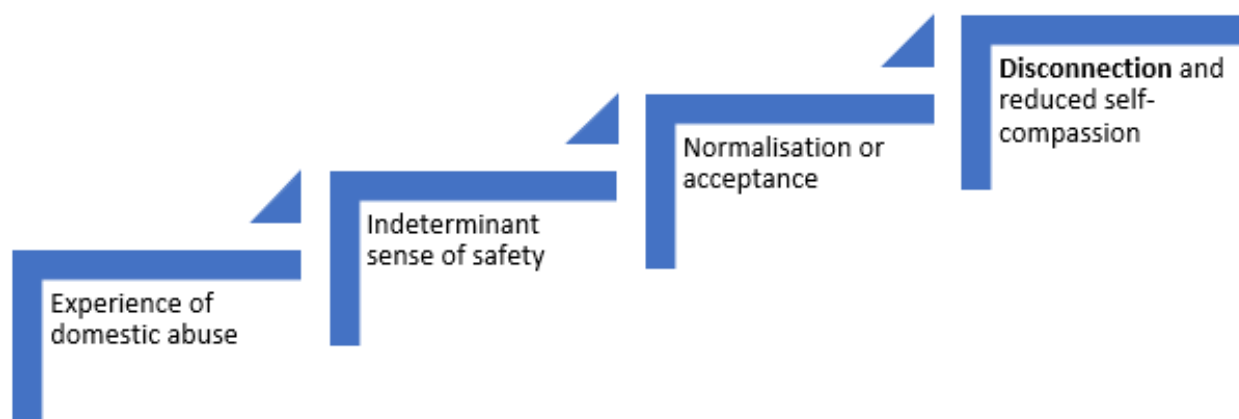


Figure 7.7. Ladder of Disconnection. This diagram represents the escalation of disconnection that can occur for either woman or health visitor.

Both data sets offer poignant insights laden with emotion, revealing a dichotomy of hope and fear regarding DA. Health visitors and mothers alike recognise its profound effects on themselves and, retrospectively, on children.

"...there are some families that you take home with you, and they sleep on the pillow with you..." (HV6)

For health visitors, the primary consideration is to acknowledge these challenges while embedding supportive practices within their professional development. Addressing the factors that lead to professional isolation enables practitioners to manage the weight of responsibility effectively.

The Role of Supervision in Safeguarding

Supervision plays a pivotal role in safeguarding and broader nursing practice. The data emphasise that a sense of belonging is fostered through meaningful interactions. While formal supervision is crucial, the challenge lies in ensuring its accessibility for every supportive encounter. A structured self-reflective tool (Figure 7.8) could facilitate this process, providing a framework for both individual and peer supervision.

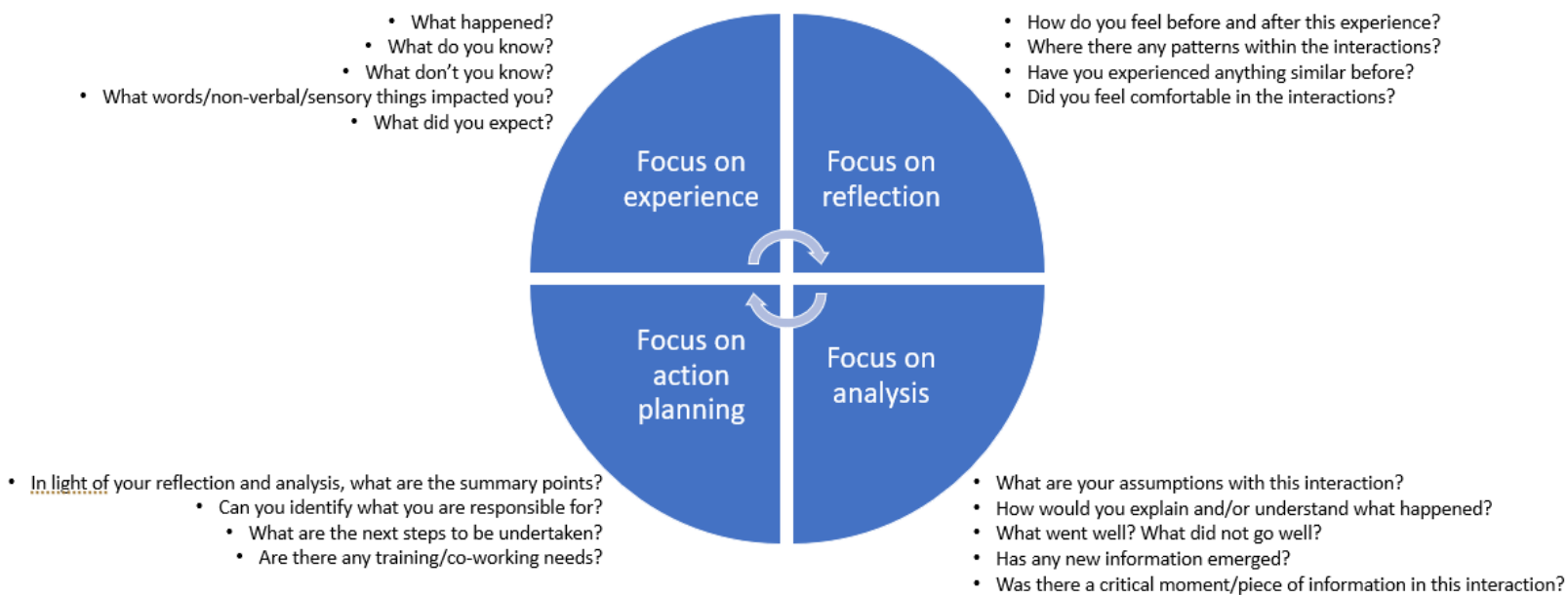


Figure 7.8. Focus on Practitioner Reflections

Navigating Guidance, Policy, and Professional Autonomy

The necessity of paternalistic guidance in health visiting is twofold: ensuring accountability to professional registration requirements, and mitigating isolation in decision-making. However, guidance and policy are historically and culturally contingent, requiring a critical approach to their application. Kass (2001) warned against public health initiatives that compromise

individual liberty under the guise of collective good. Similarly, Gostin and Powers (2006) argued that justice should drive public health efforts, particularly in addressing societal disadvantages.

Cuthill and Johnston (2019) identified discrepancies in policy regarding public health interventions in DA cases. This study corroborates their findings, illustrating how health visitors employ individualised strategies that often deviate from prescriptive guidance. These adaptations are influenced by perceived risks to both their safety and that of others.

Interestingly, health visitors find reassurance in policy guidance within clinical environments, where interventions align with medicalised objectives (Cuthill & Johnston, 2019). This study underscores the autonomy health visitors exercise in practice, advocating for reflexive toolkits that facilitate critical thinking rather than enforcing rigid protocols.

Integrating Lived Experience into Systematic Processes

The convergence of health visitors' and mothers' perspectives underscores the need for co-creative progress in public health initiatives. While patient voices are increasingly valued in healthcare decision-making (Liabo et al., 2022), marginalised groups remain underrepresented (Gostin & Powers, 2006; Hollingdrake et al., 2023). Currently, most guidance is formulated by professional bodies and experts; however, within health visiting, greater emphasis must be placed on localised, experience-based insights.

Health visiting interventions traditionally follow a linear model, particularly in risk assessment. However, this study suggests that empowering and fostering healthy connections—rather than adhering strictly to threshold-based interventions—could be a more effective approach. Byrne, Happell, and Reid-Searl (2016) argue that mistrust and labeling within interventions can be

counterproductive, particularly in cases where significant harm is not imminent. The findings indicate that building relationships founded on equality and connection reduces power imbalances, thereby fostering a greater sense of belonging and engagement.

The Momentary Approach to Health Visiting

The complexity of health visiting practice often results in tensions between child-centered, mother-centered, and family-centered approaches. The proposed Momentary Approach (Figure 7.9) integrates intersectional and ecological perspectives, aligning with contemporary recommendations in contextual safeguarding (Phillips et al., 2024; Thacker et al., 2019; Muirden & Appleton, 2022). This model encapsulates past, present, and future insights, providing a structured yet flexible framework for health visitors.

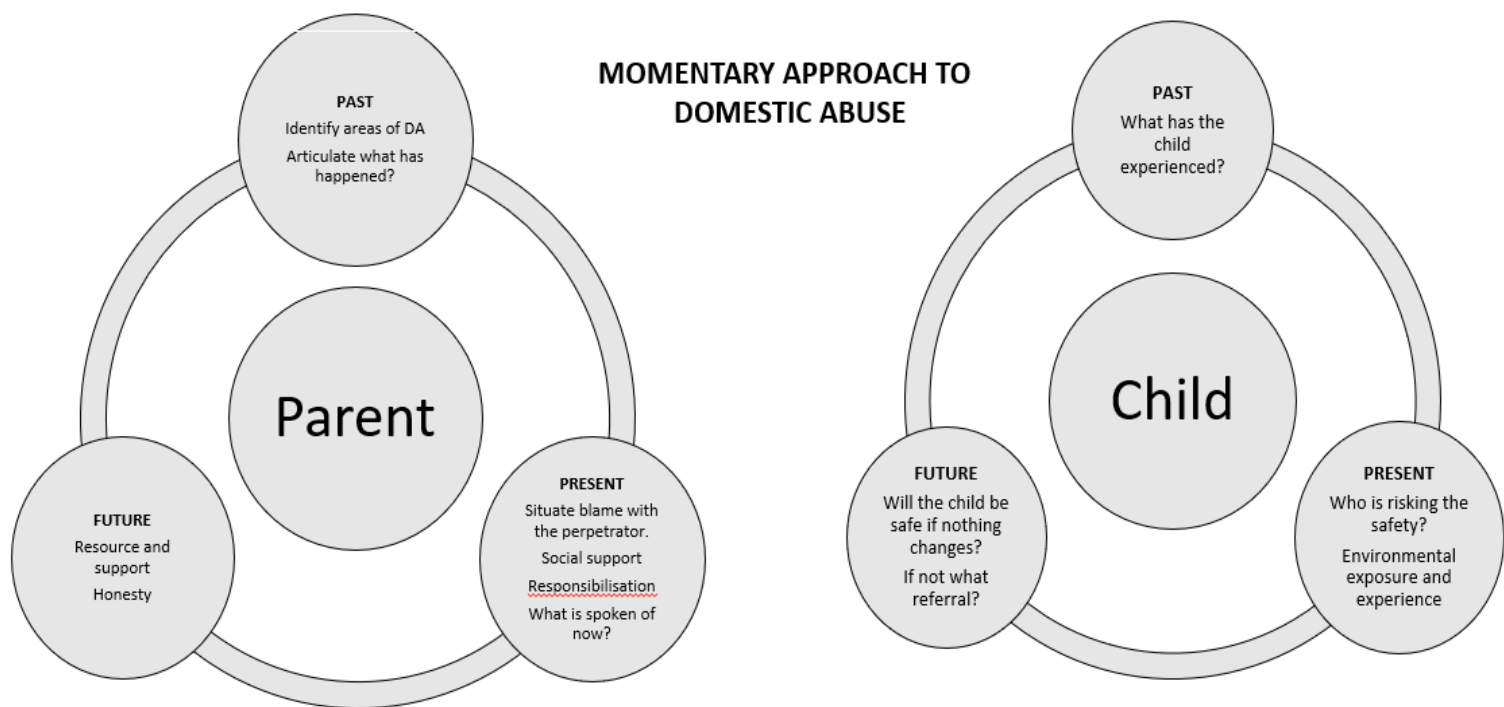
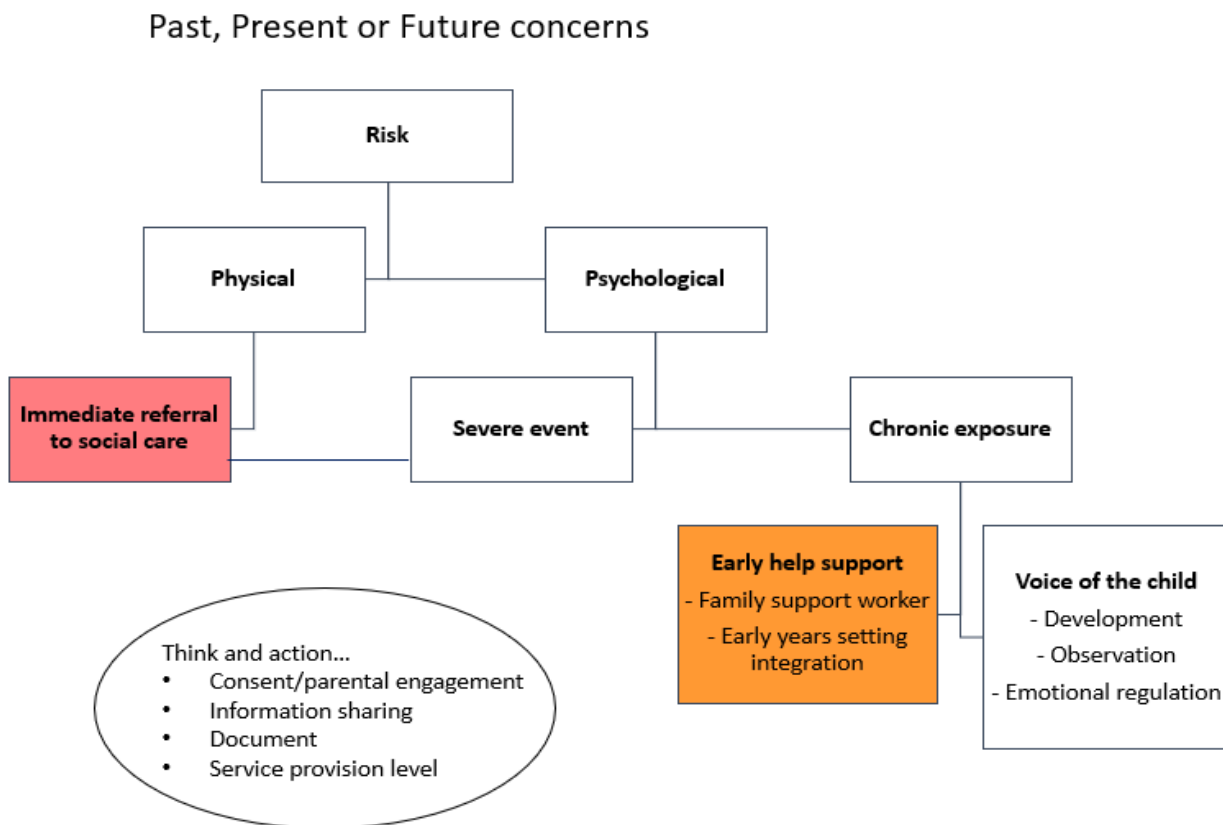


Figure 7.9. Momentary Approach to Working with Families Experiencing DA

From Intervention to Empowerment

This study highlights the nuances of DA support, recognising the effectiveness of individualised, continuous engagement by health professionals (Nell, 2021). Health visitors' decisions to refer cases often stem from professional accountability rather than an expectation of intervention. Importantly, referrals serve to highlight the unacceptability of abusive behaviour rather than guaranteeing immediate action.

Figure 7.10. Safety Pathway of Past, Present, and Future Concerns



The study advocates for a Safety Pathway (Figure 7.10), which operates parallel to safeguarding measures. This dual approach balances risk mitigation with empowerment, reinforcing professional obligations while fostering autonomy for survivors.

The Role of Self-Transcendence in Professional Practice

Rooted in the wellbeing-environment paradigm, Reed's (2014) Self-Transcendence Theory is highly applicable to health visiting. This study extends prior research on self-transcendence in nursing (Haugan, 2014; Hwang et al., 2013), emphasising that individuals are integral to their environment and central to meaning-making. Collaborative practice in health visiting necessitates recognising families within their community, culture, and history (Cowley & Frost, 2006; Cowley et al., 2013; Fanner, Whittaker & Cowley, 2022).

The study also underscores the transformative potential of life-threatening experiences. As Reed (2014) and Haugan (2014) demonstrated in elderly care settings, such experiences broaden awareness and understanding. Similarly, women who recognise their abusive relationships develop nuanced perceptions of their children's experiences. By embracing holistic health frameworks, health visitors can foster well-being through connection and meaning-making.

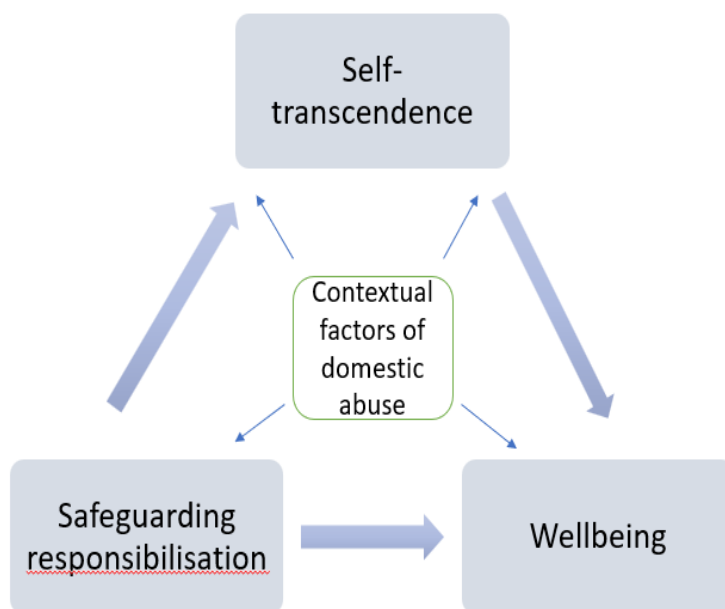


Figure 7.11. Enhancing Empathy

Adapted from Reed's (2014) Model of Transcendence, this framework illustrates how safeguarding responsibilities heighten emotional vulnerability while simultaneously deepening empathy and connection.

In the context of DA, prioritising child welfare shapes the lived experiences of both mothers and health visitors. Recognising each party's protective efforts fosters greater self-transcendence and well-being. By embedding self-regulation, hope, and citizenship into professional practice, health visitors can cultivate empowerment (Wolf & Jonker, 2020; van Tol et al., 2023). This study emphasises the need to shift from intervention-focused approaches to strategies that tackle, rather than simply 'fix,' the complexities of lived experience.

Rooted within a developmental perspective of the wellbeing-environment paradigm of health, is transcendence theory within nursing. As Reed (2014) implicates, transcendence theory encapsulates the conflicting elements of life; development, behaviour-change, and health, and challenges pre-conceived boundaries of intervention and self-care. This study supports the work previously undertaken within the area of self-transcendence (Haugan, 2014. Hwang et al. 2013) and does so by upholding the two key assumptions; that humans are integral to their environment and are central to the development of meaning-making and understanding.

Working collaboratively with an individual and family, is to recognise them within their community, culture and history; to which the proficiencies, and core principles of health visiting wholeheartedly embrace such (Cowley and Frost, 2006. Cowley et al. 2013. Fanner, Whittaker and Cowley, 2022). The latter assumption, the development of meaning-making, is embedded in the transitional experiences of parenting and safeguarding. It helps to explain how support is tailored to those most vulnerable at various stages of life. Embracing self-transcendence connects, rather than separates us from ourselves, others, and the environment (Reed, 2014).

Understanding much of the narratives relating to support, whether seen through the experience of health visitors working with mothers and families, or through the mother's

standpoint of insight into parenting and responsabilisation, fundamentally acknowledge that there is no finite solution. Rather than seeking the absolute, perspectives unpicked a mature form of reasoning; to seek meaning. Reed (2014) and Haugan's (2014) work (examined through elderly life experiences within nursing homes) translates into the themes illustrated within this study; that life-threatening experiences expand our awareness of environment and the self (Reed, 2014). Such was beautifully articulated by the women who recognised themselves within the abusive relationships, and could carefully mitigate, or shield the perceptions of their child's experience. Furthermore, understanding the concept of wellbeing, and that of the broader engagement of holistic health, grasps the diversity of fulfillment, self-perception, and experiential meaning.

Voice of the child

The findings from this study highlight the overwhelming prioritisation of children across both data sets. However, what warrants further discussion is the nuanced ways in which this prioritisation becomes evident for health visitors and mothers, particularly in moments of conflict and agreement. This aligns with the work of Powell et al. (2022), who identified child emotional health and wellbeing as core outcome priorities for both service users and professionals in the context of DA.

Health visitors centralise children in their decision-making processes, demonstrating continuous assessment and curiosity about the child's experiences. A striking aspect of this study is how health visitors perceive children as inherently situated within their mother's world, regardless of the family's overall approach.

During interviews, health visitors acknowledged the difficulty of discussing the perceived impact of DA on children with mothers. They described these conversations as challenging due to mothers' tendencies to minimise or fail to recognise the extent of the impact. However, mothers interviewed in this study expressed acute awareness of the impact on their children, positioning it as their primary concern. The assumption that women who remain with abusive partners are failing as mothers (Stewart & Arnull, 2021) remains implicit in health visiting practices. However, the findings of this study align with the work of Hauge and Kiamanesh (2020), who found that women actively recognised abusive behaviors and employed strategies to shield their children from fear, rather than denying their awareness. Similarly, Buchanan, Power, and Verity (2013) observed that mothers' protective instincts often manifest subtly. Mothers in this study described their protective efforts as emerging at critical moments when abuse could no longer be mitigated by their actions alone.

Interestingly, health visitors' perception of maternal ambivalence regarding children's experiences of abuse may, in fact, reflect a protective mechanism on the part of mothers (Haight et al., 2017). This study suggests that what is interpreted as maternal disengagement may be a strategic, albeit unrecognised, response to minimise harm to their children.

Emotion and dissonance

The emotional toll of working with families experiencing DA has been extensively examined in previous literature (Bradbury-Jones et al., 2014; Taylor et al., 2013). These studies acknowledged the difficulty of initiating conversations about abuse but overwhelmingly found that women were receptive to being asked. The current study builds on these findings,

revealing that health visitors felt comfortable with routine inquiry and confident in their role in addressing these issues.

A notable shift identified in this study is the internalisation of emotional labour among health visitors. Unlike previous research that emphasised fears about "opening a can of worms" (Taylor et al. 2013. Bradbury-Jones et al. 2014), this study indicates that such concerns have diminished. Instead, emotional labour is now primarily directed inward, with health visitors experiencing greater self-doubt about their own emotional responses rather than fearing the reactions of mothers.

Throughout this study, conflicting perspectives and perceptions of support emerged across both data sets. However, dissonance was not confined to one group; rather, it permeated all transcripts.

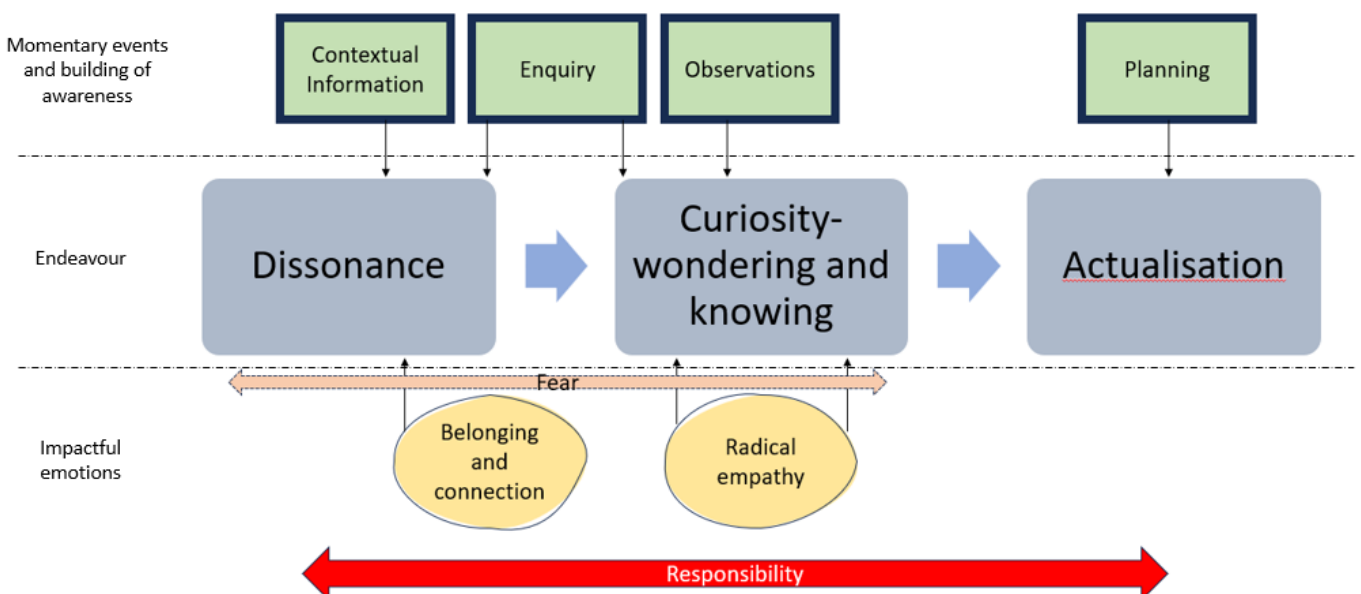


Figure 7.12. Proactivity and activity in health visiting.

Figure 7.12 illustrates the practical implications of health visiting proactivity and activity. This diagram represents the middle stages of dissonance, curiosity, and actualisation, which are shaped by structured opportunities for information gathering, inquiry, observation, and planning. The lower section of the diagram captures the emotional responses health visitors experience. Their perceptions of DA, biases, and stereotypes influence their ability to connect with women and practice radical empathy.

Fluctuating levels of fear intersect with expressions of solidarity, while belonging and empathy serve as counterbalances. This figure is valuable as it does not present a fixed goal but rather underscores the evolving process of actualisation, which is uniquely shaped by contextual factors. By navigating this process, health visitors can develop structured plans to fulfill their safeguarding responsibilities while mitigating emotional barriers.

The Power of Conversation

At first glance, the importance of conversation may seem self-evident. However, within the constraints of a medicalised approach, meaningful dialogue often lacks immediacy and impact. It is imperative that health visiting services recognise the fundamental role of supportive interactions in fostering healthier outcomes.

In the current socio-economic climate, where resources are limited and instability persist, targeted interventions aimed at protecting vulnerable individuals, particularly children, offer cost-effective and timely solutions (Marmot, 2020). The findings of this study emphasise the irreplaceable value of supportive conversations in facilitating change. Achieving this requires consistency and autonomy within the workforce.

Expanding service models in devolved nations may seem like a viable solution to increase contact points, but recruitment and retention challenges pose significant barriers. Instead, a duty-level commitment is necessary to ensure caseload families receive sustained support, allowing relationships and connections to develop. Health visitors in this study debated whether DA should be considered a health issue, yet global health organisations, including the World Health Organization (2024), classify gender-based and intimate partner violence as public health priorities. Extensive research also establishes the profound physical, emotional, and psychological consequences of DA for both mothers and children (NSPCC, 2021; Orr et al., 2023; Peckover & Golding, 2017; Lazenbatt, 2010). Leadership within health visiting must embrace principles of social justice, health creation, and person-centered care to justify a contextualised, momentary approach to addressing DA (see above, Figure 7.9).

A significant insight from this study is the evolving role of conversations in meaning-making. Interviews with mothers who had experienced DA, particularly those who had accessed specialist services, revealed that decisions to leave or seek support were often influenced by their ability to manage abusive behaviors and their impact on their children. Both data sets indicate that questions about relationships and DA often elicited ambiguous or fictional responses intended to downplay concerns and minimise further inquiry.

Previous studies have found that routine inquiry rarely leads to direct disclosure (Lazenbatt, Taylor, & Cree, 2006; O'Reilly, Beale, & Gillies, 2010). This raises the question: What is the purpose of asking? The findings of this study suggest that even when responses are not entirely truthful, they still provide valuable insights. The fictionalised narratives women present about their relationships reflect their reality at that moment. Conversations that allow women to

verbalise these depictions may empower them to navigate abusive situations and make incremental changes over time.

As service user autonomy becomes increasingly prioritised in healthcare (Veenka & Paan, 2016), and self-management gains prominence (Huber et al., 2011), understanding expectations and desires in relationships is essential. For many women, the normalisation of their relationships—whether through cultural expectations or survival adaptations—can obscure alternative possibilities. The role of health visitors extends beyond providing immediate support; they must also create moments of hope and proactive engagement to facilitate long-term, health-enhancing change (Cowley & Frost, 2006; Cowley, Whittaker, & Fanner, 2022). Conversations should be approached with the understanding that change is often gradual and may not be immediately apparent to those initiating the process.

Support Within the Moment

Understanding the role of health visitors and the rationale behind their interventions is critical to delivering meaningful care. However, this study highlights an ongoing ambiguity surrounding their positioning. The evolving philosophical discourse on DA, which considers experience, social construction, and language, suggests that current practices may continue to shift in the future. As such, it is impossible to fully anticipate the changes that lie ahead.

Embracing the unknown may be the most viable solution for fostering both intimate interactions between health visitors and mothers and broader professional practice. However, as the findings demonstrate, fear remains deeply ingrained in uncertainty. This fear serves as a significant barrier to progress. The conclusions of this study reinforce the importance of

engaging fully in the present moment, allowing for meaningful connections and sustainable change

7.6 Comparison with Previous Literature

The last systematic review exploring health visitors' and mothers' perceptions of DA found that participants considered DA to be rare and predominantly physical in nature (Eynon et al., 2012).

In contrast, the findings of this study reveal the prevalence of DA irrespective of demographic or contributing factors. This shift likely reflects increased societal awareness and a broader discourse surrounding violence against women. Both data sets acknowledge the persistent and pervasive nature of DA within households, reinforcing its recognition as a common issue in practice.

Previous literature has explored the themes of shame and blame experienced by mothers and women subjected to DA, particularly within the context of child protection (Douglas & Walsh, 2010). This study found that mothers reported a sense of empowerment following specific support or interventions. While retrospective self-blame was evident in their narratives, there was also a strong undercurrent of optimism regarding the support received and subsequent outcomes.

This study corroborates existing evidence suggesting that women often disclose abuse only when the situation becomes unmanageable or reaches a crisis point (Peckover, 1998; Eynon et al., 2012). Furthermore, concerns regarding credibility and the fear of not being believed frequently deter women from voluntary disclosure (Warman, 2023). However, research suggests that many women are receptive to being asked about their experiences (Trevillion et

al., 2014; Bacchus, Mezey & Bewley, 2002; Salmon, Baird & White, 2015). The narratives presented in this study highlight mothers' agency and resilience in managing abuse and risk within their homes, often over extended periods. Disclosure tended to occur when the level of risk escalated, particularly when children became directly affected. This heightened awareness of child safeguarding aligns with findings from Crawford, Liebling-Kalifani & Hill (2009) and Moulding, Buchanan & Wendt (2015), who emphasise maternal protectiveness.

7.7 Limitations

This study was conducted as part of a PhD thesis. Acknowledging study limitations is a crucial component of rigorous academic analysis, providing transparency regarding potential weaknesses while informing future research directions (Puhan et al., 2012). Recognising and reflecting on methodological constraints enhances the credibility and applicability of findings (Puhan et al., 2012). From the outset, certain unavoidable limitations were present in the study design; however, steps were taken to mitigate their impact.

As a novice researcher undertaking primary research, my limited experience in research methodologies was an inherent challenge. However, professional development opportunities over the course of the study enhanced my understanding. The iterative nature of the research process necessitated continuous learning and adaptation. The guidance and supervision provided by academic advisors, along with peer support, were invaluable in refining the study's design and execution. Formal and informal supervision facilitated a structured system of reflection, though, as a lone researcher, the absence of co-authorship presented additional challenges.

7.7.1 Unanticipated Issues

The reflexive nature of this study provided continuous opportunities for contemplation and professional growth. A key component of this process was maintaining a research journal to document barriers, limitations, and emerging ethical considerations. Feminist scholars have critiqued traditional academic hierarchies, and the epistemic power embedded in research processes (hooks, 1994; Hill-Collins, 2000). By resisting rigid knowledge acquisition binaries (Lather, 2006), this study embraced a “research assemblage” approach (Franklin-Phipps, 2017, p. 19), navigating challenges through reflexivity and adaptability. The overlap between creativity in health visiting practice and reflective research processes became evident as the study evolved.

A significant constraint in this research was time pressure, both internal and external, to complete the study within the designated PhD timeframe. While an extended study period could have yielded deeper insights, the temporal boundaries were accounted for in the study’s design. The application of reflexive thematic analysis through narrative interviews posed challenges regarding data saturation (Braun & Clarke, 2022). However, methodological precedents justified the chosen recruitment numbers (Endacott, 2005). While further data collection could enhance understanding (Mason, 2010), this study acknowledges its limitations while appreciating the boundaries inherent in qualitative research.

Recruitment of mothers emerged as an unanticipated challenge. To build trust and familiarity, I engaged with peer support groups and domestic abuse refuges, establishing relationships with key stakeholders prior to recruitment. Despite these efforts, well-documented barriers to

service access for abused women (Sylaska & Edwards, 2013) also manifested in research participation (Kozicol-McLain et al., 2016). Ethical protocols, while essential, presented additional complexities in recruiting vulnerable participants (Btoush & Campbell, 2009). Although some scholars argue that ethical safeguards may inadvertently hinder participation (Bredal et al., 2024; Salter, 2012), these measures remain integral to ensuring research integrity and participant safety. Ultimately, despite trust-building efforts, some women hesitated to share their experiences, reinforcing the importance of ethically sensitive research methodologies. Reflexive journaling provided a critical tool for processing these challenges and ensuring ethical rigor throughout the study.

7.7.2 Mitigation Strategies

To facilitate recruitment and establish rapport with potential participants, the following strategies were implemented:

- Engaging with refuge managers and workshop facilitators to discuss the study and assess participant suitability.
- Attending intervention groups to observe content and interact with service users.
- Participating in peer group sessions at refuges, engaging in informal conversations, and assisting with social activities.
- Supporting intervention groups by offering baby massage sessions.
- Providing study information to women residing in refuges and intervention program participants.

- Collaborating with facilitators and refuge managers to disseminate study information.

7.8 Concluding thoughts

The approach adopted in this study is a bottom-up exploration of lived experiences. This methodological stance does not seek to supplant existing literature on theories of domestic abuse, coercive control, or the philosophical underpinnings of health visiting. Rather than aiming for a groundbreaking revelation that transforms practice or policy, this research instead illuminates the realities of service provision as experienced daily by health visitors and mothers.

Thematic analysis of interviews with health visitors and mothers reveals a persistent tension between theoretical frameworks and their practical application. There exists a discernible misalignment between conceptual understanding and practical execution, often rendering decision-making unpredictable. A fundamental starting point for bridging this gap is the recognition that neither health visitors nor mothers possess absolute knowledge. Both groups consistently prioritise the welfare of the child(ren). Acknowledging this shared priority—rather than scrutinising it—facilitates more cohesive and impactful conversations. However, the findings indicate that when health visitors question mothers' ability to recognise and respond to their child's needs within the domestic abuse context, progress in conversations can be impeded.

Health visitors expressed confidence in discussing DA with mothers and demonstrated an awareness of the multifaceted challenges that contemporary families face. Women reported varying levels of support from health visitors, with notable inconsistencies in the perceived continuity and quality of assistance provided. Health visitors appear to have benefited from the

increased emphasis on public health concerns and recent policy and regulatory updates, including the Nursing and Midwifery Council (NMC) Specialist Community Public Health Nursing (SCPHN) proficiencies (2022), the Domestic Abuse Act (2021), and the updated *Working Together to Safeguard Children* guidance (2023). These developments have strengthened their ability to address adult relationship concerns, mitigating previous barriers such as lack of confidence and uncertainty in intervention planning. However, workforce reductions and the redistribution of responsibilities to multi-disciplinary team members have led to inconsistencies in service provision.

There is a pressing need for clarity in the direction of health visiting services. However, clarity does not necessarily equate to rigidity in practice. As DA experiences illustrate, truth and meaning are often fluid, shaped by momentary contexts. The future trajectory of health visiting must embrace this complexity. Practice confined to strictly objectifiable definitions is insufficient. Rather than requiring rebranding or additional responsibilities, health visiting necessitates a recalibration—one that tempers authoritative voices in favor of acknowledging the profession's existing capability and competency. The inherent dynamism of the role should be recognised and valued.

This study underscores the pivotal role of health visitors in supporting mothers experiencing DA while also identifying systemic, professional, and societal barriers that hinder their effectiveness. Strengthening training programs, considering the application of routine enquiry, fostering multi-agency collaboration, and integrating trauma-informed approaches are essential steps toward enhancing service responsiveness. Addressing the structural inequalities that underline DA is equally critical for fostering a more equitable and effective healthcare system.

Through these efforts, health visitors can be better equipped to provide meaningful and impactful support, ultimately improving outcomes for families affected by DA.

Chapter 8 - Conclusion

This thesis set out to explore the complex interplay between health visitors and mothers experiencing DA through a feminist, reflexive lens. In doing so, it aimed to illuminate the nuanced, often invisible work of health visitors, and the lived realities of women navigating support systems while enduring intimate partner violence. By bringing together both professional and maternal perspectives, this research contributes a multifaceted understanding of DA in the context of universal health visiting services in the UK.

At the heart of this study is the recognition that DA is not merely a private issue—it is a public health crisis, a gendered phenomenon, and a relational experience deeply intertwined with structures of power, care, and social justice. The central themes identified—*Discerning Curiosity, Love and Justice*, and *Moments and Opportunities*—serve not only as analytical frameworks but also as conceptual tools through which the dynamics of support and resistance were meaningfully articulated. Health visiting, as revealed through this study, is both an art and a science—a relational practice rooted in professional knowledge but also in human connection. The concept of *Discerning Curiosity* captures how health visitors navigate the uncertainty inherent in assessing, identifying, and responding to DA. This curiosity is not invasive but intentional, shaped by the desire to understand rather than interrogate. For mothers, the receptiveness of this inquiry determined the extent to which they felt safe, seen, and validated. Relational inquiry must be cultivated and sustained, not assumed. It is not merely about asking the question, but about asking it well—timed with empathy and attuned to readiness.

Love and Justice, a theme steeped in feminist ethics of care, was evident in the everyday decisions and emotional labour health visitors undertake. Love, in this context, is not romantic but radical—a commitment to dignity, empathy, and relational accountability. Justice, as experienced by women, is not just about legal protection but about being heard, believed, and supported without blame. This study contributes to feminist care theory by illustrating how the intersection of love and justice shapes safer, more empowering spaces for disclosure and action.

Moments and Opportunities further emphasise the importance of timing, context, and professional responsiveness. Health visiting is a practice marked by fleeting opportunities—doorway conversations, pram-side disclosures, and whispered truths amidst routine visits. For women, these moments can represent a turning point, a rare window in which safety becomes imaginable. The implications for practice are profound: support must not only be offered, but offered at the right time, in the right way, by the right person.

The contributions to knowledge will now be identified.

8.1 Contributions to knowledge

8.1.1 Theoretical and Conceptual Contributions

- The study reinforces the significance of reflexivity in health visiting and qualitative research. It advocates for integrating reflexive thematic analysis into health visiting practice, emphasising its role in professional competency.
- The research applies feminist theory to challenge traditional narratives of maternal blame and instead highlights the protective role of mothers. The study fundamentally

challenges the professional assumption that mothers experiencing DA are unaware of their abuse or are passive in addressing it. Instead, the data strongly suggest that mothers possess an acute awareness of the abuse and actively develop protective strategies to safeguard themselves and their children; Their apparent silence or minimisation is frequently a *strategic* decision rather than ignorance.

- The study identifies how epistemic injustice affects health visiting, particularly in DA cases. It shows that mothers' experiences are often dismissed in favour of professional interpretations, reinforcing systemic power imbalances.

8.1.2 Practical Contributions to Health Visiting

- This study highlights the challenge of prioritisation in safeguarding, and how decisions made are influenced by fear driven through professional obligation and policy.
- The study emphasises the need for health visitors to unlearn biases about DA and mothering, advocating for a shift from judgment to understanding; The relational epistemic safety model works through this process.
- The study also identifies the issue of responsabilisation with context: it highlights the burden of child protection on the mother, but also adds an additional layer placed on the health visitor as a so-called street level practitioner, reinforced by a sense of deep moral and emotional weight held. A concept critically examined throughout, highlights how neoliberal agendas have shifted the burden of safety and change onto individual women and practitioners. Health visitors, while committed and capable, often work

within under-resourced systems that expect them to shoulder disproportionate responsibility without adequate support.

8.1.3 Methodological Contributions

- The study introduces the Momentary Approach, which integrates intersectional and ecological perspectives to explore DA cases.
- Drawing from nursing scholarship, the study applies Self-Transcendence Theory to demonstrate how health visitors and mothers navigate emotional and transformative experiences within safeguarding practice.
- The study reframes conversations in health visiting as a therapeutic tool rather than just a method for risk assessment. It highlights how dialogue helps mothers process experiences and move toward change.

8.1.4 Policy and Systemic Implications

- The study argues that DA should be recognised as a public health issue and integrated into health visiting strategies beyond just safeguarding frameworks.
- The study acknowledges the emotional burden carried by health visitors, advocating for better supervision structures and frameworks to support professionals rather than one-off events focused on case management.
- The study calls for a co-creative approach where mothers' lived experiences are used to inform policy and practice, rather than relying solely on professional and legal perspectives.

8.2 Implications for Practice and Policy

The findings point to several critical implications for practice. First, health visitor training must extend beyond procedural enquiry to include reflective and relational approaches that support safe conversations. Trauma-informed practices, embedded within feminist ethics of care, should become a foundational element of professional development.

Second, supervision and emotional support for health visitors must be prioritised. The emotional toll of working with DA is significant, and without reflective spaces for processing this work, professionals risk burnout, desensitisation, or disengagement. Organisational cultures must shift to recognise relational labour as professional expertise, not ancillary work.

Third, universal services must retain their commitment to equity and access. As this study reveals, universal provision holds the potential for early identification and support, but only when practitioners have the time and resources to build meaningful relationships. Policy directives that focus narrowly on safeguarding thresholds risk missing the broader relational opportunities where real change begins.

From a policy perspective, there is a need for frameworks that centre relational safety as a core outcome—valuing the emotional and psychological dimensions of support alongside physical protection. Additionally, policies must acknowledge the intersecting oppressions that shape women’s experiences of abuse—poverty, racism, immigration status, disability—and tailor interventions accordingly. A one-size-fits-all model not only fails to protect but actively harms.

8.3 Limitations and Areas for Further Research

This study builds upon existing literature on health visiting and DA. As demonstrated in the literature review, research on DA support continues to evolve, intersecting with broader discussions on gender-based violence. Bradbury-Jones & Keeling (2020) emphasise the need to shift focus toward preventative strategies, a perspective echoed in this study's findings.

Methodologically, acknowledging diverse philosophical approaches is crucial when exploring DA in its broader societal and legislative context. Ongoing policy discussions on child safeguarding and DA legislation further highlight the relevance of this research area.

Health visiting practice within DA contexts has been explored in prior literature (Eynon et al., 2012; McFeely, 2016; Litherland, 2012; Bradbury-Jones, Appleton & Watts, 2016; Cuthill & Johnston, 2019). However, future research must integrate multiple methodologies that capture both practitioner and service user perspectives. A pragmatic mixed-methods approach would enhance data synergy and analytical depth (Bradbury-Jones & Keeling, 2020). The findings of this study underscore that DA is multifaceted, requiring a nuanced and holistic research approach.

As with any research, this study has its limitations. The sample, while rich and diverse in its narratives, represents a specific context of practice within the UK. Perspectives from fathers, same-sex partners, or health visitors working in differing legislative frameworks were not explored. Future research should aim to expand these perspectives, particularly considering how intersectional identities shape both professional responses and personal experiences of DA.

Additionally, longitudinal research is needed to understand the long-term impact of health visitor interventions on safety, wellbeing, and family resilience. As well as this, the experiences of health visitors working in diverse geographic and socio-economic settings. While this study illuminated moments and meanings within a specific time frame, future work should track outcomes across months and years to assess the sustainability of support.

Another area worthy of exploration is the role of organisational leadership and culture in shaping frontline practice. Health visitors do not work in isolation; they operate within institutional structures that either support or constrain their ability to act. Understanding how leadership can enable relational, feminist-informed practice is crucial.

8.4 Final Reflections

This thesis began with a commitment to hearing the stories that often go unheard—the quiet strength of women surviving violence, the quiet diligence of professionals trying to help. What has emerged is not a story of broken systems or broken people, but of resilience, relationship, and resistance. The conversations analysed were not just about DA—they were about humanity. About listening and being listened to. About building trust, slowly, and sometimes lost quickly. About moments that mattered, and opportunities that were taken—or missed.

In bringing the voices of health visitors and mothers into conversation, this research has offered a fuller picture of what support can and should look like. Not perfect. Not always possible. But deeply human. As health visiting continues to evolve in an uncertain political and economic landscape, let it not forget that at its core lies connection—the quiet revolution of care in action.

This conclusion does not offer closure but continuity. The work is not done. The conversations must continue.

See saw of conversations

She opens the door with a trembling hand, A mother lost in shifting sand.

Her voice a whisper, faint and low, A story of pain she dares not show.

A health visitor sits, eyes filled with care. Bound by duty, yet caught unaware.

A script to follow, lines to trace. But fear lingers in this fragile space.

Routine questions, rehearsed and light, Mask the weight of silent fights.

Bruises hidden, tears concealed, Yet in her eyes, the truth's revealed.

A home once warm, now wrapped in dread. Where love is twisted, fear is fed.

A partner's words like chains so tight, No way to flee, no will to fight.

"Tell me," The health visitor gently pleads, "I see the hurt, I know your needs."

But trust is fragile, built on sand. One wrong word, a tightened hand.

The system looms, its walls too high, Referrals made, yet lost in sighs.

Support stretched thin, time wears away. She wonders if she'll see the day.

Yet somewhere deep, a spark still burns, A mother dreams, the tide still turns.

A hand once wary, now reaches wide. A future waiting on the other side.

For in this space of fear and pain, she finds a voice, she speaks her name.

The health visitor stands, unwavering, true. A lifeline cast in seas so blue.

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Appendix

Scoping review

The use of a scoping review enables the current literature to be explored through a systematic search, select, and synthesise process (Munn *et al.* 2018), yet as Pollock *et al.* (2021) concedes, it makes no typical reference to the assessment of quality of the individual study, but serves to summarise and identify research priority. A scoping review maps the field of interest (Arksey and O'Malley, 2005), like systematic review methodological underpinning, the importance of rigour and transparency is important within this type of review (Mays *et al.* 2001). Transparency and consideration are key proponents within reflexive practice and thought, particularly when discussing influence and choice (English, Gott and Robinson, 2022. Davis, 2020). Anderson *et al.* (2008) states that a scoping review enables the contextualisation of knowledge, and identifies what we know, and what we don't know. The six stages of a scoping review as proposed by Arksey and O'Malley (2005) are iterative in nature and not limited to engagement with the ability to repeat steps comprehensively.

<u>Stages</u> (Arksey and O'Malley, 2005)	<u>Description of the stages</u> (Levac, Colquhoun and O'Brien, 2010)
Identifying a research question	Research questions should be broad in nature but provide direction for the subsequent stages. Relevant aspects of the research should be considered, including the use of terminology and definition.
Identifying the relevant studies	Decisions surrounding the search strategy are enlisted at this stage, including sources of evidence, databases, and search terms. A comprehensive search is undertaken through databases, reference list searches, and conferences/reports. It is important to acknowledge researcher constraints at this point, including resource availability and time.
Study selection	Eligibility criteria are considered following the familiarity of the evidence base. The inclusion and exclusion criteria are stated here/
Extracting the data	Data is charted, and analysis of the research is documented through review or description.
Collating/summarising/reporting the data	A framework is constructed to provide an overview, and then a clear analysis is presented.
Consultation	This is an optional stage in which stakeholder and public, patient involvement engagement can provide further insight.

Recent studies have utilised the systematic approach of searching the literature through a scoping review within the topic of domestic abuse. Henriksen *et al.* (2023) scoping review explored the interventions employed for those experiencing domestic abuse within maternity care. Furthermore, Munn *et al.* (2016) noted the use of this method of benefit when exploring factors relating to a specific topic. Unlike systemic reviews or meta-analysis', studies are not evaluated on their quality (Levac *et al.* 2010. Henriksen *et al.* 2023). This sits within the researchers own positionality of

wishing to see and hear all opinion, ideology, and framework within the arena of domestic abuse relating to experience within the health visiting provision.

Review question

The questions are positioned around the central aim of the study;

- To seek opportunities to progress and improve health visiting practice when supporting families experiencing domestic abuse.

Therefore, to consider what are the perspectives of health visitors supporting families experiencing domestic abuse? And, what are the perspectives of women/mum's who are being supported by the health visiting service during their experience of domestic abuse?

As previously discussed, the use of the term domestic abuse could be ambiguous in terminology. Commonplace within international guidance and evidence was the use of *family violence*, *domestic violence and abuse*, *intimate partner violence*, and subsequent offences and abuses encapsulated within gender-based violence including *honour-based violence*, and *female genital mutilation*. When considering the review question, rather than expanding a term to consider all the pre-defined abuses as above, I considered a term that was pertinent to current UK healthcare practice and UK legislation. However, within the searches it was important that other terms were included to broaden the search into international considerations and practices.

Health visitor is a profession registered with the Nursing and Midwifery Council under the qualification of 'Special Community Public Health Nurse' often referred to as SCPHN in appropriate literature (NMC, 2022). Just as school nursing, and district nursing, health visiting is a branch of SCPHN qualification undertaken at a postgraduate level within the UK (iHV, 2018). There are many similar roles within the nursing community that exist internationally delivering a similar service to families, these include, health visitor (UK, Scandinavia), child health nurse (Sweden), public health nurse (North America), child and family health nurse (Australia), Plunket nurse (New Zealand), lady health visitor (Pakistan) (iHV, 2018).

The inclusion of both the terminology associated with domestic abuse, and the different roles delivering similar care was important at the outset to ensure breadth at this stage of the review (Arksey and O'Malley, 2005). Furthermore, including terms and roles enabled a sweeping view of the current literature (Davis, Drey and Gould, 2009).

The purpose of the scoping review is to establish what we know about health visiting and women's (within service provision) perspectives of domestic abuse, considering the purpose of delving into insight of lived experience and envisioning recommendations to better support practice, helped to determine the direction and goal of the review (Levac *et al.* 2010).

- *What are the current perspectives of health visitors relating to working with families experiencing domestic abuse?*
- *What are the insights of women who have been supported by the health visiting service during their experience of domestic abuse?*
- *What are the broad perceptions of support, and expectations of such relating to domestic abuse within wider ideology held by health visitors and women?*

Relevant studies

The nature of a scoping review means a wide range of data sources are searched. As Hooker and colleagues (2012) demonstrated, if tedious at times, a search of wider literature can provide deep insight, proving to be more thorough than systematic reviews.

The following search terms were developed with peer support from an academic librarian.

(“domestic abuse” OR “domestic violence” OR “family violence” OR “intimate partner violence”) AND (health visitor OR specialist community public health nurs OR child health nurs* OR public health nurs* OR child and family nurs* OR plunket nurs*) AND (women OR mothers).*

It was considered whether to include the ‘AND (insight OR experience OR perspective)’ into the search terms. After discussion with academic library staff, it was decided to not include these terms as it may restrict the search as such may be noted in the analysis and/or results of evidence, rather than in tagged terms.

Due to resource and time constraints certain boundaries were placed on the search terms. To ensure a differing perspective was gained with this process (Mak and Thomas, 2022), discussions around eligibility criteria were discussed with an academic librarian. Within the databases, only peer reviewed material was included, and evidence published within the last 10 years. Any evidence written and/or produced in non-English language was excluded from the search. Furthermore, within the searches, non-subject specific topics were excluded, such included literature relating to older children (over 5 years), specific medical personnel (GP’s, obstetricians), and research collated from acute and secondary care settings. Such boundaries are commonplace within scoping reviews (Arksey and O’Malley, 2005), it was decided by refining a search within these limiters the scoping review would be achievable for a lone reviewer. However, the scoping review does acknowledge that pertinent data may have been missed due to the eligibility criteria.

Electronic databases

With support from an academic librarian, key subject databases were identified and searched with the above terms plus limitations on time frame, subject, and language; the databases included CINAHL, Nursing and Allied Health, PsychINFO, ScienceDirect and COCHRANE. There were some notable variations in the results from the databases.

CINAHL Title and abstract review	57 19
Nursing and Allied Health Title and abstract review	1,268 30
COCHRANE Title and abstract review	58 10
PsychINFO Title and abstract review	9 1
ScienceDirect Title and abstract review	333 4

Grey literature

Grey literature is any work that is not published through acknowledged academic publishers and includes government policy documents, thesis, and conferences. A literature review using terms and limiters was conducted on the Gov.UK website, Research In Practice website, Institute of Health Visiting.

Scanning reference lists in identified evidence enabled the scoping review to capture both the depth and breadth of research available, checking reference lists was of particular importance in some of the key systematic reviews captured within the searches. Citations were held on a reference manager and continually monitored to ensure the eligibility criteria was met.

Study selection

This section requires a systematic process of selecting data through inclusion criteria (Arksey and O'Malley, 2005). Furthermore, reviewing of title, followed by abstract, followed by main text occurred in each to ascertain eligibility to answer the study questions.

The CoCoPop framework was utilised at this point in the review to enable the accurate selection of evidence to answer the specific review questions. This search strategy enabled the review to stay focused on the specific review questions. Due to the nature of both phenomena of domestic abuse, and the health visiting service provision, there were large numbers of evidence that were captured within the search terms.

Condition	Domestic abuse/Intimate personal violence
Context	Within health visiting service provision
Population	Health visitors and/or mothers

Following from title and abstract review, 64 articles were then sourced to conduct complete read through to analysis whether they would be included within the review. Following this process 7 articles were considered appropriate to move to the next stage of the scoping review process to explore the findings.

Data extraction

From the final round of review, the literature was extracted and charted onto a excel spreadsheet and classified into author, date, country of origin, study aim, and discussion points.

Data extraction focused on key themes:

- HVs' perspectives on supporting DA survivors
- Women's experiences and perceptions of HV support
- Broader ideological perspectives on DA support

Qualitative Protocol

Self-declaration

The research protocol forms an essential part of a research project. It is a full description of the research study and will act as a 'manual' for members of the research team to ensure adherence to the methods outlined. As the study gets underway, it can then be used to monitor the study's progress and evaluate its outcomes.

The protocol should go into as much detail about the research project as possible, to enable the review bodies to fully understand your study.

This study has used the qualitative protocol template provided by the Health Research Authority to guide the study justification, processes, and design of the intended study.

FULL/LONG TITLE OF THE STUDY

An explorative standpoint of health visitors and women who have experienced domestic abuse within the service provision: the perspective regarding support, intervention, and outcome.

Aims

To explore the perspectives of health visitors and women who have experienced domestic abuse within the service provision.

From the standpoint of both health visitor and woman, explore the differing perceptions of support and intervention provided

Explore the perception of achievable/wanted outcome from both professional and service user.

Objectives (Through exploration, the study will further address -)

Differing/intersecting perspectives of threshold for intervention

health visitor and women's understanding of DVA, and through comparison of perspective, what are the implications that this has on service delivery (professional-client relationship)

What new insight can be generated from bringing a feminist theoretical lens to the exploration of health visitor DVA intervention?

SHORT STUDY TITLE / ACRONYM

In conversation with health visitors and women: talking about domestic abuse. Analysing experience through a feminist lens.

PROTOCOL VERSION NUMBER AND DATE

Version: 1.3

Date 30.11.23

RESEARCH REFERENCE NUMBERS

IRAS Number: 317873

SPONSORS Number: N/A

FUNDERS Number: N/A

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publicly available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:

Signature:

Date:

.....

23/11/2022

Name (please print):

.....Prof Nachi Chockalingham.....

Position: Professor of Clinical Biomechanics, School of Health,
Science and Wellbeing, Staffordshire

University.....

Chief Investigator:

Signature: 

Date:

.....

23/11/2022

Name: (please print):.....Katharine Codd.....

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Joint-sponsor(s)/co-sponsor(s)	N/A
Funder(s)	N/A
Key Protocol Contributors	N/A
Committees	N/A

STUDY SUMMARY

Study Title	In conversation with health visitors and women: talking about domestic abuse. Analysing experience through a feminist lens
Internal ref. no. (or short title)	In conversation with women and health visitor's: talking through domestic abuse
Study Design	Qualitative design
Study Participants	Practising health visitor's (SCPHN qualification) Women and/or mothers who have experienced domestic abuse AND in receipt of the health visiting service. Key stakeholders
Planned Size of Sample (if applicable)	Health visitors – 15 Women/mothers – 15 Stakeholder – 10
Follow up duration (if applicable)	NA
Planned Study Period	Up to 18 months
Research Question/Aim(s)	<u>Aims</u> <i>To explore the perspectives of health visitors and women who have experienced domestic abuse within the service provision.</i>

	<i>From the standpoint of both health visitor and woman, explore the differing perceptions of support and intervention provided</i> <i>Explore the perception of achievable/wanted outcome from both professional and service user.</i> <u>Objectives</u> (Through exploration, the study will further address -) <i>Differing/intersecting perspectives of threshold for intervention</i> <i>health visitor and women's understanding of DVA, and through comparison of perspective, what are the implications that this has on service delivery (professional-client relationship)</i> <i>What new insight can be generated from bringing a feminist theoretical lens to the exploration of health visitor DVA intervention?</i>

FUNDING AND SUPPORT IN KIND

No financial support has been provided by any individual and/or organisation in the completion of this study. Support has been supervisory in academic and professional nature.

SUPPORT (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	FINANCIAL AND NON FINANCIAL SUPPORT GIVEN
Dr Fiona Cust. Associate Professor in Children's Nursing, Staffordshire University <u>Fiona.cust@staffs.ac.uk</u>	Non-Financial support. Academic supervisor
Dr SarahJane Jones. Associate Professor in Patient Safety. Interim associate Dean in Research and Innovation. Staffordshire University. <u>Sarahjane.jones@staffs.ac.uk</u>	Non-Financial support. Academic supervisor
Dr Annalise Weckesser. Senior Research Fellow, School of Education and Social Work, Birmingham City University. <u>Annalise.weckesser@bcu.ac.uk</u>	Non-Financial support. Academic supervisor
Donna Freeman. Head of Early Years Practice, Birmingham Forward Steps. Moseley Hall Hospital, Alcester Road, Birmingham. B15 8JL <u>donna.freeman1@nhs.net</u>	Non-Financial support. NHS organisation collaborator
Ann Henderson. 0-19 years Quality Lead, Leeds Community Healthcare NHS Trust. a.henderson2@nhs.net	Non-Financial support. NHS organisation collaborator

Sharon Grant. Family support worker, Doddington Children’s centre, 28 Doddington Green, Birmingham B32 4EL. 07523943937 <u>Sharon.grant@barnardos.org.uk</u>	Non-Financial support. Non-NHS organisation collaborator

This study is a part of a PhD award at Staffordshire University and will be the main research to be written within a thesis. The researcher is undertaking study over a full time period as a student and is supported by supervisors who will have regular input into the study progress. The responsibility of the study is that of the researcher/student, and they will proposed the study design, will undertake data collection, analysis and dissemination of results. As part of the PhD award process, aspects of the study will be discussed with supervisors and external examiners within the progress review meetings. Final PhD award will be given following submission of completed thesis, and viva exam.

The researcher considered the area of health visitor provision within domestic abuse support to explore, and designed the study to caputure the voices of both professional and service user to seek exploration of the service, and make recommendations for future practice and training. The proposed study has been discussed with health visiting staff, and parents as part of informal focus groups, the aims and objectives were explored as to their validity in seeking truth. The study has also been provsionally discussed with third party organisations to seek their thoughts on the study design, and discuss collaboration.

KEY WORDS: Health visitor

Woman/mother

Domestic abuse violence

Perspectives

Feminism

Support

STUDY FLOW CHART

This chapter will provide a detailed and succinct protocol of the study intended as part of the thesis. The protocol was developed using the qualitative protocol template provided by the Health Research Authority (HRA) to guide the study justification, processes, and design of the intended study. This protocol was submitted through the Integrated research application system (IRAS) (IRAS number 317873), and received approval through from the HRA on the 19th January 2023.

The research protocol forms an essential part of a research project. It is a full description of the research study and will act as a 'manual' to ensure adherence to the methods outlined. This chapter will ensure that rigor and validity are maintained, and it can be used to monitor and evaluate outcomes. Following the preliminary literature searches and exploration of methodology, as explored in previous chapters, I considered how I would undertake my study to enable me to analyse and evaluate what I wished to explore. During this time, I considered recruitment, and how I seek support in doing so. I recruited two separate NHS organisations to support me with health visitor participation. This protocol was provided to each during the early stages of conversations between me and the organization research teams. In providing them with this comprehensive protocol, they were able to progress in providing capability and capacity approval to work with each organization, and recruit staff employed there. It is important to note that this protocol was submitted through the IRAS process as I intended to recruit health visitors currently practicing within NHS organisations. To gain insight into previous, current, and future practice was important to ensure I felt equipped to explore my intended aims of the study. The recruitment of women, and to hear their voice, and listen to their story was fundamental to my intentions. Their recruitment however was never intended to be done so

through the NHS, or universal services, instead through their own willingness to participate, without my accessing their personal information. Third-party organisations acted as gatekeepers to their recruitment, however, no systematic or monitored approval system needed to be undertaken. For their recruitment, this protocol was available and adhered to.

Study summary

Study Title	In conversation with health visitors and women: talking about domestic abuse. Analysing experience through a feminist lens
Internal ref. no. (or short title)	In conversation with women and health visitor's: talking through domestic abuse
Study Design	Qualitative design
Study Participants	Practising health visitor's (SCPHN qualification), Women and/or mothers who have experienced domestic abuse AND in receipt of the health visiting service. Key stakeholders working in NHS and non-NHS organisations alongside women and health visitors.
Planned Size of Sample (if applicable)	Health visitors – 15 Women/mothers – 15 Stakeholders – 10
Follow up duration (if applicable)	NA

Planned recruitment period	Up to 18 months
Research Question/Aim(s)	<u>Aims</u> <i>To explore the perspectives of health visitors and women who have experienced domestic abuse within the service provision.</i> <i>From the standpoint of health visitors, women, and stakeholders, explore the differing perceptions of support and intervention provided</i> <i>Explore the perception of achievable/wanted outcome from both professional and service user.</i> <u>Objectives</u> (Through exploration, the study will further address -) <i>Differing/intersecting perspectives of threshold for intervention</i> <i>health visitor and women's understanding of DVA, and through comparison of perspective, what are the implications that this has on service delivery</i> <i>(professional-client relationship)</i> <i>What new insight can be generated from bringing a feminist theoretical lens to the exploration of health visitor DVA intervention?</i>

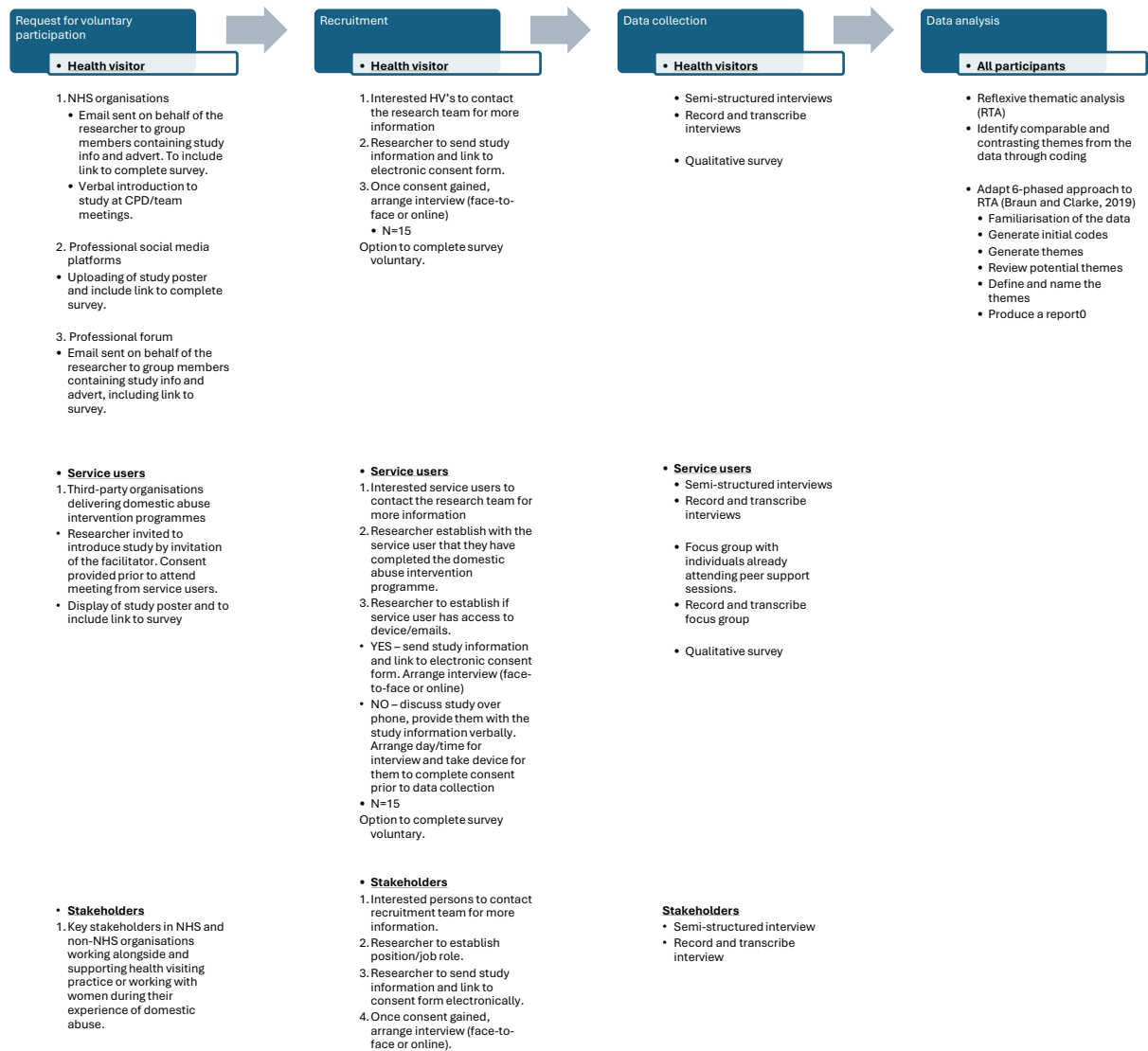
KEY WORDS:	Health visitor Woman/mother Domestic abuse violence

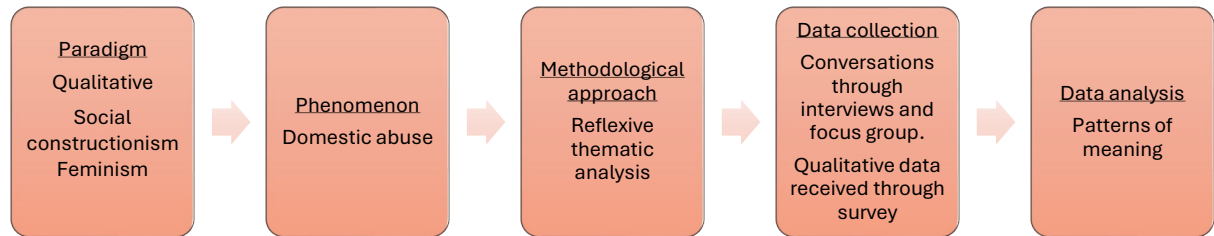
Perspectives

Feminism

Support

STUDY FLOW CHART





STUDY PROTOCOL

An explorative standpoint of health visitors and women who have experienced domestic abuse within the service provision: the perspective regarding support, intervention, and outcome.

At this stage in the research, the interventions will be generally defined as recognizing, assessing, supporting, and referring.

Through exploration, the study will further address -

Differing/intersecting perspectives of threshold for intervention

health visitor and clients understanding of DVA, and through comparison of perspective, what are the implications that this has on service delivery (professional-client relationship)

What new insight can be generated from bringing a feminist theoretical lens to the exploration of health visitor DVA intervention?

1 BACKGROUND

Domestic abuse is a worldwide social problem, the enormity is highlighted by the World Health Organisation (2021), in which they estimated about 30% of women have been subjected to either sexual and/or physical violence by their intimate partner. Statistics nationally bear no improved scenario, in England and Wales in the year ending 2020, 5.5% of adults (2.3 million people) experienced domestic abuse (ONS, 2021). The scale of the problem being even more alarming with estimates suggesting up to 30% of domestic abuse incidents go unreported, and there has been a year-on-year increase in incidents reported to the police since 2010 (ONS,

2021). This important social problem warrants lively debate and examination, as well as in-depth investigation into the phenomenon and the service-intervention implemented to expose and rid the problem.

Health Visitors are involved in all safeguarding cases in which there is a child under the age of five in the family home, whether concerns arise regarding domestic abuse through disclosure, early help, team around the child, or statutory involvement (Department of Health, 2013).

Conversations with individuals, families, agencies, and other health visiting staff are regular and on-going. The language used in these on-going conversations shapes and enables decision-making for the individual practitioner and as a joint agency process, including other professionals and family members. Enquiry about domestic abuse is stipulated in key documents including *Healthy Child Programme* (Department of Health, 2009), *Domestic violence and abuse – professional guidance* (Department of Health, 2013), and *Domestic violence and abuse* (NICE, 2016). Within these policy documents health visitors are specifically named as professionals to carry out routine enquiry, and act appropriately following a disclosure or incident.

Critics argue that domestic abuse is a human problem, not gender specific. Despite this, healthcare professionals often overlook many male victims (Barber, 2008). Furthermore, Kieski et al. (2016) identified that female-perpetrated violence is a phenomenon that has not been adequately researched and explored. Due to the conflicts within the gendered expectations of women Kieski and colleagues suggest nurses needed to allow for the possibility that as well as men perpetrating abuse, women do too. However, there is a consensus that injury caused to

women is significantly higher, and the disagreement remains regarding the motivation to 'hurt' and the action within the gender debate (Winstok, 2013).

There is limited research into the perspective and experience of health visitors and service users through a deliberate feminist lens. This body of research explores health visitor's working with domestic abuse cases, but much of this evidence is aging, particularly in light of ever-changing policy, socio-economic demographic within the UK, and constraints within primary care service provision. Furthermore, much of the evidence has seemingly highlighted barriers experienced by health visitors when delivering support and intervention. This study addresses this deficit in which perspectives of delivering best practice can be valuable; what it is like to be the health visitor supporting a woman, and what is it like for the woman working with the health visiting service.

2 RATIONALE

Health Visitors support and provide advice to families seeking to improve health outcomes and reduce inequalities (National Institute of Clinical Excellence, 2014). Health visitors have a statutory obligation to prevent and identify domestic abuse (Nursing and Midwifery Council, 2004) and moreover as over a third of cases begin during pregnancy and escalate post-natally they are ideally placed to take a lead role in delivery of support, referral and policy implementation (Department of Health, 2010). Bobby (2020) highlighted the importance of fostering and maintaining positive working relationships with families as key to enabling therapeutic interventions. Compassionate and empathetic child focused interventions drive the

four domains of health visiting that aim to enhance public health outcomes for individuals, families, and communities. Specialist public health community nurses draw on a comprehensive understanding of the ways in which lifestyle and living conditions determine overall health (Nursing and Midwifery Council, 2004). Nursing exists within a paternalistic hierarchy and historical context of domestic abuse being a 'private matter', rendering the nursing response to violence suffered by women inadequate to date (Patrick & Jackson, 2021). Community approaches are shown to be the most effective at intervention level (Patrick & Jackson, 2021), and nurse leadership demonstrated in the health visitor role being a core component to such (Department of Health, 2013).

Safeguarding children

Women are more likely to be victims of domestic abuse, with children just as likely to be victims themselves and/or witness abuse (Templeton et al., 2009). Furthermore, an estimated 90% of domestic violence within the family home takes place in the same or adjacent room to a child (Lazzenbatt, 2010). Children who are not directly injured but witness abuse become greatly distressed (Department for Children, Schools and Families, 2010), with clear correlations between domestic violence and child abuse (Harne & Radford, 2008). Ofsted, in 2017, concluded that far too little is being done to address domestic abuse as a public health issue, clearly identifying that domestic abuse is the most cited factor when children were assessed by social care. Attempts to make positive changes are noted in recent policy and practice (Department of Health, 2017. and The Home Office, 2021), however, change is not evident in reflection prosecution and referral rates. The most recent triennial analysis of serious case

reviews involving children (Brandon et al., 2014) (Brandon *et al.* 2020), found that 59% of cases involved issues relating to domestic abuse, often noted as a 'family characteristic' in reporting.

Callaghan, Alexander and Fellin (2016) explored children's experiences of living with domestic abuse. Their qualitative study recruited children aged pre-adolescent to late-adolescent age.

The study findings demonstrated the loss of agency children felt, and the difficulties they experienced in articulating their pain. They noted that children became passive witnesses to the abuse and became positioned as inert objects. The conclusions drawn from this study can be transferred to those experienced by much younger children (as seen by the health visitor).

Brandon *et al.* (2020) triennial report concluded, yet again, the voice of the child is lost within domestic abuse cases. Furthermore, striking was the gap between the child's needs and the lack of attention from professionals paid to the child. Interventions employed by professionals when working with domestic abuse will often centre on the adults, using the proxy adult to assess the child's thoughts, feelings, and needs (Lewis et al., 2018). Yet, as Øverlien and Hydén (2009, pg.479) explained "...children who experience violence in their homes experience it with all their senses. They hear it, see it, and experience the aftermath." To deny babies and children the autonomy over their experiences, is to fundamentally fail each of them.

Health Visitors are in a good position to ensure the child has a voice; with the specific, holistic assessments they undertake (Brandon *et al.* 2020). Humphreys and Bradbury-Jones (2015) examined the relationship of health visitors and women experiencing domestic abuse, as well as their children. They noted that domestic abuse will often be viewed as an attack on the mother-child relationship, with practice crucially consisting of both strengthening the mother-baby relationship, alongside safeguarding the child. The two factors should not be viewed as a

dichotomy of intervention, but both akin with one another, and intertwined. However, within highly emotive situations, such as working with domestic abuse, tensions will develop through professionals' ambiguous feelings towards the mother who does not follow advice (Lewis *et al.* 2018). This shift from mutual benefit of both the mother-baby relationship and safeguarding becomes skewed.

The Domestic Abuse Act (2021) clearly recognises children as victims of domestic abuse, whether they see, hear or experience the effects of domestic abuse, and/or their parent is a victim. However, national statistics have not yet captured this data, focusing on adults aged 16-64 years only. Estimates suggest up to 130,000 children are living in homes in which domestic abuse (SafeLives, 2015), with the NSPCC reporting a 35% increase in their work relating to children in domestic abusive homes in the year 2020/21. A true account of the number of children experiencing domestic abuse is unknown, and therefore it is paramount that services directly working with children continue to better understand and respond to domestic abuse appropriately and effectively.

3 THEORETICAL FRAMEWORK

The researcher intends to capture the argument of the phenomena of domestic abuse existing as purely subjective, impacted by social constructs. It is the unique standpoint of the individual that provides the justification of truth, while also providing a method with which to analyse reality. A need for a more standpoint epistemological approach within domestic abuse support is called for. Statistics and policy have thus far incorporated a scientific discourse of domestic

abuse, that the researcher believes, is missing the fundamental pure subjective experience. A manufactured truth is incorporated within theory, policy, and practice, that limits holistic intervention. Focused outcomes become tangibly quantifiable within the physicality of action, including the undertaking of safeguarding plans, procedures and changing of the physical family dynamic (Cowley *et al.* 2013). Such benevolent actions as previously mentioned that perpetually control an already oppressed individual can never be freeing. Is allowing the person to tell their truth, their story, the most wholesome thing a supportive system can provide? And in doing so, produce empowered perspective? Autonomous actions are concerned with liberty; the freedom to make decisions free from coercion, and agency; the capacity for intentional action (Brown, 2012). However, if autonomy is influenced by the social construct of culture, power, gender, and social positioning, then can such autonomous decisions, made by either professional or client, ever be universal and generalised? (Chirkov, 2003).

Health visitors work with a family centred model of service delivery, with the child(ren) firmly at the centre of health promotion, advice, intervention, and support (Department of Health, 2013). Gender roles and biology dictate that women and/or mother are more notably the main care provider in the early years, and therefore contact with the service involves women engaging with health visitors. Feminism seeks to give voice to the often voice-less. Domestic abuse affects both men and women, in heterosexual and LGBTQ+ intimate relationships, however, statistically, nationally and world-wide domestic abuse is a gendered issue, experienced largely by women (Office of National Statistics, 2021. World Health Organisation, 2020). Feminism has been explored within nursing and care for the last 50 years, and furthermore discusses the power imbalance between the sexes. The study will argue that

domestic abuse overwhelming impacts women, and the safeguarding of children within a family dynamic. Within health visiting safeguarding practice, their standpoint has thus far been misjudged, and misunderstood due to the differing intersecting oppressions under social, political, historical, and material conditions we share. Such complex intersections are further complicated by our culture and diversity. Furthermore, critic of the health visitor standpoint needs to be considered and better understood. This can only be achieved through narration of individual lived experiences.

A single truth is not the only truth, nor is there a hierarchy of truth (vanWormer, 2009). The approach to be undertaken from an epistemological and methodological stance views a narrative of experience within the social reality it exists in (Swigonski, 2004). Feminist Standpoint Theory goes above examining the perspectives of certain women but appreciates their views within the socio-political space (Bohrman *et al.* 2017). Campbell (2015) makes claim that social setting does not determine, but shapes insight. The central idea is that individuals can reflect on their experiences, and thus turn them into an epistemically privileged standpoint (Ashton and McKenna, 2020). Feminist standpoint theory does not require groups to be the same, but allows for different intersectionality (Hill Collins, 2004), if general experience is similar. With current trends of domestic abuse rates increasing (ONS, 2021), it would translate that there is a growing requirement for innovative thinking when it comes to service provision and support. Standpoint theory enables those in power to be challenged (Medina-Minton, 2019), for the purpose of this study, those in power will be the health visiting professionals who are delivering supportive interventions.

4 RESEARCH QUESTION/AIM(S)

Aims

To explore the perspectives of health visitors and women who have experienced domestic abuse within the service provision.

From the standpoint of health visitors, women, and stakeholders, explore the differing perceptions of support and intervention provided

Explore the perception of achievable/wanted outcome from both professional and service user.

Objectives (Through exploration, the study will further address -)

Differing/intersecting perspectives of threshold for intervention

health visitor and women's understanding of DVA, and through comparison of perspective, what are the implications that this has on service delivery (professional-client relationship)

What new insight can be generated from bringing a feminist theoretical lens to the exploration of health visitor DVA intervention?

4.1 Outcome

The study will seek to give voice to health visitors who work with families experiencing domestic abuse, and the women that identify themselves as victim or survivor of domestic abuse when they are in receipt of health visitor support. Health visitors have been noted as being one of the first universal professional groups to be made aware of a domestic abuse incident or disclosure, and often act collaboratively with families and other agencies to support and intervene. Being empathetic, salutogenic and health seeking are concepts that encapsulate the health visitor's role, and therefore continued study and research is required to capture their experience.

The experience, consequence, and impact of domestic abuse is individualistic to those that experience it. The phenomena is quantified in national and international statistics, as well as objectified at times within policy and professional guidance, however, it is well evidenced that many experiences of domestic abuse are subjective, and are often difficult to capture unless narrative processes are applied.

This study aims to combine the viewpoints of both professional and service user to seek further perspectives, and explore collaborative dynamics of support, advice, and intervention.

Furthermore, the study will seek to explore perceived and/or expected and/or wanted outcome of the working relationship. Results from this study can then be applied to make recommendations.

This study is a qualitative piece of research that will speak with NHS health visitors, service users (women/mothers), and key stakeholders (NHS and non-NHS) through qualitative survey, semi-structured interviews, as well as engage in short interviews with key stakeholders. Recruitment into the study will involve a two-armed approach dependent on whether the participant is identified as being a professional or a service user.

Design

The study will aim to seek further perspective of health visitors and women who have experienced domestic abuse, about the support provided by the health visiting service. The study will also seek the perspective of key stakeholders and individuals who work alongside health visitors, or support women during a period of domestic abuse. Giving all an opportunity to share their lived experiences about the support provided, contextual events, and collaboration, it is expected to provide further insight into individual experience and seek improvements to service provision. Using a feminist stance to explore the phenomenon of domestic abuse, it will give voice to those with experience, and seek to explore the power dynamics within their experience. Combining data from both professional delivering the support, and client receiving the support would provide invaluable insight.

There is a dearth of information/research/evidence exploring various aspects of domestic abuse, however there is limited exploration into the experience relating to the health visiting service. Previous research (Taylor *et al.* 2013. Dennis, 2014 Bradbury-Jones and Keeling, 2020) has explored barriers and challenges faced by practitioners and highlighted the need for further study within this working dynamic. This study will build from the previous evidence and intends

to capture the working relationship, as well as intersecting understanding of domestic abuse. Health visiting research has largely explored different areas of the service using qualitative methodology. Feminist theory has been well applied approach within nursing and care work, however the presence of such within health visiting practice relating to the highly gendered experience of domestic abuse is yet to be explored. Feminism explores concepts of power, relationships, socio-political expectation, and perceived responsibility, it seeks to deliver truth through experience (Ashton and McKenna, 2020. Bohrman et al 2017). The proposed study design and methodology reflects this. A purely qualitative study will give voice to both the health visitor and woman about their experiences surrounding service support within domestic abuse.

Qualitative methods occur in actual and natural settings (Holloway and Galvin, 2016).

Purposeful sampling will aim to recruit practising health visitors, with experience in working alongside and supporting families in which incident and/or disclosure of domestic abuse has occurred. The study will seek participants who are both practising health visitors with experience of working with families dealing with domestic abuse, and delivering support, as well as women who have experienced domestic abuse whilst in receipt of support from health visitors (having a child under school age). The history and context of experience alone will not exclude certain individuals from the study, as it is well reported and accepted that the phenomenon of domestic abuse exists in many guises, and the validity of experience is felt by those experiencing it. The Domestic Abuse Act (UK government, 2021) lists the varieties of domestic abuse identified through an individual, community and criminal justice lens, including acts of sexual, physical, emotional, psychological, and financial abuse, as well as acts and

behaviours considered to be coercive, controlling and threatening. Within the experience of domestic abuse, certain events or disclosures can be quantified, yet some are purely contextual and constructed within the dynamic to which the individual experiences. It is only through exploration and narration of experience can another gain access to this. The Domestic Abuse Act identifies not only adults as victims, but also any child(ren) or dependent within the household as victims of domestic abuse. This therefore calls into play a safeguarding obligation to protect those vulnerable individuals and provide them with advocacy and agency. Health visitors are ideally placed professionals to understand the complex interplay that can occur within families experiencing domestic abuse, and how intended and perceived outcomes could be achieved.

Voluntary participation will be sort from health visitors and women with experience of domestic abuse, as well individuals both within NHS and non-NHS organisations who work alongside both health visitors and women. Participation will be achieved through different sources dependent on the participant group; however, the use of study adverts/posters will be used for both groups. The posters will provide the potential participant with the title of the study, the inclusion criteria, a brief aim of the research, and a link redirecting them to a survey. Contained within the poster will be the researchers contact details (email and phone number) if further information is needed, and/or a potential participant feels they wish to take part. The adverts will only be disseminated to individuals who meet the inclusion criteria via NHS organisations or health visiting groups that are known to the individual and are sent on behalf of the researcher. During the recruitment of health visitors, the researcher will disseminate study information to NHS organisations, through the research and innovation teams, social

media platforms and professional forums. Any NHS organisations supporting the dissemination of information, conversations will be sort with practice leads/managers about any opportunities to attend face-to-face continued professional development meetings to briefly introduce the study. No study adverts or posters will be placed within NHS buildings, but any potential health visiting participants will be signposted to the researcher contact details for further information. Voluntary participation will be requested to complete a qualitative survey (health visitors and women) and/or take part in semi-structured interviews (initial and/or follow-up for health visitors, mother's and stakeholders) or focus groups (mother's). The semi-structured interviews and focus groups will be recorded and transcribed verbatim.

Alongside this data collection the voice of the service user will be sort. For this group, the researcher will disseminate study information to local authority centres and third-party organisations, who deliver specific domestic abuse intervention programmes. Different programmes utilise different approaches, and these programmes will act as access to individuals. As well as the dissemination of study information to providers, and display of study poster, the researcher will discuss with the intervention provider about a face-to-face introduction of the study to potential participants as they near their completion of the programme. Study information and adverts will be signposted to women undertaking the programme interventions before completion, and then again during the final sessions.

Voluntary participation will be requested to complete a qualitative survey and/or to take part in semi-structured interviews or focus group. For women who are residents within refuge, or work with the community outreach from refuge and currently attend peer support groups, they will be invited to take place in a focus group. Maintaining the naturalistic environment for the

women, the power will remain with the women without the need for decontextualisation (Smithson, 2007). Only women who currently attend group sessions will be invited into the focus group so to ensure all participants know one another and know that each is being supported due to the domestic abuse they have experienced. Women will only be recruited into the study once they have completed a specific domestic abuse intervention programme, this will ensure that the trained professionals delivering the intervention has successfully engaged with the individual. Recruitment will not take place with women prior to this completion so to not intervene with the specialised safeguarding work required either through self-referral, professional referral, or statutory referral as part of a social care plan.

It will be emphasised to both groups that this research is not undertaking service evaluation or comparison of service. It will rather seek the true perspective of the health visitor and woman/mother who has received support from the health visiting service in response to a domestic abuse disclosure and/or incident. The perspective will also be sought from key stakeholders who work alongside health visitors and women within NHS and non-NHS organisations, either voluntary or paid employee. Examples of guiding questions will include “Tell me what it is like working with and supporting families who are experiencing domestic abuse”. “In your own words, tell me about the support you received from the health visitor after you disclosed domestic abuse”.

Methods

This study will enlist a qualitative stance with a feminist standpoint approach.

Voluntary participation will be sort from health visitors and women with experience of domestic abuse, as well as key stakeholders who work alongside both groups. The different sample sets will be recruited through different means as follows –

Professionals/health visitors

The recruitment of NHS health visitors will be achieved through several means.

- 1) Research and development departments will be approached through NHS organisations. Study information will be provided to these departments, as well as health visiting leads. The organisation will then dissemination study information and a study advert via NHS email on behalf of the researcher. The study advert and information will include brief detail of the study including aims and methods, as well as contact details of the members of the research team to gain more information and discuss their voluntary participation. Contained within this email there will be a link to complete a short qualitative survey, if clicked on the participant will be directed to a Qualtrics form that will contain information about the study and a consent statement, if the participants wish they are then prompted to complete the survey and have an option to enter their contact details if they wish to take part in an interview.

The primary researcher will also attend pre-planned team meetings and professional development forums held within the organisation to verbally introduce the study. During these short verbal introductions, the study aims, and methods will be discussed, as well as eligibility criteria, as well presented with the QR code link to access the Qualtrics survey. Potential health visiting recruits will be signposted to the researchers' contact details for further information.

Staff will be notified of the researcher's presence at the meetings through managers who are known to themselves professionally.

2) Study adverts will be posted onto social media sites, including professional health visiting groups on Facebook and Twitter, as part of a 'call for participation'. The adverts will contain the eligibility criteria for participations, study aims, the Qualtrics survey link, and the researchers' contact details.

3) Study information will be provided through specific health visiting forums, including the Institute of Health Visiting and specialist community public health nurses research groups. The study advert will then be forwarded to members through email on behalf of the researcher. The study advert and information will include brief detail of the study including aims and methods, the link to the Qualtrics survey, as well as contact details of the members of the research team to gain more information and discuss their voluntary participation.

Service users/Women

The recruitment of service users will be undertaken through third-party organisations only (non-NHS recruitment).

A variety of third-party agencies, including local authority and charity facilitators of domestic abuse specific interventions will be contacted about the study. Study information including study aims, eligibility criteria and methods, will be provided to the organisations/facilitators of the programmes and they will identify potential participants. The facilitators will then seek consent from service users for the researcher to attend one of their intervention meetings to briefly introduce the study. Service users will be made aware of the researcher's attendance to

one of the programme meetings by someone they know through the domestic abuse intervention. If they do not wish to be present during a short verbal introduction by the researcher, the option will be given to leave the room prior to the researcher's arrival. A verbal introduction of the study will be undertaken by the researcher as the service users near the end of their engagement with the intervention programme. This introduction will include the study aims and how the data will be collected. It will also be stated that participation in the study will not commence until they have fully engaged with the intervention programme they are currently undertaking. The potential participants will be signposted to the researcher's contact details for further information and discuss participation, and a study advert including a QR code link to the Qualtrics survey will be displayed in the location in which they are attending the programme.

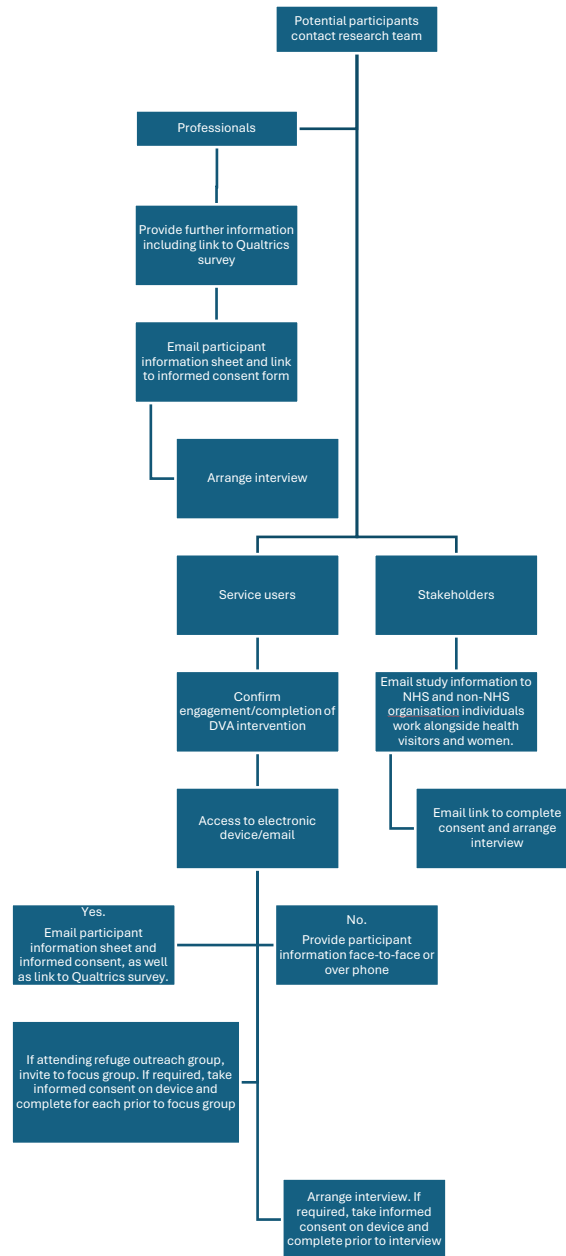
Stakeholders

The recruitment of key stakeholders will be undertaken through NHS and non-NHS organisations.

Within NHS organisations – Key stakeholders, including safeguarding practitioners, district team leads and managers will be sent study information, including a study advert via their work NHS email. The email will be sent on behalf of the researcher from the local NHS collaborator. The potential participants will be identified by both the researcher and local collaborator and the email will be sent from a person the participant expects to hear from in the first instance.

Within non-NHS organisations. As part of the recruitment process for service users (see above) domestic abuse charities, third party agencies and local authority organisations will be

approached about the study. During initial conversations with managers, they will be asked to introduce the researcher to the intervention/service facilitator. During conversations with the facilitators, as well as them acting as gatekeepers to the recruitment of service users, they will also be asked if they would like to take part in a short semi-structured interview.



Data collection

Electronic informed consent will be gained from all participants taking part in semi-structured interviews prior to data collection. Consent will be sent via a Teams link over email or taken immediately prior to data collection on a password encrypted secure device. For mother's who

are invited to take part in a focus group, they will be provided with information prior to attending about the study, and then verbal consent will be gained from each participant prior to commencement of data collection. All sample sets (professionals, service users and stakeholders) will be offered a convenient day and time to take part in either a semi-structured interview (professionals, service users and stakeholders), or given a focus group date (service users). The interviews will be offered face-to-face or online dependent on convenience and location. Individuals currently residing in a refuge and attending peer group support sessions will also be invited to take part in a focus group. Verbal communication between the participants and interviewer will be recorded and transcribed verbatim. All non-verbal communication will also be noted, for example if pauses are taken, or some distress is observed. Notes will be taken during the interview/focus group of what is said and observed, and this will be explained to the participant prior to the interview/focus group commencing. Any notes made will be anonymised and done so electronically, these notes will enable data analysis. Recordings of the interviews/focus group will be done with a physical sound recorder present in the room that is stored and kept with the researcher if the interview/focus group is performed face-to-face or online. The participant will be made aware of any recordings with rationale provided.

Sample sets may be invited to take part in a follow-up semi-structured interview. These discussions will centre around the early analysis of both professionals and service users, as well as expand on topics discussed in the initial interview. Due to the sensitive and vast subject to be explored it is expected that if the participant is happy, some areas of discussion may need to be re-visited, or new conversations entered to ensure richness of the data (Levitt *et al.* 2017).

Health visitors and service users will also be invited to complete a Qualtrics survey. Participants will be prompted to click on the link or scan the QR code which will direct them to a Qualtrics survey. The presenting page will have details of the study, eligibility criteria, and researcher contact information. A consent statement will then follow informing them that in completing the survey they consent for their responses to be used within the study analysis. At the end of the survey there will also be an option to fill in their contact information if they wish to take part in an interview.

Professionals

Health visitors will be offered face-to-face interviews at their workplace. If this is preferred, then their manager/building estates will be contacted to book a private room in which to conduct the interview. If the health visitor requests an online interview, then it will be discussed the best place for this to take place. Ideally this can take place in the workplace, in a private room that is booked to the individual for an allotted amount of time. If the interview takes place outside of work, then a private room/space in the home will be advised. The video will be requested to stay on for safeguarding purposes as well as any observed non-verbal reactions.

Health visitors will also be requested to complete a qualitative survey, the questions will be multiple choice, with some free text space so to encourage expansion of answers. No identifiable will be requested in the questions, other than the option to enter their email if they wish to take part in an interview.

Support will be offered to all participants of the study. For health visitors they will be signposted to their safeguarding co-ordinator based at their organisation who can provide supervision on specific cases or identify training needs, or to their managers who can discuss restorative supervision. NICE guidance for domestic violence and abuse (2022) states that all organisations have an obligation to provide safeguarding support and training suitable for professionals and those working within a safeguarding arena, as well as acknowledging that many professionals will have personal experience of domestic abuse. The researcher will also inform the participant of their own professional registration status and safeguarding obligation, and if any safeguarding concerns are raised during the interviews that elicit implications that impact practice and/or individuals and/or families then the researcher will escalate such concerns to the linked safeguarding lead at the organisation or local authority. Any escalation of concerns will be discussed with the participant following completion of interview and recording.

Service users

Interviews with service users will be offered online or face-to-face. If face-to-face is preferred, then the researcher will approach the third-party organisation they attended for their service intervention about booking a room to allow for this to take place. Online interviews with service users will be arranged at a convenient time and date. It will be explained to the potential participant about the importance of privacy to conduct the interview due to the nature of discussion, therefore it will be requested that during the interview, no other family members are present in the home, and cameras are left on to ensure their safety.

Individuals who reside at a refuge and/or attend peer support outreach activities within the refuge will be invited to take part in a focus group. The focus group will take place within the refuge/outreach centre straight after an activity session. Each participant of the focus group will know all the others attending and the context for which they attend as they all have previously lived/attended group support with one another. The focus group will be face-to-face, prior to commencing the researcher will ask each if they know one another and are happy to stay to take part. Consent will be required prior to commencement of the focus group discussions.

Verbal consent will be requested from all participants prior to discussions, the specific agreements of consent will be read out by the researcher and any questions can be asked during that period. At the start of the recording the researcher will confirm with all attending that they have been provided with information about the study, and in staying they are consenting to take part in the focus group and it being audio recorded. Information relating to the study will also be verbally provided by the researcher, this information will contain the focus group rules that will centre on confidentiality, safety, and respect for all participants. By taking part, the participants agree to adhere to these fundamental points by not disclosing any identifiable information about one another, by taking it in turns to speak, listening respectfully, and not using a mobile device during the focus group. Refuge workers will be present in the building for support, but only the researcher and participants will be in the room.

Service users will also be requested to complete a short qualitative survey. The study intention, researcher contact details and a statement of consent will be present within the survey.

Questions will provide multiple choice answers as common used with this sample set and topic (Domestic Abuse Commissioner, 2022), and no identifiable information will be asked in the

questions, other than entering their telephone number or email address if they wish to take part in an interview.

It is wholly accepted that exploration around domestic abuse may invoke emotional distress for all participants. Any study information will clearly explain the nature of the study, with the aims of the research. Prior to commencing and recording any interview/focus group, the researcher will again remind the participant of the nature of the study and ask if they are happy to proceed. As well as this the researcher will also inform the participant of their own professional registration status and safeguarding obligation, and if any safeguarding concerns are raised during the interviews that elicit implications that impact practice and/or individuals and/or families then the researcher will escalate such concerns to the linked safeguarding lead at the organisation or local authority. Any escalation of concerns will be discussed with the participant following completion of interview and recording. Following the interviews, women will be signposted to a few national charities including Women's Aid, Refuge, as well as local authority family support services that work to deliver specific need intervention including housing, benefits, early help and childcare support. The researcher will be unable to contact services on behalf of the participant to maintain their confidentiality in taking part in the study, however they can direct the service user back to the facilitator of the domestic abuse intervention that is aware of the study. The participant will also be encouraged to speak with their own health visiting team, GP or local children's centre family support team if they feel they require any additional support. Electronic information of specific services can be sent to the participant if requested.

If any safeguarding concerns arise in the focus group, the researcher will inform the group of the appropriateness of information shared and that everything shared in the room remains confidential. If it is felt necessary, the focus group may be stopped to ask the participant to step outside to further discuss any safeguarding concerns and then seek support/escalation from a refuge worker. Specific safeguarding information and/or situations will not be addressed within the focus group so to maintain confidentiality and safety of all members but will be escalated and shared appropriately following conversations with the individual.

Stakeholders

Stakeholders will be asked if they wish to take part in semi-structured interviews exploring their insight and experience of working alongside health visitors and women experiencing domestic abuse. Stakeholder involvement will be sort from both NHS and non-NHS organisations. The short semi-structured interviews are hoped to gain their perspective, as well as providing participants with an insight into the research to then gatekeep other participants into recruitment.

Electronic consent will be gained from all participants within this group prior to data collection. Interviews will be offered face-to-face or over Teams. Interviews will centre around the stakeholder's perception of the support offered by the health visiting service, as well as their experience of working alongside either health visitor or woman during a support or interventional period.

If any safeguarding concerns arise during the interview, these will be directly addressed with the person and escalated to their manager if required. During the data collection persons will be encouraged to not disclose any identifiable information about professionals or service users.

Data analysis

Key themes will be extracted from the data with the aid of NVivo. The researcher is responsible for the undertaking of all aspects of the analysis process. Data will be;

Transcribed.

Coded.

De-identified.

Stored/Transferred.

Accessed.

Archived.

Braun and Clark's (2006) inaugural thematic analysis (TA) will give foundation to the analytical process, however data analysis within the study will adhere to their contemporary approach of reflexive thematic analysis (RTA) (Braun and Clarke, 2019, 2022). It is hoped that the study will focus on the working relationship between health visitor and woman, exploring the support delivered, and how both felt during and afterwards. The reflexive approach to TA represents the researcher's own interpretation of patterns across the data set, furthermore, as a

registered health visitor, the researcher will act as a 'insider', and be able to place situations within the working context. The process of coding is flexible and evolves organically (Braun and Clark, 2019), themes are not predefined, but rather produced through identification of commonality within codes (Byrne, 2022). RTA encourages subjectivity, and reflexivity under the constructionism paradigm for which the understanding of feminism being socially constructed and understood sits. Analysis will be adapted from Braun and Clark's 6-phased analysis (2019) -

Familiarisation of the data

Generate initial codes

Generate themes

Review potential themes

Define and name the themes

Produce a report

The researcher is a practising health visitor and fully acknowledges their position as an insider within the service delivery. To compensate for potential study bias concepts of reflexivity will be weaved throughout all stages of the study, with consideration of researcher stance and philosophy evident. Furthermore, triangulation of data will be achieved through the different datasets. Analysis will be undertaken following each interview/focus group and transcripts provided back to each participant to ensure their voice has been captured.

Professionals

Health visitors will be recruited through their NHS organisation, their membership in professional forums, and their presence on social media groups. Recruitment will involve the dissemination of study information electronically, as well as gaining informed consent electronically, however the researcher will also attend any appropriate team meetings and/or professional development opportunities. Face-to-face study introduction will be undertaken at previously arranged meetings with health visiting staff. Upon arranging attendance to the meetings, the researcher will request that any arranged attendance is notified to the staff members as part of the agenda. The researcher will inform the research team of these meetings and take a password encrypted device with the electronic study information and consent to disseminate if required. The health visitors will be requested to contact the research team if they are interested in taking part in the study, no potential participants will be directly contacted by the research team as a first approach. Data will be collected through semi-structured interviews, these interviews will be offered face-to-face or online. Face-to-face interviews will be offered in the participants workplace, an appropriate private space will be booked by the researcher with an agreed day and time to meet there with the health visitor. The researcher will adhere to health and safety regulations and lone working policy by informing other members of the research the specific details of the arranged interview, as well as signing into the building with reception staff. If online interviews are preferable to the participant, then these will be undertaken at a convenient time and day for the health visitor. It will be requested that the participant is a private space in the workplace or home with no other

persons in the space, cameras will be left on, and audio recording used for safety and data analysis purposes.

For health visitors who have taken part in an interview, they may be invited to take part in a follow-up interview that will explore some of the early analysis of the transcripts and/or expand on areas that could not be accommodated during the first interview. Participation in a follow-up interview will be voluntary and audio recorded.

The Qualtrics survey will be designed to last no longer than an average of 15 minutes and can be completed electronically on a device or mobile phone.

Service users

Service users will be informed of the researcher attending a specific session as part of their domestic abuse intervention programme to discuss the study by the facilitator who knows them and is engaging with them. The intervention facilitator will discuss with the researcher an appropriate day/time to attend a session that includes service users who meet the eligibility criteria. The facilitator will inform the service users of this short verbal study introduction and inform them that they can remove themselves from the room if they do not wish to hear about the study or be identified. The research team will be informed of any sessions that are being attended and the location, as well as the researcher signing in and out of the building as a visitor. The service users will be requested to contact the research team if they are interested in taking part in the study, no potential participants will be directly contacted by the research team as a first approach. Upon contact with the research team, the service user will be asked if they have completed their engagement with the intervention programme, and if they have

access to an electronic device and email. If they do, electronic study information and a consent form will be sent for their consideration and completion. Interviews will then be offered face-to-face or online. Face-to-face interviews will be arranged at a convenient day/time at the setting in which they attended their intervention programme. The researcher will adhere to health and safety regulations and lone working policy by informing other members of the research the specific details of the arranged interview, as well as signing into the building with reception staff. If online interviews are preferable to the participant, then these will be undertaken at a convenient time and day for the service user. It will be requested that the participant is in a private space with no other persons in the room, cameras will be left on and audio recording used for safety and data analysis purposes. For service users who do not have access to a device/email, the study information will be provided to them verbally over the phone, and a face-to-face interview arranged. The researcher will take with them a password-encrypted device that will enable the participant to read and complete the consent prior to commencing data collection.

For women who have taken part in a interview, they may be invited to take part in a follow-up interview with the researcher. This will be undertaken to explore the early analysis of the transcripts and/or expand on area's not covered in the first interview during to time restrictions. The interview will be conducted either face-to-face or online and will be audio recorded. Participation in a follow-up interview will be voluntary.

For service users who are currently seeking support and/or resident in a refuge, they will be invited to take part in a focus group. The researcher will attend a peer support session to introduce themselves to the women and provide information about the study. The group will

then be informed of a focus group taking part following on from a pre-scheduled, regular group activity session. All invited will be from the current peer support group, and verbal consent will be gained immediately prior to the data collection. Specific consent details will be read out by the researcher, and it will be explained that in staying in the room each person is consenting to take part and adhering to the rules of the group (see below). Prior to the focus group commencing the researcher will ask all participants if they are happy to continue and know one another. Participants will not be asked to introduce themselves or provide any personal details as to the context of their engagement with refuge, participants will also be asked to not give any identifiable details of one another either, including any workers and/or professionals involved. Any names mentioned within the focus group will be anonymised during the transcription. Focus group rules will be read out by the researcher, which will include, not talking over one another/talking one at a time, not reacting to comments in an unpleasant way that make others feel uncomfortable, refraining from offensive language, turning all mobile phones onto silent mode/responding to calls or texts outside of the room, listening to one another, not disclosing anyone's personal details.

By taking part each participant agrees to adhere to these rules. If at any-point the researcher and/or participant feels these rules are not adhered to the focus group will cease and the group

will be reminded of the rules. If it is deemed necessary, a participant may be asked to leave and/or support enlisted from a refuge worker.

The focus group will be audio recorded and the researcher may take notes during the discussions.

The Qualtrics survey will be designed to last no longer than an average of 15 minutes and can be completed electronically on a device or mobile phone.

Stakeholders

Key stakeholders will be recruited through NHS organisations, or through third-party (non-NHS organisations). Information will be sent to appropriate persons via email. Within this information, there will be an introduction to the study, and researcher team contact information. It will then be advised if they wish to take part in a short semi-structured interview, they should contact the researcher directly. If contacted, the researcher will send a link to complete electronic consent and arrange a convenient day/time to complete an interview (face-to-face or online). This sample will be purposefully selected due to the nature of their job role, the support they provide, or the interventions they facilitate.

7 SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria

The below sets out the shared characteristics of participants within the study.

7.1.1 Inclusion criteria

Professionals

Practising health visitors with active SCPHN qualification in England

Experience working with families who have disclosed domestic abuse or have supported a family following a domestic abuse incident over anytime period since qualification.

Service users

Women/mothers

Over 18 years in age

At least one child pre-school age, and in receipt of support from the health visiting service during a period of domestic abuse.

Experienced domestic abuse in any capacity under the Domestic Abuse Act (2021) definition

Engagement, and completion, in a third-party domestic abuse intervention programme

Sufficient use of the English language to read and sign informed consent, and take part in spoken English language interviews and/or focus group discussions.

Stakeholders

Work alongside or support either/both health visitors and women experiencing domestic abuse.

Work for either NHS or NHS organisations.

7.1.2 Exclusion criteria

Professionals

Outside the professional qualification (inc. student health visitors)

No experience of working with families experiencing domestic abuse

Service users

Men/fathers

Under the age of 18 years

No children and/or children school age

No disclosed experiences, and/or incidents of domestic abuse

Not attended a third-party domestic abuse intervention programme

Insufficient use of the English language to prevent providing informed consent and undertaking of interviews.

Stakeholders

Do not work or support health visitors and/or women experiencing domestic abuse within their daily job specification.

7.2 Sampling

7.2.1 Size of sample

Generally, data collection and analysis should continue until no new themes/codes emerge (Bryman, 2013), however, Van Rijnsoever (2013) writes that sample size is often implicit. There is a consensus in the literature that sampling in qualitative research should continue until saturation is reached or ceasing collection of data until all categories are exhausted (Endacott, 2005).

Generally, within qualitative research the size of the sample tends to be smaller than that of quantitative research due to the in-depth enquiry, sufficient sample sizes within heterogeneous populations have been suggested as being between 14-20 people (Immy and Holloway, 2017). Larger sample sizes have been deemed as unnecessary and can furthermore lead to the loss of unique and specific experiences of the phenomena (Todres and Galvin, 2006). Within reflexive thematic analysis, both its methodological underpinning and method process, the conversations around appropriate sample size remains on-going (Sim et al. 2018). Smaller data sets may facilitate theme development, with the primary requirement being richness of data rather than quantity (Braun and Clarke, 2022). The opportunity for knowledge generation and construction will always be a potential for new understanding (Mason, 2010), with the term 'data saturation' closely linked with grounded theory, therefore not conducive with RTA (Braun and Clarke, 2022). This study will aim to produce 20-35 data sets, this is considered within the time frame of study recruitment.

The use of semi-structured interviews will enlist pre-decided questions to facilitate the direction of conversation, however, as the study progresses with data collection these questions may be manipulated as part of the reflexive process. The interviews and focus groups will aim to mirror the dynamic within everyday conversations, so to include flexibility and expansion of theme's when necessary (Braun and Clarke, 2022). The ongoing and reflective position of the researcher as not only an insider within the health visiting profession, but an outside of the individual experience, will enable the management of the questions asked within the interview (Mauthner and Doucet, 2006). This will also ensure that all themes are explored proportionately.

The use of a qualitative survey has been encouraged within the application of RTA, notably as a robust method to obtaining further insight and experience (Braun et al. 2021). The survey will provide the study with an additional data method, and is hoped to capture more participants who may be reserved about taking part in an interview, and/or feel they do not have the time to give for an interview. The questions will ask participants the how and why of their experiences, encouraging thought and insight. The data will be analysed within the RTA methodology framework.

7.2.2 Sampling technique

Purposeful sampling will occur with the total sample population consisting of heterogeneous groups including health visitors, women/mothers, and key stakeholders. Within each data sample, homogeneous groups will sort through the eligibility criteria (detailed above). There will

be the shared experienced of the working relationship within the experience of domestic abuse, however, the differing perspectives will be sourced through the differing groups.

The epistemological stance of feminist standpoint theory ensures that voice is given to those with lived experience, the feminist perspective will focus on the experience of the woman who is dealing with domestic abuse within her family dynamic. For this reason, women only will be sampled through service user involvement. The health visiting profession overwhelming employs females, which is reflected within statistics relating to other community and public health nursing roles. It is foreseen that the total sample of health visitors will be entirely, or a high majority female also, however male health visitors will not be excluded from the study as they will give valuable insight into the role through a gendered lens.

7.3 Recruitment

7.3.1 Sample identification

Professionals

1) Study information and study advert will be sent directly to health visitors on behalf of the researcher by the NHS organisation. The information provided through their NHS email will contain study aims, eligibility criteria, methods, a QR link to complete a Qualtrics survey, and how to contact the research team for further information. Conversations with NHS organisations (health visiting managers) will also enable the researcher to identify certain

meeting and/or professional development forums at the organisation to verbally present a short introduction to the study.

2) Social media posts will be uploaded onto specific professional groups on behalf of the researcher through approval via the group admin. Posts will contain study advert which includes, aims, eligibility criteria, a QR link to complete a Qualtrics survey, and researcher contact details.

3) Study information will be sent out via email on behalf of the researcher by specific health visiting groups. This study information will contain study aims, eligibility criteria, a QR link to complete a Qualtrics survey, and researcher contact details.

Any information received as a first approach will be done through persons/groups known to the health visitor, who they would normally expect to hear from.

Service users-

1) Verbal introduction to the study will be provided to potential participants by the intervention facilitator on behalf of the researcher. This verbal introduction will inform the potential participants of the researcher's presence at a meeting nearing the end of their programme to provide further information. Service users will be advised that they do not have to present during the face-to-face introduction to the study by the researcher and can remove themselves from the room prior to the occurrence.

Any information received as a first approach will be done through persons known to the service user, who they would normally expect to hear from.

Interested potential participants will be instructed to seek further information/discussion/consent by contacting the researcher and/or academic supervisor as provided on the information sheet. They will also be provided with a QR link directing them to complete a short Qualtrics survey.

Stakeholders

1) Key stakeholders within NHS and non-NHS organisations will be spoken to by the researcher through their job role/interest in the study. For those interested, study information will be emailed directly, as well as a link to complete a consent form to take part in a semi-structured interview.

Any information received as a first approach will be done through persons/groups known to the individual, who they would normally expect to hear from (NHS organisations). Non-NHS persons will be contacted in the first instance by the researcher providing general information about the study to support with the recruitment of service users (see above). Stakeholders will then be offered an opportunity, themselves, to take part in an interview.

7.3.2 Consent

Narrative experiences such as those wishing to be explored within this study are intertwined with personal identity, beliefs, and values (Immy and Holloway, 2007). It is particularly important to consider that the very re-telling of experience can change the actioning result

through (re)formation of a self-narrative. It is not only the interview itself that can impact on the individual, but also the interpretation of what is said through data analysis and conclusions. It is fundamental that participants are made fully aware of the study to prepare them for such eventualities.

Informed consent, or the participant's right to self-determination of their partaking in the study is crucial to the doctrine underpinning concepts of justice, beneficence, non-maleficence, and autonomy (Johnstone, 2011). Informed consent will be gained for all participants. Participation in the study is entirely voluntary. Participants will be given at least 24 hours between receiving study information and agreeing to take part in an interview (signing electronic consent/giving verbal consent). Participants will have the right to withdraw from study up to 2 weeks following data collection (interviews only). This time will allow for participants to fully consider their position within the study following data collection and give them time to reflect on the conversations had. It will also enable the researcher to begin analysis soon after the interview is completed and reflect the fundamental philosophy of reflexive thematic analysis of familiarising oneself with the data, generating codes and themes, and reviewing, refining, and defining themes (Braun and Clark, 2022). For individuals taking part in the focus group, due to nature of group discussions, it will not be optional to remove oneself from the study following taking part. This will be informed to each member during gaining consent.

All participants who are invited to take part in the study will be provided with study information, detailing the study aims, study design, and outcomes. This will be provided as an information poster. If there is interest in participation, the potential recruits will be directed to contact the researcher directly who will undertake conversations that detail the study and

answer any questions. Each participant will be made explicitly aware of their right to confidentiality, and that their anonymity will be maintained throughout unless specific safeguarding issues arise in which the researcher will have supervision as to whether the matter needs to be escalated. The potential participants (taking part in interviews) will also be reminded of their right to withdraw from the study at any stage. Participants will be asked to complete a signed informed consent form prior to any interviews taking place, and questions can be asked about the study at any stage in the research process. For participants taking part in a focus group, information will have previously been provided, and verbal consent will be gained prior to the commencement of discussions.

Capacity to give informed consent will be explicit and implicit. The researcher will endeavor to ensure all participants are fully aware of the implications of participating in the study. It is stipulated in the eligibility criteria that all participants require a sufficient level of reading, understanding and speaking the English language. This is to ensure all participants are able to fully complete the informed consent and take part in the data collection. This stipulation will not exclude any of the health visiting participants as they are required as part of registration a high level of competence of English to fulfil their role. It is anticipated that this may exclude some potential service users. This criterion is due to limited resources to enlist interpreting and translator services by the study. This will be acknowledged in the limitations section of the study write up.

As per HRA guidance (2018) on-going conversations with potential participants prior, during and following the data collection will assess their capacity and ability to remain in the study. The study information and conversations will ensure each participant -

understands the purpose and nature of the research

understands what the research involves, its benefits (or lack of benefits), risks and burdens

understands the alternatives to taking part

be able to retain the information long enough to make an effective decision.

be able to make a free choice

be capable of making this particular decision at the time it needs to be made (though their capacity may fluctuate, and they may be capable of making some decisions but not others depending on their complexity)

where participants are capable of consenting for themselves but are particularly susceptible to coercion, it is important to explain how their interests will be protected

Professionals

Health visitors will be informed of the study through their NHS organisation, professional group or posting on social media on behalf of the researcher. This introduction to the study will provide interested potential participants with contact details about how to further discuss their involvement. Potential participants will be requested to contact the research team for further information, they will not be contacted directly to request their participation. The study information provided in the initial approach will contain the primary researcher and academic supervisor's email and telephone number. If contact is made by the potential participant, all information will be sent via email. Following a discussion if they agree to take part a link to a

Teams consent document will be emailed to request, they read and sign electronically. No physical copies of consent will be held. The consent form will be held in a SharePoint accessible to the research team on university devices.

Contained within the Qualtrics survey will be an opening statement about the study intentions, this will then be followed with a statement about consent. This will state if they are willing to take part and complete the survey they do so with the understanding that their responses will be used with the analysis.

Service users

Women will be first approached by the study by the facilitator of the domestic abuse intervention programme they are working with. Verbal introduction to the study will be carried out by the researcher and following this and interested persons will be signposted to the primary researcher's and academic supervisor's email and telephone number for further discussion. Interested persons will be requested to contact the research team for further information, no service users will be contacted directly to discuss their involvement. Following further conversations, the researcher will establish if the woman has access to email, if so further information and a link to a Teams consent document will be emailed to request, they read and sign electronically. If they do not have access to email/device then if they verbally consent to take part in the study, prior to any data collection, the researcher can attend face-to-face with a password encrypted device in which the participant can read and sign the consent on the Teams link. No physical copies of consent will be held. The consent form will be held in a SharePoint accessible to the research team on university devices.

For women attending a peer-support group/residing in refuge, they will be invited to take part in a focus group. The focus group will adhere to the ethos of the group in remaining strengths-based and promoting empowerment through group discussions. Study information will be provided to all potential participants, and verbal consent will be gained prior data collection. Consent specifics will be read aloud by the researcher with all in attendance, and in remaining within the room each participant consents to taking part in the focus group that is audio recorded. No introductions will be requested, and each participant will be reminded of confidentiality for themselves and other members.

Contained within the Qualtrics survey will be an opening statement about the study intentions, this will then be followed with a statement about consent. This will state if they are willing to take part and complete the survey they do so with the understanding that their responses will be used with the analysis.

Stakeholders

Stakeholders will be approached via email or verbally and given study information. If interested they will then be sent participant information via email as well as a link to complete consent. A Teams consent document will be emailed to request they read and sign electronically. No physical copies of consent will be held. The consent form will be held in a SharePoint accessible to the research team on university devices.

Right to approach	All potential participants will be approached in a way that does not breach their right to privacy and data protection i.e. the research team will not be provided the contact details (personal identifiable data) of potential participations, without their prior verbal consent obtained by someone who has a right to be in contact with these individuals as part of their role.
Confidentiality and anonymity	Participation in the research will be confidential; the research team will not divulge the details of participants to anyone outside of the immediate research team (unless safeguarding issues are raised). All data collected will be coded in order to ensure anonymity. Documents that include personal identifiable data will be stored separately to the coded research data and only the research team will be able to make the link between the two. This right to confidentiality and anonymity will be made clear in the participant information sheet

Data protection and storage	The research team will abide with the Data Protection Act, 1998. Both personal identifiable data and research data will be stored securely. Electronic data will be stored on Staffordshire University's secure server that requires a staff log in to gain access. For personal identifiable data, files will also be password protected.
Informed consent	All participants who are invited to join the study will be provided with a participant information sheet. The potential participants will be given time to consider their willingness to participate and sign an electronic consent form for research records.
Right to withdraw	Two information sheets will be produced, one for service users and one for professionals delivering care. This will inform them that if they decide to take part, they will still be free to withdraw up to 2 weeks following data collection, and without giving a reason. A decision to

	withdraw, or a decision not to take part, will not affect their continuing care and support (service users) or employment (health professionals).
Safeguarding	The data collected will remain confidential as indicated, however, confidentiality would be breached in the event of a safeguarding issue or if criminal activities were uncovered. This will be made clear in the participant information sheet prior to consent.
Sensitive research	Utilising interviews to discuss issues relating to domestic abuse has the potential to re-traumatise individuals. Within the data collection the safety and wellbeing of participants will be of utmost importance throughout, and the WHO ethical consideration guidelines have been referred to throughout the study design. For service users, recruitment into the study will occur through third-party organisations rather than NHS so to

	minimise any pressure to take part in the research. Therefore, maintaining an on-going open relationship with service intervention providers is key. Conversations with domestic abuse intervention providers will be non-exhaustive and maintained through the study process, from initial study information distribution, recruitment, and data findings. These conversations will enable the researcher to understand the interventions the women have engaged with better, as well discussing any issues of participation.
Respect	The researcher will communicate with all participants prior to data collection, this will be an opportunity to discuss the research in more depth and arrange a convenient time and date to meet again to conduct the interview. In accordance with feminist principles, every effort will be made to build rapport with participants (Baird and Mitchell, 2013). This will be

	achieved by attending settings in which domestic abuse programme delivery occurs to introduce and discuss the study, as well as maintaining contact, and providing any further opportunities for data collection in the form of group interviews following the emergence of primary themes. With such a sensitive and emotive topic area as domestic abuse, good communication is essential by allowing participants opportunities to open-up, as well as achieving empathy through a deep sense of reflexivity (Baird and Mitchell, 2013).

8.1 Assessment and management of risk

The interviews will centre around the working relationships between health visitors and women/mothers, however the issue of domestic abuse will be the common factor within conversations. The study will not delve into the specifics of the personal and intimate relationships between the woman and her partner or require re-telling of the abusive incident. However, in not acknowledging the risk of harm psychologically and emotionally to participants in recounting events would fail to recognise domestic abuse as the all-encompassing phenomenon it is. The priority of this study is the safety of the participants. All participants will be provided with information about the study prior to their voluntary participation. The

researcher will reflect upon their own experiences as a health visitor throughout, and reflexively consider their own stance and thought of domestic abuse. The data collection will be done so in an open, directed, and empathetic manner, that will be purely responsive to the conversations had. It is anticipated that there is risk of emotional distress for participants and researcher due to the emotive nature of the topic. If it is noted that the participant is becoming distressed, then they will be asked if they wish to take a pause in the interview. If this is the case then the recording will be ceased and the participant can leave the room if required, if the participant feels they can continue then the interview will be recommenced. If the participant wishes to stop the interview and/or focus group and does not wish to continue following a break, then it can be discussed if they are happy for the information shared up until that point to be used as part of the data set, or if they wish to remove themselves from the study completely. Participants will be reminded they can remove themselves from the study up to and including data collection (interviews).

Signposting and conversations will occur after every interview and/or focus group due to the potential re-traumatising aspect and/or vicarious trauma that could be experienced. For health visitors, this conversation will surround the safeguarding and restorative supervision available to them through their organisation and union/professional body. For women they will be signposted to both national organisations and local agencies that can provide them with support. It can be presumed that as they have engaged with the domestic abuse service intervention this information will have been provided, as well as regular discussions and observations undertaken by professionally trained personnel. However, it can also be anticipated that this information was not fully received and therefore it is important it is

provided again at the end of the interviews. Maintaining conversations about the study to service facilitators will also enable the researcher to refer the woman back to the appropriate organisation if required.

Support information will also be provided at the end of the Qualtrics survey.

Confidentiality will be explicitly discussed prior to the data collection, and issues concerning practice and/or safeguarding stated. As a registrant, the researcher has a safeguarding obligation to escalate any concerns over practice, behaviour, or comment by any of the participants. If there are concerns noted during the interview, the interview will continue if safe to do so, and then after the interview is completed the researcher will discuss with the participant the particular concern. If the researcher feels, using their own practice judgement and safeguarding experience, that further conversations need to be undertaken with safeguarding professionals then this will be discussed with the participant prior to its occurrence. All safeguarding obligations will be adhered to in line with the Working Together to Safeguarding Children (2018), The Care Act (2014), and The Domestic Abuse Act (2021).

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

Health visitors will be practising NHS employees, and maybe recruited through their NHS organisation. For this reason, the application will be submitted to NHS ethics.

Women will be service users under the provision of health visiting however, will not be recruited through the NHS. No NHS records or identifies will be accessed during recruitment,

rather a request for voluntary participation. This sample will therefore not require NHS ethics scrutiny.

As part of the ethical application process, Staffordshire university will conduct an independent peer review, submission using the integrated research application system (IRAS) will then be sent via the Health Research Authority (HRA). Once favourable opinion is given from these bodies the researcher will progress with the study.

As per NHS REC guidance, all stipulations will be met including review of any substantial amendments prior to their implementation, records of all correspondences, the submission of any progress reports as required, and the notification of study termination or submission of study results.

Regulatory Review & Compliance

Prior to participant recruitment the researcher will speak with all organisations and third-party facilitators that deliver services to gain approval to proceed with recruitment. As the organisations include NHS and non-NHS specific guidance will be sought through relevant managers to adhere to performance Performa's.

Any amendments to the study protocol will be submitted to the appropriate stake holders prior to commencement and ensure any necessary arrangements are in place to implement the study process.

Amendments

It is a consideration that there may be instances in which amendments need to be made regarding the data collection progress. A feminist standpoint theory gives the participant the opportunity to speak their truth to deconstruct experience through narration, and then piece back together. Within this is the ability for the participants to not just take part, but fundamentally impact on the direction of conversations, feel empowered to make impactful consideration, and give rise to innovative outcomes. The researcher may have to make certain amendments to the data collection plan, this may include obtaining data through further focus groups, or interviews with key stake holders.

8.3 Peer review

Review of the study has been independent, expert, and proportionate. During the study proposal conversations were, and continue to be on-going with academic supervisors, as well as the university internal progress review in which two external examiners reviewed the proposal. These persons are expert within their academic field independently, as well as also being expert within the area of health and nursing.

Discussions have also taken place with other academics and professionals within the health visiting and/or safeguarding field, to allow opportunity for their thoughts and constructive comments on the study. Key stakeholders have also been included within in this process in particular domestic abuse intervention facilitators. Their expert opinion has been much sought, particularly relating to participation and involvement of women/mothers who have experienced domestic abuse, and how their organisation could allow for recruitment. Their opinions were initially sort as to the availability of their service in acting as gateway to access

women. Those approached included independent facilitators, local authority children and families' managers, and refuge managers. All experts were confident in the study aims and outcomes, however their involvement with recruitment was based on the fact the women could only be recruited through their services following engagement and completion of any intervention. These conversations were on-going with facilitators over the months leading to the design protocol, to continue their involvement any further amendments, or opportunities to galvanise.

Involvement of service users has also been sought during the study design. Following confirmation with academics that the study was indeed feasible from a methodological perspective, a focus group was held with parents within the service provision from different locations across England. This group of 7 parents discussed their experiences of being asked about domestic abuse as part of the routine enquiry, and their thoughts on how health visitors could best support families experiencing a wide variety of issues including domestic abuse. The researcher took the opportunity to discuss this study proposal and ask for their feedback, all felt that any study exploring experiences that could result in improvements was highly beneficial. They felt that as service users they would not be happy for researchers to recruit them through NHS records, or directly through the health visiting service for worry of professionals and/or family members being made aware of their experiences. Rather, voluntary recruitment through their engagement with domestic abuse services would be optimal.

8.4 Patient & Public Involvement

The protocol has described the involvement of service users within the study design and recruitment. The focus group arranged with parents was an invaluable tool to support the proposal regarding the aims and objectives of the study, as well as the data collection methods.

The researcher within their active practising role as a health visitor has informally had conversations with key stakeholders including health visiting staff, parents, and third-party agencies about the study proposal and its feasibility. Feedback has remained positive, with constructive comments given regarding methodology and methods. Once the study commences, service user recruitment will only occur through third-party agencies, there will be no recruitment of patients through NHS services. This will include conversations, and the display of posters/study information within non-NHS premises.

Once the data collection commences all public involvement will be discussed and invited through external organisations including local authority, charity, and refuge collaboration. The methodology enlisted, being feminist allows the participant to tell their story and shape the methods undertaken. The interviews will give rise to key themes and data, which in turn will impact on the analysis, and consider any amendments needed specifically relating to the questions asked, and the way in which the interviews take place.

Narrative transcripts will be provided to each participant following their interview, this will be done in achieving transparency and accurate reflection of the interview. Thematic analysis will be undertaken and capturing the voice of each participant accurately will ensure a true analysis and reflection is undertaken. The eye of the participant on their transcript will be integral to this process. Once data collection is complete, findings will be produced and be readily

available through any publications, conference talks and/or poster presentations. The findings from this study have the potential to directly impact on the public, particularly those in receipt of health visiting.

8.5 Protocol compliance

This protocol clearly states the design and intentions of the study, with systematic detail how any issues will be solved using a clear strategy (Tolley *et al.* 2016), however there is a consideration that as the project progresses amendments may need to be implemented and deviations from the current design made. It is anticipated that any such changes will be done so in line with HRA guidance, and timely and appropriate amendments reported to await approval. Regular supervision will occur with all academic supervisors in which progress will be discussed, as well as changes. If deviations have been made from the protocol, then they will be recognised in a timely manner. If it is noted that several deviations are made, then the considerations will be made as to the original design and conversations had with key stakeholders as to the appropriateness of the study design.

8.6 Data protection and patient confidentiality

In line with key data principles set out in the Data Protection Act (2018), data extracted from participants will be used fairly, transparently, accurately, relevantly, and only held for as long as stated. The researcher will comply with such principles and all the requirements with regards to the collection, storage, processing, and disclosure of personal information.

All personal and research data will be held electronically. Personal and research data will be stored separately in SharePoint folders accessible to the research team only.

No personal data or identifiable information will be included in the research transcripts. Once participants have consented, they will be assigned a coded only identifiable to the research team.

Professionals will be assigned the letter 'HV' and then 1, 2, 3... in order dependent on when they consented to take part in the study.

Service users will be assigned the letters 'SU' and then 1, 2, 3... in order dependent on when they consented to take part in the study.

All personal data will be held for 3 years after the study is completed, after which time it will be destroyed from all electronic shared files under the instruction of the university IT department.

All anonymised data will be held indefinitely in the anticipation that it may be made open access in the future.

GDPR

The data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). The data controller for this project will be Staffordshire University. The university will process personal data for the purpose of the research outlined above. The legal basis for processing personal data for research purposes under the GDPR is a 'task in the public interest'.

The consent for the use of personal data in this study will be achieved by completing the consent form that will be provided to participants. All participants have the right to access information held about them. The right of access can be exercised in accordance with the GDPR. Other rights including rights of correction, erasure, objection, and data portability.

Questions, comments, and requests about personal data can also be sent to the Staffordshire

University Data Protection Officer. If a participant wishes to lodge a complaint with the Information Commissioner's Office, they will be signposted to visit www.ico.org.uk. This information will all be provided to the participants.

8.7 Indemnity

The study will not proceed until approval has been granted through the university ethics board. Once this study has been approved the researcher will be covered by the university's insurance and indemnity procedures. Any claims made by participants of harm will be covered by the institution once approval is granted. Details can be found -

<https://www.staffs.ac.uk/research/docs/pdf/ethical-review-policy.pdf>

8.8 Access to the final study dataset

The principal researcher will only have access to the final dataset. As previously stated, each participant will be provided with a written transcript of their interview, however no overall data will be released until thesis conclusions are published and submission made.

It is the intention that data extracted from this study will fulfil the study aims and objectives. However, it may be the case that further analysis can be derived from further secondary hypothesis. If this is the case, then participants will be noted prior to this happening.

9 DISSEMINATION POLICY

9.1 Dissemination policy

The data, voice of the participant, belongs to them until the results are produced and generated, and/or they request to be removed from the study. Upon completion if the study, the data will be analysed and tabulated, and a final report prepared. Upon completion the data will form the results and conclusions of an academic thesis, it is intended upon completion of thesis that the study will be sent for publication in relevant professional journals, as well as disseminated at professional/academic conferences. The doctoral researcher will be the only author of the thesis and the sole owner of the study once submitted.

All participants will be notified once the results are available and can request these directly from the researcher over email. The dissemination of results and subsequent submission of a PhD thesis, and any publications/posters will remain anonymised, with no identifiable information included of participants.

9.2 Authorship eligibility guidelines and any intended use of professional writers

The doctoral researcher, along with the research team will hold authorship over the study.

Participant transcripts – refining and defining themes

Health visitors

HV1 transcript

And so, can you just tell me how long you been practising within scope and roll? I've been practising as a health visitor for 20 years. I have had varying roles, obviously started in a health visitor role, actually over the other side of our city, so I've got some experience in different areas to be fair. And then I've done public health work in terms of infant feeding. So I was specialist infant feeding worker within our health visiting service. And then I did a public health role in relation to antenatal delivery, and then most recently worked as team leader for three years in a high need area. I have done a bit of everything you know. And so, yeah, I've done quite a bit. And I've obviously experienced working with families with domestic abuse as you do. I want to hear more about your experiences of working with	Details the level of different roles... importance of experience (semantic). You can sense the confidence within practitioner capabilities here. Who am I? This is me. We define ourselves by the roles we hold Use of the word 'obviously' ... as if it's a given/it's everywhere.

those families who have experienced domestic abuse. And when I talk about families who experience domestic abuse, it can be whatever, within whatever context or criteria that they may define themselves as being, or you might recognise professionally. And can you tell me a little bit more about how domestic abuse is uncovered within the families that that you've worked with? The main way that we find out about domestic abuse is through referrals from social care. There are lots of other ways, but primarily we get referrals in from social care, and safeguarding nurses. We will be notified by social care that there is a section seven inquiry usually. And then there's an expectation from them to obviously share important about the child, then dependent on the outcome, we will level up our service to Universal Partnership plus, so we assign that level of service to clients who are experienced in domestic abuse because of the impact known on the child. And so the other way that we find out is through our own inquiries. We do routine enquiry.	Does this mean a lot of workload processing? The referral would indicate some form of triage already. Referrals are event only incidents? Safeguarding nurses based in acute settings so ?true reflection of experience/patterns of behaviour. Priorities. Threshold and workload

Its recorded in every mandated contact. So the way that we do that is using promotional guided questions to explore and talk about relationships. Not just about couple relationships, but about any relationships and so, obviously, we ask directly, have you had any relationships where it got really bad, or if there has been conflict where it's turned into violence. They may disclose when they have told me about social care involvement in the past, or we may get notifications from other professionals involved, and then it prompts us to enquire further what that might be. And then we'd get in touch with social worker and say, look, we're gonna be the health visitor. It depends what level of service we're delivering at that time when MASH get involved, but if it escalates to child protection plan like I said, that's when we get involved more. Or a mum will call and tell us something is happening. That's not frequent, but I know it has happened since I've been here. It's happened on 2 occasions. So, you know, the woman is telling us. Men don't divulge it, we don't really have that opportunity with Dad's. Even though we need to.	priority. Impact of children VS experience 'We' presume triage is done as collective? Relationship exploration. Using the prompted objective questions to explore experience. Promotional guide is not written for that specific family... does this make these questions objective? What does 'direct' mean? Honest? To the point? opportunities Disclosure = choice to share. Review of triage. Constant reassessment of need.

What are your thoughts on the issues of addressing it with Dad's? Well, the reason is because primarily in the antenatal period, I believe that maybe we don't market it very well. We've tried changing our letters in the antenatal period to say that it is about us (health visiting service) meeting all important people in the baby's life... mum and dad. But it's quite hard to invite when you don't know somebody's involved. The information from maternity services is quite basic really. Because more and more, you know Dad's are now caring for the children. Mum's go to work. I think we're seeing that a bit more. Dad's are less in the traditional roles...in the family, their decision around assigned family roles. Let's put it that way. But saying that, it's more often than not that a father's going to work. So it sounds like there's lots of different ways that you get information and once you've got that information, how do you	Example of breaking point by mum? Demonstrates the strength of women, or their unwillingness to reach out to HV? Why? Market the service? Market the relationship? approachability Lack of resource = limited engagement with Dad? Change in dynamic underpinning...does this add stress to conflict?

feel those conversations then go talking specifically about relationships and domestic abuse? I suppose it's, um, you coming from a place of compassion, aren't you as a as a health visitor going into a family like that? Because there's gonna be a lot of stress. It depends on the dynamics of where people are. If it's a relationship that's ended after domestic abuse, you're gonna have open conversations? I think the key thing is letting them know that we're happy to have those conversations and I feel that's where we come from, and definitely in our team, we have open conversations. We're not scared about talking about it. I'll talk about it. And I will open that conversation. I'll invite people in, or I'll say. "Listen, let me tell you, I've come here obviously to see how you are. And I know already about this situation, so you can talk about it with me and let's see how it's affected you." I think that's the first thing I look at. If a family has experienced domestic abuse, it's gonna affect you emotionally and physically. You checking in on the physical and emotional wellbeing of that mother. But it's hard because you're trying to make a relationship with this person if you've not met them before, and you're gonna talk about how it has it affected the	Solidarity. Example understanding of context. Understand there is stress but met with an ease of discussing... can one exist with the other? acceptance Explicit denial of fear. Manipulate the mother? Conversations become paternalistic. Truth(s) Attempt to fix? Can you simply 'check in' on this? blame

children. How's this experience and distress that you're all going through affected the children? I think that's a challenge for us because you don't want to devastate and crush a person when they've already gone through all that by saying this child's playing up because of all this situation. You have to be really skilled in the ways that you address it and the way that you manage it. So they might say "...well I don't think it's affected them 'cause they were all in bed when it happened..." So you might have a gentle conversation to say, "well, you know, sometimes people, even children, feel tension. What do you think?" So you're having these gentle, careful conversations about that, about how it might have impacted the child. You're not gonna stand there and mouth off about statistics and how, you know. Well, evidence shows that, blah, blah blah blah. I'll be honest, I might do a little bit of that. I might do a bit of that because I think it's important to be transparent and to sort of say, look, this is how it affects children. But again, you've gotta be really careful. You know, if children experience this, shouting and aggression, it can affect them in this way. It can affect them at school for	Aware of the difficulties but still expecting honest conversations? children Sometimes we hurt to protect? What does 'gentle' mean? Does this mean parent-child? Awareness that it is may cause pain, but still willing. Example of child trumping parent? Example of delicate relationship? Blame – responsibility How do we know what the right help is? Traumatic induced behaviours are signs of safety?

example. We want parents to understand signs of safety for the child. I am here thinking about how it's affected them and the children...Have they got the right help? I think we demonstrate that time and time again. And how, having those early conversations, particularly if it's not a person you've met before or you've had very limited contact with. How does that make you feel? What sort of things are running through your mind when you drive to the home ? I suppose I think what will be said will be a difficult conversation. It's gonna make people feel uncomfortable. It's gonna make me feel a bit worried about what their reaction might be, but actually experience tells me that I'm quite good at making relationships with people. Just even after the first few minutes. So it's about building relationships, and I know I'm kinda OK at that. I've got the confidence already. Obviously, I'm a bit worried because that there might be an impact on the child	help Awareness of power in conversation. Fear. Reliant on personal characteristics. Don't need long time to build relationship? My sense of belonging impacts my connection Build relationship = more time. time ..because you aren't talking to the child(ren)?

that they're gonna be upset about. They might cry, they might be emotional. So, practically, it's gonna be a longer visit, but I'll have armed myself with all the information by reading the record before and I will have thought about it....you've gotta make time for this. I've got to have the child as the focus because sometimes you'll lose sight of that. It's so easy to lose sight of it. And I see it as a team leader. And so I pull it back by taking the time to think before I act. And what I do as a team leader is I get to see which reviews have not been done, for example a 9-12 month review that is not done is assigned to me to look at and I get to read the notes and analyse the narrative...everything about where Dad was, where he is now, and for example when he's been in prison. Who's experienced mental health issues, where Mum's gone, who did this... etcetera, you get where I'm coming from. But then I'll look for the child, where's the child? Hang on, there's been no analysis of the child. That child might be 2 years, seven months and my heart sinks when I see that, that and all that stuff has got in the way of us looking at the child and just even in doing review. Then you begin to understand what this child has been experiencing.	Can observations/assessments be narrative? Retrospective questions? Truth(s) Importance of audit/re-looking at documents. Child's experience is based on parents' experience. All the confidence and experience help you to understand. Direct a conversation is power? Priorities

Your understanding of the child and focusing on that, as you gain experience, because you come with confidence and experience and knowing what to look for. You can get easily side-tracked and because parents are stressed and anxious, you are containing them quite a bit. But if you're not experienced in directing a conversation and guiding the conversation, then you just get left, you know, listening to them, and actually your focus needs to be on that child at some point in that visit. There's a lot going on and the mum's not talked about this child once in the visit, you know. So that's a symptom of what? What's going on in the family. And that's where your analysis begins. You set your stall out when you go in.... I'm here to look, to talk about, the child. As a team leader when I review records with a colleague, it's not and is never a critical conversation. It's always about, you know, "I can see that you've had a difficult time with this family, it's been really complicated. There's been domestic abuse and we haven't completed the child's review. What's happening with this child?"	Does not talking (child) mean the focus for parent is not them? You talk, but about what we want. empathy You have to empathise in supervision. Is supervision critical?

And can you tell me, are there any barriers to working with these families?	Demonstrates the weighing up of 'doing' and 'thinking/reflection'
Hmm. Lack of time, I mean, being prepared is also about having supervision myself, so I have regular safeguarding supervision.	Reflexive practice
And just, you know, getting the time to have the headspace to think about it all.	empowerment
And making sure you are up to date on all your training...signs of safety and neglect training, trauma informed training. Also think about the parent's point of view, if they've had a difficult traumatic, childhood themselves, so ACE's training.	listen with humility
Having the availability of other resources as well, advice and support...if it's a complicated situation.	Hearing stories... not just conversations/contacts
Over the years, I've listened to women's stories and I've learnt a lot from it, so you can learn so much from listening to what they've been through and how they feel.	simplicity
I've recently had training about reactive responses. It's about how you challenge other workers and the language that they use. Minimising language from professionals is a massive barrier.	acceptance LANGUAGE Minimising DVA

So there was one incident where the perpetrator had physically assaulted the mother and he banged her head against the wall, and she'd been concussed and blacked out. But also there was a lot of control, he would choose what she could wear... it was really complicated and there was no social worker initially involved. Social care then became involved, and they said to me "...and so yeah, I've been talking to this family about, you know, their arguing with each other..." And I went to hang on a minute. I said I'm sorry, I just have to challenge the language you're using there because actually this perpetrator has assaulted this woman, and calling it arguing between one and another is undermining and minimising it. Only the other day we had a meeting that somebody said, "Ohh yeah. Mum says she's, you know, she gives as good as she gets..." And I said no. Sorry I, I have to challenge that. There is appropriate language to use, and appropriate reaction. This mum was reacting to the assault. Or a professional may make out there are mental health issues with the mum, the mental health difficulties are causing the tensions and reactions in the family, but actually they're just reacting to being in a really hard situation that's affecting their mental health. I feel like I need to address language used.	Use of word 'arguing' by agencies Challenging practice Pathologisation of abuse vulnerability

Staying on training and resources, are there specific resources or policies available to you locally within your organisation? We've got our usual safeguarding policies, which includes the impact on the child. And we've got our threshold of need, which is obviously used to assess the level of need for our service and included in that is emotional harm. We had some training again about what's the difference between domestic abuse and conflict, and the impacts of the child for that. We've actually got a paediatric nurse liaison service; anybody who presents in A&E, and they have children, they will notify the health visiting service. Then we analyse it and decide what to do next, part of this may be carrying out a strategy meeting, we have these with other health professionals, like school nurses to share information and appropriately respond. Also, we have to complete mandatory safeguarding supervision. And the local safeguarding board training and policies we have access to. OK. So we've talked about families where there was statutory	Triage of threshold into the service Containment Importance of boundaries

services involved, have you had much experience yourself with those families who maybe don't reach that threshold? How does it feel working with those families experiencing domestic abuse, who you are worried about, but there isn't social care involvement ? It feels like you are carrying it, you feel the burden of that assessment in a way. But you have to be clear why we're involved, and when. That can help. We're not 'checkers' of families. We're not gonna be going in and checking-in if it is deemed safe for all those within the family. Historically maybe that's been the case, but we've really looked at the situation and we have to think about staff and stress. Caseload balance against the amount of families that there are. Staff feeling like they are constantly having to check-in with some families is stressful, that why there are levels of need and clear pathways for staff to follow. If there's been no identified health needs or safeguarding concerns within a family, then we're quite clear in what we can offer and what level of service that we will give. Sometimes even if there is statutory involvement as there are safeguarding needs, due to staff shortages, we have to remember we are health	...but is this characteristic rather than prof stipulation. boundary Does this mean threshold are dependent on resources/staffing? ...how? To the family or others? priorities

professionals, and so if there's no identified health needs for this child we won't always be attending the meeting but will give a summary of our last contact. In those situations where there just aren't enough staff, you hope the social worker is leading on the safeguarding aspects within the family. If then social services step back as they deem there aren't safeguarding concerns, then you can assess the rationale for on-going health visiting input. You just have to be very clear what the health visiting service can offer, what they will do, and what they will signpost to, remembering this is not a compulsory service. Obviously, part of that care package is going to be, um, you know, an assessment of the family and how they're doing, and it'll include asking how mum's mental health is, or how dad's is. If there is an issue, is it being addressed by another person, another health professional like a GP or a perinatal mental health team or a specific intervention worker? and is the parent engaging? If there is someone then they lead on that pathway, not us. It's more complicated than being left with the family that you know has not met the threshold for social care. We are not a service that's got unlimited resource and we have to think really carefully about what it is we can offer and let	Is signposting support? If family comes to you how may signposting prevent the full issue being seen? control Is this example of HV fighting for more but to the wrong people? Power displaced more from families

people know clearly, what are their expectations and ours. And so we, we need to be strong leaders. We do want the best outcomes for these families. Of course we do, but we need to be clear if the thresholds are not being met. For example I've not managed to go and see this family. I need to go. I need to complete the 9 - 12 month review. There have been issues with this family in the past, so for them, I can decide that I'm gonna go in and just see, you know how the family are and look at the child and see if there's any issues. When there was a social worker before there was an expectation that the health visitor could check-in on the family from time to time, and to see if Dad is living there. You know, things like that. “..Wait a minute. Wait a minute. No, we're not going to do that.” No, we're not. We're not doing that because we will do our mandatory contacts, what our remit is, but maybe slightly change the when/home. Like this family, I will visit slightly earlier. So we adapt our work pattern according to the family need, don't we? And we are very clear about people about, for example, nursery, they might ring us and inform us that they've seen a difference in a child, but then we're gonna say, well, you know	(loss of) control Does the HV service want autonomy over contacts? Or do they want to be capped on contacts? Do leaders need to take overall responsibility? Connection

what? What, what? What actions are you taking about that? Everyone is responsible for safeguarding. Do you find you are protected in your role? Are you restricted? Is there a sense to do more? Ohh God yeah. I mean of course. I think we all wish we could do more. I wish we could increase our remit of mandated visits, see the families more. And of course, because what we know. It is much more likely, the more you ask what families are experiencing, the more times you get to assess that family, the more likely they are to share with you, and the more likely you are to see the impact on the child. We are all about caring and supporting the most vulnerable children in our society. That's why we're here. That's what we want to do. But because of restrictions in numbers and resources it feels impossible at times. We have to change, we have to look at what we have.... What's that saying? "That's cutting your cloth.." We have to work with what we've got, so that we care for staff that we've got. Otherwise we're not going to have a workforce, we're just going to have to change, we have to change our practice	...is this detrimental to the service? So we limit contacts so to be able to cope as a service? boundary who am I (are we)? No choice = no hope? solidarity So do we want to sit alongside? Example of contradictions of philosophy...

according to our numbers and resources, we just have to. We have no choice. And before we might see a family more regularly, we might be a bit more open to analysis and assessment of the family, and see who else is working with the family and we could probably contribute more. Sometimes we are put in a bit of a bad press, aren't we? When we go in and start telling people what to do. Not being a service, that's too directive and instead sitting alongside families. You can't sit alongside a family when you've got a restriction in how many visits you can do. You've got to really analyse who's involved and actually, you know, let's be honest, this government wants us to use less. I'm gonna say it anyway. They've identified that they want us to do early work. Yeah, fair enough. You know, early intervention, but we haven't even got any staff to do that. So they want to look at the plan, and the plan seems to be for us to hand over to less skilled workers? Less skilled workers pay them less, save money and think they are gonna work and give better outcomes? They're already saying it's giving better outcomes. I'd like to see the evidence	fear Are we restricting so we stay valued then? The systems

for that. And so we're pulled, aren't we by this political agenda. You know local authority to take over health. I know that everybody does it different. Some areas have aligned themselves public health, we've aligned ourselves with acute services. We're commissioned by local authority but you know we've aligned ourselves with the acute services. It brings its benefits. But honestly, it brings its negatives as well. What we can do for these families? It's the bigger picture that ultimately affects families and their experiences. We've got family hubs, haven't we? Ohh, they all hail family hubs are gonna be the centre of the world. They're gonna be the centre of the world. But yet it's still all referred back to us. They've not got sufficient safeguarding policies to deal with some of the incoming referrals and WE ended up, you know, going out speaking to the mum, directing them to the right services, ringing social care, coordinating the whole thing. We take our safeguarding responsibilities extremely seriously and act appropriately. But what are the other professionals, without registration, policies, accountability. And that affects families' experiences, and we're aligning	How do we justify the importance of safeguarding? If we align with family experience, then can we fully safeguard? We become immersed in their subjective world.

ourselves with that. Where is the collaboration with that? You can't think too long about it. You've just gotta think, look, we've gotta be clear with our service. What can we deliver. We want to work together cause we know, we know, it'll improve services. And it does improve services. If you got something and your policy is not right, your system's not right. You need to change it. It just takes a lot of leadership.	

HV2 transcript

So first of all, can I just ask you, how long have you been working within specialist community public health nursing role or if you're not in that now, how long was your experience of working within that role when you were?	

About 20 years.

A long time, and I suppose, safeguarding is such a massive thing as well. And what's your current role at the moment?

Health visitor.

So within your team, are the contacts a mixture of face to face, telephone?

I think we're quite lucky that we do a lot of face to face.

Yeah, the majority are face to face.

And within your practice as a health visitor, would you say you have had much experience working with families who experience domestic abuse?

Yeah, I think it's increasing.

Is there any reason you say that?

I think when I first started, there was few and far between, but now it's just a common thing.

Presumption... opinion

acceptance

...Referrals, strategy meetings, and then everybody gets pulled in. So maybe the tolerance level is reduced, and services are more on it really 'cause they can see what effect it has. You mentioned about referrals. Is that where you feel you mostly hear about domestic abuse with families? Well, I mean when we do the initial visit, you're asking about it, aren't you? And you sort of make a position so that people can talk about it. And the impact. So we always talk about the ACE's. So we start talking about how was your childhood and how did you feel and what role models did you have? And do you get much back when you have those conversations with families, do you get much response to that? Yeah, usually they go. 'Ohh, no, no, we're OK.' Or sometimes they'll say "Well, we have our	So by talking about it = acceptability of discussing? And then does this = demonising of DVA more. acceptance We presume that families don't know, or that they are lying? Are arguments ok and acceptable?

arguments". So that's sort of an opening into, well, what sort of arguments are you having? Where abouts in the house do you have them? And who's doing the arguments and things so you know, there are openings so that you can talk. And how does it make you feel having to start those conversations? Are they difficult conversations for you to start? No, because I think it's sort of a safety thing, isn't it? You know, you want people to be safe and have a good life. And some people might think "ohh, this is my life and I have to put up with it". So I have a person that will go in there and say ohh you need to change. It's a matter of drip, drip and getting people to start thinking about what they would like and you know work out is it low self esteem? Do you find when you're talking to people about it, do they do they easily move on to thinking about maybe	Arguments a healthy part of relationships and something child should be exposed to? Truth(s) Good? From our perspective or theirs, or societies? Empowerment. Is low self esteem why this happens? Is this mis-placed blame? So conversations become more about empowerment than safety?

why they're in certain situations, like how their self-esteem or confidence has impacted their relationship? Yeah. Well, sometimes we talk about within different cultures as well. And other bits we'll talk about you know, "are you allowed to have the money?" And the role of the woman in the UK is a bit different to the role of the woman in other countries, you know. We talk alot about life within the UK, not just gender roles, or domestic abuse, but smacking and FGM. You know, general life. And then if I thought someone was unsafe or scared, I'd ask more questions. Then you will you leave it open or maybe say "ohh I'll bob back in a couple of months" or something because our job you can do that, can't you? As long as you've made a reason for it. And you mentioned conversations with different demographics. Do you work with quite a diverse population at the moment?	questions Does this mean that how women are in UK trumps other cultural beliefs? How are women in the UK treated? Do we even know what a woman is? Just because we don't do something, does it make it wrong? Truth(s) and histories

Travellers and asylum seekers, refugees, and Eastern Europeans as well. Yeah, it's quite mixed. Yeah. Yeah, it's a lot of, you know, private rent properties, shared accommodation properties. And do you find that the conversations that you would have about domestic abuse, and relationships in general, differ with those more diverse populations than maybe you would have with those who identify as White-British? Yeah. And we talk about expectations, see the expectations of married life is different. If you've got an arranged marriage, what might the expectation be? And do you find that there is a difference considering the culture regarding family roles? Do you have to explore how those roles are shaped within the family? Yeah. But with the travellers it sort of, um, sort of an unwritten rule that the ladies are going to be at home and the men will be at work. So we ask the women,	Who does it right and wrong? Aren't arranged marriages successful? acceptance Stereotyping/bias... reminds us that we are still human

"So what do you do in the daytime? Exercise and healthy eating? And how are you feeling?" The other thing that we're doing is about male suicide and men's mental health. Because the women will go "Ohh, yeah, the men are OK" because we talk about post Natal depression and ask what does Dad think? How does Dad think about this? And so some cultures are a bit like "what you're asking about him for?". You know, he goes out and he does whatever. You know, if you're together, even if you might not do things you have done together, it has an impact, doesn't it on your expectations? And if he thinks his dinner's not ready, cause you've been busy with the baby, then that leads to some sort of argument And do you find with these families Dad tends to be out at work. Do you see Dad much? No. Sometimes if he's on nights, he might sort of appear. Quite often, what happens if the women are non-English speakers, then they would be wanting to	Truth(s) So do fixed gender roles mean inequality? Is patriarchy directly related to DVA? But don't we want to see more of Dad's? solidarity

ring him up at work, and you say "it's okay. I'll... you know I can ring for the interpreter and we can have this conversation. Just us." Otherwise there's an element of control coming in from the house, even when not there. You know, we've just got to play it by ear. Sometimes the men, they like to see you, and then they'll leave you to get on with whatever you've got to do so. In your experience, do you tend to find, if there has been disclosed domestic abuse or it is known, does one family member tend to be more a victim, and another more of the perpetrator? I think I've seen both. Strangely, I've seen it from both sides. I've seen the girls that have got coerced and also the boys. You know the man in the relationship, maybe was more difficult for him to understand because he thought what was happening to him-he didn't think it was right, but also he didn't know what he should do. So you know, I may just pop round this one day and there is a hole in the wall that hadn't been there	'Strangely..'? unexpected/shocking? opportunities

before, and I say "Where's that hole come from?" Do you think there is an understanding of control and coercion within most families? Is it recognised? I think it takes some time for them to recognise it, and we have quite a few that follow the same type of partnering, they tend to pick the same type of partner. It's not supposed to be a stereotype, but it is. Being controlling. Because they seemed to go for the same type of man. Is there anything that you feel is a contributing factor as to why some women seem to go for this particular type of controlling individual? Yeah, I think it's because they like, at the beginning, they think they're helping this person, so they like to look after him. And then once he's got control, it turns into not a nice relationship at all. You know, it becomes stalking, harassment and violence.	Recognition of time, however when we routinely enquire we expect people to know straight away? Victim blame Truth(s) Are victims and perpetrators helpless? It's just going to happen?? stuck

And it does seem that they just seem to go for the same one. When you turn up at the house and you think "ohh, no, what's going on again now? Not another one like that". And do you find when you've routinely enquired about domestic abuse, or an incident has been disclosed, do the families then engage with you. What's your experience of that? Well, they seem to. Yeah, they do. I think as health we're non-threatening, I think it's the social services that have the difficulty in getting in, isn't it? I think we're sort of a soft touch, even though we can get to the same end. You know, I think with the travellers, they're renowned for not liking some professionals, and are not letting people in, but if you're a health visitor or midwife, they understand that you are there for the development of the baby and for the safety of the baby. You can't expect them to tell you everything at this first visit, can you? So you have to give it time, for them to	Perceived level of power seen of HV. acceptance ..but yet we routinely enquire. Importance of caseload working...relationships difficult to make in one-off contacts.

be able to know that you're coming back again, you ask again and see how we do this time. Is your experience that if you need to, you can easily arrange those repeat appointments? I think now it's more difficult because people are off sick, and so you are covering and meeting families you've never met before. And then it's about trying to make another relationship. So it's difficult for the family, isn't it? Because it's just like, who's this person? Why should I tell her that information when she might not come again? So that's the difficulty, I think, and understandably, because I wouldn't want to be telling the same story and having no outcomes. Do you think when there is that disclosure and you're talking it through with somebody that there is an expected outcome from either yourself as a professional or from the family member? Is there a staged or steeped process of now this will happen? Sometimes I think they just want you to know, and	connection Should <i>they</i> have to just go? fear Give someone the time to be heard. Multifaceted issue. Do we contribute to them not going by acknowledging how hard it

have ideas about safety factors, because in reality I think it's really difficult because you can't just go. Like the movement to the hostel, if it's so severe, where can you go? Where's your safe place to try and find a hostel somewhere? It's very difficult, isn't it? In the same area to try and keep the children at school so hard. And also then about their current accommodation, if they're renting and then they go to go somewhere else then it can become difficult because some councils will say ohh you need to still pay us. And then they worry about the money. So I think at the beginning, they just want you to know, so that somebody knows. And then you talk it through, don't you? To say, well, what do you think? How do you feel? If they have three or four children is really difficult for them to go anywhere. I mean you can refer to social care and usually they would refer to the early help hub. It depends how quietly they want to do it, doesn't it? And how quickly they want it to be escalated, you have to risk assess, and sometimes if it's a really bad risk, it has to come out of their hands, doesn't it? As long as you explain, you know, this is very dangerous situation	is? Or is this empathy?... but not radical empathy?? stuck Risk assess being objective? If we are subjective and hearing stories, what happened before no longer exists? Safety of home

and that I'm gonna have to do these things now that you've told me that....It's for their safety. When you go into those conversations with individuals do you have specific things that you want to talk about or is it more sort of an open conversation? And I think it's open, but at the same time, you don't know their safety network, do you? And on what they want and what they've had before, you know the history of it. If they've had it with this partner or a previous partner, because some people have moved out of area, so they've moved into this area to escape domestic abuse and maybe he's come to get them, or they've got a new person that's the same. So you have to start from the beginning, don't you and work out what they've experienced before? But if it is increasing the risk of harm to the child, it doesn't matter what they want.	histories
When you're thinking about that perspective of safety and thinking about how you have those conversations, is	Mother blame?

there a way in which you translate the safety message across? for example, is it very much about the children and their safety, or do you talk to the individual about their personal safety? Like, well, we usually talk about both really. So hopefully if you've met them before, I could talk about the ACE's and then look at resources, but sometimes all you can do is just talk through the effect of the domestic abuse, and the effect on the child, there isn't time. What is the child's lived experience, you know, living in this environment, how is the child? And at the same time, you have to make sure the adults are safe and how they're managing their lived experience. That's what social care want to know. And do you find when you're working with those professionals, say, during a safeguarding meeting, is the onus on a particular family member or parent to ensure the safety of the child or the children? Or is it a shared responsibility?	children If they have capacity, then their safety cannot belong to anyone other than themselves? acceptance When we try to capture the voice of the child are we

It's on Dad (the abuser). When it's discussed with the parents, what is their reaction when you talk about how the child(ren) may be experiencing the situation, the implications of their safety. Do the parents engage? Yeah, but sometimes they'll say "ohh they don't know. Ohh they can't tell. Ohh there's no, there's no problem" and I think that's a difficult one then because then you have to try and put it across, their lived experience... what's it like living in the house where Mummy and Daddy are fighting and daddy hits Mummy, there's lots of screaming, and so we just need to work on that really. You have to say that children, they listen, don't they? Do you have any resources or tools locally sourced that you use to guide those conversation? Yeah, they've got the domestic abuse policy, and then you can contact safeguarding whenever you like. And	simply speaking <i>for</i> the child based on our own realities? See me

then there's a clinical risk analysis or clinical risk... Something. Yeah. So that goes on all the reports. What you think the risk's are, and if you need support with that risk. Is it compulsory with to engage with those pathways or is there an understanding of professional judgement, and that they are simply tools to aid you. Yeah. So on your review conference report all the clinical risks are there. So you have to look at that. As well as the domestic abuse pathways we have a safeguarding supervisor, so if anything goes to MARAC then that goes in the records. So would you say those sort of things, that you've got to help you within your role, are they beneficial? Ohh yeah, even if it's just to give you an awareness that something's happening before you go in, and you can see on the record that something's there, then you can ask directly... "what did the police say when they came?". You know it's helpful in that way.	Appreciation that you always need objective evidence. Cannot base on just narrative alone. Truth(s) solidarity

Working within a team, do you find there are opportunities for you to come together as a team and discuss things?

Yeah. So we have a Teams group and chat. So if anybody's got a question about anything, they can put a question on it and somebody answers. Or if you don't want it asked to the whole group, you can send a message and say "ohh can you ring me" and then you can have a chat about whatever it is.

Beacuse we've been recently taken over we have team update thing's, and we have monthly team meetings as our big team.

Do the conversations with colleagues tend to be more informal?

Yeah. So I think, yeah. You can ring anybody you like really and have a chat. But at the team meeting, they maybe get you more up to date with policy. All they can say, you know, "has anybody got any worries?"

Or at the GP meetings, people who are attached to GP, like the midwife will be there. So you know, you sort of

priorities

Is it important because we keep saying it's really important?

have a bigger sharing of information there. They are formal, recorded meetings. Thinking about the wider team, and different professionals involved in it, does it seem there is always a consensus with the desired outcomes for families who are experiencing domestic abuse? A shared perspective? Yeah, I'd say it's varied. I would say it's varied, but there are guidelines out there. So when you go to your child protection conferences, the voice of the child is very important. And people have a different way of getting to the end results. Some people, if they haven't experienced it before, want to talk less about things, cause they might be worried about putting the individual at risk for talking about it. And also services have changed so much in community, it's hard to know what there is out there to support. Is there anything particular that you feel has helped you individually work with these families? Being a midwife before. And just experiencing people,	Do we not ask because there aren't the services? Complementary and contradictory at the same time. Listen with humility honesty

how people act and how you don't just jump into things. You assess what's going on and then plan. Yeah, but at the same time, you recognise that you don't know everything, do you? So if you need to ask things, you do. And do you think do you find it quite easy to ask within your team or speaking to other professionals? Does that seem quite an easy thing? Yeah, I think you have to, don't you, because it's the safety for you and it's the safety for the family as well. Because if you don't ask and you bumble along, then there needs to be some sort of organisation in you in your role, doesn't there, about what you're doing. And then also the family have confidence you know what you're doing, if you are just popping in and not really doing things and constantly thinking why should I visit now, what's happening, and what am I doing, it shows to families. So yeah, I think it's important if you don't know what you're doing, or you are unsure, you need to ask somebody.	So there must be a reason to visit, is building a relationship the reason? Too confident? Truth(s)

Are there any particular things you have changed since you qualified as a health visitor? Things that have impacted your practice? has it changed? Does it become different?

I think you have to be careful not to be too confident and think you're really brilliant and have courage in your convictions. Courage and confidence in your actions. So when you're with them you know what you're doing. So some people have been on visits and they've called the police there and then because they've witnessed a person getting aggressive. I've even asked if she wants to go you know, and if she does, I've taken the girl and she's got in the car and we've gone to wherever we've gone. A safe space like the health centre or children's centre, and then you ring the social worker and say this has happened.

You gain the confidence in what you've seen to act on it, then you refer. Some of the girls will minimise it "Ohh yeah, he's always like this, it's fine". You have to say "No, why are you living like this?"

Are they minimising it? Or protecting themselves?

Do you think when they make those comments of "ohh, they're always like this?" Do they recognise that it could be problematic? Yeah, it's just a norm. And when they talk about it, is there alot of minimising language used? do they do they convey specific events, or do they brush over behaviour? No, I think they minimise it. And how do you then respond to that? Do you challenge that at all or would you come back to that at another time? Yeah, I would. At the time, I would say, you know "What makes you think this is normal and what's happened in the past" Just try and explain the danger. And how is that taken? Well, sometimes they'll go, "Ohh. He's not like that" If	So more weight placed on incident reports? Truth(s) Example of working side-by-side with women. Break down are professionals trying to break down women? connection Share in connection.

there was no immediate risk, I'd say "OK, well, I'll come back" and you'd bob back then and see how things are.

Sometimes the domestic abuse incident reports are really good, so they'll say "ohh nothing's happened" and then when you read the abuse reports, it's like he's got her up against the wall trying to strangle her or knife her or something. So you can use the report you have to read through it together with her. And then you can say, "well, how did you feel whilst he had you up against the wall? What was he doing with the knife?" And ask "you obviously were scared enough to call the police, so what was happening there?" That helps with getting through to them.

So when they are telling you about the incident, what do you think they want to happen?

I think they want somebody to know.

They want you to know because at the time of the incident they want him to get into trouble and want him out of the house. So it's like a little warning. And then he goes back in, cause they don't press

She's scared but also malicious.

Break down

Do these exist?

boundaries

charges to this, and that's when it becomes worrying. Nothing happened to him, he got away with it. I don't know to be honest, but there must be something triggered in her at that moment where she knows it isn't right, she isn't safe and this is so much more than an argument to make her call the police. But then you do get malicious ones, where nothing's happened, but somebody just wants to get somebody into trouble. People are complex. Do you wish there was more we could do? Our role is getting a bit dissolved, so I think we're OK with our role because you can talk about their impact on the child, the health of the child, the parental mental health, and liaise with the agencies. I think in some areas they maybe have a specialist domestic abuse health visitor, which is good. You don't need us doing the job of other professionals, we are health. Do you find you have any internal conflict with what you	How do we distinguish when it's no longer health? Doesn't everything impact health? But need conflict to reflect? strength What is risk? boundaries

feel should happen professionally, and what you feel personally? I think you can't have conflict because then that's your view taking over. I think we have these guidelines in place to safeguard us and the families. You can all be asked what you think, in meetings, and then you might say "you know the risk of harm is really high here", you look at the facts. You can't have conflict in what you say and think. That's great. I mean is, is there anything else that you feel you wanna tell me about working with these families? We can't be with them 24 hours and I think some people may worry, but you can't, you can't be there in the house, can you? And probably at the beginning of your career you're thinking, "Oh no, you can't live there and you can't do this and this can't happen", but then when you look at what you're expecting it's too big... The things that they've got to do to achieve change, it's big, isn't it?	stuck Are we still seeing a misalignment with media and DVA? Truth(s)

You know it's very hard and you know for them to just leave. There are so many things for her to think about "do I move everybody to there?"

And I think resources are difficult. There are waiting lists for everything.

And sometimes domestic abuse is in fashion, I mean you see it alot on the TV...The use of those adverts before, but they seemed to have gone now, but adverts usually focus on physical violence.

Years ago, husbands used to hit and, in some cultures, they still do that. And in our culture, they still do it, also the husband goes to work and has the money, but it's about saying, "well actually you can have some of the money in your hand. He doesn't have to be the one to have the money".

What do you think is society's understanding of domestic abuse, the wider public?

Now I think I think they probably still think it's about physical, but also in town, town centres now, they're quite good out there because they have the little hubs for people that are scared at night time. So you can go

to the street angels or whatever they're called.

And they did that thing about the World Cup, that that's the most dangerous time as well, isn't it? You know, if the the team's winning or not, it's not safe for some people at home.

Then you have that person on social media who speaks to boys about how you should speak to women, but it's so sexist and misogynist, and so that's a big thing in schools, you know, trying to educate children about relationships.

HV3 transcript

Can you tell me how long have you been practising within a sort of specialist community, public health nurse role? Almost six years. Do you feel you've had much experience of working with families who have some kind of experience of domestic abuse?	

bbbbbb

Yeah absolutely. I've had lots of experience working with families in regard to domestic abuse. And across the service before or during children's social care involvement. You know, so often sometimes you can become involved when those issues have become apparent. Sometimes it's you who is identifying it, and you've advising people of what to do when again they're making those initial referrals. Did you have much experience or knowledge of domestic abuse prior to your health visitor registration? yeah, it wasn't new to me. So previously to me being a health visitor, I worked in sexual health services, so the GU side of things that then obviously the contraception side of things and HIV and all that service that was combined. So, I worked in that area for eight years and we did always ask about domestic abuse as well. Do you routinely ask every time you meet a new family or meet someone for the first time?	HV are caught in the middle of stat services Do we forget/take for granted how experienced and skilled HV's are. Invaluable resource. Histories

So yeah, it depends what sort of contact that I'd been in for, you know as in, was it just a universal contact, it would also be dependent on the environment that we were in, and you know obviously if there were partners there, or the family members then I wouldn't ask. Definitely always if I was on my own with them, as in, you know, if the baby's there, that's fine. But it's really important in how you phrase your questions and how you sort of it introduce that conversation. So I would sort of say for example, you know, if it was an antenatal visit, you know, I would, I'd obviously we would talk about lots of things, for example if they've got a partner. "Ohh, how long have you been together long?" "Is your partner living with you?" And how you would talk about relationships and about that we know one in four women can experience domestic abuse and for some it starts in pregnancy. Different types of domestic abuse, and what that could look like. I would never just ask, "if your relationship, ok?" because a question like that, you're gonna get a no response, or just a "yeah it's fine".	Simplicity Qualitative and quantitative. Questions

So, I think it's really important that you tailor it, you're questioning around relationships to an individual basis. Yet there's no right way to enter into that conversation specifically. What a equips you in thinking about how you frame the conversation and ask questions? I think it's really important to build up a rapport with the mother, you know, and a family. And I think it's really important that you, you know, present yourself as someone that's able to listen and that you go in there wanting to have more conversations with somebody, rather than going in there with your own agenda. Taylor more of a two-way conversation with people, cause I think having those skills to be able to build up to those sorts of conversations is a really good skill to developing that therapeutic relationship. And I think if people go in with, like, right. "So, I'm here to do an antenatal, we're gonna talk about this, this, this and this..." and they don't give people the opportunity to have a conversation that could really be a barrier.	Art of conversation in the listening and observation. connection Rapport? belonging What is a therapeutic relationship? priorities

When you're having those conversations, how do you find those conversations are received by family members? And I've never found anyone to be shocked about it, because I think obviously midwives talk to the women about it. I think it depends on the family's experiences. I think sometimes if you have a family that's not particularly very receptive to the health visiting service, they could have possibly had previous children's social care involved, previous domestic abuse. I think sometimes you can get people that can for a better word, be a bit like pulling teeth with conversations, not really receptive. But I feel I'm quite good at building up a rapport, but I can certainly think of examples when people have been like, "no yeah, everything's fine". And perhaps that's because of their own experiences previously. How do you engage someone who maybe isn't as willing to open up?	acceptance Truth(s) Maybe it's fine for them? Do we judge thresholds on our own (personal) standards?

I think it's being softly, softly, gently, gently. You know, going back, building the relationship. I remember covering a visit for a colleague, it was a new birth visit, and there's been reams of previous social care involvement, and I would just get one-word answers back from mum. When my colleague came back to work, I handed over that I felt there was gonna be more going on in that house than what's being said in that visit. There were no safeguarding concerns during my visit, but it's just you get that feeling as a professional, so my colleague continued to build that relationship...Which then resulted in lots of disclosure about current domestic abuse. And how does it make you feel either initiating that conversation for the first time that you meet somebody or having those more ongoing conversations? I think I'm fine in having those conversations. I've been really quite inventive with thinking of ways to talk, you know, there's been a few times I'm not sure that this dad's been very supportive. So, I'd suggest going for a walk and talk, things like that, or I will say "I better come back and see you in a couple of	Gut instinct So you don't need a reason to go back? Opportunities

weeks. And if we want, we shall we go out for a walk with baby? Go for a stroll?" it's allowed me to have those conversations, but I am experienced in it, and I think you have to be comfortable. it comes with time and perhaps I think possibly when you first are newly qualified, those conversations may not come naturally if you've never been in a position about having to initiate difficult conversations. It's quite a skill, isn't it? It's something we have, trying to be able to read the room and see all the non-verbal communication, and that two-way conversation and developing that therapeutic relationship. I think in some respects it's a skill that you can't teach. Do you think it takes a certain type of person to initiate these conversations? I think personally if I think about what people will say to me if I'm giving them advice, just generally or having conversations, you know, people will say to me, "ohh gosh, you know you'll always give me balanced advice and you know you're the voice of reason" and stuff. So, I think I do have those good skills and	So does SCPHN training not equip us? consistency gut instinct How do we learn then?

know how to be a good friend. In regard to, you know, domestic abuse and supporting families with that, I think I do a good job.

You mentioned balanced opinions, why do you think that that's important with these families?

I think domestic abuse is such a common thing for people to experience, but I think for victims that have experienced it, they don't often realise it at first...He doesn't hit me, it's not abuse. So I think it's about being able to talk about different types of abuse and what that could look like, and also it's a really fine line of how to be supportive, because there's no point in going in if someone said to me "that's domestic abuse, what you're doing?! You need to get out with your baby"....Whoa, I'm not ready to hear that. That's not abuse. If they've been in a relationship where there's been lots of coercive, you know, domestic abuse, controlling things like that, you've got to really talk about healthy relationships.

You mentioned before about some of the strategies you've used in

To have reason helps right/wrong? Or does it help listening, reflecting??
Who am I?

acceptance
If it isn't abuse for them, should it be for someone else?
empathy
Can we truly support when we have safeguarding obligations?

the past, but would you ever ask about domestic abuse if there was anyone else in the room? No, but it can be really tricky. I think it's looking at your record, isn't it? And seeing if you're going and that question's already been asked, there's been no safeguarding issues. It can also come down to professional's noticing mum's body language, What's going on? is there someone hanging by the door? So if someone else is there, be inventive. Consider asking, "do you want to come to clinic?" I've done the things like that in the past when I've had a funny feeling in the house. I've used that before and if someone from the family comes, you can say in clinic "Actually it's really busy in this room. Come up, we'll just nip in here.." You've got to try and think on your feet. You absolutely are like what trick can I pull out of this bag. Now, how can I, you know? And yeah, it's thinking on your feet, and there is never going to be one answer to that question with your experience and the current demographic you work with, do you feel culture impacts the way you ask? The way the family set up is?	What right do outsiders have to make comments on relationships? Does the question render pointless though if individual does not wish to answer? Is a question only a question when there is an answer reasonable to the questioner? containment individualised

I think when you think of cultural things, I think again, I've worked in areas with variety of you know cultures and you know everybody I've worked with, I think it comes back to again with certain, you know, cultures. And again, I think sometimes I felt that women can be deemed as sort of the person who produces babies and that's that. Maybe seen as more of a, you know, a second class citizen in the sense of that's your role, you're there to cook, clean and, it makes you feel sad. I remember once I talked about contraception with a mum, and you could just sense that, gosh, that it was really uncomfortable for her, that I've spoken about that. Almost like she felt she doesn't have a choice about babies. She didn't say that. But you know, just when you feel like, gosh, I've spoke about contraception and that's really uncomfortable topic. It's not what she said. It's just a feeling that I got.

do you think that there is a a gender dynamic in regards to domestic abuse? As in, who may be experiencing it?

Yeah, women, they're the victims as opposed to the perpetrator.

I think I have worked with families where mum has been victim and perpetrator. That's often been the case. I don't think I've

Belonging and who am I?

So many 'gut' presumptions made.

ever worked with a mum where she's solely been the perpetrator. With the woman who you said was the victim and perpetrator, did she freely talk about experiencing and instigating? Yeah. It was a really complex family and, you know, historical child protection, historical victim of DV and then yeah disclosed loads of DV from a partner. It was very blurred lines again. it all became very messy. How did Professionals and other services respond to her being both experiencing as a victim, but also as a perpetrator. Did that did that impact how she was viewed? I don't know. I don't think it impacted how she was viewed, but it was such a complex case in the sense of, you know, it wasn't just domestic abuse. There was lots of debt, risk of eviction. One of the children not going to nursery. And then they attempted to move out of the borough to avoid Children's social care.	Shame Truth(s) So is it clearer, or simpler when the woman is victim and man perp? How does clarity enable our role? Truth(s)

She then went to a refuge, she escaped DV and then got back with him, so it was really complicated. Then they make lots of complaints about children's social care, and then "I don't want that member of staff, I don't want to engage with the health visitor". Chaos. Chaos. I'm not letting the social worker in until I've spoken to that manager, social work manager.... Wouldn't answer the telephone. It really, really complex.

Do you find when domestic abuse is reported or occurs, is there often other complicating factors at play with the family? Or can the domestic be standard alone?

There was this one family, I got the visit, read the record and thought "everything's fine in this family". So I hadn't met this family antenatally. But I've done a birth visit. Mum. Dad. Babe there. The baby is a planned baby. You know, both employed on maternity leave, no financial worries and straight forward pregnancy for her to think off the top of my head and you know really nice interactions with that baby. I left, came back and did the 6-8 week mum let me in and I did the visit and I didn't ask her about domestic abuse actually, I was coming to the end of my visit and I said, "you know, I just wanted to check in with you if is there anything else that you'd like to talk about today or

Control Complicated or quite simple and prescript of DA? So it is complicated when they don't want to work with professionals?

anything else I can help with the help today?" She burst into tears. She went ohh. "It's not being good with the with my partner. I went to spend some time with my friends at the weekend. I came back and he was really aggressive and shouting and won't give me the baby. And I had to ring the police." And I said "Ohh gosh, thanks so much for telling me" She was so worried as she knew a safeguarding referral would be made as they had a baby. I reassured her she'd done everything right, and that you know, 'I'm not worried about keeping yourself safe and all the rest of it. But you know I will contact children social care because they should have made a referral. If they haven't, I'll put one in. Is that OK? And it's not that, you've done anything wrong. You're keeping yourself safe. And I'm just thinking about you and support for you going forward'. And she's like, no, that's absolutely fine. And guess what, the police, they hadn't put one in at that point, it was terrible. I think this had happened on, like, Saturday, and this was a Monday. It's funny, sometimes you can go in with misconceptions that you can go into a visit thinking. Ohh. I think that this family is doing alright.	blind

We all have our own perceptions of things we've experienced personally. How does it feel when there are those disclosures from families that you simply weren't expecting it from? I was shocked. I think that's the thing, isn't it? I think everybody, whether they've experienced in their personal life or professional life. You can make misconceptions about people. And that it was really quite sad actually with that case, because essentially, I think they'd really just struggled about that adjustment from single, well, you know just people with no kids, to having kids and I think they were stunned. His mental health had dipped and I think he was struggling with becoming a father, so we spoke a lot about services he could access. I think it was the stress of that transition. So thinking about yourself as a professional and in your organisation, in your place of work, what is there? Do you feel supported in your practice surrounding domestic abuse?	control I wonder why do we think some families are alright? Class? Socioeconomics? Race? Truth(s) blind

There is a lot of supervision and reflective discussions, safeguarding and case load management. I think it's really important as a practitioner you can get to a point where there is normalising of what's seen and experienced...Acceptable behaviour and you can become desensitised to it Do you feel there is a baseline in acceptability of what a healthy relationship should be? OK, so I think there's a big difference between conflict in a relationship and domestic abuse because everybody can have conflict within the disagreements that are just disagreements. Nobody can have a relationship without there being any sort of disagreements. When you talk and assess the relationships in the family, do you centre the child? Or the mum? I move between, really. So I think it's really important to include general conversations, "how are you mum, how are you dad?" because that's building up the bigger picture for what life's like for that baby. You can't just go into a house and keep putting	love/hate Can DA result from maladaptation? Or is it within us? Rather than adaptation from change in situation. Acceptance Does seeing something a lot equal acceptance or normalization?

your blinkers on him. Or just think about the woman. The Baby! you have to talk about the whole household. Have you ever had conversations with parents experiencing domestic abuse, and you've talked about how it may be affecting the child? how's that received by the parents? I think again it comes back to seeing if they just want to minimise it. They'll just go "Ohh no, it's fine, you know" Or "they were in bed asleep." It's those families you need to really talk about the impact of DV on children. Or they've totally identified that behaviour wasn't OK. They were concerned for the impact on the baby and therefore you don't need to have that because they already know. They're minimising it, where do you think that comes from? The domestic abuse is such a complex thing, and that often people stereotype. But when I think about families, you know that they've grown up in houses themselves that have experienced domestic abuse and lots of ACE's, and then found themselves in a relationship with a perpetrator. So I think it's	Truth(s) and acceptance How do we distinguish between conflict and abuse? Is it the individuals perception of safety and security, or is it the perception of a professionals? (with interest at heart!!?!) connection connection

really, it's a really complex thing to unpick. If they've seen it themselves as a child, that behaviour is seen as normal. So then as a professional, when you try and have conversations about impacts of domestic abuse on children it can bring up alot of things from their own childhood, and it can be really complicated for a person. The victim, if they have experienced things themselves as a child, as a witness, or worse being, you know, abused themselves, but then that's going to stir up lots of complex emotions that would be really difficult to process and would be really upsetting to process and if they're not in the right place to want to explore. Acknowledging that they are victims of domestic abuse, then it it's really hard. What are your thoughts on the health visitors remit and role in regards to domestic abuse? Do people/professionals understand the role? I think the profession understands that safeguarding is everybody's business. I feel that that's really well understood, but I think the role of the health visitor is really poorly	Acceptance What is complex?? vulnerability They are governed by their inner child? Highlights the need for health prevention...we cannot save parents, but help the children?

understood. Really. I think there's an element of 'ohh, they just knows in and they come round and ask lots of questions'. You know, I would always explain what the role of the health visitor is and what we offer and the healthy child programme to try and dispel some of those myths. But again, I think it probably comes back to individual practice doesn't it? Do other professionals understand the health visitors role? I don't think police understand. I remember going to a family and there was domestic abuse and I've pulled up outside, and there is a police van, and I thought I know where that is. I know where that house is and I get out of the car and they clock me. The officer said "Are you midwife?" "And I went. "No, I'm a health visitor." "There's been an incident. So, I just wanted to hand that over". And I'm like, right. Are you making a referral to children's social care? Or a DASH assessment with mum? They said, "I'll do it when I get back to office." So I then proceeded to go in it and did it, and I was like to the mum "Well did they tell you that we're gonna refer into children's social care?" "No." she said	vulnerability Right to ask. Right to tell. fear boundary Do HV themselves understand their role?

Why do you feel there is this misunderstanding about roles and responsibility?

Maybe as there isn't an actual person to hand over to or discuss.

So maybe they're not around enough to see because obviously when there's the reviews, often they'll just send updated police information. There won't be a presence there. So I suppose from their end, do they ever really know sort of what the role HV is because they're just there to deliver the information. They won't know the outcome of why the health visitors there originally.

There is no contact between HV and police, even when there is DV.

Boundary

When there is a high level of need and lots of professionals involved with a family with domestic abuse, does it make your work with the families easier?

I wouldn't say it was necessarily easier. I think there's obviously lots of politics in regard to social workers being consistent and obviously they have high staff turnover. So, I think sometimes it can be really frustrating that if you are that constant professional

for that family and then you're having different social workers come in, it's like we're starting from the beginning when I could have been there for a long time. Sometimes social workers want to press the reset button when they come on board which is can be quite frustrating from a professional point of view because you've been that consistent one. And ohh yes, I know they didn't go to that perpetrator programme but they're going to do it now and I'm like well no, actually, you know this has been ongoing. It's an action on the plan...Is it child focused? And what is it like when it is just you working with the family? If it's just me and I'm dealing with it, it's fine. If it's disclosed and its historical, being able to offer them, maybe another contact in a couple of weeks just to check in with them from an emotional wellbeing point of view and just see how things are. And is there anything else that you can think of within the role that you wish you could do? I think what's really difficult for families is when they get the	Team working I wonder if we view DVA as experiential and subjective, other than reporting, do HV and police ever align? Truth(s) HV moving from the subjective to the objective... again contradictory but

opportunity to do the freedom programmes that there's often not the childcare facilities, so it impacts on, you know, it makes it more difficult for people that are already in really complex and stressful situations to attend. So I think sometimes from a bigger system point of view, is it set sets people up to fail. And the perpetrator programmes, the waiting list can belong. And my ethnicity can be a barrier, they may think I don't understand. We need to bridge the gap in communities, representation, how do we empower these women in hard to reach groups? You mentioned perpetrator programmes, do you think we do enough to directly challenge someone who's instigating the unacceptable behaviour? I think often those conversations are easy to have when there's a massive situation and they're on a plan because there's a group of professionals around a table with a child. I think if you was in a visit on your own and there's been some disclosure, I think you've got to be really careful not to create risk.	complimentary, side by side all the time. What we were yesterday no longer exists...so can we start over everytime. How much emphasis do we give history? containment

Do you think, as a society, we place responsibility on the victim or perpetrator of DV? I think there is inconsistency down to the offer of perpetrator programmes in different areas. I mean, if you could go even bigger it it's about, I suppose, what healthy relationships look like and again it comes back to again when kids are experiencing abuse as a child, it normalises behaviour. So I think it's really good now that obviously in the with the schooling of children, they talk about healthy relationships. Hopefully people will know what healthy relationships are, but then there's a massive gap of what support is offered to children living with DV. So yes, the law might have changed, but what you're going to do then for those children? Mum gets Freedom programme, referral to woman's aid, but what do we offer the child? Do you ever feel your personal and professional thoughts about domestic abuse come into conflict?	How important is representation in HV? Serving communities... Shame safe

All you can do is to focus on safeguarding those children and their families and following your own, you know your own procedures with referrals and 'what-not' to children's social care and be as supportive as you can. But I think as a professional as much as I would like to see that people leave the perpetrators and can break that cycle, I realise that I have no control over it.

Acceptance

Is there anything else that you feel is pertinent to working with these families within a health visiting arena?

If there was a programme for children that have been victims.

	Empowerment control

HV4 Transcript

can you tell me, how long have you been practising as a HV? It's my ninth year I think. Would you say you've had much experience of working with families experiencing domestic abuse and violence? lots. Yeah. Do you find it sort of quite a regular occurrence or something? Yeah. And what's it like working with these families? Challenging and very different because of the different types of domestic violence that we come across. So the extreme of actual aggression and physical violence, sexual violence to emotional coercive, financial abuse from families that may be a little bit more affluent and professional types, so it's very, very different in the presentation of it and how you how you deal with it and how you manage it and how we	Patterns of abuse What does challenging mean? More work? Not being who we want them to be? Having lots of behaviours? Should it be managed?

help women manage it, and so every case definitely has multifactorial variables that you kind of come across that you don't always know, which is the best way to go and to approach those conversations. Sometimes you don't get an opportunity to be alone with the woman, that's the nature of the beast, the men are always there, and sometimes there are the obvious things with women that they don't or are afraid to engage with you because they fully understand the consequences of risk. So it's very, very varied, but equally as frustrating and not being able to always help those women to live freely and even to understand that they are experiencing it. Even that is the challenge, isn't it? Because women won't describe their relationship to you, their lives to you. And then when you're you start hearing and seeing those red flags. When you try then to suggest that something might be going on. Often women don't understand that it's even a problem because they've grown up in that same situation. Parts of they're self esteem and self worth is so low that they don't, or they don't want to see it. They don't want that it's something that they're going to have to change in their life so...Just so many complexities, just very, very different for each situation.	Fear So women are constantly managing risk? Do we set our own standards on others? Acceptance Inner child? Do women learn martyrdom? Self-sacrifice in parenting?

Is there anything that you've come across in practise that say you weren't aware of, like a learning curve for you, or did you feel with every different type of situation you had a little bit of background knowledge about it?

Sharing and connection

Yeah. One specific case where I was dealing with the family with a bereavement. So their child had died I'd known the family for a long time. And I supported the family when their child and was hospitalised and he had a brain tumour, and anyway so went into hospital and all the time I've known this family. Both parents were from Ethiopia and spoke very little. And Dad always spoke for the family, but there was always warmth and welcoming and appropriate conversations going on. It was only when the son had died, he was 4. I accidentally turned up at the house, I accidentally and opportunistically turned up at the house one day when I hadn't planned to go, but anyway, so Mum was there with the other child. I mean, she disclosed to me that there had been a long history of emotional and financial abuse going on and it was only then that I looked back and thought "Oh my God, how did I not see it?" That was a big shock to me

Truth(s) blinded by certain truths.

because I thought having seen it everyday or most of the time whilst I'm at work it's blatantly obvious that something weird going on and we can't pick up those vibes from men. But this guy was really, really clever. But there were a number obvious signs that that was going on, also the eldest child has autism. Then their middle child became terminally ill. And then there was a baby. So there was lots going on. So I think the subtleties of it probably I missed because of all that stuff going on. So yeah, it turned out the mum could speak really good English, but Dad always spoke for her, and that was his way, I guess, of controlling her. But it never crossed my mind because of the way that he behaved, always seemed respectful and all of those nice things. I guess now I look back and think, yeah, typical red flags that I should have seen. It was a long fight to get mum and the children re-housed because Dad had got their social housing in his name and all the bills and everything was in his name. So essentially she had to leave the house and everything. And so I remember I contacted the Council and the local MP in other ways I could think of to tell people how difficult people in these situations find it. So yeah, I think even then the domestic violence team struggled initially when I was	Truth(s) perspective of multiplicities Transcendence We recognise the insidious and dangerous nature of coercive control but systems are built on events (in this case life-threatening violence). Complete mismatch.

explaining the situation to them because she wasn't in immediate danger of her life, but that situation had been going on so long, emotionally she was drained, and her self-esteem and everything else was just at rock bottom and he was preventing her from accessing bereavement support along with the other children, and that's where we called it a day and I supported her to address this situation. We got them to move, but that was really difficult because I guess because those refuge places are for more life saving situations not life changing situations, I get that. But she in my eyes, she had the same right to be there as everybody else because she'd been experiencing this. Her only other options were to stay or be in a homeless B&B, and its damn squalor, living with all the drug users that live in the area. Because that's where the social put them. And that's not what was gonna happen to her. I'm not gonna let it happen. Just not happening. So that was that was long daily calls to the domestic abuse helpline. Try and get into a refuge. It sounds like a mountain was climbed, you know, with you supporting that family. I'm interested to hear about how all of	Truth(s) empathy solidarity Anger Emotional investment by HV. Do we invest due to a sense of guilt? Either our own, or that from how life and

those obstacles to getting her safe, how did that make you feel? Angry, I was angry about this system cause how is it that man can be the perpetrator of domestic abuse, and yet he gets to keep the family home that he doesn't need 2 bedrooms, blah blah, blah, blah, blah. And the wife and the kids are on the street. I was really angry about that. I was really sad and that also I had gone into the home on numerous occasions over the years, and she couldn't reach out to me. That was really sad. But then after all the difficulty afterwar, me and the support worker, to be rehoused, and managing to get charities involved, to buy equipment and things for the home, and all of that, then it became almost the relationship between us - dependency. The dynamic was changed and she became emotionally dependent on me. And that was really hard then to draw back from that relationship. So and then there was guilt I had about not being able to be there for her. She needed to become independent in her own right, so I'm not gonna do any favours by her being dependent on me and she's got	systems are. Whether we like it or not, we are privileged. responsibility Not a friendship relationship but we expect many of the dynamics recognised in intimate relationships... honesty, trust, listening.... What kind of a relationship/connection is needed?

everything she needs to know. She had friends locally, she didn't need me. Not being there for on that level, but then the professional bit of me thinking, well, I can't be there because that's not what I get paid for. I'm not your friend. I'm not her confident, I'm a professional. I was there to support her, to move on. And that's what I did. So I needed to stop answering phone calls and explained to her that that's not my role. This is not who I am. So that was really tough. That was a big lesson to learn and to maybe not be available as much as I let myself become available for that family. Has that situation changed the way that you have had subsequent conversations, and maintaining professional boundaries? Yeah. Yes, it has, yeah. Yeah, I think in all the cases that I've dealt with, each time, there's always something that you learn from, maybe not initially, but then get thinking. And next time you've got those other tools in your kit ready for when those situations start again.	Opportunities Humility How do we teach experienced practice? Need for deeper philosophical paradigm teaching...to discuss the unteachable? The construction of behaviours and ideas.

Do you think you could have prepared yourself for that situation through any kind of education or training? I think the learning comes with the concept of domestic violence and how it manifests within a relationship and how it presents itself to a professional. But I think the complexities until you see it and how each person behaves and reacts to it in the situations. I think that's very hard to learn. I don't think you kind of learn that, you can hear people talking about it, but I think until it happens to you, you don't understand the depths of it, and how complicated it is for in in each situation is very different, isn't it? So I think although learning about how you can help them and how you know it affects him. What the services are out there that can also help with people, but the rest of it is definitely experiential. If I don't think even looking back now you think, right, if each time I go to a different family with those kind of needs. Then all that stuff that I've experienced definitely has a major impact on the way that I am as a professional. Opening books and going to presentations and workshops and things are all very well but until you experience it, I don't think you fully understand.	Wonder What is supervision? Listening? Advising? Do you have to experienced something to support? We initially self-centre ourselves. Shame empathy

With all these experiences and this ongoing learning, where do you get your support from whether it's emotionally or more practically?

So yeah, my team here have always been fantastic, so each situation is different, but we all experience very, very similar things. So yeah, I can go back to the office and somebody gives you a hug and you know, it's that they're very, very supportive.

I think some of your early experiences with these families are hard, you take it on so much, and each time you do get that bit where you take it home with you and it's about you, but then eventually you start to realise that it's not about you, it's about those poor problems, those poor women. But it does take a while. I think I have to admit that it was about me for a while, and each time you're in a sad situation, there is a part that thinks you know, you kind of let yourself feel a bit sorry for yourself because yeah, that shouldn't happen to you at work. You shouldn't have to experience that grief and that trauma can be big. But it's not about you. It's about them. But it does take a while to learn that. Massive big life changing. Yeah, definitely.

Team working

Are services effective when

they align with our service?

Is that what collaborative

working is... services

working within the same

intention? Do individuals get

a say?

So do you feel you have the ability as you become more experienced, to leave the emotion at work? Yeah, yeah, yeah. Definitely. When this woman was in a position of wanting to leave and ready to, you were working with a couple of different agencies. You mentioned a support worker and a domestic abuse service. How did you find working with these other agencies? What was that like? So our outreach workers, they work from the children's centres, and they're fantastic, absolutely fantastic. So the great thing about them is they link in with social housing. They link in with safeguarding and social care, so they even have the same computer system so they can look on it and see what information is needed, and they can access those kind of thing practical things like the charities and the food banks and the baby banks and all those practical things. But I don't necessarily have links with all of them, but I can just pick up the phone and say I need this. This woman needs	Acceptance Patterns of abuse

this, they need that and they will do their utmost to help it make it work so and engage the housing and charity. Again, they were really, really good, and the charities here, we are blessed, but my experiences have been positive so I can pick up the phone, explain the situation and people will do their utmost to help. So yeah, I think even the domestic violence service you can phone, we had regular liaisons phoning. They let me know whether there was a place, you know, every morning it was if there were any places available, those kind of conversations going on so. Yeah, very, very easy. But frustrating sometimes because you can't always get what you want straight away. I'm interested in if you feel there are similarities or differences with different professionals agenda's? For example who do they centre at their plan? No, so I think my experience is we are supposed to be child centred and so the ethos of care is child centred, which you know mum is on board with, but you can't make that child's life different unless you make the lives of those women different. So if you're not focused on what the parents are	Parents are at the centre of children's world See me Wonder

doing or the situation in which those parents have become into parents, then you can't change anything, can you? It's a intergenerational cycle of behaviour. So I struggle with that often because I think people lose sight or they don't even want sight of what the parents are doing because they've become so child centred. And it can't possibly be just about that child, because that child is not on its own. The child is influenced everyday 24 hours a day by parents. So you can't separate the two. And I have to add conversations, child protection meetings, and all those kind of things where I just go round around the circles because no one's listening about the mother and it's all about the child. And it just doesn't work just. The life's not changing because you're not doing anything to help that woman alter her life situation. Just so frustrating. So yeah, now I don't think we all are coming from the same angle. And I think it's a lot about maybe the fear of missing the essence of it. So something happens to the child and all of a sudden "You weren't child focused" or whatever. Those stupid things that go on at serious case reviews.	Why don't we communicate? What is communication? Speak in the way they listen, with humility. Not our agenda but theirs. Priorities Blame Responsibility Team working... or lack of

mmmmmm

But they're intertwined. You can't separate them, can you? Family photos. It is not child centred, it's family focus, but yeah, so that's obviously a theme. You mentioned serious case reviews, do you feel we are learning from things that have happened? Mistakes, you know? Do we learn? No, I don't think so, because every serious case review that I've been to, on top of the headed page is always lack of communication. So why is it always still the fact that we don't communicate, it's still an issue. We're not communicating here today, but why aren't we cause if we're saying at the case review that we're not doing it, why aren't we changing? Why? Why don't we change the way we practice? Why don't police share information with us? Why didn't social care share information with us? Why do we have to thank them for the information, but they expect us to walk into a home and get held up by a guy with a machete, but they have flag markers on that. So why aren't they sharing that information? All the time. This is the same	Where is the boundary of privacy? Is the boundary set by the information given or known? Or do we want to know it all, and then we decide what we want to hear? The known. The truth... event or experience or thought. The right to know... on who's terms? Anger

situation. It's really frustrating. I don't think we'll learn at all, no. Do you think as health visitors, we have a right to know? Yeah. I think every agency that's working with the family has the right to know what the risks are. We've had, well my colleague was literally held kidnapped in a house with a guy and his machete. But the police knew about him, but they don't share the information. So she was, I mean, luckily she was fine. But that's not the point. Its that every time you have to beg, they never come to the child protection meetings very rarely, unless there's big history. So this one situation where when, there was a domestic homicide... The guy that owned the flat was working for the agency that helped to rehouse. And so he was round at the flat sorting out the electric and gas and whatever else he was doing for her, this young mum. He didn't know what the situation was at all. So people are coming and going, the police know this woman and her partner, you know this woman she needs protecting from her partner. Anyway, this woman died at the hands of her abusive partner, and the electrician he had no idea about any of this, and he said afterwards, if he'd had	Truth(s) Significance of historical events.... Down to perpetrators or victims? History impacting behaviours or interventions? Questions wonder

known he could have set her a secret push alarm or something, one of the police markers was as a safety plan she should have a phone that she could phone directly to the police station. He said if he'd have known that she wasn't equipped with it, he could have sorted it out with all that stuff. But they didn't tell him. So I'm still really angry about that and they're not communicating so even please between different boroughs and localities. Do you think if you knew a new mum moved into area and she had a history, with an ex or the child's father that she's not with, would that would that affect how you were with her? I think it would definitely make me more aware of her. Just the importance of building a relationship with her, so she could feel more confident in disclosing things to you. Yeah, it's just different. It's just different relationships with women that you know are from that kind of situation. You may have different ways of communicating, leaving them information where they can access, support and advice those kind of things. I mean not that we don't do that with everybody, but you're more open with other people where	Support is matched against known. Knowing connection Team working connection Practice lead by individuals.

you don't think there's a history so you outrightly ask them about domestic abuse. But if you know that there's been a history of it, you know, she might be more guarded. Just wanted to tell you because she's got experience of local authorities or whatever that's happened in the past. Because she's afraid to tell you because she's been told she's not supposed to tell you where she is. Blah blah. So there's definitely a different way of handling that relationship, isn't there? And again, I suppose it depends on the variables of that specific case, but there's definitely a different type of relationship with us. We're maybe not even directly having that conversation with them initially, but making them aware of where they can reach out to everybody and to access support and help. Yeah. So there's definitely a balance of then how you manage those situations and in how much do you know? How much do you need to know? Because that's trust. Definitely needs a trusting situation. Because even though I'm a professional she's not necessarily going to trust me to tell me the things that she knows that she doesn't wanna tell me. So yeah, that takes some time to build up that relationship with those women.	belonging Location

What are some of the practical things you would do to build that trust? I probably offered to put her in touch with the children Centre so the outreach workers are involved on a kind of a almost, a casual basis. So ohh, I'll say you know, they might want to introduce you to groups and things, and so ask her to come. She can have a bit of a chat with you and see you know if there's anything out there that you might wanna join in with that kind of thing and then probably I would go more often, so I would do more visits for that family. Definitely. That's definitely the thing and there will be more visits than universal because I'm gonna build up that relationship with her. And I'm hoping at some point that they'll be opportunity to discuss the history and what is the plan? What's is the plan gonna be for her and what she's hoping to gain and what she wants? What are her hopes and aims? So yes, that would be that probably weekly visits maybe more often and drop in and and see her to make sure that she's alright but just to get to try and see if I can link her with other agencies to offer that emotional social support as well. She hasn't got any family around. She's gonna need some	Vulnerabilities Fear Need for deeper consideration of reality and epistemology/methodology? Help and isolation Truth(s)

some form of emotional support. And so. Yeah, I'd be offering about. Do you think it matters where you have those conversations? I'm just thinking if if she's got a couple of different agencies involved, would you always try and see her at home alone? Yeah. So we can invite her to the health centre, she feels it's a bit of the more than neutral ground or yes. So the hub, the Children Centre where they have different areas where we can get together and have maybe a little bit of, you know, come for a play session. In the past where we've used a little space for play areas and we've just bought one family along. Just so the children can play with all the toys and things, and mum's got the opportunity to talk in a neutral environment. And there aren't any people around. So we do that. And even meet up for coffee at the soft play area next door. So sometimes I've done that in the past where I've met them in the soft play. So these conversations can include tricky questions, particularly relating to history of relationships. What equips you in asking those questions?	Knowledge is not power. Power lies in the action following knowledge. Honesty Knowing the boundaries. Honesty Do we only want to know about positive things? What is help? Rendered helpless in action? Who am I?

I guess the harsh experience of that fear, the initial fear. Way back when, when you first become qualified, and realise pretty damn quickly that life is not about weighing babies. Where you realise that "ohh God yeah, but this is what it is really like. So I need to up my game and actually be brave." And ask the questions rather than being afraid to cause, I think, my fear was asking the question, not so much because you don't want to hear the answer, but how was I going to help that woman emotionally? I can't wave the magic wand and make it better, so now I have to walk away from the situation knowing that she's just told me all this stuff. What am I gonna do with it? Well, I can't do anything with it. I have to leave it and work with it. But you learn pretty quickly that that's the only option to you, isn't it? So you can offer the listening ear. You can offer practical things to help her financial support and all the other stuff. But the end of it, she's still left carrying that baggage. And she's still the one that's living it. And that's what I really found hard. I still find it really hard, but I manage it a lot better. So I go there now knowing that I can't wave the magic wand, I can't make it disappear.	Self-centring... is it about you AND them? Truth(s)

So it's hard to explain in words, isn't it? How you how you behave with people, how does your body language change? It's just different. I'm not afraid. I'm not afraid now to say I'm not gonna be able to make your life better. And I'm not gonna be able to make your history go away. It's all with you still. You've still got all this stuff to deal with. But if I can help in anyway, I will. That's all I can offer and that's that. I can't ever take that away. Can't make it better. I can just be there if she needs me for the other stuff. OK, but that's really tough. I still. Yeah, I still do inwardly struggle with that little bit, whether it's helping people out financially or the emotional stuff, or trauma, or whatever it is, complex children with complex needs in the fact that the diagnosis and all that stuff. Those things are never gonna change. I'm not gonna change your situation. So why am I here? I don't really know. I do question myself. How am I going to make a difference? This person's life? I don't know. I'll go in and find out. That's all you can do. Isn't it? You go in with an open mind thinking. What is your experience of finding out about domestic abuse in a family? Through disclosure, referrals, incidents?	The 6-8 week is fundamental with discussing her. Simplicity Questions Truth(s) Is it helpful to distinguish between abuses? Simplicity

Yes. So very, very mixed and so either I haven't had any contact with the family for various reasons for a few years and something will come out of the blue, or it will be through visits, so there might be something that's happened at her birth visit or usually how I find it is go and visit. Everything's fine and then you might get a phone call or something and it will be either "Can you come and see my baby..." And you may start thinking that there is something else.

And then usually they will tell you without you asking the direct question. It usually starts off with "Ohh well you know my partners not pulling their weight or not being supportive..." That's how it usually goes. And then more unravels.

Sometimes in visits you can't always ask the question, because often you find that partner's are there, especially if it's the birth visit, because they're "...all right. Ohh you know, look at me. I've got a new baby thing..."

And usually maybe around the six to eight week visit or if I get a phone call before then, you've got the opportunity to

Acceptance

Providing knowledge is directly impacted by the shame associated with the information?

ask those questions. Sometimes they hesitate when you ask them. Direct questions. So I'll say, you know, "how's relationship with Dad and how do you feel you're coping with the changes and stuff..." Initially they might say. Ohh yeah you know it's been difficult but everything's fine. They don't always see it, do they? So they don't always see the whole situation because they're in it or because they don't want to see it. Especially if you use the words domestic violence, that's completely takes people by surprise and are just like, "ohh no, no, that doesn't happen". But actually when you pick it to pieces it is control and abuse. The man usually pays all the bills and he's got all the money. And they have to ask them for money, for nappies or milk and stuff like that. And I think ohh, that's not right, is it? That's not how it should be. And then sometimes you ask her those questions and then its abit more than just the financial abuse. Then things start to become a little bit more clear about other stuff that's going on. So that's often how I find out, more subtle situations where controlling coercive behaviour is an issue, and even that often is very, very subtle. That woman doesn't even realise that that's going on until they become quite isolated and you	Acceptance Oppression of women. Martyrdom of mothers. What happens when women become mothers?? Shame

move away from their friends and their family. And that kind of stuff where they're just being the housewife and the mother because they've given up work. You know that it's easier to deal with the women that suffer domestic (physical) violence because they can't hide from it, you know, the police have come involved. Social services involved all that's out there and it everyone knows that. Easy. But the women, I think that are on the more affluent side of life, that that's that can be a real struggle. Yeah, the whole shame of it and again with the shame goes with the culture. So lots of culture's, and we have a lot of (South-East Asian) people, whereby domestic abuse and how you talk about it, it doesn't always come down to the husband's behaviour, but often it can be about the in-laws. That's how they might treat that woman in their house because most often, the woman moves in with the paternal family and then she becomes isolated. Economically, financially, emotionally. Then they're afraid of the consequences, of leaving that house. That's even harder to bring out into the open. The emotional abuse and the coercion and control, why is it more difficult to identify?	Mothering = strength Is 'offensive' as changeable as generational shifts?

Lack of understanding and shame. I think both.

It's not enough that that people don't, don't understand or don't wanna accept. I think maybe the generational thing that's gone on before, so lots of that generation stuff, isn't it? Even with the typical British family, you kept married to your husband for years and the fact we have child benefits stems from the fact that in those days men used to go down the pub and spend all their wages on beers. So women were in poverty, which is why the government came up with the family allowances. And that's where that came from. Women just had to put up with it. And I think, you know, the 70s came and the whole 'burn in the bra 'and that was all great because then women have got a voice and now. I think the more affluent families and the diverse cultural families, there's a lot of shame involved in that. So women will find it really hard to admit.

You're economically dependent, maybe your children go to private school and that would be, you know, like you didn't wanna pull them out of school, it would change their life there. "They've got their exams, they've got their friends...", they've got so all that stuff.

But a lot of education is about the self... so should we be talking about recognising others more. Radical empathy.

Knowledge is nothing without the action.
Autonomy and agency
Belonging

It's so complex, yet it's still that woman, still living in that hell of a situation. But again, it's massively complex, isn't it?

So even with personal experience of that, you can find yourself denying all those things to the outside world because you don't want to show it. Even you don't wanna appear vulnerable. You don't wanna be another statistic. You don't want people feeling sorry for you. Don't want people talking about you. You don't want to be different from everyone else. You wanna feel like you're a lovely, happy shiny family, so you just carry on living that life.

If we could wave a magic wand and get rid of this, where would you start?

Education, I suppose. Right. Right. Back to educating children. Because that's the only way, getting rid of the stigma, we seem to have come this far with everything else in life where people deserve the same rights as everyone to the whole LGBTQ thing that's going on. You would be arrested for being gay and all that, but now you know would be wrong to even use some terminology that we used in the 80s because now you know it's offensive, so we've come a

Do we blame perpetrators or the system?

long way with that, so surely we can do more. We can achieve this to come out in the open so women learn from a very, very young age and then also boys, because the boys need to learn that too because it can be vice versa because there are cases where women have been perpetrators. So there has to be an equal amount of education at very young age...

About healthy relationships on what's acceptable and what's not, and I'm sure they do it in school in some ways. I'm sure that that's what PHSE and safe sex and all that discussed. But I don't think it's enough. It's not just about the sex and intimacy in a relationship, it's about all the nuances of being aware of somebody's behaviour and how they are, how those charming young men on the outside are such deviant horrible people that treat those women so badly.

So education right from the start because we know that men are more likely to be perpetrators, but we also know that the reason why they become perpetrators of domestic violence is because of their experiences in early life and their experiences. Throughout life, whether they are either copying behaviour or they've witnessed that behaviour, or the woman has witnessed that behaviour and then becomes

Rendered helpless?

the victim, it just carries on the whole cycle doesn't it? And schools need to provide that same education throughout the whole curriculum, not just once in a blue moon when they might get the session on relationships. It's just not enough. Not enough, is it? And the whole self esteem that when you do end up finding yourself in that situation that you have the knowledge and the awareness that that's not good. That's not good. Bye. Because that's the hard part, isn't it admitting that you're in that relationship and having the strength then to be able to get out or even recognise what's going on. It's just, it's just never ending. That's just impossible question. Is there anything else that you feel when you're working with these families? There isn't enough, isn't enough support out there. I don't think that there is enough bodies to just be able to cope with the amount of cases. These children suffer trauma, but that needs addressing, needs to be a bigger thing where there is access to all the	Do we love our families? Does love come into it? Empathy Are terms victim and perpetrator helpful?

stuff, and even with the mental health stuff, you know, for women and the domestic violence, there's not enough of those things going on to be able to access them without the waiting lists. Without the, you know, all just that political stuff.

Really, I think it would make our life a lot easier knowing that you could just pick up the phone and there will be somebody that would be able to offer them some emotional support. That will stop that repetitive cycle, wouldn't it? As soon as possible rather than later?

So yeah, but it's about money, isn't it? It's always gonna be about money.

Yeah, the system almost sets us up to fail. Through the whole thing with the education system I mean, I could be on about all day long, but the boys don't do well at school because boys and girls learn very differently and they just function differently, they're even more likely to end up leaving school early.... The beers and drugs and alcohol end up a goal, and that whole domestic violence thing goes on.

Empathy

So if we, if our education system just got off its arse and looked at what those children needed, we could maybe even just change that little man's life just a tiny little bit that his mentality would be different and he wouldn't have all these other subsequent stuff to deal with, you know, we would save millions of people not being in prison and committing crimes if we just be able to spend a little bit more time, money so a four year old doesn't experience all this shit in this life.

That would be so much better, wouldn't it? Preventing all that stuff...early intervention, about how we were gonna change all this stuff. How we gonna start looking at generational cycles going on about all this? We're still doing the same thing. Nothing's changed because none of the money, they've not put their money where their mouth is.

Have they not done anything in the government so they can maintain some controlling behaviour?

And that I think sometimes when you when you've got that in your mind, when you go to people's houses, you think 'why do I even bother because it's just pointless'. But you still do what you think is best, and that's the challenge of it, the hard part is excepting that you're not gonna make their

lives much better. Why am I bothering? Because no one else cares. But then I care. I want their lives to be different.

I was in a domestic homicide interview as the professional a few years ago, it was a grilling...

And the officer, she asked me how I felt about the father. I felt pity for him. I felt real shame and sadness, that this has

ruined his whole life and ended another. He will spend the most part of his life in jail because of the life that he

experienced as a small child, and she found that very odd.

She said. "I don't understand". So we have a police officer.

Why don't you understand? I don't understand how you

could not get it. Surely you have some educational insight

into how people's behaviour is affected by their life

experiences. He didn't do that on purpose. He didn't set out

in life to do that to that woman...Those experiences, that's

how that's evolved. And she didn't get it and I still have great

empathy with those men who end up where they are

through really through no fault of their own, because that's

the saddest part, that they are victims, aren't they?

You know, I suspect that somewhere in their life they've

been abused in some shape or form. They've had horrible

things that happened to them in their lives, and that's why they've ended up being that kind of man, without doubt, whether it's maternal emotional availability from their mother's or their fathers of whatever has happened to them. You know, there's something missing that make them not be able to respect and love and care for their wives without being cruel. Just want to fix it. Just wanna fix it.	

HV5 Transcript

So first of all, can you tell me how long you have been practising within a health visitor role? I was trying to work this out the other day and I qualified 15 years ago, so if you count those two years studying, it's nearly 18 years. I mean, it's been really hard work. It's, you know, emotionally draining sometimes, but I've been doing this role now longer than I was a nurse. So you know, I feel like I've gained a lot of knowledge. People look at me, and people ask me things now and I think "ohh what you're asking me for?" Yeah, it's cause I've been around for such a long time. Yeah. Do you feel that your practice has changed over the years? Ohh definitely. I mean I used to do a lot more visits. Um, when we first started, which we did anyway and it's changed now. I'm more able to let go of things and get people to take the responsibility themselves,	responsibility Boundary

rather than feeling like I need to do it for them or guide them or be there for a few visits. We have to do that now anyway, because of the way that we work. And so you know, it's about empowering people. And it's funny because we've got some new starters in our team and I can see the way that they're visiting a bit more than they should, because they feel under confident, whereas I go, you don't really need to go again. Regarding domestic abuse, knowledge has increased so much, but I've had so many cases, so many so many. Yeah, I can remember one of my very first ones, which was pretty horrendous as the poor woman got dragged down the stairs by her hair. I was in a really bad way and had not picked up on it. He was always there at the visit. And cause it was a new baby, but I'd not really picked up on that vibe, so I'm a bit more careful now. I think it teaches you to be a little bit more aware of other things that they might be saying, I mean, you know, you're never gonna catch em all are you? never gonna be aware of it? Ohh, but my understanding of everything has come on like child protection. But everything changes as well. You know, new legislation we've got now, like that non-fatal strangulation is now a criminal offence and you can get a custodial sentence for it.	Does accountability come down to personality? What does 'empowering people' mean? Opportunities What vibe should we be picking up on? Location

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Which is really good, but you know, a few years ago I wouldn't even have thought about asking somebody about that. So as a practitioner, how do you come to know about what's going on in people's lives? You mentioned having a 'vibe', can you tell me abit more about that? People don't give you eye contact. Yeah, you can tell when some people are just really relaxed and then you get those mums who are sat on the edge of their seat, or they might drop something in like, "You know well, my husband has control of the money now... My mother-in-law won't let me do this." And they're usually just not relaxed about answering questions. Sometimes it's your intuition, that gut feeling and I trust my gut feeling. Has that gut feeling changed over the years? Probably it's a little more attuned, I would say so. I think I already had it though. I think I can just tell when people are telling me truth. I worked on the ward before, the acute medical assessment ward, and then I worked	Legislation changes.... Can abusive behaviour thresholds change? Interoception? Do you feel it in your gut? gut instinct

out in community and I can just tell when people are not telling the truth, their body language gives off loads signs. You know, they'll sit there and not give you eye contact. They will relax, then they avoid questions, and you're out there within 5 minutes and you're like, what the hell just went on? Yeah, I went to somebody the other week, a birth visit and Dad wouldn't let the interpreter in. So, I'm like, 'OK. What's going on here?' and at the end of the visit, I have to say my gut feeling was telling me there's something not right, and we got to the end of the visit but I'm still gonna have to go back and ask more questions, because she just smiled her way through. She didn't speak English so, and you know, I still think why is he answering all the questions? So as I was writing the notes up, I thought ohh why didn't he want the interpreter? I wasn't comfortable with it. And when you feel like you aren't getting the whole picture with a family, how do you deal with that, what do you do? It depends really, if it's just a person on their own. So if it's a woman or a man, whatever. If that person's there on their own, I will ask them outright. I'm not scared of asking the questions and saying, you know,	Gut feeling is about truth telling and honesty? Honesty wonder

is there anything going on that you want to talk to me about? because not everybody knows the language for domestic abuse. You know, if you say domestic abuse, people always think of somebody punching them or hitting them or anything like that. So I ask questions like 'does your partner withhold money from you?' 'do they do anything to you that you don't like?' 'do they tell you off if you've not loaded the dishwasher properly?' or you know I ask sort of questions about housework and 'are you allowed to go out? Are you allowed to go see your friends?' I have got one lady on my caseload. Who I'm still working with. And she's had a previous abusive relationship. She's had a lot. In fact, one of her previous partners stamped on her leg and she's got plates in her leg now. She's got 4 beautiful children and three of them are grown up. And then she met another man and was hoodwinked by him and let him move in...Got pregnant. And then she made him leave when she was pregnant because of the abuse from him. It was psychological, emotional sort of stuff. Money. And she said I'm not going there again. Yeah. So she made him leave. Social care got involved, and when I went to do the antenatal, she was totally stumm. She wasn't gonna tell me about it. She didn't trust professionals. And I said to her, "I know you don't trust professionals..." Her sister got murdered as well...I said "I know you don't trust professionals. I understand that. I bet you've	Honesty Move away from saying domestic abuse/violence. Words Questions

been let down in the past. I can't fix everything because that's not my role. I don't know you, but I know what's gone on, cause social care have told me. But I'm here to let you talk about it..." It took me 3 visits before she decided she would let it all out. She moved because he'd been stalking her. He's now trying to get contact, he said he was gonna cut the baby out of her stomach. She told me it all. But it's really difficult actually, because she's now over trusting me. So she's telling me everything. You try and get them to trust you but then other professionals let them down. You get so many poeple, I've come across so many people experiencing domestic abuse and they don't want to leave, they'll tell you things, you get little snippets and you think ohh that didn't sound too right. I'm just trying to think of a specific one where I actually said, "you know, you're allowed to talk. Choose your own carpet. It's your house too..." and I got thrown out of the house... I got told to leave. So I said to my colleague, there's abuse going on and it turns out that it's been going on for years. So my gut feeling was just right with that one....Something's not right there...Why? She flipped out so much over the facts. Because I've touched a nerve and she actually apologised afterwards and said I'm really sorry to my colleague. So there are a lot of people that are really frightened to say anything.	Support is about open conversations... talking Honesty connection Boundary Can we always expect each to be

I think it's about building a relationship with them in our job. You mentioned about issues with over-trusting or dependence within the relationships with some individuals. Can you tell me how you manage that. Not very well at the moment, but I just keep bouncing it back to her and saying you need to talk. Contact your solicitor. You need to do this. You need to do that, and talk to the other professionals. I can't do that for you because I'm not part of the court process. And that I understand that you're frustrated. You know, it's all that. And I suppose it's just about being there. So I'm a sound board. And then if I am able to help I will do, like connect with the infant mental health team, so you know, there is another agency I can signpost. My colleague said you've gone above and beyond... I said "I know, I know, but it took us so long to build the trust" She had no one else. She had no options. She actually confessed to me that he strangled her during sex. We did the DASH assessment and for the MARAC one, one of the questions on there was about strangulation. And does that make you feel? Hearing details like that? It makes me cross. It makes me really cross that women are still not listened to, that they daren't tell the police that this is going on, and	equals? Is it ever 50:50??? Truth(s) Break down Who am I?

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has gone on for fear of what's gonna happen to them, and them not being believed. And these women aren't being believed. So we've quite a lot of us, as professionals, that are feeling really, really frustrated. The problem is when you take it out of our hands, we can do all this good work and then it goes out of our hands. The judge in charge on this case actually said to the perpetrator." Just be careful what you're saying to her cause we don't want to give her anything else to talk about." The judge, she doesn't believe her. So that's the frustration. I am a domestic abuse champion in the trust here. And we're doing all these courses, I did the non-fatal strangulation one... which was really informative. I understand now that they can't prosecute for past strangulations, so that lady's told me that and they won't be able to prosecute because it's not recent, but they can do it going forward so I'll be more mindful to use those questions again because I don't think anybody has ever admitted to being strangled or choked. Or sometimes they don't remember because they've passed out. Belief seems to be fundamental to building those relationships. Why do you believe women and individuals who disclose abuse?	Professional into the friendship relationship... or are they the same? Transcendence anger Is it about being believed?

Because it is everybody's experience, One person may think one thing and a separate person who experiences the same thing may feel it was a completely abusive situation where they had no control. Some people may say "fuck this" and kick them out, others can't, some may get on with their lives. But that's not every situation, everyone is different, and that, you know, if we don't believe people it denies the coercive control and emotional control. Thats in the forefront now, we know about the control, when I was younger, it was, you know, ohh theres been a 'domestic', it was about the punch and the physical violence. Well, it's just as bad as having a go at me all time cause I've not done the dishwasher properly, or he won't let me have money, or he's telling me I can't go see my friends. I don't think people really take it seriously, but as a professional with us, because we've got that time to sit down and listen, you can really get to the nitty gritty of it and you can hear their feelings, you can see how it's affecting them. Because he has an effect on those kids that are in that house as well. So that's part of our job is hearing the voice of the child. How does that child feel if that mum's being controlled by that dad? So I think that's the difference really. We need to believe	The systems It's all contextual? If everyone is different can we expect the boundaries of abuse to be the same? Truth(s)

them, to see the child. Cause it's different for everybody. So why do you think some professionals don't believe? Like that judge you mentioned. I've been in a situation where this has happened to me and didn't realise it was happening, and it took somebody else to point it out. After he left, my friend said "we all thought we were losing you." and I thought what do you mean? I changed, I disappeared. No one asked me, I've never been asked. If I'd been asked I probably would have said more, but its hard for someone to say that during the time. It's so hard to tell and ask, it's so emotive...because you can't stand up for yourself, you've let yourself down. That's why I believe them Because it's such a hard thing to admit to. How do you manage working around other agencies and professionals when you are trying to build a relationship, and perhaps the individuals is doubtful or mistrusting of the team around them? That's a hard one, it's just about talking to that person and saying, look,	We see the mum, we see the child? Acceptance Solidarity Truth(s)

you know, this is the constraints that they are working with. I've spoken to other professionals before, and said, can you explain to me why this has happened or why this isn't happening? And then explaining it to the client, cause sometimes these other professionals use really long words, or legal terms they don't understand. Or sometimes I will ask more questions of the other professionals, like asking to speak to someone on the MARAC board about a decision, because putting it down on the piece of paper does not do it justification. Sometimes you speak for them, because that judge, after they said that to that perpetrator, he took it as a pass he could go and stalk her. There's nothing I can do about that judge, unfortunately, unless I write to an MP, but I've had conversations with our safeguarding team without doing that it's difficult. It's difficult in getting it higher. Having the guts to do it anyway. How does it feel, staying with that theme of professionals having power, or being untouchable. Working on the ground with individuals and families, what's the point if those with power can make such judgements.	Do we believe statements that include abhorrence... because you wouldn't say it if it wasn't real? See me So we advocate for women, but don't want them to be too dependent on

teeth? Are they eating well, have they got enough money to be eating well.... Sticking with the holistic view and impact, when you talk to mum about domestic abuse, and specifically how it is impacting her children, how do those conversations go? How does it feel for you? Really difficult. Why do you think it's so difficult? Because they don't want to hear it and they don't understand. So there's a lack of understanding again of the words and phrases that people use. So if you've got social services involved, they will use complicated vocabulary sometimes....the lack of understanding about how to put yourself in that child's place and feel their emotions. I will often to say mum, "I'm feeling quite uncomfortable right now, a bit scared, but now I can walk out of here. So how does your child feel when they hear Mummy and Daddy shouting?" You can get some really good victim support interventions, or parenting classes, that look at how the woman's feeling, but it also includes all the children as well, and what's going on.	Is there a sense of fear here? Validity of role? Empowerment Multiplicities

Do you think there are ever too many professionals involved? Yeah, it depends. It depends how severe the abuse is. Suppose if there's risk to physical harm, to mum, to a child, even just while the child is there. I think we think we need as many people and the more people there are, then the safer the woman and child is. The woman has got more people to talk to. She has that circle around her, of people she can ring and say this is happening. Some parents are really intuitive. So the parent that I'm working with at the moment, who's got to have contact with her ex, I mean, can you imagine? She said to me yesterday, "Can you imagine if he'd beat me to a pulp and I had to sit in a room with him for contacts? How frightened would I be?" I mean, she's already frightened of him anyway. She knows, she can say how it's affecting her daughter, going to meet him. And that's why we've got the struggle, people don't really understand it as much. And we have to keep telling them over and over again But again, there's lots of other bits to that. There's lots of other threads, isn't there? You know that people have psychological problems. This effects	Radical empathy Solidarity Honesty

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an understanding ... they might be autistic, they might have learning difficulties. You know, there's all those sorts of things that are at play. We've got such a varied caseload, we've got one lady, she's professional, she's got good qualifications, but just doesn't get why her child's dysregulated and struggles with her emotions, but it's because of the parents' relationship and the abuse and all the stuff going on, so that's difficult. Do you feel there are similarities or commonalities between victims, whether they're diagnosable or just traits? I do. Yeah, I find that particular women will go and pick the same kind of relationships over and over again, so you know they'll bounce from one domestic abuse relationship to another and you think ohh, when will you learn, you know? They just seem to attract the same men that gaslight them or make them feel really lovely at first and then start... We also have a lot of deprivation, so poverty can have a massive impact...Well, it does where I work, although the some of the really physical ones, the women were professionals, as were the partners. I didn't think, maybe being so young into my career, that somebody that	Does perpetration negate ability to parent? Can you abuse and still parent?

professional could do that to somebody else. Those are the ones that are really hidden because they're better at hiding it. Does it make it more difficult to talk to them about it? Are those types of families, more professional, more difficult to speak with? Yeah, definitely. Because either the partner's always there, cause they're very aware that some professional is coming in and that will be asking questions or the mum just doesn't want to cause anymore trouble. Some women just feel like they can't say anything to keep up appearances. But I go and speak with colleagues and I know that that women is being abused, but she just won't tell me and I can't get to the bottom of it. We can't help everybody. Yeah. How does that make you feel? Frustrated. Upset that I can't help them. And more frustrated as well now, because we're not doing as many visits. So if I couldn't pinpoint my gut feeling, I could think ohh I'm gonna go back there. Like..."that	Safe Children are a product of the parenting. Acceptance Attachment disorder?

one's really low in mood and I'll go back and try..." But we're only allowed to do three to four listening visits. With the commissioning our autonomy has been taken away. Our decision making, so we can't go back in and create those relationships, although I have to say that quite a lot of us probably don't follow all the rules....And we do go back. If there is something you can't pinpoint, do you try different practical tactics? Like where you have a contact? Clinics? we don't cover anymore but some of my colleagues have done in the past when they've disclosed, they'll meet them at the health centre, so that they can have the freedom to talk, but it's more difficult now because we've got less places to meet. The baby clinics stopped, shut down, we have the baby hubs where they can take the baby to be weighed, but they have to be booked in. That's made it more difficult. But, if you were really worried about them you could say, you know, I think actually, can you come? Yeah, I probably would ask them, I'd make an excuse and try to bring them out into one of the health centres. When the partner has been there, I've done that before. You have to be mindful of texting and that, because these partners will look at phones, so I've made up a reason, like discussing women's issues or something.	Acceptance and blame If they don't say, do they even want help? Truth(s) Helplessness.

And that normally works? Yeah, has done mostly. So I was a worrying that the partner's gonna see the text message and say why she asking you about that or. how they were responding in text. Ohh, why are they making you go to clinic when she was coming out to the house? That's always a worry. I don't think if we didn't worry about as we do, nobody would ever disclose. Because you know what? Where are the people that are there to protect them? to help them get involved in other services. And it's really hard with young people. So I've got a young mum on my caseload at the moment, and she was in a really badly abusive relationship. She was telling me at the antenatal, and she's petrified of him. But she didn't tell anybody because she was frightened he was gonna kill her, and she's only 19. She found it so hard to tell anyone, because she felt there was no way out. Maybe the immaturity? No money? Their parents have kicked them out?...those are the hard ones. How do you deal with those ones?	Can you impart 'rules' in a relationship? Or is it ever changing and never binary? Opportunities..lac

Suppose call domestic violence services and see if we can get them into a refuge, but they're all full. We're finding if a woman needs a refuge place she has to go out of area...which isn't always a bad thing, being away from the perpetrator, but you would have to explain to them why it's beneficial. It's alot getting them to trust you and build a relationship so you can explain these things, and they have confidence in you.	Sanctury of public spaces
And how do you look after yourself with all of this?	Safety of home
Ha ha.	Privacy
Head space. Yeah. So we have regular clinical supervision. We have regular safeguarding supervision. Our safeguarding team will speak to us at any point. If we want to ring up for a duty and advice call. And we can speak to our colleagues. I, I regularly do the headspace app just to try and get rid of my anxiety. And as an organisation we are trialling trauma informed based psychological therapies. Because we all absorb it and it can be quite stressful and make people go off sick, it's hard to deal with.	Privacy

I think as I've got older, I've been able to shut it out more, like when I come home I think ohh this is my little piece of heaven, you know, at the end of the street, that's where the door closes on work, but it's a little bit harder now because we're working from home. I try and do something different when I finish work, watch a TV programme or something. And I switch off my phone, switch my laptop off, go for a walk, do things on your days off that are enjoyable. And what about support within in your organisation? They're really really supportive, brilliant, but I know it depends from area to area. But if you don't, if you don't look after your staff, you're not gonna have any health visitors left. And what are we short of... health visitors! Does your organisation put on any specific training to support you within your role? Yeah. So like I said, I'm a domestic abuse champion. That role was rolled out last year. So we're still getting to grips with what support we can offer, but we're also offering support to other practitioners as well.	Protection Truth(s) Youth makes it more poignant. Team working trust Confidence in truth/ in conviction/ in action?

So if any of our colleagues are in domestically abusive relationships, they can call one of us and we can help them, and guide them about where to go, or just talk to us in confidence. So the safeguarding board put on most of the training, but the organisation has a pot of money for other training, like that training I did last week on non-fatal strangulation. So we have got quite a lot of training opportunities. It does help you cause it helps you understand what that person's going through, and whats what? What support there is out there? What legislation there is out there. You know there are more charities and organisations going around sharing stories, experiences, practices etc. Getting as much information out there about domestic abuse. But I know it differs because different organisations are going through commissioning. We've been talking about typical victims of domestic abuse being women and mum's, I wonder do you have any experiences of men and dad's being the victims? One or two, when the woman's quite controlling.	Reverse our role onto another. Vicarious trauma strength safety of home

Yeah. And how did you come to find out about that? Was that through disclosure or was an incident? I think it was an incident. Dad's don't really disclose to us because that's the problem with the service, isn't it? Is that we don't get to see the dads. Maybe we see them at the birth visit and then we don't see them, because they're working. But I have sometimes asked both parents at the birth visit about their relationship...and they both may say, Oooh we're fine, and that's fine, but they're aware that I'm asking the question now. We're not hiding it. Obviously you know, if I was frightened for that woman and thought that that might cause a problem, I wouldn't. It's hard, isn't it? I mean, there's more posters going up and things. It's always posters on toilet doors. Now when you're in the pubs and there is more publicity about it now. Especially since COVID. Yeah, I think it's more of an open subject now than it was. We have to check in and support one another.	Recognising DVA experienced by staff as well. We aren't all outsiders. belonging Acceptance Should we be seeing the Dad's? Acceptance

Do you think there is enough awareness and information about domestic abuse within the general public, or even too much? I don't know really. No. I think professionally we just learn to get on with it and I don't think you can ever stop learning in our job. You know, it's one of those roles and they're saying it's ever evolving and ever learning and you know, like doing extra study. And when I tell you what we do need, we need more researchers. To find stuff out. If you had a magic wand, is there anything you would change to prevent domestic abuse? I think the top layer of our system, the judges, the CPS and the solicitors need a hell of a lot more training. We get so much training and you will even see social workers. You'll sit there and you'll be telling them about the research and the numbers of people, and they'll go "really?". And they won't have heard this. I think the training needs to be rolled out to schools, it needs to be even talked to about with young people. You know, to talk about sex education, let's talk about domestic abuse. Let's talk about coercive control. It needs to be talked about in the court systems, those	Evolvement and progress All about talking. Truth(s) Disguised awareness? Does the solution begin and end with conversations? As children are recognised as victims too, should perp's loose their right to parenting?

professionals that are handing down sentences. Even CAFCAS, I don't think they get enough training, so they're the ones that look at whether a person can have contact, but it might be alright for that dad and that child to have contact. But what effect could it have on that mum, which is then gonna have an effect on the child. It needs to be talked about more. That needs to become second nature to us, you know that it's not acceptable to treat a person like that. I'm quite passionate about domestic abuse.	

HV6 Transcript

So first of all, can you tell me how long you've been practising within the health visitor role? About 10 years, it will be 10 years this year.	

And would you say you've worked with lots of individuals and families who have experienced domestic abuse in that time? I have. Yeah. I think overwhelmingly, it's the families where domestic abuse is at whatever level, the ones that kind of stay with you. Have things changed in regard to domestic abuse, either the context or the severity? I think on a personal level, I've noticed that I'm more comfortable exploring it and also challenging it and helping women, generally women, to look at the relationship and kind of recognise actually that it is domestic abuse that they're living and experiencing. I feel like we are hearing about domestic abuse now and how the intensity in practice has increased a bit. I don't think acceptance is the right word, but I think that there's kind of like a low level of domestic abuse that is kind of accepted by professionals and multi-agencies and it's kind of left there a little bit. And the high end stuff can sometimes be managed on a	Why? Is it abjection? Morality? What makes us more confident? When does it move from acceptable to non? Who sets that boundary? Individuals or service level? Is it all interpretation?

child in need plan, and that doesn't sit comfortably with me...the threshold. And I feel I spend a lot of my time shouting out. You mentioned this lower level domestic abuse is more acceptable, is there a like an example of what that could be? Can you define it at all? So it could be that we get repeat phone calls of information through from safeguarding that the incident doesn't meet threshold to be discussed further, maybe a one-off police call out. But we know it's still going on, we know it's still there in that family. And you just feel that it's kind of bubbling away and almost waiting for an escalation. What do you sort of feel about thresholds? What's your perception of how they're measured? I think they're measured differently in different areas. So my caseload is inner city, nitty-gritty, but it's a really big patch. So I've got one patch that's real high deprivation, real concerns, and then my other half of the patch is real affluent. So the sort of visits where I'll go and think ohh gosh what have I got on? Are you dressed for this visit? In comparison to a visit, where there's	Acceptance. Should all police call-outs be treated priority? If they are emergency service and someone feels their safety is compromised? Or mis-use of services?opportunities Class and socio-economics play both indirect and direct part. Affulence protects from direct contributor and service involvement. Truth(s)

another rat going down the street, so that's what my caseload feels like. And I know that if some of the stuff that was happening in this more affluent area that was happening in the high deprivation area the social workers would be all over it. I just think it gets a little bit lost until it is real kind of high concern. And do you feel your response differs between the two groups? No, I don't think so. I think I'm quite measured in my questioning. My experiences with exploring relationships and experience of abuse (and that it does happen more), there's more kind of challenges in the areas of high need. I suppose you know there is poverty and maybe there is misuse of alcohol and drugs and that can kind of escalate issues in relationships, I've got one family that I can bring to mind. Where she experienced high levels of domestic abuse and you know, her young child was kind of living with this and she didn't, this mum couldn't understand why we were worried really, and why we're having these conversations and why we were having a child in need meeting. She didn't understand at all. She just kept saying she was OK, she didn't feel that it had an impact upon her. We've kind of turned it around a little bit for now. She's with a new partner and she's just had her second baby with this new partner. And services were a little bit concerned, and	Is deprivation and poverty the 'route of all evil' including DA? Is mis-understanding the fault of those that speak, or those that hear? Acceptance. So do people 'get out' because they understand? Blind Is shouting and arguing ever acceptable for children? Would

wanted meetings, and a child and family pre birth assessment was offered but she declined it, which she could. She was with the new partner. No concerns there, but we had a recent meeting just to kind of pull it altogether. But it was lovely cause I was able to say to this mum.... "I feel like you've turned things around. I feel like you've had a change of understanding..." because just last year when I'd talked to her about that feeling that you'd get in the pit of your stomach, you know, when you hear someone shout and you feel a little bit unsure and that funny feeling. She now recognised that and I said that's what your little girl has. She has that feeling. And she said "Why would I want my little girl to go see him (dad)? Because it's not good for her to hear all that shouting and arguing." And I thought it was really lovely actually, and we've been working with her for a while. She could be quite aggressive but she has experienced really quite high levels of abuse to the point where this guy, he took the whole window out of their house. So sort of those conversations you had with her about how it may or may not be impacting on her child, helped with her coming to terms with it. How was she with you when you had that conversation?	trauma-informed parenting say no? Honesty But we are judging? But do we boundary honesty? Children Acceptance I wonder do professionals use the child as leverage? Speak with humility? Blame or honesty

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Initially (when she was still with him), she wasn't happy with me. She didn't take it well because she felt that we were judging. She felt we were judging her. Um, but actually something has happened for it to kind of start her thinking about it. And I do think it's having the open, honest conversations, sharing your concerns at that time. Where do you think that upset, angry emotion may have come from with her initially? She knew, I think deep down in there. She knew because she'd experienced that as a little girl and that she was experiencing it as a mum again. She knows it had an impact upon her. And she's a good mum and a lovely woman. She's super protective of her little girl. So for us to suggest that actually the relationship that she was in was having a negative impact upon her child, then it wouldn't be nice to hear would it? What's it like for you, working with a mum who is seemingly a 'good parent', and they are in an abusive relationship? I just want to fix it and it's really hard, isn't it? Because when you	Is the want to fix our ego? What makes us care? Responsibility or blame Rather than asking questions is it about empowering so they are ready to speak? Fix or support By making it routine, do we normalise? Opportunities

first asked that question about it... I can remember being in a visit, I was quite newly qualified actually, and I could sense that there was something. I could sense that there was something strange, I don't know what I could sense, but I could feel something. And the dad went upstairs at one point I lent forward and I just whispered to this mum, I just said "do you feel safe?" And she went no, and then he came downstairs and we had to continue the visit. And during I had to kind of think like... what next, what next? What do I do? She's ready to talk. Because I do think it's about catching people at a specific moment in time, so we've got to always ask the question no matter what, you know, find that safe time to ask the question. It's our responsibility to get them to kind of feel able to share what's going on and how they're feeling. Cause if we don't do that, we can't get the support...Well, can't move things forward.

Have you found as you have become more experienced, has it impacted on your confidence in asking those routine enquiry questions?

I've always worked with children and families, so I don't know. It's always been there, it's just a routine inquiry question. It's just like asking how you're feeling, you know, asking about a relationship

questions

questions

words

and do you feel safe and your relationship, and if you've ever experienced domestic abuse. And I don't feel apologetic for asking that question. I just think it's part of our role. I'm involved in antenatal classes and on the final week it's all about kind of keeping baby safe, but also relationships and what healthy relationships look and feel like for you, and what they're gonna feel like for your baby. So I don't know. I just think it's kind of, it's woven throughout all the pathways, really. I'd like to think now that all health professionals would feel confident with that. Do you adapt and change how you ask, or do you have quite a standard way? No, definitely, definitely adapt how I'm asking it. So I quite like asking about relationships. I'll often kind of say, tell me about relationships, and how they feel for you. What do you enjoy about relationships? And then I can kind of ask. But if I'm in a in a visit where I'm thinking, I'm concerned here there's something going on. You know there's a punch mark in a door and maybe when I've knocked at the door I've noticed that around the lock it looks a little bit damaged. I've already got my thinking hat on.... I'm already thinking what's going on here. And I will, you know, as long as they're alone, I will just ask like "ohh gosh, what happened to your door?"	Opening a different perspective... simplicity questions Drip, drip, drip... They give abit, we give abit... opportunities Fear...of what... loosing safety in chaos? Can you feel secure in unsafety? wonder

kkkkkkkk

Ohh, if there's things about around finances, I've got quite a lot of ladies here. Who've got no recourse to public funds. And then maybe here on a spouse visa as well...I want to know about the financial situation, you know? Have you got your own phone? Do you have your own bank account? Because there's all of that sort of stuff as well. And so if I've got a mum that tells me about her relationship and she's denying any domestic abuse. But I'm thinking there's something going on, I will kind of try and share the different elements of domestic abuse, the different types that you can experience. And sometimes I'll just, if they're talking about something, I might kind of have used the phrase "I wonder..." "I wonder if that sounds a bit controlling. What do you think?" I think it just opens up a space for them to talk. How is that received, talking about the details of their relationship? I've never had a negative response from it. They say "ohh no no no, I'm not having that. I'm not experiencing that." But if I've still sat there with them, and with me thinking "ohh, I think you are." I will go back and ask more. I can remember one family where exactly like that, I kept finding reasons to go back because I could just get the feeling that there was something going on, and the control over the finances was	wonder So it has to start with what they want. fear help and isolation ...but then its not about what she wants.

really high. The control of who she was spending her time with was really high, what she was wearing, where she shopped, what she ate. And it did. It all came out. I just think we've just got to go with our gut instinct sometimes and just keep going and providing opportunities to talk. Tell me about when they do disclose some abuse. Are there any factors that impact their ability to disclose? I think they're scared, I think they're absolutely petrified of repercussions. They're scared that social care are gonna get involved and take the kids, and they're scared that they are gonna lose the home, or maybe will disrupt their childrens lives. And you know, let's face it, often it is the woman that has to up and leave and, you know, go to a refuge. And I had a caseload where we had three refuges on our patch of women that had fled domestic abuse. And they've got to the point where they'd been living with real high end, horrific domestic abuse for years, until they got to the point where they felt able to leave. So I think all those factors come in and I think some of it is like a little bit of shame, you know, they don't want everyone to know what's been going on. So when they do disclose, what do you do?	Complimentary and contradictory. Is listening enough help? priorities solidarity fix or support To sit alongside. honesty

mmmmmmmm

I get in my car and my heart's going. I think 'Oh my God. Oh my God. Oh my God'. I have a bit of an inner ticklist. I need to feel quite confident that that woman is going to dial 999 if she feels at risk. That's my thing. I need to know that they will call 999 if they feel unsafe. It's the ones where I'm not convinced they will, they're the ones that I shout out to social care about. But if I've got a woman and she's been brave enough, and trusted me enough, to share a story with me and that I can leave and get in my car and know that she'll call 999, I can go home. You know, I've given her information about 999, and I've given her information about domestic violence services. And I'm gonna be going back, and we're gonna be, you know, talking about options. I think that's the beginning of our conversation, really. But if I've got a woman who is saying she wouldn't ring 999. She wouldn't call the police. Don't tell anybody... Then I'm frightened. And how do you tackle that? I will just say, I can't leave. I don't feel like I can. I'll just say I can't leave it if I don't feel like you're gonna pick up the phone. I'll just be really straight with them. And I'll just say I need to know that	priorities See me Help and isolation Team working solidarity

you're safe, because if you don't feel safe, and can't protect yourself, how do we protect your children? Do you find when they have disclosed, do they want something particular to happen? I think if they're at the point of disclosing openly and they have found a way to tell us, I think that's them saying they want some help, and want you to listen. And I ask them if they have a plan, and I think they want you to support them with that. Sometimes they are really scared and they want services involved, and so if you feel it's kind of at that point of, you talk about other services and other agency referrals. Then what's that like? Referring on or communicating with other agencies within this area? Yeah. I think it's a really positive experience. I think that if I've got consent to refer, that's almost the easiest bit. I know that I can ring our clinical triage team we've got here, I can ring and say right, cancel the rest of my day. I'm here and I'll be sat alongside that mum. I won't do anything without her. I'll be sat alongside her and will ring social care and do a referral. We'll ring the domestic	The point when what she wants doesn't matter anymore. It flips. priorities priorities Spectrum of perspective... but no longer is a spectrum because safeguarding

violence service and do a referral together. I'll ring the Children's centre and get them involved. I think it's important that she knows that you sit alongside her doing it. And in my experience in the past where we've supported women to get away and to a refuge everyone has been really, really good in that. The Children's Centre just jump on board. And that they're a place of safety. I've used the centre before, they've sat and waited and they've been supported there. And whether it's the next day that it happens or there's a planned kind of approach, there's people around. It's when they don't want anyone involved, that's when I'm prickled. Is there any difference of working with third-party agencies or charities, to working with statutory services? I think that working with the kind of agencies that are not statutory they (mum's) usually want. If we have a mum ready to work with them, and be supported to a point they are empowered and want to do it for themselves, and they will engage, as long as they're safe we can do that before statutory involvement. But some things come with statutory involvement like (perpetrator) programmes.	is binary? Family live open or Private? Breaking point How does the media impact our decisions? No the public is involved. honesty It is a constant see-saw of mother and child. Or should it be mother VS child? Responsibility and breaking point honesty

They've got to be on board, but then equally I've certainly got a family at the moment that I'm working with where I am pushing it (onto social care). I am pushing it cause with this woman she isn't at a point where she wants to work with services and for me is where it has to be statutory involvement. Maybe she's minimising the domestic abuse that's been really quite high end, she disclosed through a joint visit that we pulled together because the baby was born prematurely, and the neonatal nursing team were concerned cause they weren't getting very many visits. Our contacts from this woman. I tried to contact thinking is this her actually scared about the unit? A mental health thing? or is it something else? I can't get into her. Eventually this baby's discharged home, we went out and I'm just really kind of straight and I just said "I'm really worried about you, about what's been going on. I'm building stories in my head. What is going on?" And she broke down and it was really high end stuff you know, he was strangling her when we had tried to visit before, and when we were knocking at the door, and that she couldn't visit the unit to see the baby because she had bite marks on her, and he'd taken her phone off her. All this stuff, but she still said she won't call the police. So for me it's scary. So you know, I've been very, very straight. I was in a child in need meeting for this particular family on Friday and Mum	Domestic abuse is the fire. What is the fuel? location breaking point and fear

didn't come, cause she's not engaging; she's frightened, she's petrified and it was going to be reconvened and I said don't invite me to another child in need meeting. I said invite me to an initial case conference, but don't invite me to a child in need meeting. So I'm quite clear about my concerns because for me these are the women that we read about in the papers. You know, we've been trying to engage with his mom for six months. I'm interested to hear whether the safeguarding of the child 'trumps' the safety of mum, or is it a dual perspective of consideration? Ohh absolutely both. Yeah, because you've got to think about the emotional impact. It's not suddenly started, this abuse that she's been living with. We don't know how long it's been going on cause she's not ever told anybody. There's so many different aspects to the little story (of this child) that's building up to a bigger picture. It's just safeguarding, the whole picture, parents, the child, older siblings, everyone. And (with this woman) she was very clear she wouldn't call the police. So that's it. That's the kinda ones that you go home worrying about. They're the ones, where you're reading a newspaper and	Do perp's get a second chance when it comes to parenting and abuse? multiplicities

there will be a comment somewhere... "Ohh well, what was the health visitor doing when she was going in..?" Do you think statutory services (social care and police) have a similar perspective of safeguarding; mum and child(ren)? I think they do look at it differently because I think we're quite heavily led on infant mental health and in health visiting increasingly so. And I think we do look at what's going on for that baby, that child in-utero and the early years. I think we're really really driven by that. The brain development and future impact, whereas I think that the statutory services, social care, can sit with it a little bit longer. You know if they're engaging. Problem is this case will just keep coming back. They come, they close (the case). The works not done, and then it comes back, and these children that are just living with it for so many years. So I don't know if there needs to be more training about infant mental health, but I think it's really strong in some areas. There needs to be stronger (consideration) of infant mental health. We have open conversations, in antenatal contacts about relationships, and you know the impact upon children and how it feels for them.	belonging HV working with Dad's/perps aswell? So is it dad VS mum VS child? Histories It all starts in childhood. Are we all just listening to our inner child?

At the start you mentioned about different dynamics that might be going on for families, particularly with deprived populations. Do you see a relationship with those things and domestic abuse? I think there's usually some other stuff, whether it's something that they experienced in their life, whether it's mental health issues, whether it's finances, whether it's housing and living on top of each other, and whether it's employment and all that. Yeah, I do think. There's generally speaking something else there that's gone on. Do you find one thing can lead to another, with one of the resulting implications being abuse in the relationship? No.....like, I've just straight away said no, didn't I? Because I think most people, most people out there have got some resilience. They've got someone that can that can rely on, someone that they can talk to. But I think you know the majority of my visits are wonderful, you know, and relationships are great. And yes, parents do have disagreements, but they can repair, and that's good for children to see as well. So it's not out there everywhere. And I do think that people have got networks of support.	All about the talk... honesty

But you know, I don't know. I don't think so. I think there are elements where I'm a bit worried when it's a a hot sunny day and the football team have been playing and they loose....That makes me go. Oh, oh, no. What's gonna go on on there when he gets home? And so what are your thoughts on perpetrators of domestic abuse. Do you find there are commonalities or types of people? Yeah. I do. I think they've not had a great time in life. Probably if we went right back in their childhood, their relationship and attachment and bond experience, their infant mental health, were probably pretty crap. And I think that we need to be working more with these young men, young, young people in schools. Is he not going to school? He is aggressive. Nowhere will have him. He's been pushed away by society. Really sad isn't it? And he's lived in a home we will pick apart, and time and again there's domestic abuse. And there's got to be some work we've got to do...relationship work to do. Do you think a time ever comes when no amount of work or support	Truth(s) Build resilience.

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will change outcomes for an individual or family? You can always work with, and give support, I've definitely had some real lovely stories on my caseload over the last few years where dad's have wanted support and have attended (parenting workshops) and have really got a lot out of it. And a little bit of that 'light bulb' moment, a bit of an understanding, a bit of an acknowledgement, a bit actually, yeah. And what about supporting perpetrators of domestic abuse, is that part of the health visitor role? I do, yeah, yeah. Yeah, definitely. Um, when they're there for it, if you've got them there. I'm much happier now that we're back together face to face, because it's much easier to kind of reach over to somebody with eye contact and even if you just said "you know what I think, I think you've been really brave coming into this room to talk because that tells us that you're ready to work and ready to move forward for yourself" You've got to get them involved in the conversation. And how how do you feel about them, as a person?	HV – are we what we do? Opportunities Priorities

I think if they want to work with services and I think if they want to acknowledge the concerns and listen, then I'm quite unbarred. I'm really welcoming of it. But if it's somebody that is still managing to control the situation, I don't really want them there. I want to support the woman, they need to be supported to get there. I'm really mindful. I'm in the middle of writing a report for a family and the stuff that I'm gonna need to put in there; that I don't really want the dad to read. But I need it in there for the report. I don't really want the dad to read, cause that might put her at more risk. So it's a bit of a balance... I think we've got to start working with everybody. I think it should be on the curriculum in school, about healthy relationships. And I don't just mean for older teenagers, for younger children too, it needs to become a normal part, doesn't it? Society, that we challenge and push back when a relationship doesn't feel safe? But I often think that these (perpetrators), they've been let down at some point in their childhood. We've spoken a lot about your perception of how other people might be feeling, but who supports you? Where do you get your support from?	Containment Strength

Ohh my team. Um, I mean a really, really good team and people that come into the office. We have got laptops. You can start at home. You could do this job by not coming in. But I don't think that's very safe and I'm quite vocal about it. People are in, so you know that you could come back to the office and go "Oh my God, I just need to talk" We access really regular supervision, child protection supervision and clinical supervision, but you don't need to wait for that. You can have it, you know whenever you want, my clinical team, my managers are fantastic. And yeah, we'll talk about it. Do you find the informal or the formal supervision and discussions more beneficial? At its different times, so my child protection supervisor, she's just another health visitor that, you know, we worked together for a lot of years and I really trust her. And if I feel like, 'right, I need some real focus time to kind of like go through what's happened, what my plan is. Am I missing anything?' I will book that on our diary page as a protected slot. Or where I've gone out to a visit and come back, I'm not bothered who's in the office, I'll go 'right. I just need to talk' and people will just stop and turn the chairs around. It's a reflective way of working. I think it just makes sure my	Consistency Wonder

practice feels safe I suppose.

And also our safeguarding team, I will ring and if I need someone to ring me back, I know the names and I know who I want to ring me back, and I'll just go 'I just need to run this by you. Am I missing anything?'

Do you feel you get support with the emotions that you may be feeling?

Yeah, I think we do. I'm a practice assessor for students as well.

And I'm always very, very clear. If you've had a heavy visit where you've got in your car and you just think 'I can't go do a happy little birth visit', you ring up, give yourself permission to ring the clinical triage team. Give yourself permission to ring them and say you'll have to cancel your next visit and move it on, and get yourself back to the office or wherever. Have time, take time. We're here. So we hear so much. We witness so much, and the majority of the job is absolutely lovely and full of oxytocin. And you know, it's beautiful.

I love it. But when you get a visit, or a call, or you've been at a meeting where it's been heavy going emotionally, we've got to remember that we've all had childhoods and some of us have experienced domestic abuse as children, or as adults now. It may

touch a nerve. So you've got to come away and protect yourself in that way, I think. And feel able to, and supported to.

I can remember we had, during lockdown, our head of nursing attend a teams meeting. And I had my finger on that button because I wanted to share my story, and I used a phrase saying "...there are some families that you take home with you and they sleep on the pillow with you..." and you know only a few weeks ago she saw me and she referred to me saying that. And that's the role of the health visitor. That is sometimes what happens. So it's so important that you look after yourself.

And finally, is there anything that you could say from your insight and your experience within the role we could be doing better or slightly tweaking a little bit?

I think having a consistent practitioner doing the core contacts would be good.

So at the moment it's not unusual, because of capacity, that someone else will do a birth visit, for example, because we've got to get it in a time frame, and then another practitioner will do the six to eight week contact to get it in a time frame. And I might be a day out of being able to fit in my diary so it goes in someone else's diary and then somebody else does it. So these families might see

a different person at each contact. And how can they feel able to open up to someone if they're gonna see them once? So I always describe health visitors as very observational nurses, but you build on your observation too. So through from the antenatal to the six to eight week visit, you're observing, and you're observing relationships and interactions, and what's going on in the home. If you've done a one off visit to a family that you've not formed a connection with, and they've not formed a connection with you, it might be more difficult to pick it up.	

HV7 Transcript

So can you tell me first of all, how long have you practised within a health visitor role? 9 years. Right, and in that time period would you say you've worked with many families who have experienced some kind of domestic abuse? Yeah, yes	

And do you feel that it's changed over the nine years you've been practising? Um, because I've worked in 2 different areas, there was some in the area I worked before, but it's a lot more prevalent in certain areas of deprivation, it's harder to get away, but there are certain pockets where there's a lot of deprivation. But I've worked there for like 5 years and in the previous place for four years. It's definitely more now, I see it a lot more in my current area than I did before.	
And can you tell me a little bit about some of the other things that are going on in these families lives? You mentioned deprivation...so what was going? Yeah. So they tend to be in either very casual work or you know, cash in hand type stuff, or mainly funded by benefits. So not having much of an income, housing tends to be a massive issues. I think housing and domestic abuse are the biggest issues for these families. Housing....there's a chronic shortage of it everywhere I think. But some of the quality of the housing that people live in is so poor, and there are	Multiplicities Domestic abuse is the fire. Consider the fuel. Safety of home Socialisation of crime and abuse.

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a lot of travellers. Landlords don't maintain the properties, so they're quality of living in that sense that their environment isn't good. They aren't the sort of places you really want to bring children up in, and there tends to be quite a lot of crime, like violent crime, knife crime or drugs as well, a lot in the areas that I'm thinking of. And there's also a very high transient population in these areas. So a lot of immigrant families coming in now as well, which can be harder to obviously access and English may not be their first language. And do you feel like, all those things that you've just mentioned, are they causative factors of abuse in relationships? Yeah, that's interesting question. Obviously, you know, I know that domestic abuse can happen in any setting regardless of affluence. But I think in certain families, I think there's a culture of it. And a lot of people have grown up around it themselves, so they find it almost not acceptable, but a part of life really, that's quite common. So I think there's almost like a cultural sense, not necessarily like ethnicity. But I think just culturally, a lot of people maybe have had experience of domestic abuse when they were children, so it's almost become a norm for them. So it's like this, it's normalised. This is what happens in	Where is home if home isn't safe? Acceptance Fuel

relationships. So I wouldn't necessarily think the causative factor in terms of economic deprivation, but it obviously doesn't help. And you know, and then there's this kind of other things like, like alcoholism, which also can come into it. And obviously you know, it's obviously multifactorial, I would say could pre-dispose families to be more, more prone to that, if they're in more stressful situations. But I wouldn't say it's necessarily a causative factor. I don't think, I don't know. I would be really interested to hear your thoughts, within a heteronormative family, and Mum is a victim of domestic abuse and Dad is the perpetrator, do you think there are any family norms? You mean like gender roles and things like that? Yeah. Yeah, definitely. I can think of one family in particular where English wasn't their first language. And the dad was an alcoholic. A heavy drinker and physically abusive to his partner, and when we started working with them, it was very much the responsibility on her to do things like get the children to school and get sorted and all those kind of things (when she was in this sort of domestically abusive relationship with this perpetrator). And it was almost like I think as professionals, we probably do have those kind of ingrown gender norms as well. Like, it's her responsibility to be doing these things. The responsibility of her even with the fact that she was in	Responsibility HV aren't outside of socialisation and norms Empowerment Disguised compliance with negative norms.

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an abusive relationship. And actually she had no self esteem. She had no money like she was really vulnerable and obviously she didn't have any agency in her own life. So she wasn't going to, you know, be motivated to do these things that society expected of her. There was definitely that view of his role being to go out and get a job and earn some money. And her role was to get the children to school on time and clean and take them to their appointments and things like that. And at one point, it was almost, this sounds really, really twisted, but it was almost seen like the dad was almost a protective factor because when he was around, he would take them to school and he would get them sorted and stuff. And it was really twisted. When you think about it because our priorities were all wrong really. And in terms of what our expectations were, I mean, it ended well in that the relationship ended and she was able to get out the situation. You know, she did a lot of work to get at that point because she just didn't have any agency. She had to even sort her immigration, why she had the right to be here. It was all very, very complicated. But the point was, I think we often focus on very specific kind of roles they (parents) should be doing. And that probably goes for people in that situation as well, like the partners, they think that's your job to clean the house and look after the children, and my job is to go out and work, so probably it's more stereotypically gendered.	Acceptance Interesting point. Are relationships ever equal when there is a baby. Blind. There will always be one with more power. Power and control. Responsibility

You're talking about it with hindsight, but can you recognise these issues when you're in it, when you are actively working with that family? It's difficult to say, I think the system is kind of geared towards dad's and men who are domestically abusive and the expectation I think is on the woman to leave the relationship, not on the man to reform his behaviour. It feels like such an imbalance. I think when you go through it, I think we just kind of accept it as the norm really. The domestic abuse services can be accessed by the mum, and she can do them, but there's very little focus on the perpetrators. It always feels a bit unbalanced but that's kind of a structural thing, I suppose, really in the work culture and wider culture, we don't expect those men to change particularly. Do you think these cultural thoughts that you've just mentioned are true in other statutory services that work with children and families? Ohh definitely yeah. Yeah. Say that. Yeah. Yeah. And there's often an emphasis. Like I said, I mean, these things are offered. These things are offered to the fathers and but it's almost like there's not really much of an expectation that that's gonna go anywhere, it's just like a token thing	The systems What's the point? knowing

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to say. "Well, we'll offer you this programme, but we know you probably aren't gonna come." You know it's very low expectations of men. It's really sad cause in my experience a lot of the time they don't even finish these programmes and often if they're in group settings, they can sort of go along and think, well, I'm not as bad as him. So I'm not sexually abusive. I'm just verbally abusive or whatever. So they don't really address the root causes and in my experience, men like that don't appear to be able to change their behaviour very easily, or we haven't found a way of helping them to do t properly. I think we do try to include father's wherever possible. Try and be like father inclusive or you know, partners. But it's a battle and a lot of men don't see it necessarily as their domain, they'll leave the room when we visit. But you know, I think we're getting better at it, but it's still not what it should be. I think in terms of considering them as an equal parent. And especially if the relationship is not, you know, they're not together, it's very awkward to try and involve them. Which is probably another of the root causes, cause they can probably feel a bit locked out of the whole system really, that it's more about mum and baby, than it is about, you know, the parents as a whole.	Men are the victims? The systems Should the service be family inclusive, or mum/baby focused? Truth(s)

Do you feel the health visitor role, or the SCPHN role comes from a mum/parent approach or a child centred approach? I feel there has been a real effort to be more father-inclusive, and I've certainly been to talks where they've got, like, dad's to talk and stuff like that. And there are groups where it's just kind of dad's. They are trying to make an effort and we always try, and you know all our letters say we want father's to attend appointments if they can and stuff like that. But I just think it's very focused on mum, I haven't had loads of experience with same sex couples. So I can't really speak to that very extensively, but yeah. So just being heteronormative about it, it's tends to be very focused on the woman, but it's always wonderful when father's are in the room and do want to be involved, and I always try to address them and include them but it doesn't come naturally, because we are so geared to mum and baby, above all else really....just historical I suppose. I'm interested in the asking about domestic abuse. So routine enquiry and you know, we were just talking about having father's or partners in the space. Do you feel that would be a barrier to routine enquiry about domestic abuse and healthy relationships?	Respecting cultural norms means we get a foot in the door. We can't preach equality, when in some cultures it does not exist? Boundary Stuck Abjection?

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Yeah. So even if the father's present in the home it's not safe to ask the routine enquiring questions, so I wouldn't even ask if they were present in another room. And the same with family members, because obviously abuse can come in the form of familial abuse as well, so it could, it could obviously put a woman at risk, and quite often, especially in South Asian families, the woman tends to live with her in-laws, they tend to live with their husband, and their husband's family. So it can be, you know, very, very difficult to ever get a woman on her own to ask that question. And we even have to be careful about children being present and overhearing, depending on the age of the child and their verbal abilities. But yeah, so it can be really awkward. And there are some women who we can't reach because, you know, we can't ask that question because of that reason. And I'm thinking about asking those questions. What's it like for you asking those questions? How does it make you feel? Um, it's never. It's never the nicest thing to bring up and it's probably something that I ask towards the end of the visit or the contact. I mean, we're used to asking all questions and discussing awkward things. But, you know, it does always feel quite uncomfortable to say it. And that	fear Do you feel safe? Or, are you safe? ...very different. questions

probably does come across. But you know, most people in the majority, in my experience, most people are understanding of why we ask it so that, you know, it's usually well received. It's just not an easy question. Yeah. And do you change the way that you ask it? I usually ask it when I'm discussing parenting in a birth visit. You know, how parents have kind of adapted to being parents, or if it's their first child and I might say, you know, because we're talking about their partner, I might say well, how are things with him? How is your relationship now that you've had a baby and then specifically ask "Do you feel safe in your relationship?" But yeah, I would tend to lead into it like that, and quite often you can get an indicator of how things are feeling. Just kind of vibe-wise in terms of the support that woman's getting in the first place. So you can usually find it an a route in like that. I'm just thinking of one other family where it was, it was a really complex situation, but there were strong suspicions that the partner was very, very controlling. And certainly he appeared to have an explosive temper with professionals and. And you know, there was a lot of things that, I witnessed that were very uncomfortable to witness in terms of how he spoke. But it was because of his controlling behaviour, it was very, very hard to ever get her on her own. And even if he was at	Pattern of abuse fear Families on the periphery of acceptable... set by whom? Stuck Safety of home Importance of safe place away from home. Face

work when you went round to do the visit, he would come home, he literally had cameras everywhere in the home, CCTV in the home to record professionals. That's how suspicious they were of us. It was very, very uncomfortable situation. And that was really, you know, even when he wasn't there, it didn't really feel safe asking that question and it felt that she might be put in danger by you asking that question. And there was never even an opportunity to build rapport enough for her to disclose anything. My suspicions remain very, very high that there was a significant element of control in that in that relationship, but how to get her on her own? It's really, really difficult. When he was so invested in every moment, and that's the kind of downside, we try to be father-inclusive, but you know, obviously, it would be great to be able to feel that we could have spoken to on her own. I know that there was social care involvement with the family and they did. They did try, but that wasn't well received.	the realisation that home is not safe for some. Safety of home
And I suppose that, you know, there are some families, where it's just never going to be possible to address it in a way that's safe, I suppose. Or we haven't found a way to do that.	Blame
And so thinking along those same lines of asking those difficult questions at home, is it sometimes easier to ask them in a clinical environment?	honesty

We don't have that many other environments and clinics where we would be able to do that I think. We don't run the clinics anymore, it's led by other staff. I have occasionally arranged to see people outside the home when it's especially hard, I'm thinking of one particular case where there was a suspicion of familial abuse and it was safer to talk more freely, so we can do it but it would be an exceptional circumstance where we would. And probably have already had a disclosure, we don't routinely do it. That's not to say we wouldn't. We would love to do clinics, but they took it off us a while ago, quite a few years ago. What's it like working with individuals and families when it is known there is domestic abuse? How do you find that dynamic within the working relationship? It is challenging because quite often they tend to minimise quite a lot of what's happened, so though there may have been a disclosure that you're aware of, or information is shared from another agency. You know, I'm not afraid to lay my cards on the table, and tell them, you know, we've been told that this incident has happened and it's not uncommon for them to kind of be quite defensive about that. Like, "...it wasn't like that..." "They've misunderstood it. It was nowhere near as serious as that." "It's fine, you know, everything's fine now. It was just a	Victims fault for not disclosing or saying more? Responsibility Trust is crucial. Group trust and individual trust. "I want to help"... Is that ego? Honesty

heat of the moment." They know all-sorts of excuses why it wasn't as disturbing, as troubling, as it actually was. So that is quite hard when you get to that point of backtracking and it can be really hard, because I think that trust is so important in that therapeutic relationship. So if they don't feel able to trust you or to just, you know, to further disclose because they're in denial, it could be really challenging to work with those families. And you know, I've not really been in the situation where you can physically see the bruises, but, you know, you're very aware that there's been very serious domestic abuse and that that's definitely happened. And then they still deny it. It makes it quite challenging to work with those families, cause you feel like 'I can't help you because you're not being honest with me'. And I have had that quite a lot recently as well, where it was really hard, actually. Um. So um, she, she disclosed quite a lot of controlling behaviour in the relationship and I was really, really concerned about what she was saying. So I ended up getting quite a lot of supervision about it. And while I was kind of looking into the family, I came across the fact that they previously had been on a child protection plan for this very reason. But she hadn't disclosed that to me at all. And so that was really difficult. I mean in the end I did end up making a (social care) referral because of the concerns, and these were the same concerns on the protection plan earlier, but it was really difficult because you know, I	Our perspective impacts practice. Fix or support Frustrating for us, but awful for families. Breaking point A lot about honesty... do we do this to maintain the power, or deplete it?

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think the trust kind of broke down between us because she'd felt almost betrayed. That I'd found this out, and that I was acting on it, and I'd felt a little bit betrayed, really, that she hadn't been that honest with me, about the previous plan. It's really to not take things personally, but that can be really, really challenging when you think 'I just want to help you, but I can't because you're not being honest with me.' And so it's quite challenging thing to work with that, but you know there have been occasions where it's been more positive and there have been people taking positive steps to move away from the relationship. But I guess in the back of your mind you're thinking is this a permanent change that is going to last? is this sustainable for this family? I think we can't help having our own ideas about how families should behave and what they should do in certain circumstances. As empathetic as we are, we probably think "well surely you can just, you know, leave the relationship" and it feels a lot more obvious to us as an outsider. So when they (the victim) can't see that or haven't got enough self esteem or agency to do that, even though it feels like a simple solution to us. So it can be quite a frustrating process working with families with domestic abuse. You mentioned a few times about trust within those therapeutic relationships. How do you go about building trust with families and	Building connection in human endeavour. connection What are the qualities of trustworthiness? Reliability, approachability? consistency Contradictory? Direct with your opinion but respectful of theirs. honesty

particularly when it might be only a short period of time you have with them? Yes you often have to get that trusting relationship really quickly. And then like you said, in a short space of time, and when you have other things that you need to talk to them about and stuff. I have quite an honest and direct approach to the family, so I think really not using a lot of jargon, not being too professional about it, and trying to find some common ground to indicate that I do have empathy with them. I do have empathy with them as a parent, you can find something positive or something that you've got in common. And you know, just from maybe a picture they've got on the wall or something they're watching on TV, you can find a way in where they can start to think this person isn't aloof, isn't alien, isn't just another professional, they actually want to help me and that they're likeable. You can really indicate that you are trustworthy, like being reliable. You know, turning up when your supposed to, you know, really basic things or, you know, just, doing what you say. Well, when you promise to do something for the family that you think isn't actually that important, but it is important to them. So if you do that, that kind of creates that idea that this person is reliable because they did what they said they would. You know you are a trustworthy person, but I think being direct because	Based on personal qualities. wonder Push it more into radical empathy?

you've only got a short space of time. You have to be direct. You can't pussy-foot around. You can't be too vague about stuff. I think you have to be quite direct, obviously, in a respectful way. But yeah, and lots and lots of kind of openness and being mindful of cultural concerns that there might be in the house. So that you're showing that you are respectful. All of those skills you've just mentioned, have they come over time? I think to a certain extent sometimes I'm more conscious of doing it than others. Sometimes probably, I think at the at the beginning, obviously where you first train and learn the job, I think it's very deliberate and you're not necessarily that natural with them. I'm quite, well, you probably say nosey, but actually curious in a nice way. I like meeting people. I think that comes across when I'm in someone's home anyway. So I think that sort of thing and I think that. Being empathetic, I don't know necessarily that can be taught, but I think the other things maybe can be more deliberately learned, but being empathetic is probably something intrinsic that's quite hard to teach. Have you ever had experience of a working relationship between another professional and with a family experiencing domestic abuse, breaking down?	Them VS us. Knowing Find the child within the family dynamic. boundary

Yeah, I've experienced both the relationship breakdown with an agency, and with a professional. Yeah. So that family that I talked about, where they were filming professionals, they had sacked their previous health visitor because she had reported them to social care; something that she witnessed that the partner said. And they had denied it and called her a liar... which was a common theme with a lot of professionals that they came across. They were all liars according to this family. So then having to go in on the backfoot of that and knowing that you're being filmed and all that, was intimidating. It's an example of the trust breaking down. I think they were a particularly difficult case and it was quite hard to go in knowing that, especially because (the previous health visitor) she happens to be a good friend of mine, which made it really, really hard to like go in knowing how they've treated her and knowing that she was extremely professional and thorough. And as sure as I could be, she wouldn't have lied about what she witnessed. But, I was really mindful of the dynamics in that situation, you have to be really careful in those situations. They would very much pull you into their drama triangle and their little debates and complaints that they had about people. So it was really hard to establish what I wanted, a good working relationship with them. But I had to be really firm about the boundaries and what I was there for and that I wasn't going to	Wider question of who are we working for? Families or the state? The systems empathy

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entertain or listen to any of their rants about how badly they've been treated by XY&Z. You can say, "Yes, that's all very interesting. But I'm here for this. This particular child and this particular reason. And that's why I'm here. And that's what I'm gonna focus on." And it ended up being OK in the end because I just kept the firm boundaries and they always tried to have a rant about how badly they were being treated by other agencies. But, you know, it was very much my working relationship with them that was good because I kept really, really firm boundaries. So I think you have to know when there's been that kind of dynamic in the past in order to calibrate how you are with them, and not get sucked in. But you know, you can't let it overwhelm you, you can't let it intimidate you because otherwise you're not going to be able to work with them if you're too afraid to challenge them. And I've got to the point where I was able to challenge with certain aspects of their parenting and decision making and things, and by the end they were quite sorry to see me go. Other situations it's been a misunderstanding or miscommunication with the family and it's been the straw that's broken the camel's back, things like that, and they might just kind of think "well I'm sick of the whole of the NHS, I'm sick of you all you're just the latest example of how disappointing you are you all are to me, so I'm gonna sack you off" so I've had that as well but again you can't take it personally. It may	We can't help but care. connection belonging

have been a technical fault, like a letter's not got sent out or the button's not been clicked that should been clicked; a minor error and that you had nothing to do with it then. You know, I think you can't really take it personally, but it's not to say you don't. It does still feel a little bit like a rejection when a family's like, no I am not seeing you again, but thankfully I think it's only happened to me once, and as she was quite an unusual woman, I think anyway so. But you don't know everything else that's going on in that family's life, you're gonna get the barrage of bitterness and vitriol that's there about a lot of other things. So yeah. Sticking with taking it personally. When you know a family is experiencing a lot of different things, do you still take things personally? I think you can sometimes, yeah. Yeah, you can. And that can be positive as well. So you can get a very positive rapport with someone that can feel really nice and fairly good. That can be really good, and can be a really professional, strong, good relationship with the family, yet it almost feels like you could have been friends with them. You know, you really click with them and on that personal level. So you know, I think you can't have that without having the flipside of feeling like it can sometimes feel like a personal rejection, because there are people that	Privilege in pain. Rewards of connection, mutual trust. connection Containment

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you aren't going to click with. That's life and for whatever reason you might have got off on the wrong foot or they might have a lot of history with previous professionals that have been involved with them and they might just not like it. They might have not liked anybody walking through the door. But it does still feel personal, cause it's like I said, it's a flip side of having that great rapport with somebody. You are gonna have situations where it hasn't worked and that might be cause how you are that day. It might not be something to do with them. And that's kind of a pause for reflection, but it's just sometimes how things are. And sometimes it's hard to repair if you don't get a good connection in the early days. So what's it like, with those families that you naturally click with and you've built a good working relationship with, and then there is a disclosure or an incident, how does that make you feel? Yeah. I think it makes you feel kind of quite privileged that they've opened up to you like that. Nice isn't the right word, but it can feel quite gratifying that they trust you enough to disclose, that you've got to that point in the relationship. I have experience of visiting a family a lot because of medical issues with the child. And we've got a great rapport, and then there was this kind of disclosure, but I wasn't that surprised,	Acknowledging their pain. honesty Boundary of safeguarding. honesty Even when safeguarding takes over, it is still their life and

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because I'd seen the dynamic in the parent's relationship for myself. But it was really great that she was able to kind of share that with me. I guess it's a rewarding part of the relationship when people feel like they can do that, so yeah, it feels like you've kind of quite a special position. To be hearing that. And when it gets to that point of them sharing, how do you go about exploring what's going on, and planning certain steps that you need to take? I suppose it really depends on the nature of the disclosure. So I always do try and say something along the lines of "...that must be really hard for you to share. Thank you for being so honest with me..." and that type of thing so that they feel kind of validated as well. But depending on the nature of the disclosure, obviously if it's serious, you know, a disclosure of very serious nature, I would be very honest again with them and say, "...because you've told me this and you have got a young child or children, you know, I'm going to have to take this further..." I have had that experience where everything was sweetness and light up until that moment where you say that, and then they say "no, that's not why I told you." And then it gets quite hard because you have to explain that you have a duty of care. But as I said, I think it	they should maintain some power (whether actual, or not!) Respect There is never not a reason for supervision. Event VS the experience.

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really depends on the nature of the disclosure, what kind of support they have around them, whether you feel that it's an ongoing problem, or it was historical, or what the current challenges are. And I would nearly always take it to supervision. So I would always explain that to the family; that I'm going to speak to a colleague about this because I'm quite worried about what they've told me, and that I will get back to them. I do always get back to them. I had a situation recently where it wasn't me that she'd made the disclosure to, but she had made a disclosure to her counsellor and the counsellor had to take that further, but hadn't told her that she was going to do that. So I think that really destroyed their working relationship, I mean she (mum) understood why the counsellor had to escalate it, but she felt really upset that she hadn't been told. Instead she was told the counsellor needed to speak to her supervisor about it and then had just never come back to the mum, so she just assumed that nothing more was going to come of it, until the social workers got in contact. So it was a really awful way of handling it. So I would always be as clear as I can be about the steps that I'm going to take and then keep them informed as to the process. Sometimes I've had it when they've made the disclosure and you've you said I'm going to take supervision and then come back to the mum and say "I feel this will need to be referred to social care" and then the barriers come up and	Pattern of abuse Is controlling behaviour ever safeguarding? priorities Reflective practice. How do you effectively intervene with control?

they might not take your calls and refuse to enter into further kind of conversations with you. But you can only do your part of the bargain, and I suppose it's a natural response. Have you ever had situations where you either don't know what to do, or you wonder if you've done the right thing? Yeah. Ohh, yeah, yeah, all the time. But that's the beauty of supervision. So yeah, that's why I always check. Always speak to someone before making any referral to social care, or making a decision. If you do that it's a really clear process for everyone. There have been times where I've had misgivings about how seriously to take a disclosure in terms of control. I mean, you know, it's much harder to quantify the risk when it's along the lines of controlling behaviour, or maybe emotional abuse. And it can be really difficult to say how much danger that that particular mother is in or that the family is in. It can feel that those situations are much harder to handle than ones where there's been a direct disclosure of physical abuse or sexual abuse, where it's really obvious. If the risk is controlling coercive behaviour that's maybe gone on for months or even years, it feels less like this is an acute situation that needs referral. How do you handle that stuff, I find those quite difficult and I think you can make a call	Social services not right for control. location Is it because we don't understand how to tackle it either? priorities Safety of home

either way sometimes in the situations, not necessarily wrongly, but it would be quite difficult to know which path to take. And there have been times when I've thought maybe I've minimised that, or maybe I didn't take that seriously enough. Or maybe I took it too seriously and wasn't as dangerous as I thought, that can be really, really hard to calibrate, yeah. So when control and coercive behaviour is a main factor, and you've done a referral, do the referrals get picked up by social care? No, no, often no. No, they don't often go anywhere other than a phone call or, maybe a one off visit to the family depending on how seriously they take it, but it's not normally something that turns into anything more than that. They normally just push it back to universal plus services or early help type things. There's definitely a feeling that there has to be physical violence or, you know, substance misuse, or something very, very concrete for them to take it on and do a full family assessment. How does that make you feel when it doesn't get taken further? Well, yeah, it's extremely frustrating because you feel it's still, you know, it's still serious and we know that that sort of behaviour, and	You can't always provide answers but encourage them to empower themselves. Fine line of professional connection and friendship. boundary consistency Therapeutic relationship.

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stalking behaviour, things like that, can definitely lead to homicides. You know, they should be taken seriously as they can escalate into something much more severe and even if they don't, it's still emotional abuse. Emotionally abusive to the children that are in the home and witnessing.... that's very damaging for them and possibly setting them up for lifelong issues. So it's not something that I think we should tolerate or should accept, but it can be really hard for, you know, social care being on their knees as they. It's not been my experience that they've ever acted much on that sort of disclosure, really. And so when there hasn't been much action, where do you go from there with working with this family? What things do you tend to then explore with them? Yeah. So it really does depend on what kind of support network they have and who they've told within their support network. So if you feel like, well, you know, a relative knows that's nearby, and you know that's a safe place to go, someone that is going to keep an eye out for this person or this family, you feel a bit more reassured. So I guess I'd try to explore there. I would really want to explore their support networks. I wouldn't do a formal safety plan with them, but just making sure that they would know what to do in the event of something	empowerment Victim blame? honesty blame

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happening. And that they have somewhere to go and they've thought about that. And just as I suppose, just exploring with them what they want to do going forward, it's really, really hard. I can think of one recently, and you know from the outside, you think extremely pretty, lovely, lovely mum, you know. But there is a lot going for her at home, in her relationship, it's really emotionally abusive, and you know it's very difficult not to say to her, "You know, you're worth so much more than this". You would want to say that to her because if she was my friend that's what I'd say to her, but she's very isolated and doesn't have a lot of support within her family. So this situation is really challenging because you know what you would want to say as a friend, and be more direct. But you have to be direct in a professional way. So I think you just have to really keep up that consistency with them, being consistently there for them so that they can carry on trusting you, so that they have got a person in their circle that they can trust and they can disclose to. And if anything further happens, just trying to cultivate as much of a support network as possible and trying to make the situation as bearable as possible. And I guess just, you know, maybe challenging them a little bit if they're falling into patterns of behaviour that we feel are destructive or harmful, then going forward, but it's not easy. It's not easy. Those situations are very, very difficult. But yeah,	Human condition and relationships are unhealthy at times... can we ever expect children to be fully guarded from this? blind Need for better understanding of trauma. It is not the event, but how it's displayed within the body. Honesty or blame

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you kind of sometimes feel like you're the only person that they can talk to about it. Do you ever have conversations about how it might be impacting their child or their children? Yeah. Yeah. So, yeah, you know how difficult it must be for them dealing with the emotional and verbal abuse, and being controlled, to then ask them how their child may feel about it. To position that conversation, that important conversation, maybe point out that it's really not nice for your child to be witnessing that treatment of you. The environment they're in, toxic behaviour or toxic language and that it will be affecting your child's self esteem. Your child's ability to, you know, regulate their own emotions and have their own needs met. And so yeah, you try and point that out in as much as you can without making them feel even more guilty, or placing blame on them. But yeah, just drawing their attention to it, because there's still that myth that if they don't witness it or if it's not physical, then it's not affecting the child. So just kind of breaking it down that little bit and saying, you know, actually the atmosphere in the house is such that it will be affecting your child's behaviour. And I've had a family recently, just finished working with them. The	Self-blame. consistency HV being used as surveillance rather than support.

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older child who's now five or six is just in school, they've witnessed a lot of domestic abuse in their life, quite serious stuff. So you know, they're now exhibiting behavioural issues that are completely understandable from what trauma they've experienced, but pointing that out to the mum, she was actually quite shocked. When we said, 'well, he's behaving like this because of everything that he's witnessed; all the turmoil and all the anguish and all the upset that that will have caused him'. Them seeing their mum like that and the fear that they'll have experienced, that's why he's acting out, because that's how he's processing it. And she didn't say much, it's really strange. People don't realise that these children are there soaking up everything that's happening to them and around them, and that it has to come out in their behaviour or their actions. They may not be living it right now anymore, but for the child, it's very much alive and they're still reliving it. It felt like an eye opening moment for that mum. She realised they were processing the trauma and it wasn't because he had some additional need or learning difficulty, it's because of everything he's witnesses and a natural reaction to pain and trauma. So yeah, it can be quite a sobering moment for people, when you start to point that out. And do you think that can be a driver of seeking support or making changes, understanding the impact it has on their child?	solidarity fear

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Sometimes, yeah. Yeah. Or, you know, an assurance to themselves that it won't happen again.

Is there anything that you can recognise within the service that is lacking when thinking about supporting these families?

That's really hard. It's really tough at the moment because we're really, well everywhere, is really short-staffed, so it can be quite a challenge to feel like you've got the time and space to build that relationship with people that's so important for them to make those disclosures and for them to trust you and continues that positive working relationship. And of course, knowing where they can seek help.

And you know, there's no way around that, it's a consequence of the short staffing levels that that will happen- we won't get the chance to build those relationships with people. There can be quite a prescriptive way to getting the contacts done, and the type of visit. And they, I mean, not always, but they monitored the type of visit we do and why we are visiting the family again. You know, they've had their set number of sessions. They shouldn't need to be seen. You know that type of thing. And that can feel quite restrictive when you don't have that kind of professional freedom to say "no...Well, I know there's no specific reason why I'm going back, but it's really important that I maintain this

relationship with this woman. I'm quite concerned about her. And I think, you know, there's something more going on that she may tell me in the future..." but you don't always feel supported to have that professional judgement call. It's alright not to have a specific reason to visit, there's that bigger picture. But then again, even if we could offer more visits, I think everyone is very scared of missing something. So that's a big fear for a lot of people that we end up not seeing children or not asking those questions because of other pressures.

And, maybe improving access to services, specific domestic abuse services. Making sure it isn't a postcode lottery... those sort of programmes dealing with healthy relationships, having that more widely accessible, that would be beneficial for families because a lot of the time they may have grown up in environments where domestic abuse was the norm. So they may not have ever experienced a healthy relationship or witnessed a healthy relationship.

HV8 Transcript

So if we could start, could you tell me how long you've been practising within a health visitor role? Yeah, I've been a qualified health visitor for 10 years. Yeah, just over. And would you say you've seen lots of families within your 10 years who have been experiencing domestic abuse? Yes, see them regularly. It can take a while for somebody to disclose that there's domestic abuse, but quite often you have a feeling before they've disclosed anyways... there's something not quite right in a family home, by the way the adults are with each other. Or the reactions of the children as well. Sometimes that can be a little bit of a red flag and a trigger.	What is instinct and gut?? Gut instinct

This feeling you've mentioned, have you honed that sense and feeling over the years, or has it always been there? No, I think I've probably honed it the more experienced I've got, and I suppose at the beginning when you were starting to hear disclosures from parents, you would often think, "ohh my gosh yes, that makes sense now". And now I actually go into the home with the view of looking at the way relationships appear. You know eye contact, whether mum particularly is speaking for herself, I've got quite a few cases where Mum has never been able to speak. Dad has always spoken over her... I've never seen them on their own. And so yeah, so even if I have a little bit of an inkling that there might be something not quite right, I'll try and invite them to a clinic setting so I can have that discussion, you know, safely without somebody else with them. OK. I'm interested to hear your experience of having that actual discussion, that routine enquiry. How do you go about talking to individuals and families about it? Well, I initially talk about who and what networks they've got, you	wonder Gut instinct Listen with humility

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know, ask about all of their relationships, and then the one with the child's parent, or their partner. How long they've been together and make it more informal and chatty. And I usually tell them I'm just nosy. I try and build up a bit of a relationship with them first. And I will say, are they supportive? You know, what kind of things do they do to support you? And then once we've had a chat and I feel comfortable and if it's safe to do so, I might say have you ever felt unsafe with your partner? And have they ever hurt you in anyway, whether it be emotionally or physically? And obviously we talk about finances, we talk about things like that as a routine. So I usually ask, do they have their own money? Are they reliant on anybody? So, you sort of try and ask the questions to unpick what might be going on. And then if it's safe to do so and I'm abit concerned about what they've said, I will say, you know, some of the things you're telling me are making me a little bit worried. You know, you're relying on your husband for money. You know, so I'll try and unpick it with them. Depending on what the conversation is, I don't often go straight in and say you know, is there any domestic abuse in your relationship? I talk first about their relationship and how they see it, the support, the finances, that kind of thing. And then if I've got red flags going off, I will then have a discussion and I usually say that it's something we always ask everybody, and so they're not feeling like it's something that's been	Trying to take the abjection out of it. Asking about safety becomes part of the everyday conversation. questions honesty connection So we get it but they don't?

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specifically picked out. And I'll explain that we ask that because we're here to support and help, you know if they need you. I'm interested, you mentioned you tend to use the word 'safe' with parents rather than the term domestic abuse. From your perspective, do you think that the families you work with understand what domestic abuse is? No, a lot of them don't. They don't. I think for them a lot of people think it's just a physical thing; if they're not hitting them, then they're not suffering domestic abuse. So that's why I try and explore things like finances and emotions. And you know, shouting, you know, normal couples will argue about things. So, I sort of talk about the stress having a new baby can cause on relationships and arguments can happen sometimes. So I might say, you know, "how has it affected your relationship with your partner? You know, are you having any fallouts, you having any disagreements with anything?" And if they say, yeah, I'll say, you know, did that happen before? And so I try and then explore, depending on what they say. Specifically with finances, they have no idea that that might be a domestic abuse thing, and control, you know, being told what to wear or who you're talking to.	wonder questions Is being controlled always bad?

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I've got a family at the moment, and I suspect there's domestic abuse going on and mum has denied it, but she is relying on him for money. She doesn't have a phone of her own. So we've sort of explored that, and why that would be a worry for me, cause she's expecting a baby. So I've tried to make it that what would happen if you know you went into labour and you were on your own, how would you contact somebody. And then talking about it she did actually say "you think he's controlling me, don't ya", which again worries me because she's still denying it, but I think she does feel controlled because she's not got any money, she hasn't got a phone, you know, he's always there. When I go see them, I had to get them to the Children's centre to see her on her own. Whilst Dad then played with the oldest child in the play and stay session, I talked to her about emotions, my worry about control, and sort of preparation for the baby. And she was expecting me to ask those questions, and even though she said no, I still suspect there's something not right there. Do you have a plan to enable her to open up more? I'm just going to keep building up our relationship. I think if they've got to learn to trust you first, haven't they? Before they even come close to disclosing, cause it must be terrifying. You know? She's got a 2 year old. She's having a baby. She's relying on this man for everything. What would she do? Where would she go? How would she manage? She's got	empowerment connection Empowering therapeutic conversations.

no money. You know nothing. And so I think building up trust is really important to start with. So trying to see her on her own at times is really important, and everybody asking the question - the midwives and the GP, you know everybody, so that eventually, hopefully one day she might disclose to somebody that actually things are not quite right. And so yeah, I think just getting her on her own and talking about what's normal in relationships and what might be worrying in relationships. So she might identify in her own mind that something's not quite right here... which I think she already is doing because she mentioned control when I asked about a phone and having to ask somebody for money. I wonder, when, if, this woman discloses domestic abuse, with your experience, and in your opinion, what do you think she would want your response to be? Believe her for a start, then ask what she wants. What does she want to happen. I suppose it depends on what the disclosure is. If she or her unborn baby or 2 year old weren't safe, and I felt they were at risk of serious harm, I would have to talk to her about my worries and that, you know, it may be that we might need to do a referral to social care and complete a DASH assessment with her, and so we can go through the questions together.	acceptance knowing What she wants. Experience meeting the binary questions. You need the objective.

You know, they'll be things that she might not have told me that but, but because of the questions that we're asking on the risk assessment and you know it could bring up, you know, anything that she's not disclosed and then go from there really. But I think the main thing is to find out what she wants to happen and ensuring there's no immediate risk of harm. It might be that we make a plan, you know that she gets together, ask if she wants to leave, but if she doesn't want to leave then we talk about a safety plan. So, making sure she's got, you know, passports, important documents together. She knows where things are so that if there comes a point that actually she needs to go, she knows where the things are that she really needs to take with her. So I've done that before in the past where we've had a safety plan, the mum had everything together, and when something happened and she had to go, she did and she had her important things. She just grabbed everything, went to the GP surgery, so we'd even thought to talk about safe places for her to go, and one of them was the GP surgery. Then the children's centre, so you know, the usual sort of safety places that we might direct them to, and sometimes those are the places they can go to because they can just say "I've got an appointment with the doctor" and their partner will allow them to go to that safe place.	See me planning Breaking point

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You've mentioned the immediate risk of harm. Have you had experiences of making a referral to social care when there's immediate risk to harm? Yeah, yeah. One where she had physical bruises, and her partner's threatened to kill her and the little one. I was that worried that if she went back to that house, then, you know, she could be at risk. So I have, we have agreed to that as well. Fortunately, I haven't been in a situation yet where they haven't agreed to a referral, you know, when it's been that serious. And I've had to refer to social care and they've declined me doing it, fortunately. But I would, I would explain to them that even if they didn't consent, if I was that worried, I would have to do that referral. And what what's your experience, if it's taken on by social care, what's your experience with working with social care, particularly within child safeguarding, when it's to do with domestic abuse? Mixed. Really mixed. I've had the odd incidents where they've not really taken it very seriously and I've spoken to social care duty and have had to speak to a manager because I was unhappy with the response that I was getting, and I was too worried at that point to allow that parent to	What women want until it contradicts what we want. fear Honesty What drives us when it comes to safeguarding? Moral compass? Our own experience? Team working

go home until they'd spoken to social care. And I think with that one, she actually agreed to speak to the police as well. And so we referred into the police. I sat with her while she phoned the non-emergency line and spoke to somebody. But then I've had really good responses from social care at other times where, you know, they've been really on it and they've got a refuge fairly quickly, they've, you know, done an assessment pretty quickly. Come to the surgery to see that parent and we found a refuge for them. So yeah, a bit mixed really. Have you ever had experience when the main concern hasn't been the threat of physical violence, but more a concern about the pattern of behaviour, and it's become detrimental to that child or mum. What's the response from social care then? Yeah, I think they're less inclined to accept a referral. There's no physical injury. Yeah, they may call and quite often by the time social care get in touch with that person, that moment to speak to them has gone. Days could have gone past. That moment of disclosure because it's bad, it's bad and they need support and help, to then have to wait, the moment has gone. They've gone back to the family home and then they've been too frightened or too scared to do anything about it. So they've not worked with social care and then the case is closed. I've had	Location (moment) The moment of asking for help and responding accordingly is pivotal. Finding moments in the fear. fear opportunities

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one particular lady that that happened to, I ended up meeting her at the GP surgery because he'd been abusive towards her, she was frightened to go home but didn't want anything doing. But eventually she agreed to a social care referral. She was worried about answering the phone. And, you know, speaking in case he heard her talking to anybody. So that was quite difficult because obviously I kept going back to the home to do support visits for mental health, and I don't know whether he knew that something had happened cause he was around quite a bit afterwards, so it was really difficult for her to talk to me. I couldn't talk to her about it because I didn't want to put her at anymore risk. And so with this situation like hers, what's your thoughts on social care being involved? Sometimes it, I suppose, it depends on the risk of harm to the child or the mum. Sometimes it's better to refer her to another agency, but a lot of agencies won't work with the mum, if they're still with the perpetrator. So they have had to have left the family home for some agencies to support. So it can be quite difficult. And I suppose at the end of the day, providing there's no risk to the child, if the mum is not consenting to any referral to services, there's not a lot we can do and we just have to hope that eventually the trust will come, or they'll get to	It's strange how we become victims of the perp... not saying anything etc. Who do we blame more, the person who did it, or the person who watched? Team working consistency Becomes mum VS child VS services.

that point where they can come back to us and say actually now this is affecting my child or you know, I am ready for support and advice. So it's really important we give them contact details as we're only there for a short time, aren't we? We can't just keep following them up because we're worried about them. It has to come from them. Have you ever had to position the conversation with mum about how the domestic abuse may be affecting her child or children? Particularly if she is minimising what is going on. Yeah. How do you find those conversations with parents? It can be difficult sometimes because as parents, you probably know already, they will say, "...well, they were in bed there asleep. They don't hear anything. They don't know what's going on..." So, I talk about the children's feelings. I explain that if she's anxious or if there's an atmosphere, or mum feels worried or scared, that child will pick up on the emotions that are going on in the home, even if they're asleep, they will. They might hear something. Hearing but not actually knowing what's going on can be more frightening for children than them actually seeing what's going. Their imagination will conjure all sorts. I think a lot	acceptance Understand with humility. honesty Does this presume that parents find it OK because they believe their children aren't impacted? What about the fact that they have to accept it based on safety? Victim blame.

of parents think, when their children are babies, they think it doesn't affect them. And so having those conversations about how it might affect the children, talking about their stress levels, how obviously stressed the parent is if there's arguing or whatever's going on for that mum, you know, if they're frightened and they're feeling stressed. That same feeling happens to their child. So just trying to put themselves in that child's shoes and what life must feel like for them. Living in a house where there's tension, atmosphere, it affects the mental health of that mum, and it will for the children. I suppose it depends on the child and depends on the age of the child, and the mum, and what's going on for them. But trying to put them in their child's shoes and what it must feel like for their children is really important. And I think sometimes, just making them think about how their own child might be feeling and what they might be thinking.... You know, "I wonder what little Johnny thinks, or how he might be feeling when he is you and your partner shouting. You know, I wonder what he's thinking. What do you think?" And trying to get them to think about that sometimes, that is a little bit of a light bulb moment. And yeah, it varies, it varies. But I think the ones that do engage in that conversation, it is a light bulb moment and they do think actually, yeah,	children But are the child and mum's experiences the same?? No. wonder "I wonder..." now you wonder. Breaking point

this must be really frightening and they're only two, but they're hearing Mummy and Daddy shouting... It just makes them think more. And I wonder, in your practise, do you engage much with dad's? Do you see much of dad's? Some. Yeah, a lot of dad's work and quite often dad's will be upstairs, and I always try and encourage dad's to come into the room, and you know, even if it's just to introduce myself and just explain who I am and why I'm there and ask them how they're feeling, how they're coping with being daddy, and that kind of thing. And I will say to parents, "I'm not just here for the mum and the child I'm here for you as a whole family". You know, we know lots of dad's can struggle with their mental health after a change like having a baby, it can be as difficult for them as it is for the mum. So yeah, just making sure they understand why I'm there. But that's not always possible. And in your experience, within a domestic abuse context, do you find there tends to be a generalisation of the gender of victim and abuser? Where I work there is a large demographic of Eastern European and South-East Asian families, and I've found in those families the wife did as she was told. The mum is the victim, but in these families, they are often governed by the matriarch, the mother-in-law, she was the	The human condition is fucking hard. approachability Patterns of abuse If roles are dictated within culture, does DA exist in those cultures?

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abuser, rather than the husband. The husband did as he was told really by his mum. But in Eastern European families there is a normalisation of how mum and dad should be. So with these families, did the family dynamic dictate the gender norms? Yeah, I think particularly in the Asian culture that a lot of the women were isolated and vulnerable anyway. Some of the ladies that I saw had just got married in Pakistan, language was a barrier, and conversations were always difficult because there were other family members in the room. And so, quite often, family members would speak on behalf of that woman, that mum. So I had to just make sure that I tried to take an interpreter with me when I went, and not use family members. You know say to them “I’m gonna talk about personal things, cause she’s had a baby” and just try and talk to her on her own. The only issue with that is you’ve still got people in the home, so you’ve got to be really careful about what you talk about, and you know, what you say. So again, in that instance, I would try and bring in mum and baby to our clinic or children’s centre to see them on their own with an interpreter, make sure that they don’t know the interpreter as well, cause quite often a lot of the interpreters will be from within that community.	Privacy Safety of home acceptance

And I wonder, sticking with these with these families where there is quite a heavy cultural difference to ourselves, do you think that there's a level of acceptance or a stance of 'this is just how it is'? Yeah, definitely. From my experience, I think there's a lot hidden. There's a lot we don't know. And I think it is accepted, you know, quite a lot of the mums I saw were there to have babies, clean, cook, and care for vulnerable family members. And I think they're just expected that that is what happens. When domestic abuse is in those particular families, it could take years before they would disclose that actually something had been going on, and it had been going on for years. Yeah, I think very much it's cultural, but I think there's a fear there. You know to actually say something, because everybody knows everybody and quite often the person who you're living with may be connected by another family member. It's really difficult. There was a particular Asian lady and her parents refused to speak to her because she'd left an abusive relationship with a cousin. They thought she brought shame on the family by leaving and divorcing, so her own family disowned her because she'd left an abusive relationship. And they just said she needed to just get on with it.	Does something only exist when we name it? fear acceptance

Do you feel there is the still shame or acceptance in wider UK society? So not being isolated within the culture or ethnic diversity, but Britain as a whole. I think you know, I think it's getting better. I think it's getting much better and I think because of the new laws, and it's talked about a lot more. I think before it was very hidden; domestic abuse. But now you go to the GP or you go to the toilet in the service station, there's little slips that you can pull off with support information. Everywhere you go, it seems that there's a poster saying domestic abuse is not acceptable and if you need support or help you know, phone this number or ask somebody at the counter or whatever it is. People didn't use to realise the services and support out there. I think it's probably still a bit taboo and still accepted in some areas, but it's definitely getting better. I hope it is anyway. And when you are supporting families who are experiencing domestic abuse, is implementing interventions seamless, or are there any barriers to support? Yeah, I think the language barrier is a big one. Not all services have access to interpreters. Services have not always been available or	Service awareness increasing, but what about trends of sexualisation/ misogyny /VAWG. Is this feminism? shame Team working

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difficult to get to. So particularly on a Friday afternoon, if you've got to make a referral to anybody that can be a bit of a struggle... And then you're worried because you've got that parent being in a situation possibly, you know over the weekend. Also getting a referral accepted can sometimes be difficult, but I feel that is definitely getting better. And that barrier of the person saying they'll accept help, or their readiness to accept support is limited. They maybe want the support whilst you're working with them, but then when you step back they stop. The woman's own emotional wellbeing can be a barrier. So when a parent changes their mind about support, what do you think is going through their head? I think probably fear is a lot of it. You know, she's told somebody, and thinking what the repercussions of that might be. Because quite often they will go back, won't they? And the fear of leaving but then going back, and what will happen then... not knowing what's going to happen to them...fear of the unknown in that way as well. I'm interested now in hearing how you process everything. Where do you get support from?	consistency fear Fear is the psychological concept of safety. Fearing keeps you safe?? Team working

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Yeah, it varies really, I think it does on case by case, how it's affecting you, but we're really good in our team. We have really good clinical support and you know, I can phone our safeguarding team if I need to debrief, or have a chat with them, to make sure that I haven't missed anything, or if they could give me advice on anything else I could do. And my manager is fabulous. We could just ring them and have a debrief with them. My colleagues are brilliant. We all know that we can call each other at any point....I can also debrief at home, and chat it through, being able to share. Those kind of things but getting clinical supervision and safeguarding supervision is really important.	Support = talk
And do you have any overwhelming feelings or emotions when you're working with these families? Frustration. Frustration that I'm struggling to get somebody's voice heard. And I, I suppose, frustration with the family when you know that there's so much going on for them and they're not in a place yet to do anything about it. I mean, I would never behave in a frustrated way with them, but there's that underlying frustration that life could be better for them if they would just brave enough to do something. And I totally get why they're not	anger Ego? Truth(s) We want more. Love? Care?
But when they've actually disclosed, when there's something going on	knowing

and they've been denying and denying, and the relief that actually they've been able to share that with you, and you can offer support. Do you find policies and guidelines support you in your practise? Yeah, only in the sense that now families are more understanding that it is actually against the law for their partner to be treating them or behaving in the way that he is. And I suppose that makes them more confident that actually they'll be listened to, and they'll be believed. I don't tend to quote the policies and things, but I will do when I am really worried about the risk of harm to her and that child if she went back to that family home. I will say, you know, that job role and guidelines require me to refer or report if I'm worried about the risk of harm to that child. I can't just not do anything about it, so I have to tell them why... but most families understand that. I more may talk about that the law's been changed so that it's now illegal for your husband to do that. Is there any other training or education that you feel has been helpful, or would be, in working with these families? No. Nothing specific, really. I mean we have we have the normal sort of safeguarding training. When I first qualified as a health visitor, it was	Objective binaries enable understanding. honesty

more about domestic abuse and filling in the risk assessment forms and all that kind of thing. To be honest, I haven't done any sort of specific training on domestic abuse as per se for a long time, but I suppose it would be helpful. Do you think that you can't teach someone how to deal with a lot of the complexities that come with these families? Or is it just through experience? I think it's really difficult because every single case is different. I think you've got to have an overview of what sort the law, the guidance, the policies and procedures of your organisation, are. So if you're not sure, you know where to look. To be honest, I've not really looked at the domestic abuse policy, but I know if somebody disclosed there is a flow chart type thing, with what actions you might need to take depending on the answers that you were given. And doing a referral ensuring it meets the threshold. But I think just making sure that all new people who haven't had that experience have got somebody that they can contact, you know, if they do need any advice or support. I think it is a little bit of your intuition and feeling that comes with the job. Some people just have it with life experience you know, it depends	knowing Gut instinct Gut again! Who you are and what you think matters. strength

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what you've been through yourself, what you've seen growing up. What work you've done in the past. I suppose it's scary asking those questions and then having to deal with the emotion of that person and that child and then refer, you know. But I don't think I've ever met a health visitor that's not been able to manage or handle it. There is always someone that can support you... what do I need to do next? Where do I need to go? Can someone come with me on a visit? And I wonder with all your experience of working with these families and being in the community, why is the issue of domestic abuse in so many homes? I think it's a generational thing. They've grown up with it quite often. You get a lot of families where it's just a generational cycle. You know their parents lived it. So what they think is a relationship, what they know, the fear of people, you know, the acceptance. That's their lot. And because they've got no self esteem, they're vulnerable, and perpetrators recognise that. With these families experiencing domestic abuse, is there other complexities and issues going on?	Truth(s) Domestic abuse is the fire.

Very often yeah. There's usually other things going on, you know, whether it be drugs or alcohol, but it can be financial struggles or mental health issues. So there's usually something else going on as well. I don't think I've really ever seen a domestic abuse case when there isn't other things going on, but maybe it does happen. Can you think of any solutions? On a wider societal level, are there some things we could do to improve the number of domestic abuse cases? Yeah. I think talking about it is really important, and just making sure that we report things if we've got a worry. You know you're hearing shouting from next door, and you're worried about that person. Just, you know, maybe reporting it because it might just be that that one phone call may enable that person to be free of it. But again, I guess you've got the other way, that you know that might make things worse if somebody's asking questions. But so many people just put their heads in the sand, you know, "it's nothing to do with me". But I think if more people spoke about it and encouraged people to talk about it, it would improve. But we do have those posters everywhere that you know, you can pull a little ticket off, on the back of a bathroom	questions responsibility transcendence

door to get support, I think that's really important that we keep doing that. And finally, why do you do the job you do? It's really hard. It's very emotional. And you know, there are times when I don't sleep at night because I'm worried about family. But then you'll have a family's where you just know that you've made a really big difference to their lives, whether it be supporting them with their emotional health or, you know, just making referrals, alleviating a parent's worry about their child, getting them seen by who they need to be seen by. You know, I've had bad days where you get told to F off. But I find it really rewarding and I love being able to support and offer a listening ear and advise to people if they need it. Yeah, I love it.	Caring isn't an option... you have to care.

HV9 Transcript

Can you start by telling me how long you've been practicing within a health visiting role? Oooh, 6 years. Ok, ok. So I imagine you've seen quite a lot? Yeah....too much. Somethings I don't want to see. And would you say domestic abuse has been a consistent feature across those years? Definitely, but in different ways.	fear Why don't you want to see it? Abjection Truth(s)

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Before it was very obvious domestic abuse, but maybe that's because my confidence in picking it up has changed, but now, it's more, I see, more coercive controlling behaviours, and the victims or the survivors aren't picking it up, and you need to bring it to their attention. Without kind of, victimising them. So yeah, I'm seeing quite a lot of that now.	Behaviours are hard to spot, both when you are in it and outside it.
Do you think that controlling part of it, has it always been there? I don't know, it feels like it's getting worse. I don't know if it's because perpetrators know what's out there for victims, and so, it's like emotional abuse and controlling coercive abuse, they're invisible scars aren't they. The person can't see and you really have to dig deep, and perpetrators they're more savvy to that.... It's more common now.	Implication there is intentional hurt and 'planning' by perpetrators. A real strong 'them VS us' sense here.
How do you feel your experience has shaped you? Is it experience directly related to being in your role, or more general life experience? Oh gosh, within this role. Absolutely. But it feeds into your own life! I will fish out documentaries about this stuff, and it makes me	Working in other people's worlds it is hard to step outside of them and re-enter our own.

more heightened to it and in practice. And oh my gosh that is on my doorstep, or that sounds like this person or that person..... but it's more about experience within the role. But it does, it does impact your everyday life. I observe people in the supermarket and sometimes think 'oh I don't like the way he just spoke to her, I wonder what it's like at home...?' I watch people's interactions, and I'm more cautious now. It's as if you want to slip people a domestic abuse support card. It's the job, I've seen so much. And with those families, when you go in, how do you broch those conversations with people? Do you know what, I'm very transparent, unless I feel it's going to put someone at risk of harm, and so far it never has, but I will just ask questions when they're there. If there is domestic abuse and it's a known factor, either it's been disclosed or there has been an incident, and there is another agency involved like a social worker, then I'm not comfortable skirting around it, or not talking about it when the perpetrator is there, because else we are victim shaming. Victims have to do all this work to prove they are safe and they can safeguard their children, but what about the perpetrator.	Has it gone too far? Are we suspicious of 'healthy' relationship conflict? awareness There is no such thing as honesty... if it comes with a 'but' 'or', then you aren't transparent. But there is victim shaming when there isn't service involvement? Do we fear perpetrators aswell until someone else tells us not to? shame Contradictory element of safety and

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I remember a few cases, particularly during lockdown, and there was so much pressure put on victims, and perpetrators were disengaging, going all over the place. And I remember it felt like I was fighting with the social worker, saying what are you doing about the perpetrator, they're not engaging!! But what would happen if the victim did the same? You would say they're not safeguarding the child, but is it not the same?? So, for that reason I'm very transparent, and I will just say. So I will say to parents 'is this how you both communicate?' If I see something and I don't like it, I will just say. And sometimes I will do it in a lighthearted way, and you know say to them '...I know it's hard and stressful when you've just had a baby...' but I will try and paint the picture or 'this is what your child is seeing...' I did some training a while ago, and we had goggles on and it showed us what the child would see, but it felt like I was sitting on the floor, and I could see these adults shouting. And after you could see the mother in another room being really upset and down, it showed her really low in mood. And it was what the child was seeing.... and so I try as best as I can to say to the parents 'what do you think your child is seeing?' and I really try and put the onus on them, back on parents. It's your child, what do you think. I mean when I'm coming, they know I'm coming. They're on	safeguarding. The one causing harm is not expected to safeguard. questions Are we Disney-fying childhood to the max? It's ok and healthy for them to see human experience. responsibility The importance of opportunities. A moment in the storm.

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their best behaviour, but when the door is closed, that's what the child lives. So I try and be as open and honest as I can with parents. There was one mum, I had to bring her into clinic, because I just felt something wasn't right, and she did, she did have domestic abuse from her partner and her extended family in the home. It was a gut feeling, I knew something wasn't right, she would just give me one word answers, and she just looked really low. And I invited her into clinic, I said 'let's just come into clinic, so I can weigh little one, and run through your health and wellbeing, just talk about post-natal things...' and she came into the appointment and it was like the gates just opened and it all came out... she actually ended up going into refuge. But I like to make sure I'm giving the opportunity to mum's and dad's... I was going to ask, do you see much of Dad's? Sometimes, I'd say more than half, but not enough. And when they're around, do you make an effort to draw them into conversations? Always. Often, especially because of the area I work in, culturally they just think, 'oh that's an appointment for the mum and the	Gut instinct Is this talk, but talk in the way I want. HV having the control? What about humility? safe Do Dad's want to engage? In the early months should the focus be on mum and baby. Can the approach/focus change overtime? Surely it doesn't have to be all one thing, all the time? connection

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baby', so if I see them coming out the room, I will say 'Oh hello, please stay, how are you getting along?' I do try and engage them as much as possible, so maybe I will say that I would love to see Dad at the new birth visit, or at the 6 week visit, but for one of those please can Dad come. And when I ask, they do come, and when I say to Dad 'oh please stay..' they do stay. It's the visits when I get there and Dad is already at work, that's usually when they don't engage. Ok, you mentioned that gut feeling. Is that a non-verbal sense when you go into somebody else's home? Being in that environment, or is it things that are said and you feel there is more to it...? I think it's definitely a combination. Sometimes I feel I'm always poking and trying to draw something out, but I do always get there...after a few visits it comes out. I'm extremely chatty, so I will talk.... and hopefully it's about what makes them feel comfortable.... so it's not about saying 'well, are you doing this?' It is asking those open-ended questions. We had a student, and I really stressed to them about not leading questions. So that woman, it was the student leading, and they were asking questions, in a very typical way you do when you're learning, because you're getting familiar with everything, and so I had to	The sense of interoception. Listening to yourself within the context... Listening with humility.

keep saying....'Ok, can we just go back to that bit...' and then the minute the interpreter left, I felt there was a different woman in that room.... She started giving abit more, which is why I said for her to come into clinic. So it's what I see AND what I'm hearing. What are your thoughts on those set 'routine enquiry' questions? I mean, I can understand set questions, you're giving everyone the same opportunity to disclose information, but I'm very mindful, it may be the area I work in, but I can't ask set questions, one person's version of what domestic abuse is can be very different to another person's. So for me to ask 'has there ever been any domestic violence? Any abuse?' Most of the time, if not all of the time they will say no. But if I ask a mum 'have you ever been scared of your partner?' or 'have you ever felt low and felt like they're not listening to you, and you're blamed for things?' and then that opens up everything. And then you unpick it, and its emotional abuse, and they didn't recognise it because it's not openly talked about. Those invisible bruises, if someone gets a black eye you're asked about it, but if you're a little quiet, people just think you're withdrawn, or you're shy or tired. So, the questions serve a purpose, but it's really about knowing your	questions Health visiting is not one thing all the time. So applying objective rules does not fit. awareness Cultural competence acknowledges that language has many different meanings. knowing

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clients, knowing your families, and knowing if that's going to work. It's like if you ask the FGM question, I've never just asked 'have you had FGM?', I will ask 'has there been any cutting down below?' 'Have you had any female circumcision' 'any cutting?' I phase it like that, because a lot of the woman who've had it done, don't consider it mutilation. To them it's cultural practice, so it's the language you use. If you've had those discussions, and you think this is emotional abuse, will you name it to them? Or do you refrain from that terminology? It depends how severe it is. Generally, I will try and get that parent to open their eyes, expand their thoughts about it. So question them and get them to think about it, and see if they come to same conclusion, and if not and it's consistent, then I do have to label it, and it hits hard, but it's about the consistency of that behaviour. And we are unpicking up, but victims are minimising it, then I do have to say 'this is a form of abuse, And the reason we call it that is this makes you feel this way that is harmful and will impact your self-esteem, the way you parent, what your child sees...' but I do have to really give a whole spiel, but they will so often say 'oh no,	Considering the terminology. Domestic abuse is an umbrella term; it is not a binary moment or event. When it is emotional, if there is acceptance from both parties of behaviour then can it be DA? Truth(s) Breaking point There is always a judgement call to be made. The judgement call is the child... any DA is risk of harm. So what is a SIGNIFICANT risk of harm?

they were just having a bad day...’ or ‘it was just a little dispute...’ but this is consistent, maybe once it led to a physical altercation, but someone is constantly putting them down. So with those conversations, do you feel you can have them in one stand alone visit? No. Well unless.... I’ve had a lot of information shared from another professional, and I’m very concerned, and I’m looking at a point that this needs a referral to another agency, it needs to be done in one visit, consent or no consent I’m putting in a referral. And so, if someone is at significant harm I will call it what it is, and try and explain why. Encourage parents to see the harm in what is happening. But as a professional I have a responsibility to escalate a concern. And what do you think is the thing that makes someone able to disclose, or discuss it further with you? I think two things. It could be someone is at a breaking point, or it’s the language you use. If you make a victim feel like a victim it’s not a nice feeling and it won't help someone to open up, because	priorities Awareness of the power dynamic. How do I manipulate the situation to get the information I want. For so many surviving and managing doesn’t allow reflexive thought. Rather it is internalized. See me We support behaviour change and containment for families, but not ourselves. Emotional buckets.

with that there can be an element of shame and you have to be aware of that and be really sensitive, and people have to feel comfortable, and you're in their home most of the time. So they need to be comfortable, and not normalising it, but saying to parents 'I know this can happen in some families and you aren't the first, but you need help' and sometimes it is literally holding a mirror up to those parents and say 'this is what you are telling me' and when they hear it back, they agree it doesn't sound good and agree that they don't deserve that. But it's hard, it's so difficult. I sometimes don't know how I do this job. It's a lot on your shoulders, isn't it? Yes. You have to come into this job and every day you have to empty your bucket, to allow every parent to pour into it... I've got all this. And it gets to a point that you do need the confidence to say, "I need to cancel that appointment, and cancel it because I'm so full", some families need that immediate support and if I can't give it them, I'm failing them. So, I need to check in and evaluate if I can contain anymore. I'm containing in every visit, but that why I don't put as many visits in. Sounds like self-awareness is important?	honesty containment Emotional buckets dictate that we must try not to fill with our own bias and assumptions. They stay separate from our world, but leak. Sit alongside our reality but inevitably seep inside over time. Presenting oneself is all about reflexivity. Humility and discerning curiosity enable openness.

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Very much, even if it's just about how you come across to parents, do you present as judgmental? Like 'ooooh, you shouldn't be doing that...' That parent is not going to open up to you, and often I will say to parents, 'I know, you are going to do everything you can to make sure your baby is safe, comfortable and fed, so I'm not coming in to judge you...' and sometimes when it's an early morning visit I will say to the parents that I am not looking at your hair, what your wearing, it's about making sure you and your baby are safe and well. When you give parents that little insight of you, it opens a little bit of a door, you can then continue with that open-mindedness. Sometimes I think to parents, 'God I'm exhausted.... they can fill your head with so much...' But self-awareness is so important. I remember as a student observing practice, and I specifically thought I do not want to be like that when I'm qualified. I remember writing a reflection and thinking about always making a conscious effort about thinking how I present to parents. Something that isn't normal to me, may be completely culturally normal to them. As long as its safe, I'm not wanting to judge... and I think if you are like that when it comes to domestic abuse, people are much more willing to disclose. They need to know where you are coming from, you've got their child's	approachability When we hit rock bottom everything is illuminated. Don't just stare down the hole at them, come down the ladder and join them. Be honest in what is and isn't achievable. Expectation is transparent, not the intention. There is a constant fluidity between the individual and the professional. Self-

best interest at heart. In every community you know there are different opinions about different practitioners. You know you'll pull up and you see all the curtains twitching.... you know, I don't want to be that health visitor that people think 'Oh god, not her...' Absolutely not! I want to come into a house when it is the in the worst condition, because you know that's what that child is living in and I want to see it! Do you think families want you to be professional, particularly the one's that are experiencing domestic abuse? I think they want a balance; they want you to be a human being, a human approach, but they need to know you can handle the information they're going to be telling you with professionalism and with care, and you are managing that information not 'willy-nilly', and share the information unnecessarily. You have to be transparent, that's being professional. As long as you're open and honest from the beginning it generally works well. Families need a balance. I always tell families when I go in 'Look, I'm nosey, but I'm nosey for a good reason! I want the best for you and your children.' Parents need abit of personality, maybe that's just the families that I work with, but they do. I've had an awful lot of community experience before, I worked in district nursing and it	recognition of both, and the want to be seen by others as well. We all just want to be seen and acknowledged. containment Approachability

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was the same then too. I'm chatty, that's me, the one that always likes to look at the dogs. How can someone feel comfortable in their own home if someone is coming in so professional, it comes across as very judgmental.	
One of the things you've mentioned is that training you did where you put goggles on and could have a view of a child... you try and consider that. Do you think other partner agencies have that same view of what is like for the child?	Fix or support Do we talk much about normality? Explain the baseline, then anything outside
I think it sometimes can be different. Some agencies come in and there is a box...this is what parenting is, and if you come outside of that box, it isn't that standard of parenting expected.	becomes obviously unusual/unacceptable. Focus on what is
Unfortunately I see that a lot, I feel it a lot from other agencies. I have parents that will say to me '...oooh that professional said I HAVE to do this, and I HAVE to do that...' Mitigate the risk... how do you reduce the risk? Even thinking about domestic abuse, what do people think is abuse? You could have a Dad and his partner is so unkind to him and he maybe thinks 'Oh she's just had the baby...' No, actually sometimes it is emotional abuse, yes understand the hormonal changes, but everyone is responsible... you do have to bear these things in mind. There is this idea of a	good/OK/acceptable. There needs to be a better acceptance of philosophy of practice within different agencies. They are fire fighting/support when there is a need.
	Acceptance

box, and the box of domestic abuse, and if the woman is a victim, she will be required to attend an intervention. But actually, will that help? What is her life like? Is this normality? But if it is, how do we tell them its not acceptance. I have a mum and she minimisies the domestic abuse, and I just thought I need to say to her 'what would you say if your daughter came home and told you all the things that are happening to you, with her partner. What would you say to her?' And she replied back to me 'I would tell her to leave...' So if its not good enough for your daughter, why is it good enough for mum? And that was the only way I could get her to understand, because I agreed with her, her daughter shouldn't have to live with that, but a lot of other agencies just think, 'oh, she's done the intervention program, she understands...' But hang on, she doesn't understand, she's still living it. He is still controlling her from outside the home... so she can get rid of agencies, but she's still living with it. So sticking with this mum and this situation, what do you want to happen? I want the ownership and responsibility to be aligned onto the perpetrator, because at the moment it's all on the mum. Because he's not in the house anymore, but he's still controlling in terms of	Can you understand and accept something, but not bring it into your life? Can I accept something is wrong inside, but outwardly accept it is manageable to the outside? The see-saw of acceptance... to use and to others. Blame The cross over between subjective health visiting and binary parental responsibility. PR is assumed and given. It is not evaluated and

contact with the children. So for me, the children are still seeing their Dad, but hang on he doesn't get what a healthy relationship is, and those children are spending time with him, and they are going to see that. You know, especially daughter's, their first love is with their Dad.... I really struggle with that narrative of 'oh, but he's a good dad...' But is he? He's exposing his children to this behaviour. You have to understand the transferable emotional trauma that he is exposing to his children. So do you think you can teach someone about healthy relationships? Or do they have to observe and experience it? I think it's difficult to teach it, because you're always going to feel a little detached from it if you don't actually experience it. Someone's a product of their environment but being a product isn't just imitating what you see, it may be seeing something and saying I'm actively going to be the opposite. I don't want that. So sometimes its that teaching, that behaviour isn't OK. It's difficult and it's hard. Do you think other agencies, statutory or universal plus, do they have those discussions with families do you think?	reassessed outside of the sphere of statutory law. Truth(s) As a child, the standpoint of how we navigate the world is through watching how our care givers negotiate it. Their assumptions are more objective as nuance cannot be developed. Children do not fall out of love with perpetrators, they fall out of love with themselves. containment To be meaningful does everyone end up

I think it is hit and miss...more miss than hit. Maybe it's because of workloads or the monotony of the job, it's just quicker to tick a box, like referred to domestic abuse intervention program or something. You tick box it, you take the human out of it. That's why I get so exhausted, it's not a physical exhaustion, it's that you have to give a lot to families to give that human approach to them, and you're giving a piece of you away for it to be meaningful, and it has to be meaningful, and I don't think every agency thinks about it that way. You know, there is a criteria, staffing issues, money issues, you know...just do what you can. That's when you get severe high-risk domestic abuse, everyone gets involved, there is an action plan, it gets ticked off, professionals set back, you know things have been achieved, plan comes to a close, and then hey, a month later a more significant event happens.... how do you change a lifestyle, change a person. You can't, you can't with such a short term intervention plan. You have to work consistently with people for them to open their thought-processes and their mind to another way of thinking and being. I'm wondering with perpetrators, whatever sex they are, why do they have that controlling nature or personality trait? Is it that something has happened to them, or it's just the way they are?	losing something? Or do we actively give something? Fix or support Health visiting is like a longitudinal cohort study. The seeds we plant, we will never see grow. Stop trying to see the tree before the roots have set in. Empathy With perpetrators there is a limited sense of self-acceptance. The see-

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If I look at my experience, perpetrators have always been through trauma themselves which has led to that aggressive control, having a need to control their fear... or, a sense of normality to controlling. I can think of a travelling family, he, the Dad was very controlling, he was extremely territorial, he admitted he was.... and I said 'what, like a dog...?' because some dogs are, and he said 'yeah'. He called his partner 'My missus'. So, I spoke with him, she was very vulnerable high risk, and I spoke to him about it, and he knew it, but culturally for him it was normal... he was the patriarch, the male, it was a sense of ownership for him. But she wasn't an object, she is a human, and he agreed, but then said 'yeah yeah, but she's MY missus...' he just didn't get it. But for me to get him to see it and recognise the control, it would be very very difficult. Interesting, So that controlling nature within that family, and it is seemingly working for that couple, can we say it's not right? And this is the difficulty because you can only equip someone with the tools to identify if actually '...you know I do feel uncomfortable...' they feel it for themselves. I can't tell them it's wrong, it's not ok for him to say that... I mean he's very open	saw is weighted down by external expectation and shame. Oppression empowerment How can we expect individuals to realise a sense or awareness that would take most years in therapy? We expect the unachievable but too scared to say it? Contradictory as often they can't leave.

about it. As long as they know if you feel unsafe, if you feel uncomfortable, that's when it's not a healthy situation you're in. That's all I can do in a situation like that... just keep hammering it home, you're not on your own, it's a choice and you CAN leave, you don't have to stay in a relationship like that. Sometimes some people want to stay in a relationship like that, they feel safe in that, maybe they're vulnerable, maybe they've only ever lived and seen relationships like that... it's a cycle. It's interesting, you've used the words 'safe' and 'secure', do you think as long as the parents feel that, it's the same for the child? No, definitely isn't... and that's when I put those googles on. You know and I say to them, 'OK, so you see and feel this, what does your child feel and see?', so for example a mum may be content in the relationship she is in, and every Friday her partner goes out and has too much to drink, comes home and is nasty to her, and she's in tears. She is there tending to the baby, and her baby can just see mummy crying and sad. You can deal with that, you know it's only every Friday, but your baby doesn't know that they can't compartmentalise it and know it's just a Friday. All they see is mummy is safe, mummy doesn't pick me up as quickly... so yeah, you have to think of that. It's a lot.	acceptance fear The point at which the child's welfare and sense of reality overcomes that of the parents. containment There are times when the emotional bucket can not hold

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Do you think within the health visiting role it would make it even more difficult to consider the perspective of everyone in the family? I mean it could be. For me to consider the impact of living in a domestic abusive house for the mother, for the infant, a 7-year-old and a teenager, that's almost too much. Without me sitting with each, how can I understand? You know sit there with the older children and go through the 'three houses' model with them so I can get their view, their perspective, it would be hard. So sometimes its where I feel I can struggle abit... I can do that work with a pre-school age child, I can do it, I'm experienced in it, I've done my courses in it, but if there isn't that pastoral support in a school for those old children and to sit and spend time, to unpick...how can we understand? It's really sad. I remember one family during lockdown, it was bad, the domestic abuse was really bad. The older child was supposed to be in school, he was on a child protection plan, but mum didn't want to send him, it's COVID right. So, I went in, and I would see the toddler and I would see him, and I would talk to him. And you know I could pick up both child's perspectives, what he would say to me, how he presented, and I incorporated all of that into my	everything for one family. But then what? Is it too late for the older children? Support or fix Contradictory – we speak of family centred approaches, but are these simply unachievable? priorities

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report, my professional feedback, it was the whole family picture. It was hard to encapsulate both, and he was telling me, he was very very open, but it was still a lot for me, for one person, to summarize and capture it all, sometimes the only way to evidence what it going on for a child is do the future picture... you know, if this carries on, this is a likely picture of how that child will be, best case and worst case. Do you think with a family like that with a high level of risk, does there need to be a professional voice representing every member of the family? Definitely, yes. Cause you know, I'm always mindful of the quietest child, you know it's that saying 'still waters run deep', I think if nobody is there to give the silent person a voice, that could be the missing bit of the jigsaw puzzle that is needed to get them all into a safe situation... they may have seen something that no one else has seen, and I'm always mindful of that, the hidden voice and the words that aren't spoken, because they scream. So, what is it like when it isn't that high level, and there are no other agencies, and it's just you with that family, what's that like?	'The words that aren't spoken...' silent screams. Help and isolation Both parties need help. If I'm containing, I need help and support. Containment

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Urgh, heavy. Heavy. You feel like you're in an open body of water, and you keep getting hit by waves, you get to the surface and there comes another wave, and it drags you under. It's the hardest thing. So how do you share and off-load? I'm really fortunate, we are a small team, but close. We just call each other, I've been on the phone for hours... if it wasn't every day, it was every other when I started in this role, me and my colleague would have restorative supervision with one another at 5 o'clock. It was hard, we're at a point now we can manage, but sometimes you need containment. The difficulty is my experience when I've contacted other teams, like the safeguarding team, they lack that understanding of the reality of the situation... you know please don't ask me about development checks, they've just disclosed domestic abuse, you know!! I've got a child with roaring nappy rash and a mum whose eye socket that looks like it's been smashed, the development check can wait! I think you need somebody in the same area of work as me to get it! You know sometimes I will come into the office and just go to admin 'you didn't hear this but...' and I just rant.... and then I feel	One can never be too specific, too expert, because you lose the sense of a worldview. Can we be an expert whilst also having a family approach? Team working Interesting point of notes/documentation being written reflections. There is always an interpretation when we narrate someone else's experience. planning

better then. I do a lot of written reflections aswell, you know to write it down, it comes out of my head and I can see it on a paper, sometimes I come out of visit, disclosures are made, and they're safe at the moment, I come back to the office and I'm writing my notes, and that's when I know my next move, what we're going to do next. Sometimes it is so consuming being in the visits and trying to think of the next step, as long as they're safe, I'm peeling parents off the floor, I have to contain them... Do you like your job? I love my job, it's so strange, it's the hardest job in the world, maybe I'm catastrophizing... there is no other job like this, it's the worst and the best, but I love it... am I crazy? But I love it. I've seen a difference it can make, and even those families where I thought it would change and get better and then it didn't, I tried my best. I have to be content with that, my limit to what I can do. The problem is you have to know a little bit about a lot of things..... You mention the word love, do you think love comes into it with these families, specifically the ones where there is domestic abuse? Absolutely. I don't think I would do it... if I didn't have passion, if I didn't have that love I would be doing families a disservice... you	Complimentary and contradictory. The worst and the best. Humility is recognizing we don't know it all, and we never will. We will never be experts in someone else's lives. Love/hate Agape love. Social justice. It would seem the love, care and attention is as much for the families as it is for ourselves. transcendence

invest in it, in them. I thrive on having the love to make the difference and want positive changes for those people, for those children.... If I knew the job was going to be like this, would I do it? But I need this... I need to make that difference for that one family, one family gets hit with that love then I'm happy, I will take the one. You may only get one thank you in a year, but that one thank you is a lot, it's everything.	

HV10 Transcript

So first of all, can you tell me how long have you been practising within a SCPHN role?	

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Five years. Five years, and would you say you've seen many families who are experiencing some kind of context of domestic abuse? Yeah. Sadly, yes. Frequently. Yeah. I mean, where I work is quite a mixed sort of socio-economic are of the city. It's like an old dock's kind of area, so a lot of regeneration going on, but a lot of poverty and a very multicultural area as well. So that can bring its own challenges as well. You know, working with families where there's more honour-based stuff going on as well. So yeah, it is something that we come across quite a lot. Right. Diversity and culture is mentioned a lot, do you tend to find there's a correlation between some kind of domestic abuse, or family-based violence within these families? Yeah, I definitely think so. Like, I guess there's some families from some areas who you're unlikely to ever see the women on their own. Generally, they'll be, you know, the husband will always be there, or the mother-in-law will always be there. So, it makes having those conversations almost impossible, really, in those scenarios. So, we also have quite a big Polish population. And I know from just	Pre-assumed position 'sadly...' I'm already adverse to it... multiplicities Cultural competence isn't just recognising the differences, but understanding

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training that I've done specifically for domestic violence in the Polish population, just thinking about the culture that they've come from and things like that... It just gives me an enhanced knowledge about that as well. And how the patriarchy plays into it, and in Poland that's an even, you know, greater prevalence kind of thing. So yeah, I think being culturally informed is really, really important when it comes to these situations. And do you think the families themselves recognise how their culture impacts their family dynamic? I think it's really difficult to have that insight, isn't it? You know, I guess it's like if somebody said, you know "how do you know what Scottish society is like?" I think when you live it all the time, it's just your normal, isn't it? So you probably don't have that insight or you don't make those comparisons so easily...it's just what's normal for you. You mentioned what is normal within families. Do you think behaviours are normalised in families? The power dynamic in the family, or the family set-up. And if you're coming from a point of questioning that, is it quite tricky for you to talk about it as an outsider? and is it received easily, do you think?	them, why and how... Does competent mean you know it all? How can you ever know someone else's experience? oppression the systems We understand we know what it's like to be part of another culture... but expect to know enough of a relationship? The nuance of living

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Yeah, I think it definitely adds an extra layer of complexity. I think obviously you know you can't generalise all families because there's obviously some families that I have worked with where these women do recognise that there is sort of an unbalance in power, you know, power struggles within the family dynamics and especially in families where you know, literally the woman has been flown in for an arranged marriage, and she's never met the family that she's coming into. She's taken advantage of by the whole family and probably for her, she thinks, well, this is normal, you know, this is how this is how families operate and this is how this society sort of operates because a lot of them, they're really isolated, aren't they? And you know, they don't get the chance to socialise or develop relationships and peer support. So probably don't get the opportunity to understand that there is a different way to live. Do you think that their threshold of asking for help, or their threshold in recognising isolation, is different from, say, a white Scottish family? I would say so. Yeah, I would say so. And that's not to say that there aren't, you know, the white population that maybe tolerate a lot of	something is recognised. Is it complex? Or just someone else's reality? Is recognising the same as accepting? Truth(s) wonder Or is there an understanding of a collective endeavour. Women have to submit within a family? Is this society set up

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this behaviour as well, because again, it's maybe culturally normal in their families. Maybe it's intergenerational as well. But I think definitely for example, a woman born into a completely different culture may be more difficult for her to recognise aspects of coercive control or emotional abuse. And you mentioned at the start when you were talking about the population that you work with, you've got some pockets of deprivation. Do you find that deprivation correlates with domestic abuse? Yes, but I think there's a lot of middle class families where women are probably less likely to share that information with you because there may be more shame and more guilt associated, like thinking "I'm an educated, professional woman and this is going on in my relationship..." and feel a lot of shame and embarrassment about that, and find that maybe more difficult to have that conversation with you. So do you think that feelings of shame create a barrier to women opening up to you?	for single mothers though? Where do these mothers go if they leave??? awareness Perhaps there are ideologies that exist alongside one another. If systems and structures do not support single mothers, how can we ask or expect them to leave? shame Shame of single motherhood and the shame of mothering in non-perfect family. How do we achieve anything if the systems and

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I'm thinking about a family that I've worked with quite recently where Mum is a midwife and I had certainly recognised that there were some concerning features of her relationship, so I arranged to meet her in a cafe because Dad had always been there at home. So, I was like, you know "...would it be alright if we met in a café next time, just me and you, and we could have a bit more of a chat?" I think it took for her to hear me say let's meet in a café, for her to think OK, there's something. You know, because she's obviously informed, you know, being a midwife, that's her professional practice. But I think she realised, 'why does she want to see me out of the house? Like, what's kind of going on here?' And I think when I had that chat with her about the fact that there's just some things I've noticed that are concerning for me about the way that he interacts with you. And yeah, it took that for her to go, 'oh, OK...' You know, you're just in that bubble, aren't you, outside of what's going on, you know, just taking care of your baby so you have to be creative in your practice. You mentioned that you'd recognised maybe some things that you found were concerning. What sort of things were they? Non-verbal things, or were they things that you'd overheard him say?	structures do not change. Or should they? Safety of home The internal and the external portrayal of the self. Should they, do they ever meet? We cannot be one thing all the time. stuck The bubble... one can exist in one but not another.

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So it was always in visits. He would blame her for issues that were going on. Like say for example, the baby was not quite at a 'failure to thrive' level, but just wasn't gaining weight in the way that you want. And a really unsettled baby. And so, they struggled with weaning as well. I think when this all came to a head the baby was gonna be about 9 months, and he said to me, "I chose her to be the mother of my child because she's a midwife and I thought she'd know what she was doing." This is the thing that really made me concerned. And that was just like, total alarm bells for me. And he would often cry and be emotional in visits about how difficult he was finding things and like I say, just a lot of blaming of the mum with some of the challenges that they were having. So that was like my first insight into things, and it did escalate, you know, it got to the point where, I think once she recognised there was a problem, she wanted to leave the flat and he locked the door and wouldn't let her leave the flat. And, you know, police are involved and things like that. So, I think once she recognised his behaviour, things did start to escalate, unfortunately.	Gut instinct Tactical from the beginning. Interception

And when you began to recognise concerns, did you directly ask her? Or approach indirectly? I think with that particular woman I was fairly direct because I was so concerned. There was one argument that happened when I was in the house and I said to them I said, "listen, I personally don't feel safe in this situation with this argument ongoing", you know, and that was a culmination of asking them to try and de-escalate, and reminding them that there was a child in the flat. And yeah, I said, I don't feel safe being in here. And I'm going to have to leave. And, you know, obviously making sure that the mum had appropriate safety plans. Generally, in Scotland we've got the universal pathway of visits that we do which are 11 visits in total, and we try to do routine enquiry every contact that we do, and you know for some families it's just your basic kind of "how are things going in your relationship?" and just opening up and other times it's like asking mum if she feels safe and supported in her relationship. It's different ways of gauging, you know, we're very intuitive. Picking up on non-verbal cues and atmospheres and environments and things. So, you tailor that to the families that you're working with.	She recognised but didn't leave... accepting? Or not reached breaking point? safe Breaking point reached when we no longer feel safe. questions gut instinct Interoception – gut is centring oneself

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Do you ever directly use the terminology, domestic abuse or family violence? I think I would only do that if I had evidence to go on to support that phrase, you know, like I say, using questions like “do you feel safe in your relationship?” you know and then you'd say things like, “does he ever control your finances or control where you go?” I would only use domestic abuse if I had evidence and could name it appropriately. Is quite important for women to realise how significant that behaviour is, to really frame it for them. You know, because maybe it's been normalised for such a long time and you know, sometimes I think to hear that term (domestic abuse) is useful for them, for them to think, oh, OK, this is being taken seriously, and this is a thing...It's not me being paranoid. It's not me being weak. It's not, you know... all those things. And how are those conversations received? Yeah, I mean we do an antenatal contact. And generally, if I see the mum alone at that visit, we I'll talk about it then.	and how we feel in the situation... is it even about the woman? questions honesty Power in the terminology. Do we use it to try and take weight off mum? opportunities

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And I had one mum recently who said, “I thought you'd probably ask me about this, you know. I think it's great that you ask mums about this.” You know, so I would say generally people are fine with it. Some people just laugh at you, they're like “of course we're fine, if you met him you would see!” that kind of thing. But generally, I would say people are glad to be asked 'cause sometimes it takes being asked for people to, you know, make any kind of disclosure. They might not make the disclosure if they're not asked. No matter how good your relationship is with them. OK. And what do you do in those scenarios where you find that there's always people around? A few different things. So obviously with the mum I was talking about, like arrange to meet her in a coffee shop. Sometimes we will share the information with the GP and just see if the woman's got an appointment coming up anytime soon with the GP where the GP can see her alone and the GP can do that kind of exploration, or see the child goes to a local nursery. We might speak to the nursery staff. So yeah, it's being creative to the circumstances and to use other agencies that we work with if we are not able to be the ones ourselves.	Routine enquiry isn't done to get an answer... its asked to begin that internal conversation... Team working Gaining the womans experience from everyone other than her...

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How do you find working with other agencies, specifically when it's relating to domestic abuse, how's that for you? I would say variable, so another family that comes to mind is a mum that was going to a parenting course...the facilitator was talking about how to manage children's behaviour and this mum had said that the dad had been assessed for ASD, but that he sometimes hits his head off the wall or off the floor. And there was one occasion where the child was doing this, and the dad forcibly hit his head off the floor twice to make him stop doing that unwanted behaviour. And this obviously really concerned the facilitator. So, she spoke to the mum on her own after the group to just explore that in a bit more detail. And the mum then shared with that facilitator about issues they were having in their relationship as well. And again, this is another family where I'd only ever seen them when the dad was present. So I said to her (course facilitator), you need to share this information with social care directly because obviously you've got a child at risk of harm here. You know, it's physical chastisement, and she wouldn't do it. This facilitator wouldn't do it. She wouldn't call social care directly. She said no, I've let you know. That's all I need to do. If you choose to take it further, that's up to you. So, she's really	Team working sharing

resistant to following what is essentially the safeguarding policy, why? And so it kind of felt like, 'oh, well, now I have to go and see this mom and try to see her on her own and try, you know, and delve deeper...' when she had that first-hand information. But I get it, I suppose, in her defence, probably facilitating a parenting group, maybe that's not something you feel comfortable with, no matter what the protocol is. But I was quite disappointed by that. How do you find working with more statutory services? say, social care, what's it like working with them? I think we probably find, working with social work, when you make an initial call, they're so overworked, and we get that their thresholds are so high at the minute because of their workloads, but sometimes we feel like we have to sit with a lot of risk as health visitors because generally social workers won't allocate. They might have it at a duty level, but they generally won't allocate a social worker so you sit as a healthcare professional with a lot of risk that is not reaching threshold. But we feel like it's often not taken to that that next level by social work unfortunately.	There is still so much fear around info sharing.... Why? The unknown or the ugly? stuck responsibility We're not sitting with risk though are we? Is it inactivity? Continued exposure

Yeah. And why do you think that is? Recognising the severity or simply their workload? I would like to think it's the latter because there's so much evidence, isn't there? There's so much evidence about the harm that it causes to children being exposed to those kinds of environments, I really hope that it is the latter, that they are just so overwhelmed. So, I was doing a new birth on behalf of one of my colleagues, she was on annual leave. And this is the lady's third baby. So, my colleague knew this family already quite well and had said to me that nothing's ever been said, but she said that she just got a bit of a feeling. So I went and did this new birth and this mom shared with me that the day before the dad had kicked her in the abdomen. And she also made some other allegations, like about the two year old, sometimes he would come into their room early in the morning and the dad would say, like, "get the F*** out", you know, so it wasn't just about the mum. It's about the children as well. So obviously I did safety planning with the mum, made sure she had contact details for Women's Aid and things like that. But I called it into social care directly because I was so concerned that a man would kick a woman who literally had given birth, you know, less than two weeks before.	to harm? Outcome not achieved? What we want isn't happening? priorities knowing I wonder if this mum's disclosure was breaking point?

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And they were visited by social work, but they didn't allocate and they ended up closing the case. And they said, oh, the dad's got ADHD, and he just needs to get back on his meds. Our minds were blown by that because ADHD can be a reason, but it's never an excuse for that at all. So we just felt like really let-down.	
Yeah. Yeah, I can imagine. And what do you think that reaction from social care does to that mom, do you think it impacted her?	Help and isolation
I mean, I think she probably feels like she's in quite a helpless sort of situation anyway. You know, she's not from this country, he is, but she's not. And they've got three children. And I think financially, things are hard, they're both working, but I think things are quite tough. The behaviour of the two year old is quite hard to manage. She's obviously got no family support around her here. And I think she feels quite trapped. Like, she feels like she couldn't manage as a single parent on her own with three children. So I think the fact that social work didn't, or couldn't do anything to help her, probably compounded those feelings.	Medicalisation and pathologisation of behaviours. stuck
I wonder, as a professional group, do we recognise the pattern of experience? And do you think other professionals, like social work,	The system is built that women must

recognise the pattern of behaviour? Or, do they place weight on one-off incidents? I definitely think that social work are a very reactive service. So, I think social work are sort of looking for those big events because if we just think about neglect, you know what an all pervasive and common form of abuse it is. Often they're not interested in that. You know, 'cause, there isn't the evidence in the way that there is with a bruise or the way that there is with, you know, an allegation by a child at a nursery or, you know, something like that. I find that they are, they are quite reactive. They'll go in kind of all guns blazing and then, you know, do a bit of investigation and then walk away again. So yeah, I think that they are quite reactive to those big events. But when it's more chronic and pervasive, I would say less so, or it certainly feels that way anyway. And what do you think about wider systems, policy-makers, the criminal justice system... do they recognise patterns in behaviour, or are they reactive? I think the Scottish Government have really prioritised violence against women and girls. So I think more and more bodies are	leave, be the anomaly in the system, even though it is the man who causes the harm. The systems breakdown If DA exists within the meeting of objective and subjective it must have equal reaction outcomes also? If women leave at a breaking point, there has to be a reductionist intervention that

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becoming aware, you know, I think Scotland was the first country in the UK to make coercive control a criminal offence. So, I think it is something that they have really, really prioritised from a policy level, whether the actual policies are having an impact, filtering down to those individual women. At this point, I guess I don't know, but it feels like it's something as a society that we are trying to address. It's a positive thing, but I suppose it's those policies, you know, are they having a real impact on our communities? That is what you want to feel. You know, it's good to feel like ministers are recognising this, and want to do something about it. But it's whether it's having a real impact on communities, that's when you're going to feel like this is great. How do you think the message does trickle down? Is it just over time? I would like to think that, just as professionals were becoming more and more informed, you know, education is becoming more and more informed, things like that, but you know when there is a football derby, there is such a marked increase in domestic violence cases on that day. It's Scotland's shame... Women have to be the victims of violence. Just because a football team loses. That blows my mind that, that would have such an impact on men. And I think	examines when this is. priorities the systems Progressive legislation. Whatever happens at the top, does it matter unless it hits the bottom? Truth(s) fuel

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that's the thing, I think what we're more and more realising is that this is a public health crisis, isn't it? Domestic violence is a public health crisis and the impact it has on you know those men that are being violent towards their partners when Rangers lose. They probably saw their dad's doing the same thing. You know, I think it is a public health crisis because it's having such an impact on boys' development as children...it's continuing, it's so pervasive. You know, it really needs something really, really bold. And I suppose we could go in deep, couldn't we about, you know, sexist society and the patriarchy and all those kind of things, those messages that are sent to men and to women from such a young age. And that's why when it was the women's football World Cup recently and people got so behind it, didn't they? And I was like, because I've got two girls myself, I want to see women's sports celebrated. How has it been that I've got to the age that I am, and still <i>now</i> we only talk about the Premier League, the men's teams, the only men's World Cup? So it's that message, that men are superior, isn't it? And that's what trickles down. Formula One, men doing it. Government CEOs, it's still majority men, isn't it? As a health visiting services, do you think we are predominantly	oppression Intergenerational violence. We model the examples set to us as children. Is the PH crisis the abundance of healthy relationships and authentic sense

dealing with the Mum's and the women? Do you think there is more we could do to work with Dad's and men? I mean, obviously we are family focused. And you know, it's not that you're like to ignore the dad's in the room, but you know, they're not on our caseloads, are they, like, on a for us? It's the moms and the children that are on our caseload. For example, we don't do a post Natal Depression questionnaire with the dads, do we? But we have conversations with them and I would document in the baby's notes about things I might chat to the dads about and stuff. But yeah, I wonder, I wonder if we should... you know, because during COVID and afterwards, more and more men are working from home. So, they are there a lot. So, I don't know whether having a conversation about domestic violence would be appropriate but chatting about relationships in general terms. You know, we tend to avoid it if they're around. When both parents are there, do you think there is a safe opportunity just to have a general conversation with both parents about issues relating to domestic abuse?	of self...? The DA is the result, not the issue itself? solidarity If the issue is the subordination of women, change will only come when women are in power Are HV trying to be all inclusive family focused when actually the service needs a tighter focus? We can't incorporate Dad's until the policy that

You're creative with your practice, aren't you? And I think there are times when that would be totally appropriate. I think if you know what it's like when you go into a visit, and you've got your little agenda in your head of things of what you're going to do, but then that can completely change the minute that you're in. It's hard to plan ahead. I think we have so many things that we have to achieve in a visit that you'd prioritise it if you felt it needed to be prioritised wouldn't you? I think that would basically be it. You know, you'd be creative.	guides practice changes. priorities
There was certainly a mum that I visited recently, and she and Dad are both dentists, so really educated professionals. So the dad had gone back to work, and mum said to me “oh, he's getting annoyed with me because I've not pumped enough through the day for him to be able to give the baby a bottle at night”. And I was like (surprised), you know, that sort of thing was a bit of a red flag for me. And I was like, oh, tell me a little bit more about that. And she just, you know, told me about how stressed she feels if the house isn't tidy for him coming home and things like that. But then, interestingly, at the six week check, I said that we often have these conversations with mum's about domestic abuse and whether you feel safe and supported in your relationship. And she was like 'Oh	Gut instinct How can we prioritise when that may be the only time we see that parent?

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no, he's brilliant. He's really a supportive partner. He's a great dad.' All this kind of stuff. But yet that comment that she's made about being annoyed with her, that she'd not pumped enough and having to make sure the house was tidy... so I said that to her. She's like, no, no, it's just, you know, he likes the house tidy and, you know, and he just wants to be able to bond with the baby. And she's giving all the excuses for that sort of behaviour. So for me, that's going to be kind of 1 to watch.	individualised
Right. Yeah. So, is that what you tend to do? If you're worried, do you just kind of keep that family in your mind?	consistency
Yeah, absolutely, definitely. You just keep having those conversations when you're able to, you know, just keep, keep on exploring, keep on exploring, keep drip, drip, drip. Isn't it sometimes?	Drip, drip effect
With families, where you have recognised something worrying, but they just don't see it... are there some families you can never reach?	We all have different perceptions of support.
Well, they may recognise, but they just feel like there's no, there's no way out of it. You know, it might be financially, they're just	Truth(s)

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thinking that it's just where they need to be at the moment when they've got such a young baby and maybe financially dependent on him. Or you know, a lot of women know if they do leave these kinds of men, they'll end up in temporary accommodation and they could end up anywhere in the city and away from the support network they have, and have to move the kids out of nursery. They just think this will have to do. And so I suppose for me maintaining that relationship with that woman and continuing to let her know that she's got support, continuing to let her know, you know what her options are, continuing to safety plan. And just, just hold that space with her when you can. And how does that make you feel? Well in some ways privileged that you know, that woman has shared that information with you and they do feel they're able to trust you. Sometimes you know you're scared, scared because if he was to get really drunk one night or something like that, what are the risks to that woman or the risks to those children? Like I was saying about the social work response, you're just holding a lot. You're holding a	Breaking point not hit... mum can still manage, so we manage around her. consistency Hold the space for her. fear containment Honest feeling of 'I'm scared for you..' that makes us very vulnerable. The responsibilisation of professionals. Perpetuate the narrative of not attributing

lot of risk. And it's wondering if I have done everything I could you know? Yeah, just holding a lot aren't you. Do you find your emotions are very much based on the relationship, on her? You spoke about how you are feeling in relation to her... do you ever get an opportunity just to think about how it's impacting just you? I think just as healthcare professionals, we're very good at compartmentalising things, aren't we? I cry at adverts. I cry at the TV, over nothing. I think that's my outlet, you know, because I maintain professionalism, and it's got to come out somewhere. Me and my kids always do this thing where if we've been to England for like a holiday or something, when we cross the border back into Scotland we cheer. Like when we see the sign... and the last time we did that, I burst into tears. And my kids were like, what is wrong with you? And I'm like, I don't know, just sometimes, like, you feel it a bit, it sort of comes out in other places. And do you find you get support at work? Is that support accessible? Do you know? we've got the most incredible team here. We actually did a team building thing the other day, and the facilitator was asking us to talk about the best team we'd ever worked in and what	responsibility to perp. containment Hold and carry it all... until we can't anymore. Our breaking point.

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and you hear about these families, and you'll sort of follow them a little bit on their journey, like, if it goes to MARAC or safeguarding... So I think it's a really enriched learning environment as well. That's so lovely to hear, it sounds like there's a real sense of togetherness and coming together, which is so, so lovely to hear. Just to draw it all together, why do you do what you do? Why are you a health visitor? Well, I suppose, my background before I became a health visitor was in gynae nursing. I worked there for 10 years and I absolutely just love Women's Health. Love working with women. And I just really wanted to continue doing that work because I'm really passionate about Women's Health and taking care of women. And walking with them on their journey through parenthood. Really. I just. I think I have the best job in the world. I love it. I feel really lucky. Really. It's a privilege, isn't it? Every day to walk into people's homes and ask them really personal questions.	We recognise we're in it for women, so why try and explain a broader net? Is women's health a dirty word? solidarity

HV11 Transcript

So first of all, can you tell me how long you have been practicing in a SCPHN role?

So, since 2003, so 20 years, I qualified in 2003 and I trained in 2002. So, a long time, to be honest. So nearing retirement, I suppose, which I don't really believe for one minute that I'm that age, but yeah, I am so four years, probably five years and then I can retire.

And then would you say that throughout your career as a health visitor, domestic abuse, has it been constantly there with your families? or have there been peaks and troughs?

Yeah. No, I think in the area's that I've worked in, it's always been predominantly DV. That's been the issue. Sometimes neglect would be maybe in conjunction with DV. But yeah, every... in fact sometimes they merge all into one and I can't remember who I'm seeing and you know, like when you go to conferences and everything. Literally sometimes they are so similar with such similar scenarios, it is quite confusing because you've got to remember who you're talking about and what's

Truth(s)

going on, and even the men, the perpetrators, are exactly the same...jobs, even backgrounds, the same sort of things that they've done. And yeah, so every single one of them. Yeah, all of them. Every child protection and safeguarding has always been DV, yeah, that's how it feels to me that it's always been there. It's always been pretty bad in the areas. I mean, obviously I've worked in pretty deprived areas, so it's always been a huge issue. But I do feel as I've got older and done it for longer, I'm finding it more difficult to understand it all I suppose. Whereas I think when I was younger, I got why they are staying with these men, etcetera, etcetera. You understand it more. Whereas I get older and I think why are you staying? And I think maybe that's because they're older and they've been in these relationships a lot longer and I've always expected that they would get out of these relationships and that's what I'm saying. So I think for me, I don't know if I am losing my sympathy for these women? I don't know. As I've got older and I've got children myself, I can't understand a lot of the time why these women stay in these relationships. And I think that's quite hard too, you know, because I have done all the training. I've just recently done coercive control training and all that sort of stuff. So, I know why they stay, but it's still hard when you're in practice. They go back	How time and experience impacts our perspective.... Ever changing. acceptance time honesty Do we place such high expectations on

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to them and they've done horrific things and I think that's where I'm struggling as I've got older. To understand. Why would they? And I think that it is quite hard for me to grasp, because I don't want to feel like that, obviously. And I still have loads of compassion for them, and I still give them a lot of my time. But then I think I don't know where does it end? I think the men are getting worse. The men are horrific, you know, and I just think there is a toxic masculinity to them, and that they are just getting worse and I don't know as a society where that'll end. And I think that it's all a bit deep for me, I think. And I think these women choose these men that are awful because they have got so little self-worth, and I understand all that. But it's hard because I don't want that for them. I want them to be happy. I want them to have, and make decisions when they aren't with these men and how they're impacting on the children, but they don't. And it's hard to try and empower them. I suppose it's getting more difficult to empower them to make decisions. That would be a benefit for the children and for her. But it's got worse over COVID and with everything... It's just got worse in our area. I see these men and they speak to the women terribly, and they just get away with it and nothing ever gets	women, how do we work through our own assumptions? Interesting how concepts of compassion and understanding can change as we move through the life course, and the transitions of general social expectation. (desire for) Empowerment How can we expect women to have self-worth when they are so weighed down by shame.

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done. And the police. Oh, the police, that's the other problem we have is that the police just don't do anything, so these men will beat these women up or, I mean really do really bad stuff, then the police don't do anything and then they go on the run and they can't find them. And you just think, well, I could find them. They'll be at their mother's house! You know, it feels like they're just getting away with it. And it's really frustrating for me as a practitioner. We go to these meetings with the social worker. We're obviously trying really hard to make the children safe. And then the police are like, you know, we don't know where he is, or they skip bail and they can't find them. So, they don't even turn up to court. And that's what I mean. I find that the most frustrating thing is that they're getting away with it. There are no consequences, and they know it. Maybe as I'm getting older I'm finding the toxic masculinity awful, so bad. And I don't think anyone realises how bad it is. You know, they talk about it, like on social media and all that stuff, but it's literally awful and they get away with it and there's no consequences for them. And I think that's where the frustration probably lies about it all.	oppression As much as we try and be altruistic in practice, we always must centre ourselves in the situations. We need to place ourselves in it to begin to unpick. Discussion point of accountability... what are we accountable for? Oppression What are they accountable for? If you don't acknowledge it, you can never be accountable. Statutory services only hold individuals to

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You know the police they want the mum to do a statement, but when she doesn't want to, there isn't a case. And then the social workers will drop the case.... It feels like you're banging your head against a brick wall with it all. They're just getting away with it. And I think that's what's very frustrating as the years have gone on.	account dependent on the event, not the story.
Do you think that the context of the DV has always been similar throughout your career or do you think that's changed?	Patterns of abuse
I think it's a lot worse. They're nastier. Definitely. I think in the beginning it was more emotional, they never used to really lay their hands on them. Like in the beginning, he was very much going off cheating, drinking cocaine, all that sort of stuff. The actual physical abuse wasn't really there. I don't think, whereas now it's like proper beating them up. Like I said, digging graves, you know, strangling, you know that sort of stuff... because they're under the influence of drugs and alcohol. It's just hard working with them and then they're not even getting a sentence. It's why I get so frustrated.	There is a change in wider societal acceptance of behaviour ... people recognise patriarchy, but there is also an acceptance of toxic masculinity... just how some men are?
I think in the beginning it's not that bad, it's more low level abuse, and you understand why they may go back, but then it gets worse and worse. I know that's always been the case, the	Does abuse ever stay low level? Who sets it as being 'low' level.

women going back, but I just think on my caseload, it never was, I suppose. And I think that's probably just a different level of abuse, isn't it, that these women are experiencing now, whereas they didn't before. I wonder, you mentioned about the increasing 'toxic masculinity', do you think attitudes from women have changed? Perhaps what they expect from a relationship, or what behaviour they will accept? Yeah, I think they have. Desperate isn't a good word to use, but I can't think of a better word for it. They want to be in a relationship no matter what. That's what I found. I don't think that's changed, to be honest. I think that they are seeking something that they obviously hadn't had when they were children or from their family. Desperate to have this happy family, and they will put up with anything and the way the men are. I think they just want a happy family. You know their childhoods and everything and their traumas and their 'ACE's' and all that sort of stuff. It must play a huge part in how they just accept this man's level of awful behaviour's. And the way these men talk to women, like they really hate women. And so I will always challenge it and they absolutely	acceptance Shaming women. Why is it any man will do for some women. If we empower women and girls they will stop needing any man. Is it dependency... financial? Company? Fear of being alone? We're all just seeking a connected unit. Whilst we use the word accepted, are we continuing to not lay blame at the perp. If

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hate it. I remember one case, it was a meeting over Teams, and the mum and dad were there, as well as the Dad's mum, and so it all kicks off, and the paternal grandmother didn't even realise how badly her son was speaking to her (mother of the child). He was there speaking to the mother of his children really badly, and then she (paternal grandmother) said to me "don't speak to him like that..." and she said I shouldn't be biased. And I just said to her "did you hear what your son has just said to the mother of your grandchildren?" And I just thought 'there you go...' it's so entrenched isn't it, they're allowed to get away with it, even with their own mother's. So he thinks he can say it to his girlfriend or the mother of his children. It's generational, isn't it? And the mum's of these men are scared of them because they're probably kicking off and all that sort of stuff is learned behaviour. It's been entrenched for years. The women don't think that they deserve any better. And they do because overwhelmingly they're really good mums. You know, you sit there in those conferences and you go through the signs of safety, but you say to them (the mum) it's not because of your parenting, your parenting is fine, it's because of the risk that this man poses to your children. They want the fairytale with this man, but they're not going to get it.	they accept it, it's partly their fault. Patterns of abuse Men are let off much quicker than women are. Fear Contradictory because as a societal we see some women as accepting of this behaviour and therefore complicit? ... but yet we plan the safety with the victim, not plan the behaviour change with the perp.

You mentioned mother's of these men being fearful, I wonder, do you have a sense of fear in regard to talking to these families? And do you think it's based on you as a person, or your profession? They just don't frighten me because I see them as the problem. I speak to my own safeguarding supervisor a lot, you know how I feel... About how I feel about these men, I have no respect for, you know? So, it comes across very easy. And so, then I end up, maybe, arguing with them. I just look at them and I think 'you don't frighten me'. And they don't have respect for me, and I don't want them to respect me at all. I'm not bothered about me. I will stick up for that woman to the end. Do you think other professionals are the same as you in regard to their fear, or being scared of them? No, I think social workers are, that's the problem. That time I was in that conference with the (paternal) grandmother, the social worker was there too, and she never said a word. And I'm like, why are you not? I didn't say it to her, but you just think, why is it up to me to say it to him? That's unacceptable. What you're	honesty If we lose respect for something do we stop attributing accountability? Solidarity What is respect? What does it mean? Is it different to different people? fear We're all people, we all experience fear. Our emotions can overcome the power we hold.

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doing to your ex-partner, you know? I think they (social workers) just bowed down to them because they're scared of them. You know, we're nurses, aren't we? So, we are sort of used to it a little bit, aren't we? Speaking it as it is, and I'm older. Whereas the social workers just, they pussyfoot around them, I think and they don't really stand up to them. They don't challenge them. I had supervision after that thing that I had with that bloke and it was really good because the mom actually started standing up for herself and saying "don't speak to me like that", because, I felt like she was empowered. Not that I'm the greatest or anything, my manager said, "oh, yeah, you know, that's really good because she obviously probably never felt like that before, that no one ever stood up for her". I just think that's so sad. And that's insane. And the social worker was just letting the dad railroad the whole thing, you know, dominate the whole conversation, so it'll all be about them. It won't be about the children, it'll be about how they're feeling, how crap the mum is. You know, all that sort of stuff. And I just think, why aren't you bringing it back to the children that are being impacted by this, you know? How do you find conversations with mum, when you are discussing the impact on the children?	Professional complicity in abuse. empowerment Social justice of using your voice. Are we always focused on children? HV focus bounces between mother and child... in constant flux. Is an honest relationship being able to say anything? Being

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I think a lot of the mums I work with I've got quite good relationships with them, so I feel like I can say, and that's the whole point, isn't it? And that's why sometimes you do side with the mother because you're there all the time listening to her side of the story. When you have a good relationship with the mum, you can say almost anything. You know, she knows half the time that she's not safeguarding them. You know, she knows that. And I do try and sort of say that I understand they're the father of the children and it's a really difficult bond to break. And I always try and put across that I understand that that's how you feel. But you know children are in the middle. But I do get why they want to be with them. Because like I say, having children with a man is huge deal, no matter what the relationship is like. You have to understand, but you have to remind her it isn't acceptable, for her, or the children. But the safeguarding onus is always on the mum and what she has to do. The perpetrator behaviour just gets minimized.... So I went to one (meeting) and he'd tried to strangle her, etcetera, and he wasn't allowed to see the children without her (social worker) supervising. So, we had loads of meetings and then the social workers closed the case because	open about all your thoughts? Is honesty about being mindful of the information you give? blame If we don't respect perp's/ poo-poo them, then how can we ever include them fully to attribute accountability? priorities Statutory threshold cannot be movable? Or can it? Can it change within the context? But the context considers

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mum was letting him in. And, you know, you just think this is the whole point of the abusive behaviour.... It's part of it. Why is it OK to just close and not do the work? What, to get them off the books? I don't know, I feel like some thresholds are so movable at the moment, almost like they've (social workers) given up with it all. You know they haven't even done a safety plan, and the excuse was 'well, I couldn't get in to do the assessment because Mum kept letting him in', Yeah, but that's the safeguarding risk isn't it! And sticking with this family, after the social worker closed the case, did you still carry on maintaining some kind of contact with mum? Yeah. Yeah, I did. You know we're only supposed to go if there is a health need, and I wouldn't go if I felt there wasn't a need for me to go. You know back when I was training, you'd go back every month, whereas now I stay in contact on the phone, and make sure I do the reviews and stuff, so I'm always keeping in touch. They know I'm there if they need me. But if they're fine, and everything seems to be going well, and the children are in nursery, then I think 'everything will be OK'. But it's difficult, with the managers and the organisation targets, they want the	experience, not just event. Consistency Power struggles of what takes prioritization... and who makes that call? Parent, HV, manager? Add in litigation RE safeguarding and registration it does not equate a smooth transition and movement between the three.

new births doing... someone else is prioritizing your workload. But everything is health... I suppose the school nurses just go if there is a health need... I wonder, you mentioned earlier about you having good relationships with the mum's. How do you harness those relationship? I think it's trust. I think trusting the health visitor has been abit dodgy over the years, but if they trust you, they will tell you anything. I worked around this area for 20 years, I know these families, and they know me. I'm a constant. You know I went to one and the daughter I saw in the family years ago has had a baby, so I'm seeing the grandchildren of the original mum's! But I know the families, I know the dodgy families, I know the gangs. I have knowledge, and I know what I'm going into. I think they're much more trusting , it's not just me though, it's the whole team. And even with COVID, it didn't really affect our relationships with the families. We're all very similar how we provide care to these families, and that helps because they don't distrust	Comes back to honesty and trust... where are the lines drawn? consistency Do we gain trust from others by demonstrating our binary stance on what is acceptable and what isn't?... 'I will stand for this, but not that?' Is that contradictory to subjective principles of HV practice?

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anyone. A lot of people don't like health systems, but our families they really appreciate us. Knowing the community well, do you find during a birth visit, or a first contact with a family, and asking the routine enquiry questions, do you get many disclosures when there isn't as much of a relationship? They'll definitely tell you about previous DV. I only have disclosures about stuff I already know about. Like an incident. So if I already know about something, I will also talk about it But they're happy to talk about previous DV with other partners and not current. But yeah, I think we generally always know if there's been an incident at DV because we hear about it, from themselves, or the midwives. We've worked there such a long time, we're really good at sharing information. You know, you're not going in there blind. On (computer records) older siblings won't be on there, so any issues from old we wouldn't know about, whereas with the old records you would read it all. We've got really good support networks with our colleagues as well. You know, if we are all the same, and no one's doing anything different, we can all be really supportive of each other.	Team working We are all still compartmentalizing our histories and past... does anyone ever fully focus on the present? The present context only exists because of the past experience. Digital data sharing barriers. If we all do the same, is there any space for creativity and progress within service provision?

I'm interested in hearing about how you manage your own, personal perception and thoughts about domestic abuse, and toxic masculinity, and how you support women within your role. How do you settle those internal conversations? I would never vocalise how I feel personally to them. I wouldn't because I know they can't want to be in their situation, so it wouldn't be helpful. I want to support them and be there. They know it's not a good situation, so they don't need more attacks. They know the impact. I think particularly these days, they know about the long-term impact of themselves and the children. They seem to understand it and acknowledge it. And that's the difference, I don't think it was as widely acknowledged, so that's good. That's what they need is support, you know that's how the message is getting through, from support. I've got one woman that's a Roma-Slovak woman, and she was with him since she was fourteen. He tried to strangle her whilst she was asleep. He's been on remand for two years, and recently released. She has a new address, a new life. And she is adamant, she's not getting back with him. And I believe her. She's had so much support, she has been able to make that decision. Maybe it's her, she has	Boundary So, we're never fully honest. We accept the boundaries to the information we share. Implicit mother blame 'VS' explicit. Women know. empowerment Support and surveillance. Breaking point Does support = insight and awareness? A process and therefore cannot be a binary decision. Is it the power to change or the ability to

deep insight into it all, she gets it, but maybe it is the support. There is obviously a process they go through, it has to be right for them, they have to decide, they have to say “No, I’ve had enough” and it’s as simple as that, they won’t put up with it anymore, that’s when they go, or ask for help. But they need to be empowered, because power to change is so lacking. But when they get it, they’re the ones that can actually do it. So is it as simple as money, resources and postcode lottery of where you live? And do you find the people that get the most support are the ones who have experienced the most physical or sexual violence? Yes, definitely. I think most of our families don’t see the emotional stuff, and coercive control element at all. So I point it out to them, I spell it out to them that he’s done this, he does this... and that’s why it goes unreported for years and years, and only comes out when it’s hit explosion and become physical. Have you had cases where there has been a social worker involved and it’s not been physical? just emotional or coercive control? In the beginning, probably not, it’s nearly always physical when the social workers are involved, and then all the coercive behaviours come out, don’t they? I don’t think it can be physical	make the change. The action or the willingness to do. acceptance But if it doesn’t exist for them, should it exist for us? Break down It’s worrying to us, is it worrying to them? acceptance

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and not have a history of worrying behaviours. I know I shouldn't keep saying it, but it is generally the man, doing the abuse. The problem is they don't report the worrying behaviour because they don't see it as abuse. They think that it's normal, and that's the problem... in society it's normalised and minimised. And the children living with it, it will normalise it for them, and then its just a cycle. I remember you would see neglect loads when I first started, particularly the state of neglect with homes, really unacceptable conditions, because they're homes when they were little were like that. But it has been talked about more and more in society, how to clean, expectations, and I don't see it as much. It seems to have got better. But these families where the abuse is going on, the houses are tidy and clean, and the children are turned out and their basic needs are being met. But the cycle of abuse, it continues into generations.	Wider expectations trickle into individual expectations and into homes. knowing
Could I ask you about the terminology and words used when discussing domestic abuse with families. Do you use those exact words, or do you describe it with feelings or actions? So if there were concerning behaviours I was seeing or hearing, I would explain it to them, but I wouldn't use the words 'coercive	Break down Truth(s) Are all relationships controlled? One exerting power over another. Is the see-saw

control', it's a buzz word isn't it but I don't know if people really understand what it means, so I probably would use the words domestic abuse because people know those words, those words aren't new, they are well established. I think they understand those words better. I think with those words (coercive control), they're over the news and everything, but until they've (perpetrators) put their hands on them, they don't see it as domestic abuse. Also with these women, they've got such low self-esteem, poor mental health, they (perpetrators) mess with their heads, they know they are vulnerable. Call them names, belittle them, going off all weekend, other women... and the women don't see it. The men manipulate these women. They're so clever. That's the thing with these men, they're really nice when you first meet the, always really nice, and I think they use that manipulation on professionals as well, they pretend, they're faking it, almost controlling the professionals as well. But when you're low, you accept that behaviour, you don't expect anything more. I think the only way is showing women that they can have more... they don't have to be in these situations with these men. And you have to bring boys up to be nice to women and girls, and it's not acceptable to have and behaviour with girls. It has to	ever balanced? So when does control become domestic abuse? It has to be when the one experiencing it senses it? Patterns of abuse Something only exists when we say it does?? Signs of insecure attachments.. 'love bombing', seeking physical connection quickly and committing quickly. empowerment Has the political systems already created the next generation of perp/victim with increasing inequality and deprivation?

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start early, and at school. I think school nursing being lost doesn't help. You can't change behaviour that's been there years and years. I can only see it getting worse if I'm honest, until something changes. I always remember one of the safeguarding nurses saying it, the reason it's getting worse is that women used to be in the kitchen and looking after the children, but now they've stopped doing it, we want equality, rightly so, but that's where it went wrong. Everyone is fighting back. Men used to get away with it, didn't they. It's just such a mess. I don't know what the answer is but I don't want it going back to women just being doormats though, and going back into the kitchen. But that's what I think. That's what men want, isn't it? They just want that woman to sit at home whilst they go out and get drunk with a mate. And the other problem you've got is drugs as well. There's huge amounts of drugs where I work. Cocaine is not good. And the other sad thing is that these men, will go out for the weekend. No, not come home. Go on cocaine, alcohol. And their safety plan is for that man not to come home. You know, that's how sad is that that they're so frightened that he comes back and does whatever he wants.	Truth(s) Is the problem that women still want equality within the patriarchal world? Rather we should create our own rules? Truth(s) Men are lost? Men more likely to seek avoidant/extreme behaviours to mask their own loss of self... is that the root problem? None of us know what our meaning is?

And that's why I'm so interested in hearing, you know, everyone's insight into it, because you sit on a sofa with it and talk to women about it.

What do other people think? That you've spoken to? Do they feel it is getting worse?

Yeah, I've been incredibly fortunate to speak to lots of health visitors, and of course health visitors have so much experience prior to their role, they're nurses or midwives as well, and all that experience is brought with them. I get a sense that everyone recognises a pattern, and it feels as if rates are increasing generally. Perhaps because we are all talking about it more that's why, or perhaps it has changed in nature, become more insidious. I find it so interesting to hear the thoughts who work with normal families every day, how difficult it can be, how it is managed, how they navigate their own personality and feelings, and their own lived experience, how they stand in the face of something that isn't nice.

I think that's comes from your nursing though, because I think, and I don't know what it's like now, but nursing 20 years ago

There is a sense of searching here.

Reflecting on professional evolution that intertwines with personality.

honesty

when I used to do it, you would daily get patients and relatives kicking off at you, and you just learn how to diffuse it, even though I'm not very good at diffusing. I say it because I know I could handle things better when it's happening and when I've reflected on it, but I just say how I feel. I get frustrated thinking, why is no one else? I don't understand it. Why do other professionals just think that that's OK, but it's not. I don't know. Would I have still been so straight with them 10 years ago, 20 years ago? Yeah, I think I would have been. I'm not scared of them. Why would you fear them? Do you think there's an argument within 'keep your friends close, and your enemies closer'? In that to get change to happen professionals need to keep these perpetrators on side? Yeah perhaps. I don't know why they do it, but I think they're intimidated by them. We had one, this lad. We have loads of gangs where I work, they don't kill each other, well they do, but constantly fighting. So this bloke was a gang member, and he's beating up his girlfriend. She's been with him since she was 14, and social services were doing an assessment on it, and basically he wanted still to see the child. Even though there was still gang	Truth(s) Professional complicity... is it easier to view someone someway dependent on the presentation. 'you don't look scary, therefore you aren't?'

fighting, and there was even a shooting on one of the roads. So he turned up to this meeting, and you know in their photos they're all in gang clothes and big gold necklaces and stuff. But he turned up with his mum in this fancy suit. And I remember the social worker just saying "of course you can see the child..." and I just thought, what? He's a target, what if he's walking with the child and they shoot him? I'm not interested in their charms, these men come across as so charismatic. But yeah, he got to see the child. And that's the dichotomy isn't it... they can be beating the mother up, but still viewed as good enough parent to see their child? So it continues because she still has to have him in her life because a judge has ruled he can see the children. Do you think a parent hitting or hurting the other co-parent negates their ability to parent? 100%. I think if you are emotionally dysfunctional enough to hurt somebody like that, the mother of your child, then surely that's a risk to that child that eventually they could do it to that child. You know, when they grow up or when they get older, or I don't know. I think it's a huge risk. If you're capable of hurting somebody that you're supposed to love. And they don't seem to have any respect, and it doesn't	acceptance blame Is there accountability for the perp? responsibility acceptance A binary consequence of parenting; PR. Unless

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mean anything to them, does it? They go from one woman to another, having babies... I think it's a huge safeguarding risk. But generally, they're still allowed to see their children aren't they. There is this big thing surrounding 'PR' (parental responsibility). The men know it, and the professionals.... Like the police will be involved, but they'll say 'well, he has got PR, so we can't stop him...' And the social workers will say it... You know I've said to women who have had really tricky times with their man, you know and they're not sure, and I've said to them about putting him on the birth certificate, to take their time and think about it. Having parental responsibility is about care and safeguarding, and they think PR gives them some control over women... they're not bothered about the child, it's about maintaining control over the woman. They say 'you can't do that, I've got PR', their interpretation is that they can take the child when they want...There was one family and the Dad use to see the children and take them out, and every meeting I would be worrying he wouldn't return them. And if I'm thinking that as a professional, why is it so easy? But he did bring them back, but it was massive amounts of control he still had over thar mother.	statutory services say otherwise, you maintain legal rights to parent that child. awareness control

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How do you even do a research thing on it? Because it is so massive. Do you have to pinpoint things? Yeah, I mean, personally I have found it so easy to go down rabbit holes, but you acknowledge there are so many opinions and views on it. I have found it incredibly beneficial to my own practice to hear all these opinions and thoughts and reflect. You know, its true though, people's lives. Whenever I'm feeling rubbish about my job, I go to these houses and they make me feel like I remember why I'm doing it. That's why I try so desperately, I want it better. Try and show them this isn't acceptable, and I think with this job it's small wins, you don't get big results, and that is hard sometimes. As health professionals we like big measures. We're in it for the small wins? Yeah. And I think there's not many of them, but I think, like when I said about my supervisor saying about that instance when I stuck up for that mum in that meeting, and then she had the courage to say something, they're the moments aren't they? It was only a small win, but I felt like I had actually done	Apage love and care. transcendence The small wins is the social justice. Who am I The small wins are the moments we see radical empathy at play. Interesting, when you are entrenched in something, it is difficult to see it... abit like our expectation of women to see in when they're still in it.

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something. But you know what made me laugh, someone else had to point it out to me, because I was frustrated with myself for escalating the situation, I was consumed with having a row with that bloke and his mum. And focusing on that rather than actually the positive thing that come out of it. So that's insane, you don't even realise it yourself until you talk to other people. It's great that that conversation helped you to reflect on your practice and recognize the positive moments. Having those moments of reflection, either alone, or with colleagues is so important. Yes, for me, maybe because I have been doing it so long, and there are moments I feel I could have handled better, I need to talk about it... because you look back and wonder if you did the right thing, and everyone needs reassurance, and when you've been doing it a long time, you don't get freely given the reassurance do you? As long as there isn't anything anyone is complaining about you can just carry on, and I think that's a problem. Making sure targets are met and all the new births are done on time is not why we came into health visiting. How can someone else say if one thing is more important than another	An enormous moral pressure to do the right thing. wonder Prioritisation of what is important.

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We have someone in their 70's still working. It's a hard job, but it's a good job. You get passionate about it. One thing I would like to add, what needs to change. With visiting, you see these families and work with them, and then they go to school and then that's it. That's where the damage is all being done, and the good work undone. The school nurses used to be so involved and there, but no more. They need to be. I looked at some records of older children, and everything stopped after 2 years, that last mandated contact done, and then nothing. Never saw a health nurse again. What's that about?	just think it is to be accessed when something goes wrong? ill-health? But if you don't see, that you won't seek help. PH intervention only exists because those with the eyes to see have identified need. If there are no eyes to see, or no one within sensing there is need then does need is exist, and therefore intervention required?

HV12 Transcript

So, first, can I ask how long you have been a practicing health visitor for? Around 14-15 years. OK, would you say you've seen a lot of families experiencing domestic abuse?	

Yes, it certainly is, especially families that are on plans and this often a theme that's running through, you know, something has escalated, and the family are now on a plan. I think we're now providing a different service to when I started and there's probably not as much opportunity to get to know the families, so they maybe don't feel as comfortable to divulge any information. I certainly don't feel like people tell me about domestic abuse when I go to see them for the core contacts as frequently as I may have done. When I, you know, when they felt more comfortable, when they knew who I was, when the service was different. Can you tell me abit more about this, the differences in the service? I just think the way that we're delivering the service, you know we've had to because of the cutbacks in terms of staffing and service providers and commissioning. I think that we certainly see it in the UP (universal plus) safeguarding element, so the families that are on a plan maybe have gone on a plan because of domestic abuse but it's hidden. So do you think there has been a change in the relationship with health visitors?	Consistency Domestic abuse is at the crisis point. Anecdotal evidence that when there is risk of harm to children, the adults can no longer maintain healthy relationships. When they have experienced a breakdown in relationship, they need to build a new one with you. So its hidden because there isn't the services available? Nothing there to acknowledge

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Those relationships, I think, you know, sort of holding those caseloads where you see them for every contact... it's gone in more recent years because of how we've had to restructure to be able to deliver the healthy child program. Right. And can you tell me, talking about domestic abuse, is it something that you try and broach sort in every contact with families? Yeah, in every contact, I think most healthcare professionals do now, don't they? So yeah, it's certainly something that I would ask at most visits, and you know, it's weaved into a conversation and not just a direct question or '...I've got to ask you this...' I do try and talk about it, and the reasons why we ask, but I feel in recent years, I don't feel like anyone has said. I'm not saying that I got disclosures all the time before, but I just think that maybe families felt more comfortable with me as a familiar practitioner. You know, seeing them more regularly, they saw me at clinic, they saw me for every single contact with each child. It's different now...I don't feel like there's that relationship built up as much now.	and support, it has to remain in the shadows. Have populations evolved, the way we parent, and therefore HV needs to evolve and adapt. consistency

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So thinking about building those relationships, what do you think are the key elements that make somebody who is experiencing domestic abuse feel able to open up? I think maybe trust and not feeling judged. I think you can only get that from when you have built that relationship up between the health visitor and the client...I think that only comes after a while. People would feel reluctant to divulge if they're not sure who you are, or you know, they've just met you for the first time, and that's the last time they're going to see you. So how can they feel safe to tell you, you may not be there again. And can you tell me a little bit about how you ask routine enquiry questions, or is it a broader conversation? Yeah, don't get me wrong, obviously everything is tailored to that client because we know that sometimes it's more difficult to converse with some people. So you know, it's about trying, in this role, you've really got to try different things to allow for people to feel safe to start opening up. And so maybe it would be a conversation about how does it work at home? Like '...now you've got a new baby who does what...' a conversation about how a couple met, or just to get a little bit of background first, and then you can gauge how supportive a partner is. You know, sort of	Connection An individual's disclosure is based on what is happening with that professional? If we don't make that relationship, then it is never talked of? If we don't ask it doesn't exist, and if they don't tell, it doesn't exist? individualised What is the point of routine enquiry at the first contact then? Or rather than routine enquiry it should be 'conversations

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questions along those along those lines ‘...do you feel supported and how's it going since you've had the baby...’ or whatever stage of life that they're in with their under-five child, and just ask from there about feeling safe or feeling threatened. But I try not to just ask it as a question as a tick box because, I feel that that's just never going to be effective. Right, and the words ‘domestic abuse’, do you tend to avoid them or use them directly? If somebody asked me what I meant, then I would, but I don't usually use them when I’m talking about someone’s relationship. It would be ‘do you feel safe?’ or ‘do you feel threatened?’ You know, sort of along those lines, really. And then I would talk about the differences of domestic abuse if I could gauge that maybe there was some hesitation, or you know, it just depends how that person would answer, if they looked confused or they looked as though they may want to talk about it a little more, then I would expand on the different aspects of domestic abuse and what that involves, you know, control, coercion etc etc. But if a person says ‘Ooh yes, I understand why you ask, my midwife has already asked me, and no, there is nothing I’m worried about...’ then I wouldn’t expand, I would feel	exploring the adult relationships?’ questions We ask so many ‘feeling’ questions in HV. What does it feel like.... How do you feel.... All examples of the subjective and experiential experience of life. These are all subtle ways a person feels seen and heard. How you feel is important and therefore you matter enough.

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that they understood why I was asking that, as they're aware that we're going to ask that question because they get the reasons. And what's it like at the other end when the family are on a plan and there's statutory services, and an awareness of some particular issues, is it easier to talk to those families about it (domestic abuse)? Yes, I think so, in the sense that we're all aware of why we're there, and that maybe because its discussed a lot it might feel easier to talk about it. You, they've had to address it with a social worker or the police or something. And so maybe that's a conversation that is <i>easier</i>, not that it's easy, I don't use that word really, but that maybe they feel, you know, less judgement because it's been discussed already. They know that services are there to help at that point. But yeah, maybe that's more of an open conversation about how the relationship is going and it will be regularly asked by the people that are involved. I'm wondering, when there's an awareness of domestic abuse, what is your experience of the gender dynamic of the perpetrator/victim?	It's about what we feel aswell. All the feels. words A skill to move from the feeling of something, to actually the binary definition of something. I wonder if HV would ever disagree and say 'no this doesn't sound like DA to me...' acceptance

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Yeah, I have not worked with any families that are same sex parents that have domestic abuse, predominantly the families that I've worked with are male - female couples and although I have been involved with some families where it is the female that's the perpetrator, it's often the male perpetrator. And when it's at that level of statutory involvement, do you find that both parents are as involved in the planning? I do. I have been involved with families at that level where I have felt that the male, so the father or the stepfather, has just stepped back out of it and then it's left to the mum to do all of the meetings, and I have been involved when the mum has brought that up, that it's completely unfair. "I'm left to do all of this because of something that was done to me..." Yeah, they recognize it, and so do we, they're the one's left with all the statutory services involved, and they are feeling victimized. You know, having to provide lots of time for appointments and core groups and meetings after appointment after appointment with different services, whether that is the school or health or social care.	So it's all down to our perception of their understanding of what <i>it</i> is. An awareness = an ability to speak freely. The animal is out of the cage and we can call it what it is. The element of shock and surprise is gone. responsibility Women feel this and see this. planning

And I'm interested, when a family's been working at that level with other services, and then it's dropped down or social care step back, what is your experience of how the service manages that? We would go back to the universal level of care, unless there's any ongoing health issues. So we will be focusing solely on health at that point. We may make a note on our health records for a targeted review. So make sure the same practitioner goes to see that family, rather than invite them to a generic clinic or, you know, get reallocated. So we would do that when they'd been on a plan previously, but yes, they would go back to universal services otherwise. And so whilst we're sticking with families who were who were at that higher threshold, what's been your experience of working with statutory services? Yeah, I think it's been positive overall, you know, the outcomes have been really positive for some families. I'm thinking just off the top of my head in more recent years really. I remember one, she had a key worker, and she was almost enlightened, she really loved that worker. She said how well that worker had had a	To be aware of something 'wrong', a professional cycle of control, yet we contribute and sit within it. But when the power is weighted, the one has to take control (for the sake of the child!) planning Safeguarding works at an objective principle of safety in actuality and event... We work subjectively until we don't (hits safeguarding), and then to nothing? Or back to a relationship of experience, not actuality.

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positive impact on her life. Her appreciation of the awareness of domestic abuse was brilliant. And so for this particular family, what was the health visitor's role within the team? I often find, and I'm sure many health visitors do find, it easier when there's multi agency involvement because we can be the specialist public health nurse, be a nurse-health visitor, rather than everything. You know sometimes when you go into a universal contact and there are potential issues or whatever, whether they're struggling or anything, there's a lot to take in on those and visits, there's a lot of ground to cover to be able to recognize where the need is. And I find that I can do the health role, really well when there's other agencies involved. And I suppose thinking about working with these families, how do you feel it impacts you personally or how do you deal with any internal emotions? Umm, I think it just depends what's going on. You know, in the house. Do you mean how I would be with the family? How would I interact with them? Or just how that would affect me?	empowerment This is it. When we get it right, it can be transformational. Even if you only touch 1 in every 10... priorities Having someone else be objective, take that element, we can be the experience/subjective listener. Everything impacts our health though...?

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Yeah, I'm wondering how it all impacts you personally, and if there are any restorative things you do? Yea, so I think the informal supervision you get from your colleagues, you know where you might talk about it, you know, '...can I just tell you about this one?' And to ask what they may have done is always helpful. And I think in terms of personally, you know, it's great to know about Claire's law. I tell all my friends about Claire's Law, if they're ever dating or anything like that, because it's very interesting when you get into the conference room and the police share this information about previous domestic abuse...things that no one knew about. So I think it's something that I've talked about more, even in universal contacts, if we're talking in general about, you know, keeping yourself safe and relationships and things like that, that's something that I would mention from time to time. So yeah, just having that awareness of things maybe and in terms of my own emotions, I think it would be just a towards getting support from the team you know. If I felt that there was something, you know, highly emotive. And what about when you're dealing with those families, and a	The notion of 'team' in every way. We're all searching for reassurance. belonging If for women breaking point is based on the child, if there has never been a child before, breaking point is not reached and therefore no evidence documents exist. Great concept in theory... awareness

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disclosure has been made, or there is an incident, and it doesn't meet the statutory threshold, how does that feel? Umm, I think again similar, you know, just making sure that I'm doing enough to support that family. Maybe I would ask colleagues, you know, 'do you think I did the right thing here, or do you think there's anything more we can offer, or what would you do?' The longer I've worked in this job, it doesn't get easier, I think sometimes, you can start to overthink can't you, because of the changes going on, we've changed the way we work in the last few years because there's not the resources there, there's not the staff as much... and so you do every contact with a level of anxiety. Maybe it's a second thought about things that I've done. And like the sign-posting to other services, maybe that is something that I would want to run by my colleagues just to be sure that there's not something else that somebody else is aware of that I could offer. So, it's about that sort of worry, in terms of families getting everything they need because you know resources are different now especially from when I started. There were many children centers and lots of available free services out there that families	You're aware of it and therefore it exists. Awareness=existence. planning It's not breaking point for statutory services or that woman. They can manage and contain for longer. Scaffold the survival. vulnerability Pandora's box is never fully closed or open. The fear we have in even approaching the box. Anxiety is the

could access, you know, be more in the community. I think that's changed recently and people maybe seem more isolated. There's not as many things going on, especially post COVID, groups and classes and children's centres, things like that. Maybe people feeling more isolated now and so it's about asking people in the team about, you know, is there anything else that you can think of? And I'm wondering if we could take a minute to think more broadly about domestic abuse in populations, do you feel like it's something that's always been there? I don't feel like I've got probably as much sense of what's going on nationally versus locally because I don't feel like we've had the opportunity in recent years to engage more in forums and webinars and things like that, that we would all benefit from, you know, having a, a greater understanding. And again, because of how the service is running now compared to when I first started there were always opportunities for training and resources. Uh, there was more money, obviously... that's a definite change. So, I do feel we could, we would, benefit from more information.	alarm of our interoception. HV re-experience the relationship even when they other person is no longer present. Truth(s) Restrictions re-set the balance... of resource management? Do we wish for the old when frankly society has move into the new? Reassurance and help. awareness

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I think looking at it in terms of a practitioner, I think it's always been there and you know, there's been more campaigns nationally, that are making people more aware, especially with social media and you know this things that are shared more widely. I know there's been the campaigns when there's been things like the World Cup or sort of football related tournaments, or things that have been going on and the issue is shared by the local police to raise awareness. And do you do you feel like the families that you work with, that they have an awareness of it? Do they recognize the different contexts of domestic abuse? Umm, I think culture comes into that massively. And so, yeah, I think sometimes within families, it's encouraged to be brushed under the carpet, and you know, the wider family have known about it and encouraged no involvement from police or services. It's difficult to answer that because I think we have so many families to consider, so multi-cultural...it's just so wide you know, a wide spectrum of families. So it's hard to say whether I think we are aware of that impact or not. Do you feel that culture impacts the family roles?	Truth(s) Awareness=existence. The information is there, but we have to seek it. acceptance

Yeah, maybe more traditional roles, you know. You know what the mother or wife should be, you know, sort of doing versus what the man, husband, father, should be doing. And do you think families have a grasp on coercive behaviours, or controlling behaviours, or is the focus on incidents of violence, or one-off events? I think in more recent years there's a recognition, there certainly seems to be more information out there on coercive control, on TV, adverts, and social media. And with that there's a wider understanding of everything under the umbrella of domestic abuse. I think in more recent years there has been a wider recognition of finances and things like that. And in fact, domestic abuse is not just a physical injury. And I'm wondering, when you're working with these families whether they have any agencies involved or not, are there differences in your hoped outcome or perhaps expected outcome? Are do they feel shared with the family? I think for me, I don't know about other professionals, but I think empowerment is a big thing, you know, to empower that person to recognize it. That's what I want. And you know that they might not be ready to do anything about it. Sometimes, as long as	This concept comes up again. Activities that are gendered (typically) are bad... or are they? And that's what they want us to think? awareness Perhaps it has the potential to unbalance the bigger picture. As long as breaking point is not reached, the experience of the adults can be mitigated.

they're feeling safe in terms of the children and you know, if it's not at the statutory level, then just a recognition and a feeling of empowerment. That's what I would like to get across when I talk to the families and for them to understand they can get support and help... there are people to help. Have you ever had any situations where the safeguarding of the child has trumped sense of empowerment being the outcome? Yeah. Certainly. Especially when the recognition just was never there, you know? It was minimized. Hidden... Lies and there's no other way for me to describe that. Yeah, I've experienced both sides of that. And how does that feel for you when you feel like someone's being dishonest, lying essentially? I suppose for me, as a nurse and having that caring role, particularly for the children, I just feel really sad for the children. That's how I feel, you know, from the children's point of view, their wellbeing isn't being prioritized... but I know that's a simplistic view. But I can get that. I understand that because there's lots of other things that are going on and, but, it can feel	We all have different expectations... empowerment As awareness increases, existence increases. priorities Why hiding it? To survive? Can anyone say it's there other than the individual if it's hidden? Perhaps it is prioritised and that's why it's hidden?

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like that when the child is there and the detrimental impacts are so well known. I'm just wondering what your thoughts are on how we begin to start dealing with domestic abuse? I think again, whether it's just that you're in a role for so long that you can see a cycle in terms of how government funding really, really helps, you know when there's lots of awareness and training and resources and services that are out there, that can help families. And that can have a positive effect. We know that the current state of the finances for a lot of families, it's a struggle that so many families are going through and that has an impact. But certainly, when we worked more closely with children's centers, we were seeing people regularly... We were familiar faces in the community, not just us, but family support workers, community link workers and, you know, groups that were being run, and just various things in different faith organizations. So, the families knew the same people, you know and felt less isolated. Oh, I don't know the answer really, but from working in this role for so many years now, it felt better then, before, because there were more people available to talk to.	awareness Empowerment is about awareness...and understanding. consistency When there is more of us, we feel a team, we feel less isolated, we feel more seen.

I'm just wondering, so you mentioned sort of families feeling isolated. Do you feel the service feels quite isolated too? Since COVID, it's a mixture, hybrid way of working. Everybody got so used to working remotely and we have the technology to do that now, people still tend to work that way. Yes, it can feel really isolated in as a way as we used to know, and work within the local areas, and we knew that the Children's Centres were always open, so if we wanted to pop in and have a coffee or use the bathroom or, you know, just have a space to sit and make some phone calls, we could do that. And where I work now, a lot of those have closed, obviously, because they were funded by local government and that funding has gone. And so there's not, there's not the, you know, the joint working ethos as much anymore, so you do feel on your own more as a service. We've covered so many areas, but you know, I think what's so invaluable is that you've had a long experience working within the role, and the recognition of the ups and downs aligned with the political landscape. It's hard to not get political, like obviously, you know, that's not something that we can change. And while we're working here, and	Team working belonging We need to exist in teams, in tribes. 'no man is an island' Help and isolation Ideology of the importance of the self... great until you need people. You need scaffolding, we all do.

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especially when you've done the role for such a long time and you see how good it was for families and the services that were there, and then to the difference now and yes, obviously domestic abuse still existed, it was more of a sense of community, and a sense of accessibility of services.	Is the change the natural progressive and evolvement of society? There is safety in the consistent... we fear it, but yet expect women to embrace and undertake so much change.... consistency

HV13 Transcript

OK, so if we make a start, could you tell me first of all, how long you've been practicing within your SCPHN role? Umm yeah, so I qualified as a health visitor in 2019, so since then full time. I've done the perinatal mental health lead role, and now I'm in a team leader role. All in the same team. And at certain times during COVID we were relocated and did the immunisations for a while. And so since sort of your training, have you found that you've seen domestic abuse? What's been your experience? Yeah, quite a regular thing. I think when most people start health visiting they realise how prevalent it is, more than you probably think beforehand and, it definitely was in my experience. So yeah, quite frequently. And you know, not always in a sort of safeguarding arena as well. It's not always hitting the social care threshold and, but, it's still there, underlying, or kind of concerns	Its only when we enter homes, we increase our awareness... so how do we expect others to? awareness

about control, but not nothing that's hitting a threshold to kind of have that additional social care support... It's always more stressful to hold those families when you've got no-one else involved in the case. Why is it more stressful? Because it's on you. Like, you have your safeguarding supervision and colleagues, but it's just you. You weigh up the factors. To have someone else with those statutory powers to say 'yeah, it's fine..' or 'no, this is enough to worry us and we will assess...' either, it's not you making that call. Making the call is the stress. Yes. I wonder, those families who you've identified as having concerning behaviours but they don't meet a threshold, how do you manage that? Do you step outside of a universal service? Yeah, yeah, definitely. So in our workplace they are quite flexible. We don't have, like some areas have, that they put visits in for you and you have to really push hard to justify going in... in our area it's based on your judgement of what is needed. So definitely one of the families that I've got in mind I visited quite a lot more than you would normally kept in touch over the phone, definitely more of an enhanced service, but nothing specific, just	Why is it stressful? The onus and accountability we hold if anything goes wrong... responsibility The fear of lone working and making the right 'call'. Noone wants to make the wrong call when there are children and harm at stake. Responsibility.

kind of 'as-and-when', like it was needed and just yeah, more enhanced service than I usually would. And with that family, you've got in mind, where did those worries come from, was it a disclosure or incident? So back to the beginning, I think it was during COVID when she was pregnant and gave birth. So originally, we weren't doing face to face antenatal contacts at the time. So, we did them over the phone so I didn't get to meet her before baby was born and then when the baby was born, we were also doing a phone call to complete the new birth assessment. But then visiting to weigh the baby and sort of see the family. She was considered universal. But then after I've done the new birth visit, the GP contacted me and said "I don't know if she's made you aware of all these sort of things which are going on and that she struggles with a mental health...she's got this ex-partner who isn't the baby's dad, but he's been very violent and abusive in the past, he lives far away, but she's concerned about this guy and he's been contacting the GP surgery and telling them all sorts of lies..." So after that point, I obviously contacted the mum again and went to see her and she told me more detail of what happened. She explained it hadn't ever been through safeguarding channels and	Having the autonomy over your contacts mitigates some of the anxiety and stress. You don't have to prove why you need to see a family. There is no justification for that interoception. histories The stark reality of contacts during lockdowns... missed connections with families. Professionals

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she hadn't got support for it really in the past. So we have something called the domestic abuse hub in our area, so I referred her to that with her consent. They assessed the history and current situation, but they said she didn't meet the threshold for social care getting involved. And I think over this period of time that I worked with her, I maybe sent another 2 referrals into this hub and again, yeah, nothing ever came of it because he was out of the area, even though he was contacting her... you know, trying to harass her over the phone and sending parcels to the house, and all sorts, and threatening her. And they said it didn't meet the threshold for any sort of additional action, because he wasn't in the country (within the UK). And so, there's also other stuff going on at home. So I offered extra visits, extra contact, extra support. She revealed that at home, where she was living, her parents had also been abusive to her as a child. Like hitting, controlling behavior, controlling who she sees. So domestic abuse was perpetrated by them, from her parents. So yeah, that came out too, but obviously she's still living at home, and you know, it's very difficult for people to find housing. As she wasn't working, she couldn't afford to put a child in nursery, and so it was difficult for	depended on one another more than ever to share. But what about when it feels like services are more and more working alone. Patterns of abuse transcendence

her. And difficult visiting, I had to try and coordinate it with when the parents weren't at home, so that she could speak more openly. But she was very scared of social care getting involved. Every time there was an incident, she'd ring me and be like "...I just need to tell you that this has happened because I don't want you to think I'm not being honest with you..." And so she was, you know, really anxious and worrying that her child's gonna be taken away from her. But there was one time where this ex-partner had been harassing her family, and they've got really frustrated and annoyed about it, and made her ring him. And then there was this massive argument. And the parents kicked her out of the house and she went to live with her grandma for a short period of time, which wasn't appropriate, there wasn't enough space. Eventually, even though she didn't want to, because she wanted to get out of that house, she ended up going back because she felt like she didn't have any other option and she didn't wanna go into a refuge or anything like that and didn't wanna lose that support off her family, and even though they were abusive towards her and controlling her behaviour, she didn't wanna lose them. They're the only parents she's ever had, so it was very difficult for her really, to kind of break out of that, and leave them.	multiplicities More to the story... there is always a beginning, middle and end. We cannot live in the middle/present... we need the whole story. Boundaries How did this individual become the person they are now? The fear in the unknown. Stuck

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And that was what it's like, this sort of situation... managing it because of with all the different complexities to it. Eventually her child went to nursery because I really thought that would be beneficial, you've got other people seeing this child and being able to support if I wasn't able to, you know, or you know, while I wasn't there, you know, because I can't be there constantly. So that was a positive. Yeah, and I had to hand this case over as well as I moved to this team leader role, and that's always very difficult being that we don't see how it ends up, and you feel like you know so much about the family, and the details of it, and you've built that relationship which was very difficult to build, and then you kind of feel, 'oh gosh, now I've got to pass that over to someone else, and give that responsibility to someone else.' So that was quite a difficult experience as well, yeah. I'm interested to go back to this case, at the beginning, before you'd spoken to the GP, had you had any conversations, maybe not specifically relating to domestic abuse, but just about her current or a previous adult relationships? So yeah, we discussed domestic abuse, like I asked about domestic	The sense and need to be honest can bring about fear itself. Calling things complex... does that make it seem unachievable or unavoidable? Negative weight.. perhaps multiplicities. She's managing. We're managing. We're all just trying to manage and exist. Empathy We want children seen by others so the accountability of risk isn't on us? You become part of the story, and it's hard

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way more likely to share stuff with you earlier, and they don't want to really broach it with a stranger who's speaking over the phone. I'm wondering, you know, after you spoke to the GP and you went back to her, and explored what had been said more, how was she then? Did she open up? At the time, I would have said she was completely open with me, and she did open up. She was quite happy to, and she gave me, you know, really personal details and was happy for me to put that down. About this ex-partner, she was completely open about it. But in terms of all the things going on at home, she didn't reveal any of that to me, and it must have been over a year after being in regular contact that she eventually revealed to me what it was like at home. I remember I did a referral to the hub about it, and they didn't shut it completely. We have like early intervention workers who are like family support workers, and they did six weeks of intensive work trying to find out what specific support is needed. So someone came in and it was at that time that she didn't tell the worker about the family and how they were, but she did tell me. You know, it's just interesting that timing when she decided to say	out by the same HV?? Connection The AN is the scaffolding to the working relationship. consistency time

something to me about what was going on with the family, and not this key worker because the family were there. Every time there was a social care referral, the family got really edgy and were like, 'they can't come in here.' They were like, you can't say anything, putting pressure on her. So it was at that time that she did share more about what her family were like. Where do you think her fear came from? Did she ever tell you why she was worried? It was around her ex-partner, she was worried that her dad was going to have done something to him if it turned up. And so I think it was about her ex partner, but also her parents reaction. You know, I'd go around, and she would be really open with me, about how he had sexually assaulted her and all of this, but as soon as the parents came in the house, she wouldn't want to speak about this ex-partner at all. She would give me sort of glances of like, you know, don't talk, and then want to change the topic on to something else. And so, I thought originally, it was just, maybe they didn't know the full details and it was quite personal and she didn't want them to know about it. But then since knowing what was going on with the family, I think it was more she didn't want the family to know how much she was divulging to	HV becomes entrenched in someone's world without living it. control So much of the fear and anxiety has nothing to do with them directly...

me, because I think she was worried that her parents might think that then she was going to tell something to me about what they were doing, or what they had done in the past...I think she's grown up in that household, and that's just all she's ever known. But I think she realized that that's not normal, you know, for parents to have brought up like that and she wants something different. She was always keen for my support, and when we talked about housing and getting another house she was really keen for it. She signed up for the local housing association, and every time her mum found out she wanted to bid for a property she'd start... these little comments to her, like, "uh, you're not going to cope on your own", "How are you gonna afford anything? I've seen your bank statements, and you know you're not gonna be able to do it". "I'm gonna tell children's social care this about you..." all these sorts of things would come in. So, it was really difficult for her being in control, she was in that kinda relationship with her parents, and knowing that it wasn't a good environment for a child, because obviously that's not gonna be a nice experience for the child being in that household. And hearing those disagreements and having that sort of tension around them... and I explained that to her and about the impacts of that, and that itself is quite a difficult conversation, because	protection Safety of home

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you're telling this to someone who has also experienced domestic abuse, and well she'd been through it as a child as well really with her parents. It's a difficult one to swallow for someone who's been brought up in that environment, telling them, well, you're sort of doing the same to your child, but she's allowing a child to stay in that environment. And so, I think there were quite a lot of conflicting emotions about the situation. And yeah, like I said, I'm not sure on the outcome of it all. I presume she's still there, but you always hope, don't you? ...that they've got out of there. But for this family I was also the health visitor for her brother as well, well for his baby. If I'd have known they were related I would not have had both families. I'd hear one side of the story for one person, and then I'd hear off the other. Sometimes they'd be on good terms, other times they'd be saying all sorts of stuff about each other. But the consistency was that the grandparents were both very controlling and quite toxic people to be around and that was kind of the view of both of them. It's a shame because she (grandmother) would always put a wedge	control honesty

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between the mum and her brother's partner, stopping them having a friendship, she saw the relationship as a threat.

Did you ever question Mum's ability to safeguard the child?

Yeah. Yeah, absolutely. And this is why the referrals went into children's social care from me on several occasions and from the GP, and we continued to liaise with each other because we were, for a lot of the time, the only professionals involved. The mum knew I spoke to the GP and we would share information, she was fearful of it, but she understood why.

And yeah, so that's why those referrals went in because she'd always say, you know, "I want to move out, I'm trying, I don't like being in this house, and I don't want my daughter growing up in this environment." So she was verbalizing what she knew she had to do. But there was never any constructive movement forward, to getting out of that situation. So, yeah, there was a big risk there that she was putting the child at risk, although she was aware of the risk, she was maybe too vulnerable at times to safeguard herself.

I'm wondering with those referrals you put into children's social care, would you say they were child focused, or was it mum and

Team working

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child focused together? Child focused, because that's the risk, what we know to this very vulnerable child. And at the end of the day, if the mum wasn't wanting to get out of that situation, it's kind of her choice at the end of the day, you know, she's an adult. She's capable of making decisions for herself. She has a level of choice as an adult. But when you've got a child, they don't have that choice. They are just growing up in that environment and that's where the difference lies really. But obviously within that, it's the parent that can make those positive choices for their child's wellbeing. But I guess it's difficult because it's all tied in together. And I mean you do build a relationship with the child, and with the parent as a health visitor, you're there for both, right? You know you're there to support both their mental health, wellbeing, and safeguarding. But yeah, the priority is obviously on the child, but it's sort of intertwined, isn't it? It's a shame because obviously it's not this mum's fault that any of this has happened, but it's always, you know, it ends up being their responsibility to protect the child. What's needed is just for the ex-partner to stop harassing her, and the parents to either do some sort of work on themselves or just	stuck Perhaps individuals build a resilience, and an adaptative ability to withstand conflict. A new baseline. blame Is it only a choice when you have awareness and understanding?

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allow, you know, break off that relationship... but we don't work with those people. We work with the parents of the child and that's all we can influence really.	connection
And I'm wondering, when the referrals bounced back or they just said, 'oh, no, it doesn't meet the threshold', how did that make you feel?	priorities
Very frustrated and worried because I would always try and sort of argue my point so I wouldn't ever just put a referral in and have it come back, I would always want to know why...or what have they done to assess the situation. You know, there's this risk and they speak to mum over the phone and she goes "No, nothing's going on and everything's fine, you know, and I've blocked my ex-partner and I'm happy at home". And then it, they just take her word for it. And so often, that's how it goes with children's social care at the moment, and I do think it's quite unsafe. So I do like to have conversations about those referrals and the outcomes, and how they've come to those outcomes.	To empower and encourage positive choices does that have to mean actual changes? Or making the choice to change your mindset... is that enough when there is a child?
And we do have our own safeguarding team as well in our organisation, for the health visitors and school nurses, so you can share it with them as well. You know make a plan with them, how	

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to evidence your concerns and things, and what support you can offer. It sounds like you spent a lot of time with this family and reflecting on the support you could offer, do you feel you put your emotional energy into this family? Yeah, absolutely, yeah. It was one of those families, we all have them, that they take out so much of your mental and emotional capacity. And it was one where I'd constantly be like, right I need to check in with them, even though there might not have been anything that's specifically happened, they'd always be on my mind, so I'd want to check in with her. All this is a way of dealing with that uncertainty, maintain that level of contact to help your own worries about it all you know, you wanna keep an eye on, and just offer that extra support. But I did have support through supervision about this family as well, as we have individual safeguarding supervision every three months and group supervision every three months as well. So even though usually I would discuss child protection cases, I would discuss this one, I just thought I need to focus on this one, because like with we said before, you've got other professionals	responsibility The fear of being the only professional, but then when you include others, the fear becomes frustration because they don't agree with your assessment? Help and isolation HV capacity to contain and carry.

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involved. You know, child protection cases, you're not on your own, it doesn't feel like you are solely responsible, but with this one it kind of did a lot of the time. You can hear that you obviously got to know the family well. Can you describe what you felt your role was for that family? So predominantly it's looking at how it's impacting on the child, so assessing the child's wellbeing and development... it's like the core of what you're doing. Obviously, if there's anything out of the ordinary with development, I think with this child they had some slight speech delay so were referred for support for that, and then obviously it's emotional support as well for the mum because she struggled with her mental health, I think she found that useful to talk to someone who she could trust. I think a lot of the role is linking with other professionals and coordinating, trying to get the child into nursery because that would be benefit her development, and trying to support getting the housing banding up, ring the housing association, support letters. Ringing the GP you know, trying to book an appointment if she was feeling particularly low. Obviously if there is a safeguarding element and there is risk, referring on to social care and there was a lot of times when I tried to get them involved with the women's centre, get her to groups and things like that. Things to help a person holistically.	containment transcendence Maintain contact to elevate our worry, not theirs. Help and isolation You feel responsible, but if social care say no, everything's ok, can you release that responsibility?

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But you can only do that if you already have got that relationship with the family, that they're keen for you to do that and they respect y'all views of what would be helpful.	Individualised
So do you feel to get to that point with all those things that you were doing, you needed that whole journey in between and time with the family?	Who am I?
Absolutely. Yeah. I think it's the most important thing, building the relationship. It builds their understanding of what we can offer and builds a trust that we we're not there to criticize and judge and you know, just look at the homes and make sure they're nice and tidy. You know people still think that, we're here to criticise how they live their lives and how they parent, and refer to social workers.	Demonstration of the step away from medicalised nursing. SCPHN is way over to the side of what is considered ill-health.
When you build a relationship and get to that stage, that's when they will come to you with things rather than you trying to prize a response from them. So, like with this mum and like I say, she would volunteer information, you know, she'd ring me when I hadn't rung her to tell me about things. You know you can be that one person, if they're worried about the child or their relationship, or whatever it might be, they can contact you.	connection You need respect. For respect you need trust, for trust you need connection and care, for connection

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So I think that is the most important thing, is the frequency of contact and to get to that point of trust. Do you think, from this mum's perspective, with her experiences with her ex-partner and parents, she recognised it as domestic abuse? Hmm, I think definitely with her ex-partner. But I think only them, because perhaps she just thought domestic abuse was being violent, she didn't recognise the controlling element as being part of domestic abuse, especially initially, and I don't remember her ever referring to the relationship with her parents as being like domestic abuse. But, I think she knew it was. She could eventually recognise that it was controlling, and that they wanted her to themselves, and they didn't want her to have her own life. Because I think there is a sort of common idea that it is just within a household but with partners rather than with family members, which it obviously can be. And so no, I don't think she fully would have categorized it as domestic abuse. So, in your experience, like this case, when domestic abuse is involved do you find there are many other factors at play? Other issues?	and care you need to feel seen. How can we describe the journey and what may be needed when it hasn't been travelled with that family yet? approachability connection consistency

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Well, like for example, with most child protections I've ever worked with, there has always been domestic abuse from what I can remember, it might not be the main issue or the reason they were on a plan, but it's always there. You've got like the Toxic Trio, which is, you know, can be a complex thing. You know maybe also addiction, mental health... That's why it so often does come with those other complexities, it triggers a perpetrator. There are cases I'm involved with at the moment, the actions are focused on the domestic abuse and often on the mum, because in these cases specifically, the dad's don't wanna be involved in the plan, and they don't wanna be involved in any of the actions and they don't acknowledge their part in the domestic abuse. So then it becomes solely down to the mum to manage that risk. A conference I'm at tomorrow, the mum doesn't even want it, she doesn't want the plan. She doesn't like going to core groups, but she was a looked after child herself when she was younger, and that's kind of the reason that she doesn't want the involvement, and doesn't want to go to the meetings cause it's traumatic for her. We have a programme where I work that helps victims recognise the signs of domestic abuse, and how to avoid getting in those unhealthy relationships in the future, and so she's done that in the	awareness It was important to reinforce the control... was there need for domestic abuse here? A focus made on relationships across the board.

past. And one of the points of the plan is for her to do it again, she only did it a couple of years ago and she could reel everything it says about signs, and so she's kind of like, “well, I know I know it...”, but, you know, obviously it hasn't stopped the unhealthy relationship because it's not just down to the victim of the abuse, is it? And that is the main difficulty I think, is engaging with the perpetrator and switching that support over to them as well...making sure the perpetrator has a plan of what they need to do. The problem is, like with this case I'm going to tomorrow, the chances are that it will not be on a child protection plan anymore because the actions aren't being worked towards. And since the plan started there haven't been any more reports of abuse, you know, the child is a current victim of abuse. You keep them on a plan forever just in case something happens, and obviously it doesn't sit well with anyone involved, but it's reasonable to ask what are we having this plan for when the parents don't want to engage and there is no longer immediate risk? Do you escalate it if the parents don't turn up to core groups if we feel the threshold is being met for looking at removing the child, or do we de-escalate?	These issues are the result of.... Triggers? Or adaptive behaviours? If we're all adapting to the reality we know, then it can change.... Get to the root cause. responsibility How can perp's just not acknowledge their part in all of this? Truth(s) Recognise the trauma and prof control, but see why it is needed. Contradictory and complementary. Becoming/belonging Doing something is not the same as becoming something.

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	Truth(s) Women can be told about these behaviours, but if men are never given support, they will continue... knowing The silence within the plan can hide everything. Priorities Press pause and statutory services stand down. What is the consequence? The child would not be removed if the parents weren't engaging but

	everything was seemingly OK.. An interesting point raised... what is the end game. If we don't all play ball, the parents don't engage, but the abuse and risk pauses, then what? The statutory intervention works when objective events occur. When the events cease there is often no room for statutory involvement as it simply cannot exist in a world where there is silence. It either is, or it isn't. When it 'isn't',

	everyone is deemed safe, enough.

HV14 Transcript

Can you tell me about how you are with families experiencing domestic abuse? So I find that the best way is to be perfectly honest with the clients about why I'm there and obviously that's where <i>it</i> comes in. The difficulty and inconsistency with other services working together but not always sharing information. They kind of triage the families in their area and then by the time we go out, we've got limited information and there are questions about them have consenting to other professionals. So, it's really difficult as health. Like to know if the parents want us in that	honesty A sense that we are honest, but others are not... not families, but other services? Info sharing

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house in the first place. Then the other day I went out to one, there's an unknown male in the kitchen. I don't know who he is. The grandma is in the living room, and the mom is saying to me 'what's the reason for this visit?' And I literally had to think on my feet and say why I went out....an ad-hoc visit. But then she said she only recently seen the health visiting service for her child's development review, so I couldn't attach the visit onto that either. But I didn't know who this man is, and the grandma is, I didn't feel safe enough to talk about it. You don't always feel safe. I didn't feel comfortable doing that because the way that this mum was very defensive. And I'm wondering when you're having these difficult conversations, when you're working with these families, how do you feel? I think the reason that I'm so interested in it is because, looking back when my youngest child was little, I experienced it. And I remember my health visitor coming out to me. She was so posh, and she was at the new birth, and she said, you know, "have you ever experienced domestic abuse?", she just said it like that. As if she was asking if I wanted a biscuit with my cup of tea! And I remember thinking, all these years later, "if I did, I wouldn't tell you!" I remember that because I didn't have that connection	The concern about their safety can easily become a concern for our own safety and for ourselves... I was worried for you, and now I'm anxious! Who am I? We cannot leave ourselves at home. They travel with us into work. We build connections and how to be as an

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with that one health visitor. And so, I always, that's always in my mind that.

First of all you need to try and build a connection and it could be over anything, anything silly or superficial. But if there's a connection, if the mom doesn't feel judged in any way, and if you speak to people on their level, and there's different levels of speaking to people because people are all from different backgrounds, aren't they?

And then I think that if you have a little step in, and sometimes it might be that you park that in your head and think 'hmm, there's something not quite right here...but right now isn't the right time to address it.' I'm gonna revisit that at four weeks or six weeks.

And so it's hard because you know, when you leave that home and you have little red flags popping up, Spidey senses are telling you that something else going on or even if you see someone acting a bit controlling, or shutting the other parent up, and stopping them mid-sentence. You don't want to make things worse in the situation when you're there, but equally you've got it in your head. That's why everything goes in my notes because you know, with the workload, you can't remember from one week to the next. And then next time I go, I have a look at it and see if I've got an opportunity to speak to this person on their

own. Or sometimes it's surprising and shocking if notifications come through, because people are good, aren't they? Good at putting a face on and an act. And I just think because I know what it's like, I've been through it, I know how hard it is to actually tell an outsider, or someone that's not a family member, what's going on in your private life....It's really hard. You know they may feel disloyal, they've just had a baby with this person, so they're taking on all the responsibility of keeping the family together. You know all that kind of thing. You almost look further back into that woman's history, they haven't been raised with aspirations to think '...well actually, I know that I don't deserve this, and I'm gonna put myself before everything...' I think even women who are raised in loving homes, they can struggle with that cut off point where they say this is unacceptable to me so I'm gonna do something about it, and that's really hard especially when feelings are involved you know. But only that woman can decide. All you can do is support them, but you can't make them decide whether now is the right time or not. But then of course, you have the priority of children in that scenario, so the mom may not feel it's the right time or want to leave, but is it safe for the children? What's the risk to the children if they get caught up in a	Interoception. Truth(s) We can't unsee and unhear things. Comes with care and empathy... Empathy Solidarity Are we all just putting on an act? Fake it.... The courage it takes to pull down the mask. To recognise the courage in the experience is never taken for granted. empowerment

conflict? Will they be hurt? Emotionally affected? Development impacted? How will it affect the child's attachment to their parents?? You know I wish sometimes I could have a little camera into that home so you could see and then show the parents what it's like. But there isn't and we're there to support, so if there's no immediate risk to the children... And of course we're there for the Dad's too, because they can be victims. But the priority is still the children, especially that child that has no voice, and you have to see past what the parents are saying. Also, there are mom's who are clued up if you like, they've been through the system, and they know, maybe they won't tell you as much because they understand how information is shared. So, they are fully aware that '...if I say too much to the health visitor, she'll talk to the social worker and it gets escalated to child protection', and they know that. So yeah, I mean it's, it's difficult, isn't it? Unless its completely taken out of the parents' hands and referrals go through. Yes, it sounds like a constant juggle... Have you ever had conversations with the mum about the potential impact it's having on her young child or on the children?	An intergenerational patriarchy that touches us all without direct action. The power and dominance so entrenched it cannot be singled out. Priorities They must hit the breaking point. The children become an objective subject to surveillance. There is now a consequence that is measurable, no longer just experience. priorities Do we wish we could surveillance more? knowing

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Of yeah, lots. How do you find those conversations? I think that I can think of one that really took it on board and I actually got her to agree to the (intervention) programme, which touches on the impact of domestic abuse on children as well. And there are perpetrator programmes, but I think there are only two in the whole city. So with all these programmes they may agree to do them, but then don't turn up. So yeah, so sometimes they will do that or sometimes they'll agree to do it, but then they won't turn up. Or you hear the classic '...oh they don't know, they're upstairs asleep in their room' and I will say something like well how do they know the child is asleep, because most children will wake with commotion or noise. You know, and I will talk about how it may impact their development, them at school, maybe on bed wetting, them not forming friendship, and just general fear and feeling unsafe at home. Because that's it isn't it, it's the one place a child should feel safe. But as a mom being presented with that information, it's hard. It's hard to be confronted with it and of course it would be so upsetting. Most mothers confronted with that information would be upset.	..."tell me what it's like..." but then also, that doesn't matter because there is a child... There understanding and awareness of how support meets surveillance. Do we give credit for this understanding? children

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Actually, I think that a lot of women don't realise and they minimise the effects of the domestic abuse because they don't want to confront the situation that they're in. It could open a lot for them, Do I stay with this person? Can he change? Is he willing to go and get help? And at least there are perpetrator programmes now, years ago there were none. I wish there were more and if it was up to me, we would be teaching this stuff in school. It goes back to that, teaching it before things get out of hand. Teaching it to the children so it impacts their children. I know I'm saying boys, but they need support. Just go back so that boy knows that's not the way to treat people, and even when they're in their boy groups and that. You know when the world cup comes on, and men are drinking and all that, and guess what domestic abuse increases. You know, drinking and drugs it can change them, but it doesn't make you a man doing that to a partner. Ohh, but women as well. Because women can be very combative when you know, say their partner came back and they had said they was gonna be back at 2:00 PM and he came back at 8:00 PM, you know he did another few drinks. You know, women can be very combative, and that's also a form of abuse. You know, it	awareness There is an overwhelm fear that your action, or inaction now, could cause harm in the future to your child. Awareness An adaptive sense to keep you safe. "I can't acknowledge it, because it's the worst". Conversation about healthy relationships. World cup again! The acceptability of

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might not be physical, but it still it could be, you know, a lot of verbal abuse. So you know that could that could be looked at as well. You know, I'm just saying that verbal abuse also impacts children. Do you find that mum's, if they're the victim, have to do a lot of the work when working with services? Yeah, I've had this recently in a child protection conference actually. It was raised, the Dad was the perpetrator and in this case we were asking the mum to jump through all these hoops, do these programmes, all these things. And I think it was the midwife that said, I am aware that we're getting mum to do all this work, and where is the perpetrator? And because they did want to remain in the relationship. You know, we wanna educate mom's so that if they're not in an abusive relationship, and they're not going back to it, that for future relationships, we wanna make sure that she can make the best choices that they can. You know in relation to a potential partner. But yeah, we look at the mom as the one who's responsible for the children but they've both got parental responsibility... but it all goes back to women.	behaviour when there is pack mentality... I wonder about verbal abuse.... When does the line cross between anger and frustration and abuse? Mum moves from one controlling cycle to another... but this one has name badges.

Women being treated less fairly than men in general, and I mean if you look at the legality of it, they've both got parental responsibility and yet we target the woman as being so much more responsible, and the man is kind of an add-on really. But saying that you know the roles can be reserved and it doesn't have to be the man that is the perpetrator. The woman is, or same-sex relationships. You know it's a much smaller percentage than man and woman relationships, but I would venture and say it isn't so clear with responsibility to a family court just for the pure fact that one's not a man and one's not a woman. And do you think social care recognise that a lot of responsibility is placed on the victim to make the changes and be responsible? I think that there are some progressive social workers out there. There are many that just kind of go with the flow and they don't question it. If anyone questioned it, they would realise that actually we seem to be blaming the mother for being in that relationship. And of course we have to be direct and say, you know 'you are an adult, you are choosing to remain in this relationship, but your children don't get to choose...'	empowerment Choices need understanding and awareness. responsibility Responsibility held by mum is recognized... but we still go along with it. So awareness and understanding isn't enough... contradiction.

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So we can support that mom and they can support that mom, if she wishes to, for him to leave or, more likely, for her to move with the children and be in a safe space. And then I suppose ultimately, if the father, if the male is the perpetrator, and the mother is not, we expect for her to do whatever she can to keep them safe. And if she refuses to do that, you know, then the children aren't safe and we can demonstrate that, then that escalates everything.

I think that some of the new social workers are the ones that question it, but the older ones don't.

Yeah, I'm interested as well, because you're in a slightly more specialised role within health visiting, do you think that when domestic abuse is known, should interventions and support be referred out of health? Like to third party agencies, charities or statutory services?

If I had a magic wand, then the answer would be more specialized health visitors that can work with families. It's a difficult question because health visitors encompass so many things. You know, if there was no development concerns and no health issues and no mental health issues... but that's such a wide-reaching statement, because, if you've got a woman that's

blame

Choice is nuanced and subjective. For those without choice there is no subjective thought. It's all objective... it will harm...etc.

Truth(s) Do they ever
leave?

So if the perp doesn't promote safety it's overseen, if the victim doesn't maintain safety it is highlighted.

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suffering domestic abuse, you can guarantee hand in hand there is gonna be maternal mental health issues, anxiety, low mood. Because one affects the other, and so and that's why I think health is so important because we cover that many things, we're the workforce that goes out from pregnancy right up to five years old. We're the only workforce really that knocks on the doors and gets the doors open for us, for such a length of time anyway. I mean, I know that midwives obviously go in, but there's no workforce in the UK like health visitors that cover such, nearly a 5 and 1/2 year span, to have the ability to go out ad hoc. Knock on the door, and I think 9 times out of 10, you know, health visitors are tenacious. You know, if we don't get in the first time, we'll go back, we'll go back because we care about the clients and it's on our heads. We are the individuals that are tasked with seeing those children and making sure they're OK. So yeah, so I started off by saying yes, it would be great if we had specialist health visitors, domestic abuse health visitors. It's not that I'm saying that only health can deal with that, but only the health visitor covers every point of that family. It's never a single issue, it may be maternal mental health and domestic abuse and issues with child development and parenting... it's difficult just	simplicity knowing If DA is a result of a far deeper issue(s) then we can never expect it to stand alone. HV know that DA impacts sense of self. responsibility

getting agencies to come in and focus on one thing, because it's never just a single issue. But who can? Who can focus on it all and have the capacity to do that? I mean it's health visitors, but we haven't got staff or vacancies, you know here and I'm sure it's the same across the country. I just think we aren't valued. It's a really interesting point you make about joining the dots and needing a whole family approach. I'm wondering when you're chatting with parents, perhaps very early on when you are building that relationship... when you are talking about how they're relationship is and issues relating to domestic abuse, what sort of words do you use? Do you directly ask about it and say 'domestic abuse'? How to do you form those conversations? I mean firstly my main issue is that we predominantly do this just with the woman, you know just talk to her about relationships and domestic abuse. I mean why? Why don't we talk to both parents about it? I mean I know about ensuring safety and the likelihood is if it's happening it's the male perpetrator and female victim, but we just direct the exploring questions to the	There is power in doors opening for us without question. We keep pushing because we care. boundary If DA impacts every area of life then you need a holistic viewpoint. What other regulated profession does this? The demise of HV through de-valuing.

woman. I get we never want to make the situation worse, we don't want to escalate a situation when we leave. But, in an ideal world, I would be able to go in on a first visit and talk to them both about healthy relationships, you know.

I wouldn't be too 'wordy' and say 'right now, I'd like to talk about domestic abuse..', but what you could say is and 'how do you guys feel that your relationship is?'

I'd like to think that we could, if we're asking the people, the parents, to come together and build a stronger relationship, and talk about the impacts of maybe raised voices on their children, it would be nice if we got to a point where we could have that discussion with them together.

Obviously, I'm not talking about significant offenders here because that's not my remit anyway, you would need specialist intervention from people regarding those people and you have to consider safety of the mum, the children and the health visitor and the dad.

Like if we had a mom and a dad living together, and the dad was a perpetrator and there was verbal abuse, it would be good if we could get to a point where we could have those discussions with the two of them about the effects on the children. In an ideal world you could sit down and say 'Well, look, this is the impact

wonder
Are we trying to include
Dad's/men when we
simply can't?
We perpetuate the
narrative that the
woman holds the
decisions with DA...HV
recognise this and
rather come from an
angel of empowerment.
questions

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on the children', you know? You know talk to them how children deal with it, bed wetting, more clingy towards you or any other adults? Have they been fearful of known adults where they weren't before and you know, and have they not wanted to go near the other parent because something's in their head that they heard last night? These are all things you could talk about and get them both to think. And I suppose if it is a very mild, lower level, then it would be possible to have those conversations. You'd have to know that the parents were on board, and that there's no risk to anyone before you have those conversations, but that's a preventative way, isn't it? Where, you know, parents know about these effects in pregnancy before the baby's even born or early on in pregnancy, because it can affect the unborn. But like with the significant DA, and especially when the police are involved, they're way past that stage then. And that's when it needs to be specific and targeted intervention. And then there is the other issue of women that seem to attract these men, the men can spot a woman who may be vulnerable, and they lock onto them. We have to talk to women about those red flags, if somebody's overly eager to start a relationship, or meeting a man online and they don't know anything about him	A interesting thought, but it quickly becomes an invasive in privacy (home private/sanctuary). Are we asking parents to build relationships? responsibility Remember this is DA HV and there is the remit for such conversations? Encouraging parents to view experiences through their eyes.

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worker closed it soon after and the mum ended up having a significant mental health breakdown. She was admitted as an inpatient unit and all the children were dispersed between whole family members. And that's just one case. I've got so many like that. Do you find that when there is domestic abuse, there are other factors as well? Umm, it's not always substance misuse. I would say on the odd occasion, I mean, there's not always diagnosed maternal mental health, but it obviously affects the maternal mental health, which I ask her every visit. And at every contact I ask 'How are you feeling today?' 'Are you OK to manage your day?' and however you asked them you document it. Because I know if I'm pulled up in court I look back at that... And so I wouldn't say other issues go hand in hand, but when you're living with it, it's going impact your mental health. You know you're constantly worried someone may report you, and you might be worried about finances. So it effects every part of your life, it spreads... Do you think poverty and deprivation play a part?	safety Demonstrating that the effects of DA can be more damaging and have the potential to introduce new threat... The systems There is a weight to knowing the history and experiences of a family. It does not negate the

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Definitely. Yeah, definitely. So I think you could get a couple that have never experienced any kind of explosive domestic abuse, but life's hard and there are verbal arguments, and it builds to not arguments but verbal domestic abuse. When there's no money, the house is freezing, there's no food, and you've only got £20 left in the electric meter. That could make the happiest of couples you know, failing under the pressure, and obviously with the cost of living as it is now, the houses that I'm going out to that are freezing, and I just keep my coat on because they're too cold. And then I document that the house is so cold. I will ask them if they're able to pay for heating. The rent has gone up, and obviously the rent comes before anything else. I will ask if they want a food bank referral, and sometimes they say yes, and sometimes they don't. So there is so much stress for these families. You could see how the stress impacts the relationship passed the point of normal arguments. You know we're at the coalface... I try not to watch the news, but I'm interested in politics, but it drives me crazy. I hear about all these millions of pounds that have been wasted on ventures, or on unsafe equipment, or on statues, and you just think 'I'd love,	parents ability to move on by recognizing previous history. (self)protection Demonstrates the fear relating to accountability and registration. HV recognise the overlap... these are not siloed/stand alone issues... they CAN NEVER BE. Knowing

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I'd love to take one of these people in charge out with me on visits, show them what life is really like! I did some filming with the Institute of Health Visiting, me and my colleague, and they asked me 'if the Prime Minister was stood next to you, what would you say..' And I just went on a little rant. And then we took the CQC out; myself and my colleague, and we took them to the worst cases that we could think of because we were thinking, well, if anyone wants to come out with us, we can show them. I don't know, it just feels like they're that far removed. The people in power don't really see the impact of the decisions that they make. Do you think we as health visitors, ever become a bit desensitised to it, because we see it so much sometimes? Or is it still shocking? Do you mean in the home environment? More related to domestic abuse situations? Right. I think the more experience I have, the less understanding I am to these perpetrators. That's how I feel now. I'm just older, I'm 50 this year, as a woman my patience runs out with these men. I have to be professional, but I just think I feel like taking some of these women or girls under my wing and saying, 'you know, there's	There is a clear awareness of distinction between healthy conflict and DA. Truth(s) Even couples who have healthy relationships can succumb to unhealthy ways. It isn't just adaptive behaviours, it is contextual. Or a combination of the two? wonder 'we're at the coalface' Sitting with families in their homes. See me

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better out there you can do...' I don't make a personal comments about their partner, but I make sure they know they have choices. You know, yes, you might have two kids under 5, but you can change your life around. From what you've seen now, if you want to, you can go and get an education. There's childcare funding for you. There's a safe place to live for you. It's not easy, but they've got choices. This doesn't have to be your life. It doesn't have to be your lot. But some people don't have families or friends to support, and there aren't opportunities to get these women and girls things to aim for... I can aim higher, you know. And sometimes the families are the ones that are keeping them in the relationship because for whatever reason, you know, a lot of families are interlinked, aren't they? You know your parents are putting pressure on you to stay, don't upset the apple cart. Stay where you are. The very first case I was talking to you about, the mother was there as well as this mystery man. But I knew from the notes the mother had said to this woman that under no circumstances to divorce the dad, even though he was abusive in every way, but she is not to divorce this man. She'd bring shame on the community and shame on the family.	solidarity blame When you are exposed to the outcome over and over you lose the ability to understand why one can hurt another. Empathy? An intolerance of cruelty?

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And the golden rule is to not make it harder for the victim, or escalate a risk of safety. So I couldn't say anything at this visit. Who's this man? And I know what the mother has said to her daughter, and that pressure. So I literally had to make something up quick. I just blamed it on an admin error. Yes, you do have to really think on your feet. Do you think having those difficult conversations, there's an element of being really honest with parents? Oh, the way I work is to be honest, and so if I know, let's just say the best case scenario. So, the mom and the dad have temporarily split up, and we've got lots of information from social services, which we don't normally get, but the Mom's given consent for the health visitors to be involved and share information. And I go out. The mom knows why I'm coming. I don't discuss it on the phone anyway because I don't know who I'm talking to and, when I get there, the mum's there on her own, and me and her can have a one-to-one open conversation. So the first thing I'll say is, you know, introduce myself and show my badge and I'll say the areas that I work in, and that I work with specifically Safeguarding families and there might be different issues. And I tell her the reason that	Women band together. Solidarity in the unspoken. It isn't as simply as leaving and setting up again. We need support and encouragement to do this. If you don't think you can, you someone who says you can. The power of social pressure. control The power of shame. Shame holds the weight of it not being

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I'm there and I'll probably start off with, 'And how are you feeling?' I want to know who lives there, and the basic lay of the land, you know, what's your family's day like? And do you have any health issues, physical or mental health issues, what's the status of your relationship with them, and what support have you got? And all that kind of opens up the conversation. I would never go straight in and say, 'Oh so where are we at with this domestic abuse?' But I would ask direct questions, like about the kind of abuse, how long has it been going on for, how are the children, any issues with their behaviour. And I would have that honest conversation about the impact on the children if I felt appropriate, you know, what they heard, what they saw. I would talk about different interventions there are to support her, and how other mum's have found them beneficial. Yeah. OK And do you remember there used to be drama companies who would come and display real like scenes, like abuse and stuff. And how conversations can feel for other people. Yes I know what you're talking about... To have something like that again. Because as well there are so many changes, like with 0-19 services, that's coming here. I don't know how I feel about it, I mean what about training, I don't feel	individualized, but how letting everyone else down is worse. honesty

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comfortable having those conversations with teenagers. You know, at a young age in school there are so many things that need to be discussed. But when you think about it, there's so many issues that predominantly affect women, really. And then you hear women saying about, you know, these movements like, you know, 'not in our name' or something but, you know, it can feel that women are some kind of subset in society. You know I feel quite equal, but if you look deeper, subtly, it's still there. Are we actually equal?	Wonder and questions Every new introduction is setting the scene, get the story before the present script is unpicked. Without realizing a birds-eye view into this woman and her child's life. The nuance of merging direct and indirect questions. Some things have to be straight forward and known. fear

	A sense that HV can adapt and are malleable they can evolve with structural change. The fear is powerful. The HV workforce are predominantly female. Oppression is felt by all, regardless of power held and badge worn. The silent solidarity.

HV15 Transcript

So how long have you been qualified for now? So just over 12 months... Yeah, and I was a public health nurse, community public health nurse before. I worked as the public health nurse in a different team, and the placement came up in	

this team I'm in and everyone was like, 'oh, it'll be lovely there' kind of thing. So I didn't know really what to expect kind of thing, but I've noticed a rapid change just in the last 12 months. For example, what we get through allocation. And especially going to the hub model, I think that's impacted as well. Would you say, in regard to your working with families who are experiencing any kind of domestic abuse, whether it's at statutory level, or early help, or even just disclosure, do you find that you see it? Yeah. So it's a topic of conversation, I would say on a daily basis within the office, whereas before it probably wasn't. And it's the cases.... So we've had one today, myself and my colleague, a visit that I've been to. And then I was the coordinator today. So my colleague's been out doing a new to area. She did it a couple of weeks ago. Dad's an orthopaedic surgeon at (local) hospital. Mum's got a job. We went and did a new to area because they've moved across from (out of UK), originally from (outside of UK). They're very isolated. So, home start are involved and they worked really well, built up a lovely relationship, but Mum is disclosing	The normalization in the day to day. Always isolation, either logistic or felt. Help and isolation

in drips with the home start worker that there is historic and current domestic violence. So it's not being disclosed fully.... these are the cases.... and they are we're getting more, they are so grey that CASS (children advice services) won't pick up. So, it's gone through CASS twice; home start have made two separate referrals and the outcome is always for the health visitor to review. And we have this conversation, like I said, probably daily in different formats, but it still boils down to the same thing. What do we do? What can we do? In this example, there is a slight developmental delay, but nothing massive. It's not significant. When we speak to mum and she says "oh, we're doing really well. Thanks for asking." And that's literally as much as it goes. So when I left the office to come here, my colleague, she was on the phone, she called safeguarding, and then you have to wait for a phone call. You have to wait for the phone call back. And she was like, 'what do I do?' And then she said, 'they'll say, like, do an early help.' And again, we don't have massive experience. We go to early help meetings, but quite often we're not the lead professional that does the early help. And it all depends, whether Mum will make those disclosures.	Never an outpouring, but a drip by drip exposure. boundary The grey is the fuzziness. The unknown. The areas were objective accounts merge with subjective experience. planning The relationship of the adults is everything... it impacts everything. responsibility fix or support Do we take a moment to consider, why are we calling safeguarding? What are we wanting to ask them? Perhaps this demonstrates the importance of

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The fact that dad is very regretful. So how do you approach this? How much is Dad remorseful? does he want to change? It's financial control. A little bit of coercive behaviour, and historical physical abuse to mum, never to the child. Well, that's what mum discloses. So yeah, from the referrals is 'health to review'. Where do you move with this? There's another case that I have been to this morning, so this little girl, three years, five months, three years, six months. So, she has been known to the health visitor on and off. It's very cyclical because I've looked back at the notes. And I would say every three to four months we get a CASS referral. We go out. I've been out. My colleagues been out, and I actually had my safeguarding supervision last week, and normally in the safeguarding supervision you discuss one of your child protection cases, but I thought, no, I'm doing alright with them. There is a plan and I know what I'm doing with them. But this one is grey again. Mum and Dad, both on the birth certificate, never married. I think Dad hid a lot of his mental health concerns. His health worries, his addictions. Mum got pregnant. They have a baby. And Mum has put a lot of measures into safeguarding herself	supervision for those newly qualified? Is this just reassurance? Is early help misleading? Help implies it is a defined thing? Is it acknowledging that you can only do, what you can do, and no more? Priority is not the same as statutory threshold. HV recognise the importance of exploring the grey/subjective cases.

and her child. Mum's isolated in a way, the fact that she's not got her parents, she's got some good people around her, but they're not family. There's a non-molestation order in place. That's been there for the last five months and it's about to come to an end. So yeah, there was a notification from the police because he broke the non-molestation order because he has been sending a lot of obstructive and obnoxious text messages. Continual calling, the fact that he's managed to get into the property; he slithered his way up into a bathroom window and into the property. He makes threats to kill. There's been physical abuse. There's been a lot of mental abuse and there is such a long catalogue of history. The police have said if he continues he will get a custodial sentence. There is no unmet health needs with mum or the child. So, I was like, how am I going to get into this? How am I going to say anything any different because she's been through Women's Aid. She's done the intervention programmes. She's got a sig marker on the property. She has changed her contact details, he's not allowed to come to collect from nursery without it being a prearranged situation. Dad has got diagnosis of schizophrenia, I think. He has also got alcohol and drug addiction. So it goes back through the system	Patterns of abuse We gain a sense here of how invested the HV is in this woman/child's experience. There are descriptions of actual events intertwined with thoughts of feeling. Fix or support There is a sense of wanting to fix...? stuck

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if she wants to report it, she has to go through 101, and she said the last time she did that, it was a 2 hour wait. She said she doesn't have the physical and emotional time for that. She basically said "what's the point?" She's keeping a log, but ultimately isn't recording it with the police, and so it's not creating a detailed picture is it? I think the last referral came from a neighbour, you know it's a quiet road and they look out for each other... the curtains were twitching this morning when I pulled up...I think they look out for one another, which is lovely. The thing is the visits we would like to see both parents to complete assessments, you know seeing him, how he is with her. But we don't see him, but you have to consider the consequences of his mental health, his behaviour, etcetera, and it's not being reflected. And the thing she never wanted us contacting nursery, she always wanted that to be kept private. However, he did go and take her from nursery, but because he's on the birth certificate and because they didn't know the full extent of the story, they had to let her go with her Dad. I asked her, "do nursery know now?" and she said "yes". And we talked about why she hadn't told them, and she was embarrassed. She said "'cause. I feel like I've brought a lot of this on myself". We talked about if she	conversation... there is always more to tell, more to hear, more to listen. The inability to be 'safe' without the correct resources. wonder The need for privacy and understanding the service is not statutory. We can never fully surveille.

could move, sell up and go, but she's got such a lovely home, and a business that is connected to the home, and her clientele. So basically she is going through the family courts, but that's not going to be an easy process. You've articulated and captured that situation so well, and all the stuff going on for families. You mentioned needing to have challenging conversations, how do you feel about those conversations? How do you prepare yourself for those conversations? Or can you even? Sometimes that element of go and see how it goes. So example, if I'm going into a new birth, I've kind of got like, I suppose, like I've got a script in my head, everybody does it in a slightly different way... I'm like trying to make notes and I've tried to get prompted notes that I can refer back to. But it's also trying to then make that organic conversation, and I suppose, like this morning, I'd already been to that house. I mean, it was 12 months ago and a lot of could change, but I suppose I was fine in the fact that, for example, I knew there wasn't going to be any recording equipment because that man, that abuser or whoever, isn't in that home. Because you know one of my colleagues is friends with a midwife, and she said one of her colleagues had been caught by an Alexa device.... you can dial	martyrdom This demonstrates again how much HV invest in other people's lives. How we become within it and then struggle to take a viewpoint. priorities How do conversations become organic when they are so weighted down by tick boxes and things that need saying?

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into the Alexa and listen to the conversation. So not knowing the house, I always say “are we the only ones in the house? Are there any devices that are being listened on? Or like the baby monitor or stuff like that. So that impacts. And like, it's harder as well when the child is home. Especially over the age of about two. You know, and if there's a grandma or a friend in the house... I mean I've asked people into clinic before. Not that we are clinical, but there's no softness to it at all is there? You know and getting the baby there and things, it all heightens their anxiety before you've even begun to have that conversation. Which is so hard, and then where do you refer them too? If they've told you something, you want to be able to do something going forward.. That's true. Wanting to help... it can be difficult. Can you tell me how it feels for you, having that information, holding that information? It's terrifying at times. It's frustrating. And it always makes me wonder how people do that safeguarding role. So when you ring like CASS, or you ring like the duty line, or you ring to escalate it, or like the social workers and stuff like that, they are giving this swan analogy. Where	Example of home not being a place that is safe for us to be in. Safety of home HV want to feel they are approachable and accommodating. Fix or support fear

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they're just floating, yet their legs are kicking. But like it blows my mind sometimes. I think, 'Oh my gosh, I'm potentially leaving and I know it's not me 'cause, I'm not the perpetrator. But they've built up a relationship with me to tell me these things'. And maybe what they disclose comes through CASS or something, the police have been called, but I would say there's a lot that falls under threshold. So much domestic violence comes through new to areas. They've moved areas, in with in-laws... for a job. And they're lonely and isolated. And then there's that financial implication, yes, because they've got the big house and the car and stuff like that. But then they've also not got any real disposable income. I had one lady, so she'd got a 2 year old, whose father had been in prison had been released. They'd visited, it was on restricted visiting because of lockdown, and there had been previous domestic violence when she was pregnant. She gave birth whilst he was in prison, he gave her an STI. He was controlling. He went to prison, but she wanted her daughter to have a relationship. She hid it all from her family. So her mom, her aunt, everything like that. Then even from prison, he was able to manipulate the situation, saying he was changed. So when he	accountability A sense of insecurity within the decision making and accountability. Start again syndrome.... But we can never remove the past.

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came out of prison, his release address was back to her flat. During that time when he was in prison, he was in, I think he was released just after her second birthday. So, for two years. She'd got herself, a lovely flat. She'd gone back to work at six months. She'd built up a career for herself. Her little girl was at nursery. They were well dressed. They were well presented. They were cooking healthy meals, you know, they'd got so much going. And he'd manipulated the situation and within weeks of him being back, he was physically abusive and mentally controlling the situation. So she'd said enough's enough. But then he still wanted contact with the little girl, one of the few blessings, as they weren't married and he was in prison, he wasn't on the birth certificate. He would videocall his daughter, and even on those calls he was abusive. She brought like a burner phone effectively to record what he was doing. Then he put out a hit on her.. Basically a payment of a large amount of money for her life. This was escalated to the police. She got a sig marker on the property. He was involved in a lot of nasty things alongside, like the domestic violence was like minimal, it was awful, but that was minimal compared to what the police had got... This one time she'd rung, even though it was a Sig marker on the property, it	Patterns of abuse We hear women's stories and we believe them... how can we relate and sympathise with Dad when we don't engage with him? control The power of manipulation, or love, or desire?

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was 4 hours and 22 minutes for somebody to come. She'd done everything, spoke with Women's Aid, CASS, she'd accessed all kinds of different support. Like we're escalating it and everything, it was like, really intense. And her last only real option was a refuge and she was really reluctant to do that. Because she would have lost everything. She said, "I know they're only materialistic things, but like my sofa, my fridge-freezer. When I'd got nothing I made sacrifices to go back to work, and look at the lovely things we've got now." She said, "Oh I know that seems really pathetic, but actually these things are really valuable to me".

It got to the point the police weren't arresting him yet as they were obviously monitoring him for other things, and the domestic violence and GBH would be additional charges. But it got to the point there were armed weapons and she had to go. She had to leave and go into a refuge. She'd managed to save just enough, and she moved. She moved up... north somewhere. She'd been going up and down. She'd sorted a job out for herself with the company she worked with so she could transfer. I remember it got to one point she was too scared to go do a food shop and I took her a food parcel. I was only visiting in the middle of the day.... And this is all in a nice

Break down

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lot for you on your shoulders. I wonder, do you have any boundaries with families? Or do you give whatever they need? I think sometimes you try the hardest to do that, to put those boundaries in place. But I have a supportive team as well. So, like I said, like we've had conversations today. And I didn't mention I was speaking to you, so its not that this has prompted conversations this morning. We use one another as a sounding board, and rely on one another. One of my colleagues, she had a family on a child protection plan and then mum just decided, you know what, we've got to go. And my colleague spent a good few hours one day last week trying to find out where they'd gone. So they'd gone into a refuge in ...(a different area), and the mum had text and said we might only be here overnight and she was like, why? And she said because there isn't the space for us here. You know and she said to me "I don't know if it's a good thing or not, that they've gone. Cause you know, these children still haven't got a secure and safe place." Our team leader is quite 'black and white', you know with how she sees it. So you know we have to say why we do those	The weight/power given by families to HV... do we want it? Help and isolation HV recognise the power in listening. The sadness that only she was listening... everyone should listen. Inconsistency in the service when practitioners know it is what families want and need.

listening visits. You know it might not just be domestic abuse, there could be low mood. But if she'd had her way, she'd be like, "no, we haven't got time to offer the listening visits", so unless they disclose anything, you're probably in the house for an hour, and that's it. So that causes a lot of conflict in my head 'cause I'm like, with that mum saying, "oh, you're the only one that's listening to me" or "you're the only one that's cared". I'm like, 'Oh my gosh'. But then I feel the pressure then, because I'm like, 'right, I need to fix it!'... I am like that anyway. You know it's interesting you mentioned your team leader being quite black and white. A lot of the writing about this topic seems to change depending on who, and there is a conflict between what the experience is like verses the actual events that happen. Sometimes a focus on disclosures, incidents with police call outs, statutory intervention.... Yet in health visiting education the subjective experience of life is talked about. How do you find your experiences of hearing about people's lives and what they are like, and having the autonomy to make certain decisions, particularly if it goes against what you're 'told' to do? Sometimes yes, I do, but other times I think we're overruled from a lot higher up.	Truth(s) Boundaries come with experience and resilience and self-reliance. priorities Interesting point. That there is stability in the unsafe... One can navigate steps around the storm. Leaving means removing the unsafety, but importantly the stability. Safety is sort in chaos. Listen with humility vulnerability The target driven core contacts do not reflect

Say for example, the justification of doing the six-to-eight-week contact. It's been done in clinic because last year staffing was really poor and we had members of our team that went into the central hub. All of those things. So to be able to keep up with KPI's (key practice indicators) You know we actually value our families, and we know our demographic, and we know how our area works, and we know what worries our mums have, and we know the fact that we need to know about evidence-based research. If there's been a news article in the last few days about something, we need to know a bit about it because they're going to ask they are going to pay privately for this consultation and they are going to get a private midwife. But at the same time there are also very working class families that are in poverty that need to access resources. So, the range is massive. So going back to the six-to-eight-week clinic, it came to the beginning of the year, we were back to being well staffed, and we said, "We'd really, as a service, as a team, like to go back to doing home contacts for the 6 to 8 weeks contact." And our DCM (district clinical manager) was like, "Yep, I support what you're saying, girls". And she was like, I get that. She was like, "...if the KPI's start to slip, then we'll have to reassess". Because you know in clinic it's mix and match, so you don't know these	the lived experience. One cannot discuss everything in one contact. Relationship building is transactional. Perhaps a safety net of over-rule. I cannot delve deeper.

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families. You get a half an hour slot... yes, you've read the notes well. I always do like a proper check. So, I make notes and I've got like 'C-section wound was still weeping or query tongue tie or look for birth mark'... Because I want to deliver a really good contact. But then you're talking 1,000,000 miles an hour. Because you've only got half an hour and sometimes it's the first time they've been out with baby. So, getting them undressed and dressed on the scales is a big thing for them. So, she (DCM) was like, 'Yep, I agree. So, from this day, everybody books a home visit.' She was like as long as you put them in your diary, because I don't want to be nagging you. Yep. Lovely. The thing is we had one of the band 8b's or something in that meeting. They came to see what a team meeting was like or something, and you know, the first thing that came out his mouth was, "what about the KPI's?" and you know not even 24 hours after that meeting, our DCM sends us an e-mail saying that it's come from higher above, from this this band 8 that no, we weren't able to do it in homes. It needed to be in a clinic setting because it was better for the KPI's and the performance indicators... it's really heartbreaking. It really was. Because you know it wasn't just one voice saying it, it was the whole team, even our admin. You know, it's been hard for them as well. You know we would have	We have to state it, because there is a sense we don't? An interesting loss of aim when practitioners become more senior.

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mums ring everyday, and obviously it's changed from duty, to the central hub now, and obviously the phones have gone quiet, but they got to know the families as well. All the points we put across, and they were just like 'No... it will impact the KPI's...' You know the organisation brought in (external consultants) to look at workload and caseload. I had a lady come out with me, she'd no concept of the NHS, let alone how health visiting is done, let alone what it is like for children and families... and she is telling us how to manage our caseloads. You know her saying to some of our AP's (assistant practitioners), you know working for 15, 16, 17 years, paid the top of their band. The service we give to families would be lost without them... and she just could not grasp that. You know the thing with domestic abuse, you see low mood. They (AP's) do the nine month (contact) ones, or they've seen them in clinic. So when they do them, they try and pull them out, or they try and juggle the list so that there's a little bit continuity, and actually they get that really responsive reaction from them. And then we're able to follow it up. You know one of the girls has just left to go to another organisation where they are doing all the universal work... what we learnt at university, you know, like the traditional health	Professional power creates a narrowing of role understanding. The see-saw balance within the profession. The service does not function within a medicalized model. We simply are not that.

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visiting model. The difference between how you're taught. It's going to be a really interesting time. It's different from practice, completely, completely. But then interestingly, I was talking to one of the girls that used to be in our team. She's gone into the central hub. So, for four vacancies within the hub, they had 70 applicants. And I was like, "no way, you've made that number up". And she was like, no, no, seriously. And I was like "really?" And I was like, "so why won't anybody come and work in, like, the localities in the district?" She said, interestingly, she said the first question they asked in the interview was would they be interested in working in district teams? Apparently, a lot of people were quite offended by that question because a lot of people's reason for applying to the central hub is cause of the hybrid way of working. Two or three days working at home. Oh, gosh, yeah, there's a lot of change afoot, isn't there? But it sounds like, you know, it sounds like, you're doing a really good job at trying to remember 'why I'm doing this, what it's about'. Yeah, there are times when you think driving to work and you're	The gap between education/theory and practice. How do we tighten this gap!? Consistency and knowing Another reflection of how we can't just be our profession. We have

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like, “what on Earth am I doing? Why don’t I just go and pack shelves...?”	lives and sometimes as much as we know one thing may be good for another, it needs to work for us. Statement summing up the multi layered role HV do. Not a sense that there isn’t enough money in it, but a sense that jobs could be simpler?

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Women/mothers

SU1 Transcript

What was your HV experience? Did you see the same person or the same team? So, with the situation of being with (child's) dad. With the first appointment I didn't flag up any domestic abuse then, I didn't even realise I was experiencing domestic abuse at that point. When it came to going to some appointments, between 16-29 weeks that's when my relationship crumbled and that's when I disclosed, I had been in a domestic abusive relationship and my life was in danger. The midwife told me she would let other people know. I had 2 main health visitors during my time, both 'Sharon'. The first health visitor, everything was by the book, I was still very much in denial, so as she was asking me lots of questions, because they knew I was in a domestic abuse relationship, before I did. They could see, they were waiting for me to catch up. I actually asked them later, 'why didn't you tell me I was in a domestic abuse relationship?', and they said 'we wasn't allowed to tell you, if anything it's just hints and tips. My relationship broke down a couple of times while I was pregnant with (child). First was when he put me through the lie detector test	Living in the everyday and norm. Until we don't... Acceptance Asking what professionals want to ask. Listen with humility. Empowerment is self-discovery. Empowerment

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and I had a mental breakdown with all the pressure, and then my older kids left home. So the first thing I went to the midwife and then the health visitor stepped in, and she came round 6-7 times or she made me come round the hub between then and me having (child), and then she stayed in my life until (child) was maybe 1. Again, after having (child) the relationship broke down a couple times and I would pick up the phone and I would say 'I'm sorry I've gone back', but there was never anything aggressive, she was very supportive. As was the doctor and family support worker. I had those professionals in my life, if it wasn't for them I would probably still be with him. The health visitor referred me to the freedom programme (domestic abuse intervention), they all knew each other, the doctor would call me and they were a great support. My home became a sanctuary again, I had space when we broke up to pick up the phone. At the end of the relationship which was July 2021, we went on holiday, and he raped me. I knew they would support me, I picked up the phone and called the health visitor, I initially thought I wanted to speak to my first health visitor, but it was a different one. I said down the phone 'I need help', she didn't try and keep me on the phone, she told me to come into the office, she sat with my whilst I called the police and women's aid, and she stayed with me the whole time for 6 hours, she went on to take me to the police station, she took me so I could go and get	Fuel to the fire of DA. Fuel. Fear of perpetrator and professionals. Fear of the P's. Fear Home is safe until it's not. Safety of home. Event being the last straw. Breaking point Not feeling alone.

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Claire's law. Once I was aware of what I was going through they all crowded around me, they surrounded me and kept me going. I could cry, how amazing they were. It's why I want to give back. When I moved I saw a new health visitor and my family support worker is here, but absolutely brilliant. That's so lovely to hear, having those people, having a backbone is fundamental. Did you ever feel with any of the professionals did you ever feel they were coming with an agenda or explicitly saying anything? No. I've seen the paperwork, I've seen the reports, they always knew. They came with friendliness and support. In some ways I wish they had, because it was the knock on effect of my kids leaving home. But I understand why you can't. I understand that if I've reported rape and stayed with him I know social services would have been involved. I think if anything I would wish someone would have said 'you are in a domestic abuse relationship'. I couldn't see the wood for the trees, I was him. My sister used to say to me 'you're in a bad relationship' and my friends, but still you stay, so if a professional did would that change? But once you was involved you were there on my back. But I know I've had my experience which has been positive. But never felt there was any other agenda.	Solidarity Complimentary and contradictory. Be friendly but be professional. Approachability. The self disappears. Who am I?

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and when there were those conversations, what sort of things were asked? did the health visitor ask specific details or events? I think I told them, I didn't wait to be asked. Thats when they said 'well there is the freedom programme' (intervention programme for domestic abuse). Because I wasn't allowed to do anything after I had (child) and after I had the break-up I was still living that life, but then someone said come to the children's centre. I listened, and I started to come out and live my life. I decided I wasn't putting up with this anymore. And the counselling, the health visitor and family support worker did that, and I wouldn't be sat here if I hadn't done the domestic abuse counselling. so when the HV was talking about these things you access, did they get your permission? So you were aware of conversations. Yeah. That was after leaving the relationship. Before I was so in denial and they knew I was. So alot was done then to talk to me 'are you ok?' and I would say 'everything is fine' So when you were in that situation and he was still there, with the conversations with professionals, could you say it as it was? yeah, when there was the big arguments, everything would come out, it got to the point I couldn't cope anymore, and you were there. But then he wormed his way back in my head again, and that's when you would hear 'its ok, he's back', but I would see the paperwork that said,	Pattern of abuse The abuse continues after the relationship ends. It is not just about 'leave him'. Does denial protect us? Deflect attention. Protection Solidarity

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'she's gone back again'. My first health visitor, she knew his previous family support worker, because he had 2 older children, and she knew what sort of person he really was. But she couldn't tell me. so did Sharon, knowing him, were there conversations with him aswell? Or was it one and one with you? he would make sure he was always there. Even we decided the name Harley and he said to the midwife 'No, it's this name...'. But Sharon said that's domestic abuse later. But Sharon would never cancel, she would never be late. But near the end he would know I would call Sharon, that's when he started to pull back, and that's when I could be myself and talk to her and ask her questions. and when you were with him and then not, and then again. Did that impact on your relationship with professionals? no, they stayed the same. Me personal, I felt like a liar. I relied on you guys and I wondered 'would they understand?', but now on the other side I know you do. I felt like the liar, they were consistent. did that consistency, did that help you to open up? Yeah The fact you had these 2 main Sharon's, was that a thing in enabling you to open up? Eg a new face, would that effect you opening up? Yeah. It's hard work to keep talking about the situation you've been through. To keep saying it again, and opening up, and your child is	Consistency Who am I? Consistency is key. Knowing someone and connecting with them. Making new connections is tiring. Story telling

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there. You feel bad getting upset in front of them or maybe baby is crying so you don't get your words out. It's very important it stays consistent. I know people who have had different health visitor and different care packages and I can see the difference between them and me. I feel very lucky about the support I've had. Do you feel like when they were coming and talking to you, did they focus on you and your relationship, or did they focus on your child? I feel it was more aimed at me, or though there was (child) as a newborn baby. There was 2 other children, his children aswell. More spoken about me as a person, about how I was feeling, as the main carer, me, (child) then the 2 kids as they were there. I made sure I spoke about the other kids wellbeing. It was very more focused around me. Obviously, they came and weighed (child), talked about his diet, and checking his milestones, and that stuff and generally looking at him. I breastfed (child), but there were no issues with feeding, but Dad would bring up that. He would say 'is he getting enough', he was negative, and he opened up that. He made those comments whilst they were there. how did your HV respond to his comments? he would say I've got mental health issues, I've got BPD and automatically tell people that. So you automatically go into that train of thought of how you deal with someone going through that. But he	Importance of reliability. With instability and unsafety, we need steadiness. Consistency Parents sense who the care is focused on. Prioritises Families aware HV don't make personal judgements about people? Prioritises

I think I was constantly in the denial, and lying, covering up for him, but that comes with the guilt. Because he said I had depression, I was going through the menopause, anger issues. So I was dealing with all that, and in a way worried and petrified you would take (child) away because I was with a bad man, because I was trying to make him happy, me and (child) happy and make professionals happy. Trying to cover it all up with sprinkles. Knowing now how transparent it was, there is a guilt. There was a worry, what if I pick up the phone and say....but I still did it. Because if that was the case and they were worried about (child) then so be it. I knew I didn't want to be there, but I knew I had to be there. It was just a horrible vicious circle, and it still is to a certain extent. did anyone come to you and say ' If this doesn't happen...' your worst fear realised, (child) would be taken. Did professionals ever say that? No, I did. I did ask if I go back again are you going to take (child) away? She said, no, not take away but we would have to step up, I can't remember the words but work up that ladder. So, you did have that awareness of the potential... Yea, that was towards the end. knowing that information, was that more of a factor to drive you to not go back? Yea,	out but wanted attention. Martyr yourself Constant self-doubt fuelled by guilt. Antidote to shame is compassion. Martyrdom Honesty to professionals. Truth(s)

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haven't heard anything. Then it's a shambles because you arrived and it either should be on the internet or in person, and then every time I go I have the screens put up, and then I go and say 'where are the screens?' and they say 'oh, we'll go and get them'. I'm petrified of that man, to stand and look at him, for what he's done to me, completely obliterated my life, and the screen.....which isn't put in place! In that respect I don't feel they understand domestic abuse. I want to invite them all to the intervention programme.

I also feel with everything....in the news, men say oh here is another one complaining about domestic abuse, another one jumped on the bandwagon. Thats the kind of attitude I'm getting from a lot of men.

When it's mentioned I feel men pull away or roll their eyes.

do you feel in yourself, in whatever you identify in this situation, do you feel as a woman it impacts how people view you?

I would say yes, people who don't necessarily know me....if I'm talking to a woman, it's very accepted, if I'm talking to a man..... with the police, solicitor, courts they are usually men. If it wasn't for him showing who he is, I would have had a real battle showing them who he is. It's only because of what he's done, he's been his own undoing.

It's only because of this, I feel I have their backing. All the time I've spent with them, the police, solicitor, it's just another piece of paper to them. Ummm..which I think is wrong. Decisions are being made

The systems

about (child) and he can see him without them even knowing me, knowing him, or having all the information present. Or listening to the backups, the midwife, she was willing to give a statement, and they've rejected that. The recordings, they've denied that. It just empowers him more. They all know, they say to me who he is. But they have to jump through all the holes of the system.

I think in a sense I'm lucky...there is a lot of support out there for women. I stand up to get more help for men, I know they might not want it. In regards of being a woman in the courts and police, I think we are treated equally, they work on facts. The last court dates have been specifically about him... he's said he has ADHD, bipolar, autism.... he wants the 10 minute break (etc). I've spoken to my doctor about it, but I don't want the label of it, I believe I have PTSD which is where my panic attacks have come from. My doctor has turned around and says that 'it's most likely you do have it in some kind of form with what you've been through', but I've said, 'let's just leave it at that'. I don't want it labelled or put on a record, and you know, I'm looked at differently....I will find my own way and move forward from that. I'm at a stage I want to move on with my life. I

Question	Truth(s)
1. The number of people who are not in the room is 10.	True
2. The number of people who are in the room is 10.	False
3. The number of people who are not in the room is 20.	True
4. The number of people who are in the room is 20.	False
5. The number of people who are not in the room is 30.	True
6. The number of people who are in the room is 30.	False
7. The number of people who are not in the room is 40.	True
8. The number of people who are in the room is 40.	False
9. The number of people who are not in the room is 50.	True
10. The number of people who are in the room is 50.	False
11. The number of people who are not in the room is 60.	True
12. The number of people who are in the room is 60.	False
13. The number of people who are not in the room is 70.	True
14. The number of people who are in the room is 70.	False
15. The number of people who are not in the room is 80.	True
16. The number of people who are in the room is 80.	False
17. The number of people who are not in the room is 90.	True
18. The number of people who are in the room is 90.	False
19. The number of people who are not in the room is 100.	True
20. The number of people who are in the room is 100.	False

Control

can't go out and get job, unless its 16 hours else I lose my court funding. I want to give back and use myself. The court case is dragging, this is family court, CAFCAS has been out and spoke to both of us. The next one CAFCAS and the court will decide when and if... with (child). I don't want to be the person saying 'you are not seeing your son'.....I've just given the facts. It's now whatever the judge says, but after this there is criminal court, I'm still in this trap. It all started with me putting prohibited steps in from taking (child) out of the country, because he is a very clever man, he's been in this situation before and has full custody of his children, he did this to her (his ex-partner). When I put the prohibited steps in from him taking (child) out of the country, the judge said it was ok for him to put similar steps on me to stop me from taking (child) out of the city, so I still feel very controlled, I can't live my life... that sense... you guys, health visitors brilliant, police, court not. Predominately health visitors and family support workers tend to be women, although I do know there is some men here (children's centre), police, judge more likely to be men. and they say police are narsasstic, so you're coming up against the same type of man you're trying to leave. I know of other women, my sister, have been completely opposite to me. She made a complaint about the police and they are completely different.... I could have easily made a complaint about the police at the beginning, I didn't out of	Fear dictates actions (or inaction). Keeps us safe. Fear Is manipulation an after consideration...can you see it in the moment? Say sympathy and mean...? Understanding/ listening?

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fear and I didn't want to be against the ex-partner and police. As I have explained about what happened with my solicitor, I haven't said anything, and I won't be saying anything or making a complaint, because at the moment I don't feel it would help my case. So again, manipulating men and it's not fair, but having to put up and shut up until the court case is done. And hopefully I will get a new solicitor, and then I don't want to label, but I hope it's a woman, and I hope it's a woman judge and a woman barrister. And I hate saying that, cus that's the stuff he would say. But it's my experience you get more...sympathy from women than you do with men. I'm still trying to promote and make sure men are getting this. The men are still very stuck in what men should be, but the women are more accepted, more ready to get help..... but the world has moved forward in different ways and it's not acceptable. But if the men are changing and there is no help out there, then it's not going to change. I have heard of this programme of the police going into schools and talking about healthy relationships and how to talk to women. I'm glad I'm not nasty towards men, it helps I'm a mum to a boy. I don't want to come across and say men are this, men are that. I can sit here and say I don't hate (child's) dad....it takes just as much energy to hate	Women are vulnerable in abuse and seeking help. Accepting because we know we need help? Acceptance Love/hate have nothing to do with abuse. Love/hate

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somebody as it does to love somebody and he doesn't deserve any of that, me and (child) do. Sorry completely off subject. No, it's so lovely to hear that, this peace... I don't think I would have had this outlook, thinking and feeling this way, if it wasn't for the support of everyone, the health visitor, the family support worker's.... I can't thank you enough, I wouldn't be here if I hadn't got you guys to turn to. Yeah I've put the effort in, but if it wasn't for you guys being there, being a crutch, I wouldn't have put the effort in, because I wouldn't be here. A final thing to end on. Say if I sat here as a newly qualified HV and I said to you ' I've got this new family I've just met and somethings just not right' is there anything you could offer, with your experience, to say do it or do this? I would say make sure you turn up to your appointments, make sure you're on time like you say you will be, be welcoming, focus on mum. If dad is there and being awkward, still give him that time, cus she's still guna get it in the neck when you've gone but surround mum. Call her into the office to see if Dad stays home... maybe do some body language, I know I sat there with my hands in all the time, so I didn't make any movements. Look for that eye to eye. There's that up and coming thing where you can draw on your hand to ask for help...	Support enables the power of emotion to change. Or does time just change emotion. This time too shall pass. Time Be consistent and reliable! consistency Help isn't just a word, it's a full body response. Be a friend. Approachability

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But if anything come across as a friend, rather than a professional. It's hard, as much as my first HV was lovely, the difference was second Sharon was a friend, as much as she was still doing her job. It was harder to speak with Sharon (first) than Sharon (second) even though I still spoke and confided, but Sharon (second) could have got anything out of me, because she was a friend in that time of need. You know... there wasn't any of 'oh you shouldn't do that or this' like you would from family.... I had sharon to confide in, regardless of whether I was aware. so finally, we've already talked about where you want you to be, in 5 years. A feeling... you and the family....where are you going? my yellow brick road... it's completely changed. I was a blank slate, wiped clean. I can sit here and thank him for that. I am so much more open-eyed, happy, stronger for that and even though the bumps in the road.... I am so much happier and confident from having that clean slate, so thank you to him. I'm trying to run it, but I've got to walk. It's my relationship with my older son and daughter..... talking about (child), being pregnant and going through the domestic abuse, as much as he shouldn't have gone through it, he was my saviour and I'm so grateful for him and we have a fantastic relationship, and fingers crossed, if he does get access, he doesn't spoil it. (child) is such a happy little soul. He has got little outbursts of how his dad is, but I	Trying to run, but I've got to walk. Time

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try and put a positive spin on it. 5 years time, I'm bigger and better than what I am. With the court, there is nothing more I can say or do.... he's already done what he's done to me....It doesn't make a difference to how I live my life. It's that you can't do this to me anymore, you've committed a couple of crimes.... I've stood up to the man who hurt me. I help people.....people here and then people say 'why do you make friends with broken people?' and I say to them because I was once broken...these are going to make fantastic friends when they get over what they're going through. And for me, great friends are those that understand what I've been through. You can read something off a book, but living it.....	

As services when working with mum's, do you have an opinion about how they should approach mums? With the support you had from your	

health visitors, did they approach you in a positive way, or did they focus on the negatives of your experience of domestic abuse? So with my health visitors, they already knew him (perpetrator), from previous, so it was them waiting for me to be ready. And it was when I was out of the relationship with him, but I found out they were keeping a close eye on me. Cus the health visitors they don't usually stick around long if everything is ok, but she did with me. She made me feel safe that she was there. I was in denial, I was in a bad relationship, I didn't know what was going on...it was hard to focus on the day to day. From his point of view, he wanted them out of our lives, of course. He was very negative about them being around. I liked having them visiting, for me and for(child), to see him being weighed. And stuff. If someone had turned round and said to me you're in danger I wouldn't have believed them. The family support worker out me on the (intervention) program, and that was when we weren't living together and I got it. My view of how he was, it was coming to light. I had that time. He didn't understand what I was doing, when he did find out he was angry, but I'd finished it then. Before then, and I was still in it, I didn't even know me, but they (health visitors) knew that. The health visitors, support workers they all knew each other.	You have to be ready. Time Safety is a feeling and a presence. Feeling safe

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and they were great to accomadate that. But it was nice that they knew me well enough, they wanted to see me with him (baby), and I wanted them to see me with the baby. Because of my ex, and the things he would say to me, I felt so judged because of that, so it was nice to be seen as a parent. There must have been 10-15 times I met my health visitor and they could see me and the way I was. They saw me grow. I'm wondering about how you were spoken to about any concerns. I wanted to get your insight about what your thoughts are on being directly questioned about safety or support? I think in the beginning it was very difficult, he was always there, at every appointment. Wherever he was there. I like what they do in the hospital, and they pull you aside and say you need to do something alone with the woman, I got asked then 'was I safe?' I was still in denial, so I said yeah I was fine, but I had lots of visits with a high-risk pregnancy that I saw them in the hospital lots so they asked again and again. It was like they could see it, even though I denied it, they kept asking when they could. Perhaps I would have got more help, if I'd have then... but it's turned out alright in the end I guess. When it came to the paperwork, it all felt very factual, to the point, but then afterwards it was informal, they seemed interested in me and they wanted to get to know me, and that's what changed. I liked	Judged as mother Truth(s) You have to be ready. What is denial? You tell yourself a different reality? Connection

them to know me as a person, and as a parent. Without everyone I would still be, if you hadn't had hung around for me.... What would you say then to professionals if they don't seem to see the person on their own, their partner is always there? I would say stick around, stick around for that cup of tea, be that friend because it is a lonely, dark world. And keep linking with other services, create an umbrella around that person. Because with me, it was denial, and when he did what he did to me, I knew I could turn to the services and report it. It was the health visitor I reported it with because I knew they were there and they supported me. So when you called the health visitor, did you say 'I'm in an abusive relationship'? No, I just told them about the event, when he raped me, and she said 'we need to report this to the police, this is domestic abuse.' But by then I had decided I wasn't going back, but she was there with me, and there when we contacted Womens Aid. Did you mind her labelling it? Calling it directly domestic abuse? No, I needed to hear that, I needed that label. As soon as she said it, it was hard to swallow, but I would never have called it that myself, I needed her to say it, everything had become the norm. Her saying that, and me doing the (intervention) program, that's when it came	Connection can shine in darkness. Solidarity Truth(s) Denial you lose a sense of reality, and naming DA reshapes the reality. Control DA is about power, but no

together, I saw it. I never thought it was domestic abuse or domestic violence, I just thought I had a bad partner. So he used his mental health as an excuse, and still does today, and I used it as well to professionals 'Oh he needs help...' I was fed that by him so I would just say it as well. He tried to drag me into counselling, put it on me, I needed help. He filled it....you can't see the wood for the trees. And that's why them sticking around and seeing I was doing right by ...(baby), they were just waiting for me to see it. I think if it had continued I'm sure they would have stepped up the game.... I remember saying to the first health visitor 'if I don't leave, are you going to take(baby) away?' and that was the point I was starting to come out of the denial, but then you move into just being scared, still don't know what to do. She didn't say 'yes, he will be taken away', but she said something like it needs sorting, and then I flipped back into denial and I said everything was fine. When he used his mental health as an excuse, did the professionals ever pander to this? The first health visitor, she didn't take any of it... he used it to argue with me, like 'she's not listening to me...' and I would say well they're here for the baby and try and calm him down. Others knew him and what he was like, but I knew the way they looked at me. The courts pandered to him. They're getting better, but it's still so black and	accountability. No empathy. Truth(s) Fear Denial becomes fear. Mental health is subjective then we have to believe? Truth(s)

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white. Maybe they're starting to see it.... it's the police and courts, they don't get it. The health visitors, family support workers seem to get it. I've still got criminal court, but until then.... just live. Do you feel believed? 100% Did you ever feel unbelieved? Ummm... maybe at the beginning, again though by the police. But by the health visitors, 100% believed. People have said since, I'm so pleased you're out of that relationship, they were completely behind me. Is it important to you to feel safe with professionals? Yeah. Yes. And what can health visitors do to make you feel safe? Be held. Taking that time to sit and listen. If you're given that opportunity to talk, well someone has to sit and listen. Simple things, like having a cup of tea.... chatting about what's going on in the area, try and get them out and about. Stick around, that odd phone call 'You alright...?' In the past I've had boxes of food, escaping a relationship you need money for food, so linking you up with that. Simple things that you can't manage.... just stick around for that little bit longer.... making sure she's linked up in the community, the GP, the baby clinic, the dentist, so she knows. Make sure there is a professional at the	Listen with humility To hold and be held. Reliability. Solidarity

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baby clubs, so there is someone there in case a parent needs to talk. If you've been kept inside, alone, you need this stuff.	

SU2 Transcript

So if you take your mind back, to when you started having these experiences in your previous relationship. Was there a health visitor involved at that time? Can you remember? No, not really. You mean in... (in previous locality)? No, no. At what point did you start seeing a health visitor? Was it after your eldest was born, or was it before they were born? It was a midwife first. Okay right, okay. Yeah. So, I was pregnant with my second child, and then I had, you know, a regular check-up.	

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It was just a follow up and she asked me if there is any, you know, any domestic abuse that I'm going through. I said no. I was really afraid to, you know, the change was really scary to me. And then the minute I was leaving, I was just opening the door. I stopped and turned around and I told her I need to tell you something. And that's when I actually, you know, the whole thing started. Right. Can I ask where were you when you told the midwife? Yeah, the doctor's surgery. Yeah. Was it just you and the midwife? And what was it that made you feel you could say something? Because I felt if it's not now, then it's never gonna happen. I don't know. I just. I just got strong at that moment and then I decided, OK, I'm just gonna tell her. Yeah. Ohh I regretted it few times because I was scared of the change, they make you feel, you know the abuser, they make you feel that you can't cope on your own and you should stay with them. You know you feel you can't do it and it gets really, really scary. But then you know. Looking at it now, I feel like this is the best decision I've ever made.	Fear. Strength Fear. Change is something to be feared. The moment when we least expect we find strength in the fear.

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Yeah. So I was, I was happy that, you know, the midwife really helped. She got everyone involved. She talked to the GP and she talked to an IDVA. And then they got involved. The social services and the police, everyone got involved. Yeah, but it started with the midwife, you know. Yeah. Yeah. Okay and how far pregnant were you then? Can you remember? Yes, early, it was early. And what was that like having more professionals involved? Did a health visitor become involved? I met one when I arrived to ... (new locality) and they were checking on my eldest child. She was three then. She just referred me to the children's centre for if I needed any help. She gave me a phone number saying this is the centre number if you needed. You know you needed to talk to someone. That's basically it. Okay. And can we talk about that visit, when the health visitor came. Did she seem to know your history of experiencing domestic abuse? Yeah. Yeah. She came to the refuge where I stayed. I was there for a reason, and she visited all the families there. Yeah, but I think she	Is that it? Help Prioritises Because it's known it becomes less of an issue? The

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was more concerned with the child rather than with myself. I was pregnant there, so had a midwife looking after me mainly. But after I gave birth to my second, I saw another health visitor when I moved into my own home. At the refuge they just talked, you know, asked me questions, if I'm OK and that's it. Are you OK? Do you need to talk about anything? That's it. It was more like a chat, just sitting down with someone and being able to talk about it. Did you want to talk about then? Do you feel it helped you in any way chatting it through? I wanted to move on, to be honest, I didn't want to have to go to the (Intervention programme). I told them "I want to move on. I don't want to keep talking about it". But then I was... you know ... now I think I was wrong. I should have actually gone to the programme and talked about it. I eventually went to the programme, and it helped me. I thought that's that, and that was enough for me.	negative of normalisation. A chat... with closed questions. That's it. Part of the abuse and disempowerment feels like not wanting to engage? All about talk. Help

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Can I ask, did you have any other support, other than professionals at that time? Anyone else that you could talk to? Yeah. My mum. Yeah, we would talk for hours. And then my best friend, she was living about an hour away. I used to live close to her back home, she and I moved to the UK around a similar time And yeah, and we'd spend the whole night talking when she came to stay. Yeah, it really helped me. That's great you have friends and family in your life you can talk to. Can I ask you about when you had your first child, did you have a health visitor then? Yea, after she was born. Yeah, they came. And was that a home visit? Yes Can you remember during that visit, did they mention anything about domestic abuse? Ohh yeah, they asked me, but I said no. It was really difficult to actually talk about it at home. Because everyone would be listening.	Safety of home Home in unsafe.

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I mean, I know she asked my mother-in-law to leave the room because she wanted to speak to me, but I know my mother-in-law can hear me through the door. It was really difficult to tell anyone about it. And then you know, I tried to tell a pharmacist years ago about it, but he was busy doing something else. He was doing a prescription, and he just said to me, “I don't know anything about domestic abuse”. And that was the only time I was strong enough to actually talk about it. So I let go, and things got really, really bad. And until you know, I was strong enough to actually tell the midwife about it... But that was with my second child. Right. So that health visitor who visited after you had your first baby, did the same one come back? I'm not sure. I'm not sure to be honest. That's fine. Can you remember if that health visitor asked you again about domestic abuse? Or if you can't remember who, do you remember being asked again by any health visitor. She might have asked me once or twice. No, it was the same health visitor.	A missed opportune moment can take a lifetime to recapture. Oppurtunities Listen with humility How do we hear people?

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really like her. But I don't think it's about the number of visits, because I think they just come to do their job. And although she's friendly, she's been talking, it still feels like a question-and-answer session. You're not having a cup of coffee with her, you know. You mentioned about the issue with your mother-in-law being at home. Do you think if you'd have been in a clinic, and you were alone with the health visitor. Would that have made a difference to saying something? It's just being in the environment. You know, when you are at home, where the domestic abuse is. Just that environment is scary by itself. You feel like you can't tell because you are in the house where the domestic abuse is, but if you're taken out of that environment, I think it's easier. And was it always home visits from your health visitor? Did they ever see you anywhere else? No, they used to bring the scales to the house, it was around COVID, so I think that's why it wasn't clinic based.	Safety of home The abuse becomes the space.

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Right, and during the visits, was your mother-in-law or a family member always there, and if so were they always asked to leave? Yes, but it's it was, you know, the visits in the living room, and the door was made of glass, even if they closed it, you could still hear what was going on. The living room was right next to the kitchen. I know she would have been listening. It was difficult even just to nod, saying, yeah, you know, help me. It was them all, my mother-in-law started the abuse, then my husband and then his sister. Everyone basically. And when everyone is abusing you, they make you feel that there's something wrong with you rather than with them, because there are three of them, and obviously 3 can't be wrong. Yeah. So it took me a really long time to actually realise, you know, that's enough. I wonder, how did you find your different experiences with the health visitors, the first who asked, but didn't know, and the second who knew your history and you were in a refuge. Did you feel your experiences were different at all because of the knowing? Yes. So the second health visitor, she was really young. She was about my age, maybe younger, not sure, but she sounded like around	Deserving of the abuse Shame Approachability Ask questions from the heart.

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her late 20s, early 30s and she was full of life, you know. And you know, she used to say, “OK, we should have a cup of coffee together”. And she was more like me rather than an elder person. And when she asked, she actually meant her question. She asked in every session, and she'd look me in the eyes and she left the paper. She looked look at me and said “do you want to talk about anything? Is anything going on?” She didn't really read the question from the paper, she actually meant it when she asked the question. So after a couple of sessions where she asked me the same question, you know I thought, “OK, let's talk about it”. And she was really friendly. She acted like a friend rather than a professional that needs to sort the documents and the paperwork. Yeah. So I think that's what helped. And did you ever feel judged at all or like she was making assumptions? She treated me like a friend. Like she wanted to help her friend out. And even after I left, she kept texting me and phoning me and asked me about the new baby. She said when you come to, just call me and, you know, we can have a coffee together. I know she was busy, but yeah, that gesture is, you know, is just enough. What was it like after your second child was born, and you moved again? What were the professionals like?	Time Approachability Contradictory? Do we know what we want? ...or treated as an individual? Truth(s) Why, still (!!) doesn't information get shared? The systems

At the hospital, I felt no one knew about my situation, which was really strange. I thought they should know. Because when I was giving birth the midwife, she told me “Okay you can call your husband now. So, he arrives”. And I had to say, no, I'm on my own. And she looked surprised when I answered that. So I felt really strange. Like you should know.

I don't think anyone knew in the hospital about the domestic abuse,
it was just those who visited me at home, and those who didn't know
I just gave them a quick brief...

Did you want to tell? Did you want to tell people?

I think I wanted them to know. Especially the midwife. You know who was with me during labour. I feel like, OK, you should know I need support. I need someone to hold my hand.

And thinking back, after you moved and were no longer with your ex, did you mind telling professionals about what had happened?

Yeah, it was alright. I didn't mind it.

So after having your second baby were you in the refuge? Or did you have your own place then? No, no. I had my own place back then. Oh, OK. And then so the health visitor who saw you in the refuge, did they come and see you after the baby was born, or was that a new person? No, it was a new person because the refuge was in another area, the health visitor team is different. Yeah, OK. And then, did your new health visitor at this point know about your experiences of domestic abuse? I had to tell each and every person you know, every single person. Did you tell them because they specifically asked? Was it they knew nothing, or wanted to hear more about your experiences? I'm not sure. I'm not sure to be honest, some of them seemed as if	Truth(s) They don't talk to each other, but expect us to talk? That's it

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they actually knew. They asked me if I'm if I was alright and if I needed help. And the others seemed that they had no idea. Right, and when they asked and you told them, did it change anything for you? Not really, no, no. I felt that they just came to check the baby and just leave. Yeah, rather than, you know, stay and talk about it. But they also, you know, all of them. They told me if I needed something, there is a phone number. Yeah, but that's basically it. So did they ever talk to you about how it may have impacted you? Or if it was still impacting you? Not really, no, they didn't discuss it. They were just asking like, are you OK? Are you managing well, that's it. You know, they would just check the baby and leave. Do you want them to ask more about it? At that time, I feel like I wanted to talk for hours about it, but at the same time I felt like just leave me alone. So I had like, mixed feeling about it. Yeah, but, you know, my mum, I was talking about the same	Is that it? Complimentary and contradictory. Prioritises

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thing over and over again with her. So, she was she was a good support, you know.

Do you feel like, as time has passed, you want to talk about it more now?

From the time I left until I was here, I was just settling here. I wanted to talk more about it. I wanted to tell because I couldn't tell anyone about it for years. And so I just wanted to let everything out. I wanted to tell everyone, "look what happened to me", you know, and no one knew about it.

And then after I had, you know, the (intervention) programme, I felt like more at peace, and I didn't need to talk about it anymore. It doesn't matter. It's not really that important anymore. It's doesn't affect me that much anymore.

Did anyone ever talk about the domestic abuse and if you felt it had any impact on your children?

Yeah. Yeah, it was part of the abuse. So, when the social services got involved, it was because the abuse was affecting my child and that was why I decided enough, because they started abusing her as well. It was emotional abuse, not a physical. But they (social worker) told me I was a high risk, and it would have, you know, evolved into a

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I'll give you another week so we can find you a refuge." It felt more of a threat than her supporting me. And she said "I want to get this done before I go on holiday, she wants me to fill the documents and get it sorted. And so I thought, 'OK, I don't care about your documents. I have a child, you know, and I'm pregnant'. But that was that was the reason I left. Really. You know, in no time, just a week. Did your abusers know anything? Did social services ask anything of them? No, they closed the documents. You know they closed my case right after I left. So when I left, when I went to the refuge, the social services phoned me and they said, are you safe? I said yes, they said "OK, we're closing the case then.' That was that. And have you had any contact from social services since that phone call? No, no, no. That was the only time, yeah. Okay, and at any point, have you felt you needed to call them if you didn't feel safe? No, the social services?	Social services can't support, but can only intervene? Approachability

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Yeah. I didn't want to get involved with them, to be honest. I felt they were really cold, and they didn't really care about me like a person. They cared about their paperwork. I thought, no, I'm not gonna talk to them, so if I needed help, I'd talk to the refuge. Anyone at the refuge or I'll talk to my midwife or health visitor. But I won't talk to the social services now. So, once you were at the refuge, where did you get your support? So the midwife, she talked to everyone. The IDVA actually took care of everything, she was the most humane person I've met, yeah, she said 'Don't worry about it'. She got the police and the social services involved and she spoke to the refuge. And she told me 'when you are on the motorway, just call me'. Yeah, she was really supportive. Yeah. So she was just there for a short period. She would make fake appointments, you know, like I don't have an appointment, but it's just to tell my husband that I have an appointment. So I used to go to the hospital and meet the IDVA there. She used to get me a room. One of the delivery rooms, you know. And we just sit there and talk about everything. You know, she was planning everything really good.	Control At crisis you need someone who can methodically plan and organise. To get out you have to trust in the control of another?

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Right, how long did the planning take? Two or three visits. Wow. So quite quickly then. Yeah, really quick. It was really quick. Yeah. And then as soon as you are on the motorway and on the move, you know, and all of this planning, it's happening. Was there any point, any point where you felt unsafe from your abusers? Not really, no, I got really good support. So, when I left, my brother came to get me. I met him with my daughter and some things, and we left. We just left. On the way I was really scared, especially when my husband started phoning me when he realised I wasn't home. He kept phoning. I think he phoned me 30 times or something. Yeah. And so my brother's spoke to the IDVA. She told me to lock my phone and not use it. So from then I just used my brother's phone. We arrived and went straight to the refuge, and they were really, really good. They were very supportive, very knowledgeable. And so every time I was really scared, I just picked up the phone. I	Solidarity empowerment

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had a phone in my own room that's connected to the reception. So I just tell them, like, he's threatening me. He's saying this and that. And they would say don't worry about it. He's doing this and that to threaten you, but you're safe, they would explain. I didn't do any (intervention) programmes back then, so, I didn't know what's going on. But they explained it, and they seemed chilled. So I was a bit relieved that, OK, they're not scared, so I shouldn't be scared. Yeah, they were really helpful and they gave me a book about, you know, domestic abuse and control. They had a nursery there, and they helped my daughter. They just took care of it. Yeah, that's brilliant. I'm. I'm so pleased from all that you went through, you had those good experiences with services. Thinking about now, so in the present, are you still seeing your health visitor? Do you still see anyone? Not really much. Do you feel that you could contact them if you felt unsafe or wanted to talk? Yeah, yeah, yeah.	Approachability How do we make someone feel safe? What is care?

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I feel like I know what I'm doing and what's going on and where to get help. You know, by this stage.

And looking back, do you think it matters who is giving you the support?

Not really, no, I just needed someone to keep me at ease and make me feel safe and supported.

Once it felt like someone cared, I felt so comfortable. And you know when someone actually cares about you, they truly care about you. You know it, you can feel it.

Just to ask, can you remember were all the professionals involved, midwife, health visitor, social worker, IDVA, were they women?

Yes, yes, they were all.

Do you think if any of them had been men, that would have impacted how you had conversations, or how you may feel?

Yeah, I feel like a woman will understand a woman better than a man.

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Yeah, I got a man GP involved. He was the head of the surgery. I used to go to him and he gave more technical support. Like he told me that I need to check for trackers around my car before leaving. But I felt like a woman is more emotionally involved. A man, a man would give logical support rather than, you know, being cuddly, that sort of thing.	Listen with humility
Do you think ethnicity or culture would impacted the way you had conversations, or felt with professionals? Hmm, not sure to go. It's never thought about it this way. I come from an open-minded culture, I think. I think that's why I didn't get along with my husband because they (family) are from a more conservative culture. Although we're from the same country, I'm from the capital where everyone is just open to everything. They're more conservative, so I'm not sure if that would affect the way I perceived men being involved because actually, one of my midwives was a man. And that didn't really affect me at all. And you know, I treated him like everyone else. I didn't really mind having a man involved. So I think, yeah, I don't think my culture really has impacted it. It's interesting to hear your thoughts on that, So thank you for that. I really appreciate that.	Time

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through is actually an abuse, so just having that knowledge would make them think about it.

And you know, when I did the (intervention) programme, there were many Pakistani people and they seem to have the same culture where they're living with in laws, and it's just the norm what they're going through. Although it is an abuse, I think they wouldn't know this is an abuse. It's just what everyone's going through.

Is that how you knew? Did you read something, or did you just know it wasn't right?

I felt something's wrong because I've never seen it in my family. I've never seen it in my friend's families. I've never seen it anywhere.

That's why I'm telling you, you know the capital where I'm coming from is different. But for him and his family, it was normal. And that's when I felt something is wrong. I tried to search it, you know, search it online and I found on the government website about emotional abuse. And that's when I actually started, you know, reading about it and realising that it was an abuse.

And it was just a matter of, you know, a couple of months before I actually talked about it.

When you say, it was normal for him and his family, do you mean how they treated you as the wife?

Yeah. Sometimes his friends would talk, I would hear, they would mention, like their mother was interfering with their life.

Commenting on the number of children the wife should have. So it seemed the norm.

Thinking about your future, and your children's future, is there anything more you want?

I just want to raise them without them having any psychological issues. You know, I just want them to be normal, you know, just to have a beautiful childhood and I want to give them all the love and support that I can give. I want them to play and enjoy what they're doing. I want them to think about me and know 'OK, Mummy loves me. You know, I love being with her.'

...that's basically all I want.

And what do you want for yourself? Is there anything you want for yourself?

It's just being successful at raising the children. And I'm having some time for myself and I'm reading books, I'm painting. I'm going out.

Yeah. So, yeah, I think I'm doing good. Thank you. Thank you so much for telling your story.	

I'm interested to hear about the way you were talked to from professionals after you had disclosed the domestic abuse you were experiencing. I am wondering if you have a particular feeling if you were spoken to in a positive way, focusing on your strengths, on you, or did conversations take a negative perspective that centred around how the abuse may be affecting you and your children? So, umm, initially my midwife and the GP, they were both involved. And then later the hospital was involved. Umm, they were all really focusing on me and the conversations were really positive with them, and they were very encouraging, and they kept telling me that I'm doing the right thing. The negative impact on me and to the children was mentioned if I stayed, but they knew I was really really scared. I was terrified and of the idea of leaving, although I wanted to. I was scared of, you know, I was scared of the unknown... what awaits me and the children.	Empowerment Fear Fear of the unknown.

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They identified that and they encouraged me, and even, my GP, she told me about the story of someone who'd been in my shoes and that she's really happy now that she left. The social services, they weren't that positive, though. They were very intimidating... Like if you don't leave, we're gonna expose you to umm your ex-husband. So they focused on the, you know finishing the documents and the paperwork and you know get things done instead of, actually asking how I feel about it, and about me needing time or more encouragement. So they really hurried me like... "you need to leave, if you don't leave this time, we're going, we're going to the house"... Basically. So you mentioned that you were really scared and fearful during that period of the unknown. OK, well, I was terrified. Yeah, which is completely understandable. Do you think that, like the antidote to fear is being empowered or, people being very positive? Did that help to minimise your fear? Yes, it's when everyone tells you you're doing the right thing and go	Control Time As bad as things may be, you still need time. empowerment

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But at the same time, they cared about me as a person, but they still recognised the impact of everything going on with my children because I'll be the one, you know, raising the children, and being with them. So I think it's kind of interlinked.	Care about mum.
So one of the things that I'm quite interested in hearing your thoughts about, is about being believed. I wondering if you ever felt there was an impression of minimising, or somehow acceptance of domestic abuse because of culture? Did it ever feel there was a sense that in some cultures this just happened to women?	
I was told even without giving much details that nothing justifies domestic abuse. Nothing at all. They were very empowering. So, the health professionals, they were emotionally involved in my story, they were crying and even my GP on the last day before I actually left, my GP, she came in and she just gave me a really warm cuddle, and she left straight away, and then the next day my midwife, she told me “Do you know why she left the room straight away?” and I said “no”, and she said it’s because she couldn’t say goodbye, that I meant so much. They were emotionally involved in the whole situation and just it's very humane of them that they actually, they didn't question me, they	Solidarity

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 didn't say "Ohh well, many people go through this, it's not that big of a deal". They actually told me nothing justifies it. And it's really, it was really empowering, and it made me not question any decision I'd taken about leaving, you know, because I'm an equal human, not just a wife of a husband. They're amazing and when I left, I sent them a big bouquet of flowers and a thank you letter because I wouldn't be here without them. Honestly, I feel like they saved me. They saved my children's life... They worked as a team, you know. I even called the surgery, I can't remember why, and the reception knew me and said we all talk about you. You think you will leave and that will be it, they will forget you, but they didn't forget, it makes me happy that they actually care about me as a person and I'm not just a story, not just a name, you know, on a paper. Yeah. 	 Empowerment Opportunities See me To be seen and not be forgotten.

Have you had a named health visitor or particular health professional involved since your youngest was born? Not particularly one person, just whoever my appointment was with at the time. And has that ever been the same person? No, always different. Was that a health visitor? So, from the beginning when they first came out when he was first born, and then again for his 9–12-month review. So, was the last time you saw a health visitor, at your 9–12-month review? It was.... until I moved here, and they assigned a health visitor to me as I was new to the area.	This woman is in refuge but no named HV. Missed 6- 8 week review.

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So up until you being here, were there ever any conversations about domestic abuse? There was at the 9–12-month check, when I went into the centre and I disclosed that I wasn't happy with my home situation, but I was still a little bit secretive, and careful about who I told and what I said. But I disclosed enough to her that she felt I needed more support, and she gave me lots of leaflets. She was very caring in the sense that she did sympathise with my situation, I didn't disclose everything, but I did say I was a little down and depressed, and that I wasn't getting on with my partner. I didn't disclose domestic abuse because I wasn't ready... maybe she picked up on that, and all she could do was give me some leaflets about domestic abuse... safety numbers. It was quite a little bundle, and I thought 'this is great, but now I have to hide these...' So, they went from my baby bag into my top drawer next to my bed, but I was so scared he would see them and know I had spoken to someone and say what's been going on. But nothing was ever followed up after that... So just that conversation...? Yeah, just that conversation.	Opportunities Missed opportunities to build trust. What is the antidote to secrecy... honesty/openness? Truth(s) Is support signposting in this way? Is this even signposting? Example of putting woman at more risk. That's it Missed opportunities. Why?? Can we expect some to help if we don't explicitly say? But

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So, between then and now (you being here), has there been any health professional supporting that transition? No, no one. And that's why I felt let down in a way... I had given clues that I needed help, not in a direct way... you know, 'I need some help....' and you should pick up on that, as a professional.... I don't know if, if my situation had have been worse and I'd have been being beaten up daily they <i>should</i> have picked up on that. When you had that conversation during the 9–12-month review, was that a conversation that you entered into because you were asked a question? Or was it something you mentioned without being prompted? I think if I remember back, I think she asked me a question.... How are you feeling? How's home life? And I think she could probably tell from my face, that I couldn't answer it, and I think she said, 'just have a moment... you can say anything to us....' And then she said 'I tell you what, you can have these leaflets, and you can talk to these people... that's the right thing to do...'	surely that's the point of curiosity. Opportunities On cliff edge of support and opportunity to talk... but then fell off. 'I want to hear, but actually I don't. Tell these people...' Questions Is a cry for help non-verbal. The stories we tell ourselves.

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Taking yourself back to that moment, did you want to be probed more? I guess so. In a way it was a small cry for help. I didn't know.... I didn't know the support out there, I felt like 'I'm a strong woman, I need to deal with this, I've got a small baby, I should be happy...' and just get on with daily life.... Have you always felt like that? Yeah, that's just how I am... I want to be strong... resilient. Do you think that goes back to your example of parenting? Your childhood? I had a great childhood, but my mum's not good at opening up to her feelings... I've only seen her cry once.... so, I guess I'm like her. I could tell you about my past, what's happened, black and white, but I couldn't tell you how that made me feel... because then it opens up a can a worms. I feel it's a weakness, like I shouldn't get upset. I feel strong if I don't get upset. I felt more that way when I	Opportunities So experiencing DA makes you weak and vulnerable? Who am I? Histories Do women learn from their mum's? Experience is different from feeling. Martyrdom control

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was with him.... because he would ridicule me if I cried, so I held it back, and now I hardly ever cry, unless it's really poked out of me. Would you say though that saved you at times....? Yeah, I guess it did, yeah. I mean going back from having a tiny baby, I would have benefitted from a lot more support... I breastfed him exclusively as I did with my other son's, and I believe because of the stress I had at home and the mental torture I had, I couldn't produce the milk I needed for my baby. All I got from him was 'you don't have the milk, you can't feed him, just give him a bottle...' I wasn't good enough to breastfeed him, I couldn't produce the milk.... I ended up with mastitis to the point I would latch him on and my toes would curl and I would think, I'm still gonna do it, I can do it... stubbornness, I was gunna breastfeed him, and every week I would take him to the health visitor, to the clinic to get him weighed and every week I could see he wasn't gaining (weight) and I could see his graph going (down), and they said 'you're gunna have to top him up with formula or expressed...' So I spent all night expressing, feeding, expressing, so I got probably only 2 hours of sleep a night from the time he was a tiny baby to him being a few months old, even expressing I was only expressing a few ounces of milk... but I was so tired, so	Breakdown Staying in a DA relationship is the most resilient thing you can do? Opportunities Sense of failure was a moment to scaffold the woman. Break down

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stressed out, so overwhelmed, I was losing weight, I wasn't eating, wasn't drinking... so I gave him formula. I remember the first time I did, I was devastated because he seemed to enjoy the milk... he drank it like it was this amazing milk... and all my partner would say is 'look at this, isn't this amazing, let's just give him bottle's from now on...' and I felt a failure, and it beat me up even more. But then I thought, why not do both... and I'm still breastfeeding him now. I didn't give up. I let my baby lead me for what he wants. Sometimes he wanted the bottle, and sometimes he wanted to latch on to me... and I'm still breastfeeding him now....	
That's your strength....	
My stubbornness, yeah!	
So, it sounds like he was still quite little then?	
Yeah, about 2 months old, I was having weekly check ins.	
Did the health visitor ever ask, are you getting support at home?	
How's home?	
No, there were never any questions about that, or my mental	
health, or what was going on at home, it was simply a case of 'he's	
	Surely it should be recognized that sense of failure will impact MH. Would anyone with a sense of failure have that if they have support at home?

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Right, and his development review, was that in a clinic setting? Or were you in a private room? Yeah, that was in a quiet room, in a health centre and I was called in... And do you feel that made a difference? Yeah.... definitely. Because I feel conscious others can hear me, and with other mum's.... it's natural that we judge... the way they are picking up their baby, what they're saying... you can hear. I can hear other women talking. So why would I disclose when other women can hear. To the outside world I'm a happy new mum. I cry in secrecy. Can I ask, did anyone else in your support circle know? Were they aware? No not really, I have one best friend. But we drifted. She had a baby who's 9 months older, and obviously busy. We drifted, and my partner didn't like her, and perpetrators do that... we did text now and again, but it was my partner at the time... he was the one causing me the stress....	Complimentary and contradictory. Women empathise and understand BUT also judge. Shame

And can I ask, how long did you feel the stress? How long had it been going on? I'd been with him for 3 years; I suppose it was a gradual increase. Him having bad tempers, throwing stuff, and when I got pregnant, it was quite a stressful pregnancy. I was working at a call centre, but I'd work from home, it's safer (with COVID) if I work from home, which was great, but on his days off I'd sometimes work, he was always around. He would do little things, like he would clean my car.... which was great, but if it was dirty, he would come in and have a go at me whilst I was working on a call, to the point he would make me cry, whilst I was at work with a headset on, so I would have to pause a call. He used to really upset me, to the point I would long for the days he was at work.... It was throughout the pregnancy... Did the midwives ever ask how things were with you and your partner? No, I guess they asked the normal questions, you know the tick-box exercise, but I didn't tell them the truth, you know 'Yeah, I'm happy...' Can you remember with the midwife or health visitor, were the words domestic abuse used? I think they were, yeah...	Two faces of perpetrators. Break down Pattern of abuse

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And what are your thoughts on those words reflecting your experience? Ummm... before my experience, I believed domestic abuse was just physical, because I'd never experienced it before, but being in my situation, it crept up on me throughout my pregnancy and with him as a tiny baby, it started slowly and built up. I think once I put in the research with so many sleepless nights on my phone of 'what's domestic abuse' and 'what's a narcissist' and he fitted the box of that description, I started studying more... the signs, I educated myself, what I should do and who to contact, how to get out.... and I planned to leave 6 months before I did. Having a new baby, I was tired, I started to move important stuff out, like my passport, documents, stuff if I to just leave I had important things. Was that just you making those plans? Yeah, just me. I put money in a savings account and did it on my own, just being stubborn and strong. You know I could do this on my own. All I ever wanted was that family unit, I didn't have a baby for us to then split up. I wanted it to work, I never wanted to be a single mum. I was with my ex for 20 years and we split up because he continually cheated on me, so when I met my perpetrator he	Planning planning Always thinking of the next move.... control Love bombing.

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swept me off my feet, gave me everything materialistically, promised me the world, and we planned to have a baby together, and it was lovely at the start....Then I felt trapped, I got pregnant and thought 'this is my life and I have to just get on with it...' that was my life and I signed up for it. I thought everyone would judge me for getting with this person and getting pregnant with him, and now, I'm leaving him. I stayed until I couldn't take anymore. Do people in your life know you've left him and the reasons? Yeah, a few people know the reasons why. Only a few people know details because I've not disclosed... I don't want to be the talk of the town; I don't want to be gossiped about. And when I go and visit my friends, I don't want people asking, I don't want to get upset, I don't want to let my feelings out... I want to be the happy person; I don't want to be weak and be that 'domestic abuse survivor...' Is there anyone with whom you can let it out? Yeah, I have my case worker here and she is amazing.... she's lovely, and I'm opening up. Guess I do need that person I can open up to, and disclose the intimate details to... things that happened. But on the flip side I like to squash it down and forget, and if everyone comes to me with their problems, I feel better and I	The shame we feel to be responsible for a 'unit' Shame See me Self-hatred and punishment. protection We can't push down the feelings. connection connection

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with them all in my own bed, I breastfed them and it was easier, and its natural.... me personally, I have common sense.	
Do you think health visitors do that a lot.... reeling out guidance? Yeah, especially the young ones... just ‘this is how its is’. They do have some experience, they’ve seen loads of babies and children, but do they know what it is really like? Is it that human experience? Yeah, yes.	Approachability Be a friend.
When you're talking to professionals, do you want them to be more informal? Yeah, I appreciate that, just being more friendly.... I prefer that. We’re not in the 1960’s anymore, we can be friendly. Do you think going back to that clinic room for his 9–12-month review.... rather than the health visitor giving you those leaflets, if instead they had started a conversation would you have gone along with a conversation? Yeah, I guess so. I had no one else to disclose to, to have someone outside, asking me friendly questions, yeah, I would have opened up to them, I would have... which may have shown her some red flags about what I was going through at home... rather than just	Opportunities Every moment is an opportunity. We only want to speak if we feel we will be heard with humility. Truth(s)

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asking the tick-box questions... to me it didn't mean anything. If they'd have dug deeper and asked more questions, I would have opened up more. Do you have a relationship with the health visitor now you're here? No, I met one lady because I am new to the area. A really nice, older lady, and she was pleased how (child) was, it was a half an hour chat... she knew why I was here... Did she ask you about anything? She didn't have to really, she knew why I was here, but nothing personal. Did you want her to ask you anything? No not really, just to check on (child). Had it had been before I got here, I would have, but I am here and safe. Your decision and thinking to come here, was there ever a consideration of other professionals finding out and questioning the safety of ...(child)? I hadn't really thought about it... but in the run up I did think maybe social services might want to check, check in on me and him..... I did wonder if they would give me a call and ask questions. It wasn't a worry, more of a passing thought and a wonder. I knew I hadn't done anything wrong, and I feel like if they did, I would	Just because someone knows do we stop asking questions. When is the time to stop talking? Women function on objectively keeping their child safe. See me Safe Nothing to hide, nothing to show. But what if hiding keeps you safe? Breaking poing

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have been happy to talk to them and them to see the children.... You know if you've got nothing to hide, you've got nothing to show. I know I'm a good mum. When my older child came to live with us, my perpetrator took it out on me. He didn't like my other son, that was always a stress... and he (older child) mentioned a few things at school, and the school got involved, but I was happy for them to get involved, because at that point I knew, we needed help. If he (older child) is starting to say things at school, he needs help, that's enough. That was my point I knew, I needed help.... it was affecting him. If it was just me, I would have put up with it for a lot longer, but it wasn't me. When he came to live with us, it just escalated. So he (older child) would come in from the garden and start playing with the baby's toys... you know, a completely normal thing for him to do, but my perpetrator would get so angry and snatch the toys away, so he (older child) would just go upstairs and take himself away, and then he (perpetrator) would throw the toy upstairs and shout at him 'you can keep the *** toy' and he would lose his temper to the point it would make me angry. I would shout 'what's going on...', it was completely normal for him to play with the toys, and he (perpetrator) would just take the mickey out of me and it would make me so defensive... he's my son.... It was because of	Prioritises Women get out for the sake of the child, not for their own sake. Advocacy and agency. Help

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him (older child) I got myself out of there. I didn't want him (child) to get more involved, I thought this can't escalate, I can't put up with this, I can't let it affect him, him living in this environment. He didn't like my son, he (my son) knew this. So, when he (perpetrator) was in the house I barely saw my son.... So, when he (older child) says things at school, did a health visitor get in contact with you and say that information had been shared? No the safeguarding SENCO from school called me in and we spoke, and I started telling her stuff, and she put me in touch with this charity, who I rung, but I only got abit of support from because I felt I couldn't keep ringing them because I didn't know what for... you know I can't keep ringing and saying 'I don't know what for...' I would rather talk to someone face-to-face. The teacher at school checked in on me and talked to me. She invited me to this mother and baby morning, and we would chat there.... Would you say, moving to the here and now, do you have a sense of safety? Yeah, I do. Yeah, it's improved since being here. Initially when I arrived, I felt very safe, but I didn't like being here... I went from having a whole house to just a room.... I didn't know anybody, I didn't like it, some other women who weren't my cup-of-tea... I	When help is asked for, is talk enough? Safety of home Swap one prison for another.

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Do you think the children feel safe here? Yes. My older one, yes, and the baby, he's happy as long as he's got me. I'm with him all the time. I'm more relaxed now... I don't have to worry. My perpetrator was really picky if there was a mark on a wall, or it was messy... he would really upset me, I was the blame for everything.... but now I'm not walking on eggshells. I used to snap at (older child) if he spilt something I would snap at him because it would cause a problem, I would get stressed.... it would be so overwhelming. It was a lot. I haven't lost my temper since I've been here. I was never angry. But I learnt to fight back and shout at him, I would get so angry. He would always swear at me, and the night I left, he was calm, and he started recording me and I lost it.... He couldn't see what he'd done to me. He was turning around on me! It was the abuse, the way he treated me, my body literally was 'fight or flight....' I got to a point, and I walked into a shop, and something triggered me, like a smell, or someone would say something that he would usually say... I would get heart palpitations... I had panic attacks. I started to recognise it was the abuse....	Reaching breaking point. Breaking point The abuse becomes an alarm. Time Listen with humility Time. Listen with humility. Truth(s)

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Can you remember your reaction to being asked that? I said everything is fine.... I guess I wanted it to be and thought it would be after I gave birth... he would change, he would be different. I thought he would be more caring towards me because I have a little baby. If I ever shouted back at him, he would say to me 'I'm gunna lose my **** if you ever shout at me with the baby in your arms...' But I didn't, I would never shout at him, never. Maybe raise my voice, but I wouldn't shout, and he would accuse me of shouting..... Is there anything else you would like to say about your experience with the health visitor? I guess when the midwife and health visitor come out first, when the baby is tiny, usually the Dad is gunna be there, he's off work. They shouldn't ask questions then, not at those times, be mindful if they think there is domestic abuse, don't question when he is there. If you think there might be, ask mum to come for a health check or something.... something the Dad doesn't need to be there. Do it earlier. I love being a mum, they're my little world.	Children are the priority.

SU4 Transcript

Can you tell me how your health visitor became involved during your experience of domestic abuse?

I remember seeing them when my baby was first born, maybe once or twice, and then I didn't see them for a while. Something

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| <p>told me they always came out when there was a small baby at home, and it was to make sure I was OK. So, she came round a few days later. He was out that day, he worked most days so it was good she came round when he wasn't there. She asked about what had happened, and I told her. I figured she knew and I couldn't handle lying anymore. She asked me if it had happened before, him pushing and shouting at me. I just told her, I told her he always had, we argued a lot, we always had. But I told her, I used to get in his face as well, but I didn't anymore, not since I was near having the baby because he would always push back, and I got scared he would push me and I would fall. So I had stopped arguing back because he always took it to the next level. So I told her and she was really kind actually.</p> <p>Had you spoken to the health visitor before about arguments and how things were between you and your partner at the time?</p> <p>Ummm, no. When I was first pregnant the nurse at the hospital and at the midwife clinic asked me because she saw on my notes that I had had domestic abuse before, when my older kids were little, and we chatted about stuff then, but not since. I remember this nurse asking if he was helping with the baby, and if we had arguments and stuff, but I just said everything was fine, so that was that. She</p> | <p>Example of openness by HV.</p> <p>Truth(s)</p> <p>Is honesty always context dependent, or does personality play a part?</p> <p>Break down</p> <p>Self-defence.</p> <p>Truth(s)</p> |
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| <p><b>oldest had had a social worker around years ago with my ex, so I knew. She told me she would get someone to come to the house to chat or whatever.</b></p> <p>Did you like speaking with the social services?</p> <p><b>No, they just tell you stuff and leave. They act as if you don't get it, and they treat you like a child. It's better to just hear them and wait for them to clear off.</b></p> <p>And did you chat about what was going to happen with the health visitor, like a plan or anything?</p> <p><b>You mean with her and stuff?</b></p> <p>Yeah, anything really that would happen.</p> <p><b>Yeah, we talked about calling the police and I should do it if I was scared. She said I'd done the right thing. She talked about the kids hearing it, which I knew. That bit I got abit pissy with, because I didn't want to be told about that... but I get she had to talk about them, that's why she was there.</b> She said she would talk to the person who had visited me, and come and see me again, maybe with the person.</p> <p>Did she ask you about you and your partner at the time? What was happening there?</p> <p><b>I mean I knew I wanted him to go. It was my house. She asked me if I was happy with him, it felt stupid to be asked at the time because</b></p> | <p>Fear at home and fear from professionals.</p> <p>Fear</p> <p>The systems</p> <p>Speak and leave (in actual and supportive sense).</p> <p>Planning</p> <p>Priorities</p> <p>Shame</p> <p>Re-affirm actions positively. Should we reaffirm if we don't agree. Mum's protecting and prioritizing children.</p> |
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| <p><b>I remember thinking, ‘you joking?!’ but she was the only one who had asked me if I was happy. She talked about other people I could talk to about feeling safe and stuff.</b></p> <p>Do you mean support services?</p> <p><b>Yeah, people who worked with people having domestic abuse. I knew about them, and I would always call the police if I was scared.</b></p> <p>You mentioned domestic abuse, I’m wondering about those words....</p> <p>Did the health visitor use the words domestic abuse with you, can you remember?</p> <p><b>Ummm.... I’m not sure. Like I’ve used those words, and I’ve used them since my previous time working with social services, so I use them, and I think the social worker said them again to me. The nurse when I was at the midwife said it, because she read in on my notes.... I don’t think she (health visitor) did though. She talked about being safe. When I saw her again she called it domestic abuse because that’s what everyone was calling it, and I wanted him out, and that helped using the words then.</b></p> <p>OK, so when you were talking about it, that first time with the health visitor after the police had come out, were you happy with how she was talking about your relationship at the time?</p> <p><b>Yeah, I mean I didn’t need her, or anyone else to name it. I mean using the name domestic abuse helped when I was speaking to</b></p> | <p>To be told otherwise is shameful.</p> <p>See me</p> <p>Do professionals miss the obvious and simple questions. Are they the most fundamental.</p> <p>If we know, why do we wait for breaking point?</p> <p>Truth(s)</p> <p>Using ‘safe’ ‘happy’ gives it feeling.</p> <p>Domestic abuse gives it experience.</p> |
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| <p>people who could get him out and help me, but just talking about how I was with it, I didn't need her to say it. She seemed to talk about safety more, like with the kids and them feeling safe, and with me, if I felt safe with him. I dunno, I'd never really thought if I felt safe, but I get it now. I've done the Freedom Program (intervention) and I know now, I understand, feeling safe with someone is so important, even if you don't like them, if you feel safe it's so important. When you don't feel safe, you can't let your guard down, you can't say what you feel or want. It's like you're holding your breath.... It's knacker. She talked about that, about feeling safe, and what happened in the moment I called the police, and when I didn't feel safe. It was those moments I knew it was coming, I could feel it around him, like an air. I knew he was going to blow and start, it was me feeling the unsafety of it all.</p> <p>I wonder staying with safety, did you feel safe talking to the health visitor?</p> <p>Yeah I guess I did. I felt safe because I already knew, I knew I needed out, so it wasn't like a new thing I was saying and I was scared. But I could say it straight because I wasn't scared of talking to her. Yeah, so I guess I did feel safe.</p> <p>Was there anything she did or said to make you feel safe?</p> | <p>Safe</p> <p>Break down</p> <p>See me</p> |
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| <p>Ummmm... well I guess she just listened and didn't give me funny looks, like she was judging. She just listened and then told me I'd done the right thing in calling the police. She talked about the kids and stuff as well, and she didn't make me feel like a shit mum. It happens with people sometimes, they make you feel like a crap mum who doesn't want good things for them. But she talked about normal things and how like the mornings before school were hard, and she would find them hard as well with her own kids, like normal things, they don't wanna get dressed and stuff. She was just normal with me.</p> <p>And do you feel that was important for her to just be normal? And talk about herself and how she had kids and stuff?</p> <p>Yeah, I liked that. The midwife did it too, talked about kids and normal things with them, like being tired, and it being non-stop. They were normal people, mum's aswell. I didn't feel like they were just staring at me and thinking I was wrong or whatever. Like, you could laugh, and just say how you felt with them. I used to have one social worker who was like that as well, but I think she was new and maybe didn't know how to be, but the other social workers, they come round and just ask you questions, talk at you and like talk like to you like you're at school again.</p> <p>Do you think you can ever be too normal as a professional person?</p> | <p>empowerment</p> <p>Approachability</p> <p>Solidarity</p> |
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| <p>Ummmm. I mean I wouldn't want a person I need to help and do things to act like they don't know anything. Do you know what I mean.... Like they have just come round for a chat and then won't bother. But I think if you want someone to say stuff and I suppose like you, you have to be normal. And just be friendly and have a laugh abit. <b>If I don't like someone, I'm not going to tell them, why should I, if all they do is judge me?!</b></p>                                                             | Approachability |
| <p>Ok. And when I mention the word 'trust' and working with professionals, what do you think?</p>                                                                                                                                                                                                                                                                                                                                                                                                                        | Honesty         |
| <p><b>You mean what does it mean?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Consistency     |
| <p>Yeah, what does it mean to you?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 |
| <p><b>Well it means I think they know what they're doing and they are going to help me. Be straight with me and don't bullsh*t you, like say if you're going to do something, and oh my god, if you say you're going to come see me, come! My old social worker just wouldn't turn up and then would all of sudden, like when I don't want them there. So whenever they would say 'I'll be over at 11 on Thursday' I didn't believe them. So do what you say. And just be nice, like what we were talking about.</b></p> | Consistency     |
| <p>Yeah, OK. And did you trust your health visitor?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |
| <p><b>I mean yeah.... It's weird cus I didn't really know her, but I just felt like I did, and she said she would come back and she did, and she</b></p>                                                                                                                                                                                                                                                                                                                                                                 |                 |

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| <p>said she would call, and she did. I asked her to fill that grant form in as well for me, and she did. I mean maybe she did things that she didn't say to me... I don't know, I don't know what she thought of me, cus we all think things about people, but I couldn't tell. She was friendly and chatty. So yeah, I trusted her.</p> <p>It's hard when you've seen people over the years, like different services and stuff. You would think it makes you trust them more, but I think it's made me trust people less. You just get let down, or things get said and then they don't happen. When it's one time you can forget it, but when its over and over, you just can't be bothered anymore. I don't want people bullshitting me, just be straight you know.</p> <p>Do you think, after seeing and talking to the health visitor, you would talk to her again if something was worrying you, or you needed help?</p> <p>Yeah. I mean I know that it may not be her again, I know enough about working with services that you never seem to see the same person... that's rubbish, I mean why they can't do it that you see the same families. I swear if they did that so many more people would open up, I mean about anything, anything they are struggling with. I've got friends and know people who deal with so much crap, or struggle, and you say why don't you reach out, speak to someone, and they just say 'what's the point'.... And I get that, so many times</p> | <p>Honesty</p> <p>The systems</p> <p>Martyrdom</p> <p>Consistency</p> |
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| <p>would have made me think about it in a different way.... I don't</p> <p>know. It's so difficult to think if I would do something else. In a way</p> <p>I think it would have to be really bad to tell someone at the first</p> <p>time you see them, and you've just had a baby. I duuno how many</p> <p>people say it then, but I can't imagine it's many, but yeah, to ask</p> <p>abit more to get people to think about it. And I suppose the more</p> <p>you ask normally, the more you aren't scared of the answer, or</p> <p>what they will say if you say 'yeah, domestic abuse is happening to</p> <p>me...' you know?</p> <p>You know, I know so many people who live with this shit, and it's</p> <p>not just women, I know men who put up with pushy and mouthy</p> <p>girlfriends, but the real crap does seem to be done by the men. The</p> <p>women seem to have it worse, but what I mean, my sister, she's</p> <p>had it, my friend's.... My dad wasn't really around and when he was</p> <p>he was vile... it's everywhere, and everyone knows it is there, but</p> <p>it's just one of those things you know. It's life. But if someone says</p> <p>'this isn't right, and you don't have to put up with it', you think</p> <p>'yeah, I don't' why do we put up with it? Because it's normal, but</p> <p>it's not normal. You know. No one has got money, it's hard at the</p> <p>moment, but you don't have to accept the shit at home from your</p> <p>partner. Nah. I didn't really think about everything after my eldest's</p> <p>Dad, but after this time, I really listened to the Freedom program</p> | <p>Questions</p> <p>Acceptance</p> <p>Empowerment</p> |
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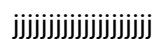
(intervention), and I thought, 'Nah, I don't need to live with that'...

maybe it was just the program, or maybe it was people on my side,

but I do, I'm there. It's me and my kids first now.

SU5 Transcript

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| <p>Thank you so much for speaking to me. Can I ask first, about what you remember about seeing the health visitor?</p> <p><b>So I remember seeing the same person twice, I think, after my baby was born. Yeah, and then I used to go to the baby clinics to get them weighed, and then I saw someone when the baby was about 1 I think. I did the questions about how she was doing, and they saw us for an appointment. And yeah, that was about that.</b></p> | <p>Universal contacts.</p> |
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| <p>OK. And can I ask in any other those times with the health visitors, did they ask you about what was going on at home, about your relationships?</p> <p><b>Um. So they knew who I lived with... my husband, my sister-in-law and her kids, and my parents-in-law. They asked me about who lived in the house. They asked abit about the family helping with the baby, you know nappies, feeding, when I needed to sleep, could I ask someone to help and stuff. Yeah that sort of thing.</b></p> <p>Right ok. Did they ever ask you about anything to do with domestic abuse, feeling scared, feeling, or being hurt by the people at home?</p> <p><b>No. Everyone was always at home you see in those visits. My husband was there, and I always knew the others could hear and stuff. So I guess, it was busy, so they didn't ask me. I think maybe the first visit the health visitor may have asked me if my husband was supportive and helping when he went to get a nappy, and I said 'Oh yeah...' because I wasn't going to say anything in those few seconds alone, was I? I was on edge all the time, and the last thing I needed was anything to make it worse for me, like them hearing someone asking me something, and then I would get it. It would be harder then, so I didn't want her to say anything, not when everyone was home. I was pleased she didn't ask more actually.</b></p> | <p>I wonder how we ask... if we ask 'what' going on?' people will give details, but we want feelings?</p> <p>Histories</p> <p>Sometimes not knowing, not asking is decerning awareness.</p> <p>Right now, I can't know, and I can't tell.</p> <p>Time</p> <p>Fear</p> |
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| <p>Yes, I understand. You mentioned about feeling on edge at home. Do you think there was any way you gave off a feeling or sense of that?</p> <p><b>Do you mean, how I was?</b></p> <p>Yeah, I'm just wondering if feeling that way, changed how you were talking to people?</p> <p><b>Right, yeah. I think I definitely changed, I mean if you would have seen me then after speaking to me now you would see it. But I suppose she had never met me before. I think I was just quiet, I used to feel uncomfortable being asked anything about myself. I found the whole thing with midwives so difficult because they would talk about my body and how I was feeling, and I didn't want to think about it. I used to just move over the questions. I liked talking about the baby, that was lovely, but the minute I used to get asked about me, I would change the subject or move it on. So, I don't know if I gave off a sense of being on edge... but yeah maybe I did, because I wouldn't want to talk.</b></p> <p>Did you ever worry you were giving off a sense of feeling uncomfortable about talking?</p> <p><b>Ummm.... Yeah, I'm not a big talker, but I was always worrying that people didn't like me, or that I was doing something wrong, but then that would make me feel more uncomfortable and I suppose shut down more. It was a horrible cycle.</b></p> | <p>Who am I?</p> <p>We lose every sense of who we are.</p> <p>Who am I?</p> |
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| <p><b>lot about babies, and feeding and things, so I listened to her, and followed her instructions. So that was good. She seemed very friendly and I wasn't worried about asking her a question if that's what you mean.</b></p> <p>Was that important at the time, that she seemed friendly?</p> <p><b>I suppose. But I knew she was there for the baby, so it was fine. I didn't think there was anything that could change with my situation, so it would have been fine either way. But I suppose it is a lot easier to talk about anything with someone who listens to you. I suppose in those visits I felt a respect from her, I was a mum, and she respected me as a mum, because she listened and smiled and nodded when I told her things, like feeding my baby, dealing with the colic. She didn't act like I was doing anything wrong. So yeah, that was nice.</b></p> <p>And can I ask, those times at clinic, did you see that same health visitor.</p> <p><b>No. I think I saw her a few times in the room, but there were loads of people.</b></p> <p>Right. And were you ever asked in those clinics how things were at home? Or anything to do with domestic abuse?</p> <p><b>No. It was just why you here... baby need weighing? Any problems with feeding baby? All about the baby. Though that was what I was</b></p> | <p>to see the inside from outside? Is that where HV can help?</p> <p>Listen with humility.</p> <p>Be friendly is to really listen and get to know somebody.</p> <p>Prioritises</p> <p>We set our own expectations. The boundaries of conversation.</p> |
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| <p>the bit about sometimes feeling low, not really about me. Just about the baby.</p> <p>What would that have felt like to be asked just about you?</p> <p>Oh, ummm... maybe I would have been uncomfortable. But, you know, I went to university back home, I like to read and things. And you know, even I forget that sometimes, I see it now, and I remind myself, and I'm going to get a job when she is at school. I want to use my qualifications and work hard. But then, I suppose it would have reminded me I was more than the life I was living. That would have been good. Even to be asked about work, or what I liked to do, I'd forgotten it all, so even if I couldn't answer it maybe would have got me thinking. I don't think it's just about being asked and saying things though. It's little things like looking at one another, how we are now, that matters, and smiling at someone. You feel like you are someone. I always used to look down, if I was out, at home, anywhere. I don't now, if I'm talking I look at someone, because I want them to feel like I am seeing them. You know. So being asked would have been nice, but I am very happy to be a mum and talk about my baby, I do feel the health visitor looked at me and saw me. And that was enough then. Maybe that helped to make me stronger, I don't know, but she did see me, and I felt seen in those visits.</p> | <p>Who am I?</p> <p>Loosing yourself to then re-find yourself.</p> <p>See me</p> <p>If you can't talk, just being seen (in every way) is fundamental.</p> |
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she popped over once a month and anyone could come and see her who was at the refuge. Just a quick chat, weigh the children, ask questions, anything. That was so lovely to know, like another place of safety. She couldn't offer me anything at that moment, but just knowing she was there incase.

And how did that feel knowing someone was there if you needed anything?

Great. The worst stuff was out there. The hardest bit felt like it had been done, and I felt like I could say anything now, I wasn't scared to say things anymore. It's like support that is just there to catch you IF you fall. Noone intends to fall or wants to fall, but to know there is someone just incase, its reassuring. This whole place feels like that, a net to catch you.

Catch me if I fall. The net isn't always in use.

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| <p>Right, well I have had 2 different health visitors, one with my eldest, and the current one I see. I didn't really like the first one, maybe just different personalities, but she was a lot older as well, and she always seemed very uppity with me. My current one I get on well with, she's younger with a couple of young kids of her own, so she seems to get things abit more. Both the dad's I've had issues with, so I see my health visitors quite abit.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>Connection</p> <p>Families feel the connection. It needs to be more than just the professional title.</p>                                                                               |
| <p>Would you mind telling me about what was happening with your children's dads, regarding why you saw the health visitors quite abit...?</p> <p>Yeah, so my eldest, he lives with me but is under the care of my mum. We all live together, me, eldest, my baby, my mum, her partner and my younger sister. So 4 years ago I met this bloke, I was really in a bad place. I wasn't on any medication for my Bipolar, and was drinking a lot and self-harming. His Dad was part of big group of mates I hung around with, anyway, I got with him and afew months later I was pregnant. I moved in with him. He was vile, bad boy thing, he was always in fights and loved to control everything. I was abit late booking with the midwife, but they were really nice, they got me a social worker. When he was born they made the decision to place him (eldest child) with my mum. I think the health visitor was at those meetings when I was still pregnant, but I can't really remember, anyway he went to my mums but I stayed were I was. The health</p> | <p>Vulnerability</p> <p>Understanding an individuals history helps to position their current situation.</p> <p>Vulnerability can be built on like a wall of bricks, adding and adding.</p> |



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| <p>you remember the first health visitor, you mentioned that there were meetings before your eldest was born and you think they were there.</p> <p><b>Yeah, I'm sure they was. It was only a few weeks before I had him and there was the meeting and they said about the baby going to my mum's. I was adamant I was staying with him (ex), but they weren't going to let the baby come to that place. It was a craphole to be fair, where I was then. Lots of people, parties and stuff. It wasn't a place to have a baby. They said for ages if I didn't leave they needed somewhere else for the baby, well my mum volunteered. She done it with sister's kids, they lived there, and I was there abit, so it made sense. Anyway, it was decided. The health visitor definitely saw me then just before the baby came at home. We chatted and stuff.</b></p> <p>Can you remember what you chatted about?</p> <p><b>Ummm.... I think she was mostly asking about everything that was going on, you know, like with my partner at the time. As I say, I don't lie. I've had people, social workers and things in my life since I was at school. I know what is going to go down well, and what isn't good. Anyway I knew she knew, of course she would have known everything, but she asked me to tell her.</b></p> <p>OK. And can you remember how you felt telling her about what was going on? Were there any bits you purposefully didn't say about?</p> | <p>Prioritises</p> <p>Stuck</p> <p>Blame</p> <p>This mum has MH issues and yet we separate her and baby. Should this be the last resort... separation?</p> <p>Honesty</p> <p>Vulnerability</p> <p>Even when we know, we should still ask. Ask and listen with humility.</p> |
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| <p><b>Nah. I told her everything. My head was all over the place, and I was beginning to see that my bipolar was affecting everything. I think I had spoken to someone by then and I had a plan to start my meds once the baby was born. She asked me about when I met him (ex), what we was like and stuff. I don't really know how I felt, I don't remember. It was just another person to tell.</b></p>                                                                                                                                                                                              | <p>Truth(s)</p> <p>A point reached when you don't feel.</p>                                                                      |
| <p>Was there anything's about your ex at the time she specifically asked you about?? Or did she just let you talk?</p> <p><b>She mostly listened and filled out some paperwork I think. She talked about me and the baby mostly, she actually didn't really talk about him much. She talked about the baby being with my mum and how I felt about that, what I wanted to do, stuff like that I think. I just chatted. She felt abit like a teacher, and abit like I was explaining myself. I didn't care though by that point, I knew what I wanted to do, so it just felt like another person.</b></p> | <p>See me</p> <p>Even when parenting is removed, it is important to still have a say, and feel you haven't lost all control.</p> |
| <p>And what about the second health visitor, can you remember meeting them?</p> <p><b>Yeah. My old health visitor told me she was leaving and that someone else who worked in her office would be coming, so yeah I met her at my mum's and I think I was about 6 months (pregnant). We just chatted really then, I got things abit more together, and I still had the social worker and family support worker. We just chatted about what</b></p>                                                                                                                                                      | <p>Connection</p> <p>Ground work of connection and getting to know someone. Details can come later.</p>                          |

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| <p>my baby's Dad, he just doesn't like me doing stuff. He's never hit me, he can be abit pushy, but it's mostly him wanting to know everything. Sometimes I just lie just to get to him because he pisses me off so much. (He's) in every part of my business. The stuff the family support worker and she talked about made me see that. About <b>feeling like a prisoner all the time, it can be worse than getting punched in the face. At least when you get punched they feel bad for abit and they're lovely. When they are just a control freak it never ends, there is no let up.</b> It's like 'get out my face' all the time. All the time. I remember the health visitor saying to me how the way he is must affect my bipolar and mental health, cus he always says to me that he helps, he helps keep me on the line with it... you know if he is asking about my meds, or where I'm going it helps him to help me, but she was so right, it was mind games. He makes me feel like a kid sometimes, like I can't do anything on my own.</p> <p>Do you think her talking to you about more day-to-day things help you to open up and talk to her?</p> <p>I mean, maybe, yeah. As I say she would ask me stuff and maybe I didn't realise. What I like is that she doesn't write down stuff, you know. I swear I could so easily forget she's a health visitor.</p> <p>Can I ask does she use the words domestic abuse with you?</p> | <p>Pattern of abuse</p> <p>Prison is a sense.</p> <p>Love/hate</p> <p>No apology with control, no let-up.</p> <p>Fuel</p> <p>Abusers need a sense of importance and need.</p> <p>See me</p> <p>A professional, who isn't.</p> <p>Contradictory.</p> |
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| <p>Yeah, yeah. I probably do more though. I dunno, maybe because of everything I have no issue labelling it, and I know what it is. I know it's not just hitting or physical, it's all the mind games as well. It's just part of the conversation I suppose. I see it and it doesn't shock me, I don't mind saying it to other people, yeah, you know 'I had domestic abuse done to me...' I think it's men to be fair, they have a side, and if you push, or if that switch is flicked inside them then that's it.</p> <p>So would you mind telling me when you first heard the words domestic abuse, and how you understood it to be? Like what was it to begin with, and do you think about it differently now?</p> <p>Yeah, so I know about it because my Dad was a control freak with my mum. They argued a lot, but she gave back. So when I was at school social workers used the words domestic abuse. I knew them though maybe cus I'd watched something in Eastenders, so people use the words and you know it's bad relationships and hitting and stuff. I know it sounds messed up but I think with my ex when I was young I wanted someone like that... you know I wanted someone who would tell me, do stuff for me. I didn't want to be at home, so being with someone that wanted me there all the time was easier. And you know for a lot of the time it was nice... I went shopping, was partying, all that so it was fine. But it's the mind games, them making you feel like you're going mad, that's the crazy stuff, that's the hard stuff. Like why</p> | <p>Acceptance</p> <p>Her acceptance and normalization of this thing happened.... Is that always a good thing? Does it become flippant in its severity?</p> <p>Love/hate</p> <p>Safety of home</p> <p>Why do we seek being controlled?</p> <p>Who am I? We think it makes up safe? Is safety freedom? Is freedom safe?</p> |
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| <p>would you make someone feel so stupid. They're kicking you, but not really kicking you if you get me. It's part of it, but it's so harder to tell when it starts, and why. You know, a punch is a punch. But with the mental stuff you feel like you're just going crazy. So maybe it's changed for me in that way.</p> <p>Do you think having the professionals has helped you to see that?</p> <p>Maybe, but I think I've lived it. I know what it feels like. I guess where they've helped is they talk about it when you're in it, maybe talk in a different way. So like the (intervention) program talked about them being 'king of the castle' and what they would do and say to make sure that was the way. It was like 'yeah, he does that!' The problem with a lot of the people though, they just make you feel like you've done something wrong. I don't want to feel like a kid, like I'm getting told off. That's when I get pissy with them, they make me feel like I'm in school and there is no respect. Like don't ask me if you're not going to listen, or not believe me anyway!</p> <p>Thinking about respect, what does it mean to you?</p> <p>Like, what I think it is and stuff?</p> <p>Yeah, I'd really like to hear what you think.</p> <p>OK, well it's letting someone speak isn't it, or not just hearing half the story and then you add in the rest. I've had that so much... if you want to know then listen!</p> | <p>Are relationships ever equal?</p> <p>Belonging in the inequality?</p> <p>Stuck</p> <p>Becoming unstuck</p> <p>is treating</p> <p>experience with respect.</p> <p>See me</p> <p>Listen with humility.</p> <p>You can tell when there is no humility.</p> <p>Truth(s)</p> |
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| <p>Do you think being believed is part of it?</p> <p>Ummm... yeah and no. I mean, yeah because if you are hearing me just believe what I'm saying happened to me. If you aren't guna believe me then don't bother asking! But also I get that people say stuff, over hype something, or miss something out. Bullshitters, I know plenty, so that happens.</p> <p>What about when you're asking someone about their relationship, is believing them important?</p> <p>Oh yeah. Again, it's like if you are guna ask then believe that person. You know you can still think 'yeah, but I bet you're a shit...' but you can still believe what they've said. Especially if you want to help someone. That's the thing about the (intervention) program, they say it and talk and there is no question whether or not something happened, actually they don't even ask. It's just like you're here because it happened and we don't need to ask again or check. You know, sometimes with domestic abuse you don't want to go over and over. It is what it is, end of. You know all the women there, it was different for us all, but it's the same. It hurt, it didn't feel good, it made you feel sh*t, and that was what it was really. You know I've had so many f**ked up things happen to me, but to me they've just happened, it's like, whatever, next. But that's the thing when you feel that and then someone else goes 'whaaaa... what happened, what did</p> | <p>Awareness that narratives are not always reality.</p> <p>See me</p> <p>Do professionals have to believe everything said?</p> <p>Discernment is through judgement.</p> <p>Judgement based on personality, experience, context.</p> <p>Acceptance</p> <p>Blame</p> <p>"... it made you feel shit..." the one</p> |
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| <p><b>you do...' and stuff it makes you feel bad. One person's whatever is another person's horrendous, you know?</b></p> <p>Yeah, do you think you can name a relationship good or bad?</p> <p><b>Maybe, sometimes. Like you can be a good partner and not hurt them, but I dunno, what is alright for me, isn't for someone else. But then again, that's what I learnt from the health visitor, that I didn't see it at the time, and it was only when she chatted about it I got it.</b></p> <p>Do you think you can have good and bad relationships with professionals?</p> <p><b>Yeah. Like for me, if you do something and I don't like it and you are a professional that's it for me. Don't come into my house and treat me badly and then think it will be fine, it won't.</b></p> <p>So it is different from the relationships you picked?</p> <p><b>Completely. I didn't want or ask for all these people in my life, knowing and telling me. I get some of them have helped, and they're alright, but I didn't ask for it. Whereas my relationships are mine, you know. I don't have friends because I don't want people in my business, I have my family and my kids.</b></p> <p>Would you be able to label your relationships with the health visitors as good or bad?</p> <p><b>They were good. Different, but good I think.</b></p> <p>What made them good?</p> | <p>feeling mother's don't want.</p> <p>The spectrum and changing boundary of good and bad.</p> <p>Respect</p> <p>Respect.</p> <p>Privacy is precious and not something to be given away.</p> <p>Approachability</p> |
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| <p><b>Listening and talking. Talking about my babies, about my life. Not just about the past and crap that had happened. Being nice people. I liked them.</b></p> <p>Did you want them to like you?</p> <p><b>I didn't care... they can't hurt me, so whatever you know. Just give me the respect that's all.</b></p> <p>Do you see or speak to your health visitor much? Can you tell me about that.</p> <p><b>Well I see her probably every month or something, usually she will message me the day before and check and then pop over. Sometimes she meets me at the (children's) centre, sometimes she will see my mum, it depends. She mostly comes to home though.</b></p> <p>Do you contact her or speak inbetween?</p> <p><b>Nah. Sometimes like if I have a question about the baby, like food or something then I will message her.</b></p> <p>Just wondering, if you had a question and she didn't message, do you have a office number to call? Or is there a drop in clinic?</p> <p><b>I think there is an office number in the red book, but I don't really want to speak to anyone else. You know, there is a lot on and stuff, and *** (current health visitor) knows me and the boys, and everything, so she gets it, and there won't be loads of add on questions. That's what I don't want seeing different people and having</b></p> | <p>Respect is not the same as being liked.</p> <p>Consistency</p> |
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| <p>stuff. And yeah, I guess it's the same the other way round. You can't see someone every month for a few years and not get to know them, right? That's people isn't it. It isn't a computer that doesn't mention the small stuff to you.</p> <p>When you say the small stuff, what do you mean?</p> <p>I mean like the bits in-between, you know, 'Oh I took the kids to this soft play at the weekend, you been...' or 'you watch whatever programme last night...' You know, that stuff. That's how you get to know people. You see their lives, and it helps you to build something with them....</p> <p>Do you think it helps to build trust?</p> <p>Yeah it does. <b>Someone lets you in and shows you a part of them then you give back abit. If I was working with someone, and believe I have with some professionals and they give you nothing, no piece of them, but then they expect you to open up then yeah, that ain't gunna happen is it, not really. It's a two way thing. You trust me, and I trust you.</b></p> <p>Is there an element of honesty between you and your health visitor?</p> <p>Like if she says something that you don't agree with, will you say, and vice versa?</p> <p>Yeah definitely. I'm the sort of person that will say anyway, if I don't like something, but we do say. I know its bad but I've told her to naff</p> | <p>Simple things are important.</p> <p>simplicity</p> <p>connection</p> <p>Being seen as an individual.</p> <p>Everyone has to give something to get more.</p> <p>The power in opening up has to be equal. Meet me in the open.</p> |
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SU7 Transcript





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| <p>Can we start by you telling me about your experience with the health visitor service.</p> <p><b>Yes, so I haven't had much contact with the health visitors over the years, just routine I suppose. So I have seen a health visitor after each of my three children has been born, and then been along to some weighing clinics. I had my third baby during the pandemic, so everything was different then anyway.</b></p> <p>Could you tell me how your experiences were different with your third baby during the pandemic, compared to the health visiting service prior to the pandemic?</p> <p><b>So I think when it all happened (COVID shut downs) I was about 30 weeks pregnant. It was a really crazy time wasn't it? But particularly being pregnant, everyone was worried. Luckily for me my antenatal appointments with the midwives continued at the surgery, but everything else changed. Like a scan I had to attend, only I could go, and the health visitor just sent me a letter before the baby came. I'm sure before then I had a visit both times before. Anyway, my baby's dad couldn't be there for the birth, but it was fine, and then I didn't see a health visitor after they were born. I remember a phone call that lasted probably 20 minutes, just a lot of questions, and then seeing the health visitor at a clinic when the baby was 6 weeks old. It was very clinical, I mean... masks, aprons,</b></p> | <p>Social distancing made us lonelier.</p> <p>'That's it?'</p> <p>Do we (professionals) look back and wonder how this happened?</p> <p>Such uncertainty in the world the did the collective matter on day to day? Or was the message it did</p> |
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| <p>space, and things. You couldn't imagine it now. I think if it had been my first baby I would have really struggled, thinking that was it, but I suppose for me, it was my third baby so I didn't have time to be hanging a lot for visits anyway.</p> <p>You mentioned then, 'you couldn't imagine it now..' could you tell me more about why you think that?</p> <p>Yeah so, I know it was only 3 years ago, but I don't think we would ever do that again. We know the trauma and the issues it all caused, shutting down I mean. I don't think we could ever ask people to do it again. I suppose we all did it then because no one knew anything, and there was so much fear, so no one questioned it. But it was hard. Particularly when trying to see a health person.</p> <p>What was the worst part of that experience for you?</p> <p>I mean for me, it was the isolation. So for me it meant having to be home, and the children be home, and my ex be at home. All the time. There was no escape, and no one coming. For me, seeing midwives and health visitors was always a protective thing, like he wouldn't kick off, or do anything whilst people were visiting. It was like time-off. So because he knew no one was coming, he didn't have to manage his behaviour. He could trash things, tell you what to do, and be generally vile and it didn't matter because no one was coming. And you know before you could say, "Oh, I'm popping to</p> | <p>and therefore we had to isolate? What about the collective of bringing up children?</p> <p>When we need to embrace non-verbal communication and see another's world, how can this be achieved with distancing?</p> <p>Fear</p> <p>Unsafety + unknowing = fear.</p> <p>Help and Isolation</p> <p>Safety of home</p> |
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| <p>at the beginning of us dating, he would remark on what I was wearing, like ‘can’t you keep your boobs for me, you look trashy when your top is so low...’ even though it was never low! Or later on, just say little things like ‘I thought you were on a diet...’ or ‘isn’t the healthy eating working?’ Things like that, and over and over you just doubt yourself. So having someone be nice, it was like a counter balance abit. But then you were isolated, so there was no balance. And you even got a sense in maternity, everyone was just worried about their own safety. So yeah, people were helping without me even asking.</p> <p>So can I ask, you asking for help was that you realizing it all? Or was it you reaching your limit, but you always knew what it was?</p> <p>So yeah, I always knew really. He was controlling, as I say I knew he used to make fun out of me, and do things to make it harder. I knew him breaking things wasn’t normal, it wasn’t good, but I don’t know, you just learn how to contain and manage it so well. I swear I could manage a hostage situation... you know, I know what to say, when to say it, when to keep quiet and stuff. I’m an expert. But I was OK at managing it. For me, I asked for help but he kicked off at my daughter one day, like started shouting at her, and broke her dolls house thing up in front of her. That was it for me. I couldn’t manage that. So I called a helpline. From that moment it changed,</p> | <p>Play the game to control the monster.</p> <p>Help and isolation</p> <p>Stuck</p> <p>When the victim is in manage-mode they need to focus. When they are in help-mode they need support.</p> <p>Containment. Can the two modes</p> |
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| <p>talked about to them, you know. If someone says something isn't right, you feel you're more able to get out.</p> <p>Thank you for that insight. Do you think any way of re-wording it, or the health visitor asking a different question would have helped?</p> <p><b>I don't know really. I do think something that is wrong needs to be named, you know like a thing you do or happens that crosses a line.</b></p> <p><b>I suppose if you didn't use the words domestic abuse it could so easily become random arguments, or just bad behaviour.... But that isn't always completely wrong? There is a difference between two people arguing, you know even shouting, or being emotional, it happens doesn't it, but that doesn't make it domestic abuse. You know I think perhaps the domestic abuse is all the stuff around the actual argument. So the minute you call behaviour controlling, or bringing on fear, that's when it is domestic abuse?</b> Oh, I don't know actually. It's just the whole thing isn't it. The whole package is domestic abuse. That's the other thing talking to people here, there is never just one hit, or one bad, bad argument, its months, years of horribleness. Of managing the outbursts and the fear. So I don't know, the only way is to say are you experiencing domestic abuse, but then you could ask 'do you know what that is...' or maybe ask if you have to manage the other person's emotion or behaviour, that's the thing isn't it.</p> | <p>Acceptance</p> <p>Patterns of abuse</p> <p>There needs to be a binary of it being something, or not being something. A line crossed.</p> <p>Conflict is needed in relationships. Conflict is not DA.</p> <p>But we all use our behaviour to control?</p> <p>Is DA just a one-time event? It only exists over time? Why do</p> |
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| <p>Would you mind if we talked about fear and managing safety a moment?</p> <p><b>No that's fine.</b></p> <p>I just wanted to hear more about the fear and management works.</p> <p>Like, was there a moment, or a flick of a switch perhaps in which you felt you needed to start managing his behaviour, or really think about how you were reacting?</p> <p><b>I don't think there is a moment, well not for me. The fear came in the hours after an outburst, after him breaking something. The problem is when someone can break things and shout and obviously make you scared, you wonder where their on/off is. Like, why would you want to scare someone by going crazy? So the fear is in you wondering what next. And that's the thing you can't keep thinking 'what next, what next', because it's so tiring, so it is better to try and stop it reaching there. Particularly with kids, you can't be thinking, 'what if he strangles me in front of the kids', I even thought about what if he kills me... you know would he hide me, so the kids didn't see, would he do it at night, what would he tell the kids... all those things. You can't keep that up. I know some of the women here managed to keep that up for years and years, I couldn't do it. So you manage it to stop the fear I suppose, not the</b></p> | <p>statutory services</p> <p>focus on events</p> <p>then??!</p> <p>Fear</p> <p><u>OK</u> Within</p> <p>parent/child</p> <p>relationship.</p> <p>Knower/unknown.</p> <p>Scare/fear inducing =</p> <p>safety =</p> <p>control/power.</p> |
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| <p>don't do an exact thing all the time, but maybe take some washing, or have the kids for abit, or go for a walk. I suppose it's no different. So just sitting there and talking about something I expect you to, helps. It's a reminder that good people are still out there, and if you need that action, they will be there.</p> <p>So for you, what is help, particularly thinking about your experiences and coming into refuge?</p> <p><b>Help was time and trust I think. The minute you make the decision, whether its over afew seconds, or afew days or months, you need to trust whoever is helping you can get you to safety. Help is that bridge from scared to safe. But you put trust into that helping person. They also need to give you time.</b> It can take time to organise and sort stuff, definitely when you have kids. Nothing is quick anymore!</p> <p>Did you feel that trust with the health visitors?</p> <p><b>Yeah, I did. I know I didn't go to them for 'help me' bit, but I knew I could go to them. I knew about the helplines and charities, but if I didn't, or wasn't sure I think I would have asked the health visitors. I dunno, nurses, midwives, you trust them. They are usually really nice aswell, just nice people, normal people. Not the police, who you're worried to say things to, or social services, I would worry about things happening without me knowing, because they can do</b></p> | <p>Time</p> <p>Help doesn't have to be directly focused on the concerning issue. Help can be a sense, a feeling, an all-encompassing value shared.</p> <p>Trust</p> <p>Help requires care, time and trust.</p> <p>Knowing you can do something is as</p> |
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SU8 Transcript

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| <p>First of all, at the moment, would you say you have any communication or contact with a health visitor?</p> <p><b>No not really.</b></p> <p>When did you last see one?</p> <p><b>About 4 months ago.</b></p> <p>And what was that for? Was that because you came here (refuge)?</p> <p><b>To refer him (son) to speech and language, but it wasn't the best. I mean she just told me what things you've told me, ummm... being consistent with him.</b></p> <p>Did they do the referral for you?</p> <p><b>They did, but it's waiting now.</b></p> <p>And were you here (refuge) at the time?</p> <p><b>Yeah.</b></p> <p>And when they visited, did they chat about why you were here at all?</p> <p>Or talk about your history?</p> <p><b>No.</b></p> <p>Prior to that, did you see a health visitor at his (son) one year review?</p> <p><b>No.</b></p> |  |
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| <p>When was the last time before the speech referral contact you last saw a health visitor?</p> <p><b>I'm sure it was when he was a couple of weeks old.</b></p> <p>And was that at your old address? Or here?</p> <p><b>Old address.</b></p> <p>And was that just one visit at home?</p> <p><b>Yeah. They come out when he was first born and that was the last time. So yea...it's been a long time.</b></p> <p><b>And when I had social services, and the meetings, they were there, and I remembered they struggled what to say cause they hadn't met him and didn't know anything.</b></p> <p>Right, so a health visitor was at those meetings, but they didn't see you outside of those?</p> <p><b>Yeah.</b></p> <p>How did that feel for you, to have people in your meetings who didn't know you?</p> <p><b>Frustrating. I was thinking 'why are you there when you don't even come see us...?' They didn't have anything to say cause they didn't know us.</b></p> <p>Who else was part of your team other than a social worker?</p> <p><b>There was a health visitor and early help team.</b></p> <p>And are you still having those sort of meetings?</p> | <p>Professionals get invited even when they don't know much.</p> <p>There was a real sense that this mum did not trust me, or health visitors. But why should she??</p> <p>Her experience speaks for itself.</p> |
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| <p>That's brilliant. Have you been supported with getting set up? Is the support from the workers here?</p> <p><b>Yeah. I've got a counsellor, she's really supportive as well. I've got two key workers and they're amazing. As much as I want out, I am going to miss them</b></p> <p>Well it's been home, and it's what he knows isn't it I suppose?</p> <p><b>Yeah. Yeah.</b></p> <p>And so with the plan, going back, did that centre about the domestic abuse? Can I ask, how long had that been going on?</p> <p><b>A long time. My first perpetrator, we were together for 10 months, and social services said to me 'It's either him or him', and then because I didn't make the choice there and then, he moved out, but he knew where we lived of course, and he lived at the back of my mum's. I would call the police, you know he punched me in the face with (baby) in my arms, so I called the police, he was arrested and then a couple of days latter he was round saying 'I'm sorry, I'm sorry, I've changed...' so we tried to sort things and it didn't work, and that was when they said that was that.</b></p> <p>OK. That sounds a really difficult situation for you.</p> <p>Can we go back to when you were expecting him (son). Did anyone ever mention anything about domestic abuse, or about your relationship?</p> | <p>Patterns of abuse</p> |
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| <p><b>No. I met my perpetrator when (baby) was 6 months old, but I knew who he was, he lived behind my mum's house. But it turns out, when you're in a relationship they are completely different people. Ummm, but when I was pregnant , my midwife was really good, she was there with anything, questions, support. Me and my sisters all had the same midwife you know, so that really helped you know.</b></p> <p>And so when the health visitor came out when (baby) was a few weeks old, did they ask about his dad? How things were there?</p> <p><b>No. nothing, they checked his weight and that, and that was it.</b></p> <p>When you got with your perpetrator, did you begin to notice anything that worried you, or made you scared?</p> <p><b>We met and then a month later I got myself my own flat, and then a month after that he moved himself in... and that's when it all started, and he got hooked on drugs, drink. I tried to get away when that started, but he said he would get help and things. But he didn't, and it got worse...more drugs. And then it all started kicking off.</b></p> <p>You've mentioned your sisters, I'm just wondering if they were/are aware? Are they a support to you?</p> <p><b>Yeah. Yeah they are.</b></p> <p>And before it got to the point of it kicking off, and you ending up calling the police, did you ever consider reaching out for advice or support off anyone?</p> | <p>Inconsistency within relationship.</p> <p>awareness</p> |
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| <p><b>No, I knew about women's aid and things like that, but I had no idea about places like this. I thought refuge's were for people who have come from abroad and stuff like that....</b></p> <p>And, I wonder, with hindsight, do you think you would have reached out earlier, knowing what you know now?</p> <p><b>Oh yeah. Yeah.</b></p> <p>Would you worry about reaching out for support?</p> <p><b>I mean, I had social services involved already, so I suppose if you came here, there would be no need for social services to be involved, but I mean, they were involved already with me. But I wish I had known about places like this. You know, if I'd have known about places like this, it wouldn't have got as bad, gone on as long as it did...</b></p> <p>Right. So thinking about when the health visitor would usually contact parents about seeing the child, usually just before the age of one, at that stage, if someone had come and asked you 'how's things in your relationship..?' would you have told them what was going on?</p> <p><b>Yeah. I mean it would have been so hard, but if anything I would have asked for them to see me another day when he wasn't there. I needed someone to speak to. I mean when it all started I probably wouldn't have said anything, but as it went on, if someone would have asked, I would have said, 'look, I need to get out...' But I didn't</b></p> | <p>Communities don't know services and support are there unless they are informed.</p> <p>The systems</p> <p>Knowing there are options and choices is more likely to encourage women to leave. Having professionals involved does not prevent perp's hurting.</p> <p>See me</p> <p>...I can't say, so can someone say for me..?</p> |
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| <p>have that support. I kept saying to my family I needed to get out, and I would go stay at theirs, but when I went home, he would know because he knew my every move.</p> <p>It must have been so difficult.</p> <p>And you know where I was living, he had friends in that area, so all he would do is ask them and they would watch me as well. I mean 3 o'clock in the morning, one time he was banging on the door....</p> <p>I wonder, do you mind, being and knowing what you know, it being called domestic abuse? What feels right for you?</p> <p>I don't know. To me, I get it was domestic abuse, but for me to name it that, it hurts you know. To know that me and my little boy have been through that. My second perpetrator, it wasn't just me, he did it to him (son) as well.</p> <p>Can I ask you abit more about that feeling, that it hurts.... Can you tell me anymore?</p> <p>It's a guilt thing, cause with my second perp, I did Claire's Law... when we got talking, he told me about false allegations about his ex-girlfriend, and then so they came up against his name, but I didn't think anything, because he told me straight off, they were false. But if I'd have listened to people, this wouldn't have happened.</p> <p>I understand, but you are not to blame.</p> <p>Can I ask, what would you like to call that experience, that period?</p> | <p>Professionals can start the conversation...</p> <p>Love/hate</p> <p>Shame</p> <p>Betrayal. How could you when you're</p> |
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| <p><b>I mean I look at it as a difficult period, but a learning curve. Because I think I know now, what the signs are, what to look for....</b></p> <p>Was it a short period between your first and second perpetrator?</p> <p><b>It was nearly a year... But we left the day after he hurt him...</b></p> <p><b>I rang the social worker and said what happened.... I rang his nan as well. They rang the police, so I ended up with all three on my doorstep.</b></p> <p>So, there's been a lot. In his 2 and half years....</p> <p><b>Yeah, and I always feel bad you know. Those first years should be the best for him...</b></p> <p><b>But I get support from my sisters, and his nan. His dad is in and out, but his nan is involved. And I know how strong I am. You know, I've got talking to someone online, and we're doing Claire's Law and if anything comes up that's it, because its not just me, its him (son) as well.</b></p> <p>And back to recently, when the health visitor came last time to do the speech and language referral, did they mention about future planning for you? You know, had you thought about where to go next and things?</p> <p><b>No, literally just his speech.</b></p> <p>Did you want to talk about anything with them?</p> | <p>supposed to love me?</p> <p>Awareness</p> <p>Belonging</p> <p>A sense of longing still exists. Basing continuing on events rather than feelings. I wonder if the biggest harm to victim-survivors is that they can no</p> |
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| <p><b>No not really, I was happy to just talk about him, you know</b></p> <p><b>sometimes I need that, I don't need to talk about it all. I can sit down</b></p> <p><b>and talk about it all with my keyworker or counsellor, but there are</b></p> <p><b>times when I don't want to focus on that...</b></p> <p>And so thinking ahead, if a health visitor was to ask, would you talk about it?</p> <p><b>I would, but just mention it I suppose. I don't want it to be my life</b></p> <p><b>you know. It happened but I'm moving on.</b></p> | <p>longer trust</p> <p>themselves.</p> <p>The focus is the</p> <p>child</p> <p>Truth(s)</p> <p>Does healing come</p> <p>when we are ready</p> <p>to finally talk about</p> <p>it all?</p> <p>After thoughts –</p> <p>It took time for this</p> <p>mum to talk with</p> <p>me. Re-reading the</p> <p>transcript I can</p> <p>sense her hesitancy</p> <p>to speak openly with</p> <p>me. Understanding</p> <p>her experience, it is</p> |
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|  | <p>clear why. She has had inconsistency in all relationships. I felt after speaking with her, and again reading this transcript that she has not acknowledged the hurt she experienced and rather pushed it down/away. Her healing was not complete?</p> |
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SU9 Transcript

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| <p>To start, do you have much memory about seeing any health visitors when your children were little?</p> <p>Ummm... <b>I think the thing that sticks out is when my daughter was born, the home visits. Me trying to put on a front, like everything was great.</b> I didn't admit until it was... ummm, months, that I didn't feel a connection with her. Like post-natal depression. My two sisters had a baby at the same time, and I felt so different and really bad because everything was great with them, but I didn't feel it. But I'd had an emergency c-section, I was put to sleep... it really affected me.</p> <p>And is your daughter your eldest?</p> <p>Yeah she is.</p> <p>And can you remember, did you have the words for it at the time to name it?</p> <p><b>Not really. I made an appointment at the doctors and they prescribed me some medication.</b></p> <p>How old was your daughter at this point?</p> <p><b>I think 4, 5 months old...</b></p> | <p>Shame</p> <p>Whose benefit was the 'putting a front on' for?</p> |
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| <p>So until then, you were just getting through? Did you open up to anyone else?</p> <p><b>No... I felt I couldn't, I felt inadequate. I didn't want to feel like a failure.</b></p> <p>And at that time, did you have any support off her dad?</p> <p><b>Ummm.... Yeah we were together, we were together on and off for 11 years. He could see it in me, but I don't really think he cared. He was in the home then, but I was doing everything... cooking, washing... just on automatic.</b></p> <p>Had anyone else asked how things were at home? Like the health visitor?</p> <p><b>Ummmm Yeah, yeah, they asked, but I just lied. I just felt I couldn't open up. They asked... I was good at putting on a front. Which I knew I shouldn't have been doing...</b></p> <p>Did you recognize or feel any worries in your relationship at that time?</p> <p><b>No, not really. He worked hard, and I just thought I should be doing it all...</b></p> <p>And so when you found the strength to speak to the doctor, how was that?</p> <p><b>Just felt like a weight had been lifted, that I'd said. I think I was put forward for counselling.</b></p> <p>Did they ask about your daughter's dad?</p> | <p>Failing at parenthood... is there a worse sense?</p> <p>Responsibility overload</p> <p>Shame</p> <p>Why do we mask and hide? Is it people-pleasing?</p> <p>Fear?</p> <p>Truth(s)</p> <p>In the re-telling of stories we create fluff around the horror. For our benefit or for those that listen?</p> |
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Yeah, but he was OK then. He was indifferent really. It got bad when she was about two.

Did anyone ever specifically ask you about domestic abuse?

**No, no.**

What is the age difference between your children?

Just over two years.... I remember before my son was born, I stopped seeing people. When my daughter was two there were social services involved. We had had a massive argument and the police were called and he was violent. He went to prison for 4 weeks. Everyone was involved then but I did everything so they closed the case.

Right, and then when you were pregnant with your son, did anyone bring that incident up? Ask you about it, or just after he was born?

I'm not sure to be honest. I think they asked if social services were involved, so I may have mentioned it...why social services were involved.

So after your son was born, how did your relationship with the children's dad evolve?

Ummm... it stayed OK for abit. I think I just felt resentment because he made out the relationship was going down hill because of me, I wasn't giving him attention, but I was shattered.

Truth(s)

You start the  
conversation, and I  
can continue it...



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| <p>Can you remember the health visitor coming when your son was little?</p> <p><b>I can remember a couple of times them coming round.</b></p> <p>Can you remember those early weeks with your son, how did it differ from the same period with your daughter?</p> <p><b>I had a very different birth with him, I had a natural birth and it went well. I think I was left to it more.</b></p> <p>Did anyone ask you about your relationship in those early weeks?</p> <p><b>Ummm... I can't remember. I just floated through. I think if it had been brought up in conversation, you know, how are things with the dad, and talked generally about domestic abuse I would have picked up on things sooner. Maybe I would have opened up. I think a conversation about domestic abuse for new mum's is a good idea...</b></p> <p>Do you think, at that time did you recognize the dynamic of the relationship with him?</p> <p><b>I could recognize it, but then he'd always threaten me saying the kids would be taken away from me, and then he started abusing drugs more and more, and then I thought if I do it with him because I thought it would keep him at home and he would be with me, which was the stupidest idea, but I thought it was the best decision at the time. But it just got worse, the abuse got worse, he was paranoid all the time, and then I felt more resentment because he was stealing</b></p> | <p>Opportunities</p> <p>Fear.</p> <p>The efforts mothers go to keep the family dynamic.</p> |
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| <p><b>off me, and I was still doing everything with the kids and in the house.</b></p> <p>And was this all happening whilst the kids were quite young?</p> <p><b>Yeah, it just carried on.</b></p> <p>Can you remember thinking back about the times of contacts you had with the health visitor? To explain, there is a criteria of contacts that families should get contact, so antenatally, a new birth visit, then again about 6-8 weeks, and then development review when they are around one and two and half years. Do you remember seeing them around these contacts?</p> <p><b>I can't remember you know.</b></p> <p>Do you think, if conversations had have been started at those contacts, how are things with you partner? Do you feel safe? Would you have opened up to a conversation then?</p> <p><b>Yeah, if it was brought up. If they reassured me the kids wouldn't be taken away, yeah.</b></p> <p>So was that a big fear for you?</p> <p><b>Yeah. Yeah.</b></p> <p>And was that because of what he told you, or did you hear that from elsewhere?</p> <p><b>Him, he would always tell me. Because once I started taking the drugs, he would threaten me and say 'that's it, you don't deserve the</b></p> | <p>Fear</p> <p>The services meant to protect us are the ones we fear the most...</p> <p>contradictory.</p> |
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starting to find evidence that he was drugging me and sexually abusing me, and I found evidence of somebody getting through the bedroom window... so I thinks that's.... how... you know. So I couldn't do it, I didn't even feel safe going to sleep, so I couldn't do it, I had to leave.

Were you still working social services at this point?

I went to my mums, the kids were already there because the police had been called out, and from my mums I came here (refuge), the social worker brought me here. It wasn't even that he was doing it to me, it was the fear that he was getting other people to do it to me you know.

And how are you since you've been here? Do you feel safe?

Yeah, I mean, I had nightmares when I first arrived here that he'd followed my mum in a taxi and found out where I was. I woke up believing he was there, I had to get a staff member to look. I was so scared, so scared, he always told me he would never let me go.

Did he ever talk about himself as a dad, and the kids, or was it focused around you for him?

It was always about me. Even if we were broken up, he would phone and ask to speak to the kids for 2 mins, and then he say pass it to your mum and he'd be on the phone to me, or he would turn up after work, and he'd follow me around the house. It was always

Fear can make us do  
so many things,  
things that we  
wouldn't recognise  
to do any other  
time.

Control

Does perpetration  
of abuse stop and  
you can function as  
a parent? Is this  
patriarchy at its  
best. We

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| <p>about me. Since he left, I would never stop him from seeing the kids, he's still their dad, even however toxic it was between me and him... Yeah he'd done things around them, like drugs, but they are getting older, and my son does miss him. So, he's got a chance to see them, and I've spoken to the social worker, if it really is about the kids for him, he'd stop the drugs, he'd do it for them, right? He would, but, we'll wait and see.</p> <p>Can I ask about the support you've had, good and bad, when it has been positive, what have been the things that have made that so?</p> <p>Ummmm.. I think, especially here, there is empathy. It's not just sympathy. Talking to someone who's been through similar experiences helps.</p> <p>Are there any other things professionals can do to make you feel safe?</p> <p>Ummm... just communication is the key. Keep the communication open.</p> <p>Did you have consistent workers?</p> <p>The last social worker, she was brilliant, the kids loved her. I think it is important you get along with someone, and if you don't feel you have that relationship you say and get someone else. Just being able to say can I work with someone else. There can't be hostility.</p> <p>Can you tell when there is someone you feel you don't gel with?</p> | <p>congratulate men for being Dad's even when they do the worst things in the world. Not just structures, but mindset. Power Connection Human connection of experience.</p> <p>Open honesty that we cannot work well with everybody. I'm trusting you, I have to like you. Connection Sit alongside me.</p> |
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| <p>So I've had four children over the last 9 years, so I suppose there has been a health visitor in and out constantly over that time.</p> <p>Seeing the baby, and then seeing them when they were abit older, and then again a baby, and so on...</p> <p>OK great, and what has your experience been with working with the health visitor?</p> <p>Ummm... I would say pretty positive. I had my fourth baby during COVID lockdowns so that felt different in that I didn't see an actual person, just phone calls and things. But before then, it was health visitors coming to the home, seeing them in meetings. I think I've had 3 main health visitors over the years, maybe one of them was more of a nursery nurse, but they worked in the health visiting team. It's been good though, I know they've really helped with getting things done for my children and my second child particularly with referrals and stuff.</p> <p>Can I ask what those particular referrals were for,</p> <p>Oh yeah, my second child has autism, but at the time when he had his 2 year review thing, he was delayed. Autism is in the family so I knew about it, but the health visitor got some support from the singing groups and things at the children's centre, and then I had the nursery nurse work with us over a long period doing different activities to help their speech and things. I think then when he was</p> | <p>Quickly get a sense that HV service has been consistently present throughout this young family's journey. There alongside.</p> <p>Consistency</p> |
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**they wanted to check we were all OK I guess. It was nice that they really cared how things were, and how the children were.**

Right OK. So thinking about that incident with your husband, had the health visitor ever visited prior to that time specifically to talk, or support you, with issues relating to domestic abuse or safety at home.

**No that was the first time.**

Right. Can you remember if the health visitor had ever mentioned domestic abuse to you, or talked to you about being safe at home, or your relationship with your husband?

**You mean any other time?**

Yeah. Any other conversations that may have occurred during any other contact.

**Ummm... it's hard to remember exactly, but I know that there had been brief mentions of domestic abuse previously, I mean perhaps with the midwife first, asking how things were at home, was I happy, had there ever been any violence, and stuff like that...**

**With the health visitor, they have definitely talked about it when the babies have been little, I think it was more of a chat about my relationship, and if there had ever been any times I was scared, that sort of thing. After that incident, I suppose because it was out**

**there in the open, it was discussed more, in those appointments**

Opportunities

Truth(s)

'Are you happy?' 'Are you safe?' closed questions that focus on a present moment. What about everything prior to that moment?



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| <p>Yeah... I mean. Relief as I say. When you're not happy and abit scared at home you are on edge all the time, it's like home isn't home you know. It's something that is always there, you can never fully relax. He used to check up on me all the time, I mean he still does that, but not like it was for a while, I felt I couldn't be me for a while, I was just him. It's stressful, it's a lot. It was like that for about 2-3 years, slowly building, checking my phone, putting a tracker on it, blaming me for the baby crying, making me feel useless. I would get paranoid that is was me, I was a rubbish mum, and I couldn't go anywhere without him. I think back and I wonder what the hell happened, but I see how it all did happen more now. So yeah, when it's that, every day feels hard because you are pretending it's great, I mean you've had a baby, it's a miracle, you should be happy. So when everyone knew, and the conversation was scary, that weight started to lift. The health visitor took the lead with the conversation, you know asking me things, and then constantly asking me what I wanted, what I think, I think I slowly got my confidence back. I wasn't as stressed, I could breathe a little. You know, no one ever seem shocked, or like they were judging me, they weren't even judging him. No one said a bad word, but just focused on help and what I wanted to do. Just the lifting of worry, that's the best way I can describe it.</p> | <p>before... but he still lives it?</p> <p>Safety of home</p> <p>Who am I?</p> <p>Managing perpetrators behaviour AND managing to keep secret. The relief comes from not managing anymore.</p> <p>Home is unsafe.</p> <p>See me</p> <p>Truth(s)</p> <p>You start the conversation....</p> |
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| <p>You mentioned that the conversation was about what you wanted to do, what you thought. Did the health visitor ask you about what had happened, what you're relationship was like?</p> <p><b>Yeah she did. I mean she'd met him a few times, not loads, so maybe had a picture of us in her head. She asked how long I had felt worried and not happy for. She asked me if he'd been violent or aggressive before. I think at that moment because it was out there in the open, I just said it all, I figured I didn't want to lie and tell part of the story. You know, I was worried she would be offended that I had lied and hadn't said anything when we had chatted about how things were at home before, I was worried about that! But she wasn't, she didn't even mention about when we had spoken about things before. She mostly focused on the now and future.</b></p> <p>Did you want to chat about the past and how things had been?</p> <p><b>Not really. I think you spend so much time thinking and worrying about it, you are constantly considering each move you make, what you say just in case it sets him off, that you are done with talking about it. I am a naturally optimistic person and I don't like to dwell on the past too much anyway, so I was happy to not go through all the bits of it. As I say, it was chatting about what I wanted to do.</b></p> <p>Did she talk about referrals and things during that visit? To any other professionals I mean?</p> | <p>Shame comes from judgement. When judgement no longer is an issue, shame retreats.</p> <p>Shame</p> <p>Solidarity</p> <p>Truth(s)</p> <p>The reality becomes the story you tell...</p> <p>The angle of truth changes, but there is still some truth.</p> <p>Managing the feelings of others... driven by a fundamental doubt of who we are.</p> <p>Team working</p> |
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| <p><b>and that was the thing. I can manage it, but I couldn't let the children see that.</b></p> <p>Did the police or the health visitor mention social services at anypoint?</p> <p><b>Yeah, the police said they would notify them because I had children. I think a social worker called maybe 2, 3 days later. We talked and I said I had left and gone to my sister's. I can't really remember what else was said... but yeah that was that. When the health visitor came she said she would speak to the social worker, but I said I had already, but she still said she had contact them and tell them. I wasn't too bothered to be honest, the children were fine and they were safe, so yeah, that was that.</b></p> <p>Did the health visitor chat much about the children at any time during that first visit after the incident, or in the appointments with the family support worker?</p> <p><b>Umm.. yeah, like she weighed them, we would chat about weaning, sleep, usual things. I remember one of the sessions in the program was about the impact on children, it was a hard session. I don't know how I feel about it to be honest, I think you could so easily feel like it's another thing to feel bad about you? Like, I am rubbish because I let my children be near this... but I suppose you have to try and brush that off, but it was hard. I remember one of the</b></p> | <p>The breaking point moment pivots on the perceived protection of children. I can no longer look at you to protect myself, I must look at my child.</p> <p>Statutory services deal with the breaking moment stuff. The moment in time.</p> <p>Shame</p> <p>Responsibility</p> |
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| <p>appointments we talked about, I think when I said about going back home after a few months, the children were talked about, you know, what did I think they wanted, how would they be... those sorts of things. It felt a lot at that point you know, feeling guilty, being the one to make the decision to go home, and still having to think about how we would manage. I mean he (husband) knew I think that I wouldn't take it anymore, he knew anything else that would be it, so I felt OK about going home, but it was still me having to make the next steps, do the next thing, not him. It's difficult because I know health visitors are there for the children, I know they have to think about them first, and it's good they do, but with things like this, as a mum you so quickly feel like you are being told off a bit, you know... I get why they have to say it, but sometimes you want to say back, 'you think I don't know this stuff? You think everything I have ever done has not been to protect them?' You know, all the times of managing, and just staying quiet, just letting him go off, it was so it was near me, not them you know. But it's fine because I know some situations are a lot worse and children get caught up in it and hurt, so I know that.</p> <p>So can I ask when thinking about how the conversations are had, focusing on you, or focusing on the children, do you have any thoughts on how your experience went?</p> | <p>Perhaps we are so conditioned to believe is a bad thing. I failed my children so I am bad. OR, I failed my children but it's OK. Priorities</p> <p>Victims manage perp's behaviour, manage expectation, manage planning, manage leaving, manage resolution.</p> <p>Do professionals think that women don't get it and</p> |
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| <p><b>You mean with how we chat about what next?</b></p> <p>Yeah, anything to do with talking about you and the children relating to your husband's behaviour up until that incident.</p> <p><b>Yeah, I think it all went as well as it could. As I say, I get why they ask about how the children feel, and how they need to be protected, and I get why everyone needs to speak to social services.</b></p> <p><b>I do think it was good that those chats about what the children felt weren't had straight away. I think it was good that she (health visitor) had met me before and obviously knew that my children came first because I had left, and I had called the police, she knew that without me having to say because it is what had already happened. I think if she had come round and started chatting straight away about how I had somehow let them be at risk I would have shut down. You need to be built up a little first. That's what they said in the (intervention) program as well, they would do that session near the end, that way it was hoped everyone had been able to think about things first and make positive steps first.</b></p> <p>Can I ask what sort of conversations you had with the health visitor as your regular appointments continued after the police call out incident.</p> <p><b>Yeah, so they were mostly either at my sister's or at the children's centre. I got to know her and my support worker well, so I suppose</b></p> | <p>recognise it. Why do professionals think victims minimize it?</p> <p>Priorities</p> <p>Empowerment</p> <p>Listen with humility</p> <p>HV must support first before they surveil.</p> <p>As a HV 'you, now me'... always in that order?</p> <p>Conversations about the child (protection</p> |
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| <p>they were more friendly catch ups. Like how I was, had I had any contact with my husband, how the children were, all that sort of thing. Just checking in with me.</p> <p>Can I ask, when you decided to return home, did you discuss this with the professionals you were working with?</p> <p>Yeah, I always said I wanted to sort this and get home at somepoint. They knew me being at my sister's was temporary, I couldn't move there permanently, and I wanted to be back in my own home. So it was never really an announcement, I always said that's what I wanted, so I guess we were working towards that.</p> <p>They never said 'No you can't', or 'we're not happy with that decision', they just heard it and chatted through each step. It was very supportive and as I say, just focused on what I wanted and stuff.</p> <p>Did those conversations and meetings go how you wanted them to?</p> <p>Was there anything you would have liked that didn't happen?</p> <p>No, I think everything worked well. As I said, the chats around the impact on my children were hard at times, but I understood why. I suppose they had to mention it, but I got frustrated because you know, they knew me, they knew me as a mum, but yeah that was all. Apart from that they were both so supportive, and everyone at the (intervention) program. I knew that they just wanted me and</p> | <p>and safety) must be discussed within the present and future tense, not in the past.</p> <p>Truth(s)</p> <p>Listen with humility</p> <p>Be a friend.</p> <p>Priorities</p> <p>To empower, individuals must have control again. If professionals control decisions,</p> |
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| <p>my children to be safe and that was always the thing. I always knew that. I think because she always made me feel that, I was happy to be really open and talk through things, you know, there was no other agenda, they had no other plan. Everything was very open.</p> <p>We'd had discussions earlier on about my other housing options, we spoke about the council housing and the (charity) housing options, I knew they were there but I never wanted to look into it, but I knew the options, so I guess that was good. It's never a bad thing to know you got options, you know if something goes wrong, there is a plan B. That's how it was chatted about, more like a plan B.</p> <p>So once you had finished the (intervention) program and returned home did you still see the health visitor regularly?</p> <p>Umm, maybe once after I moved home, and then not for a while.</p> <p>She said earlier on, when I was at my sister's that she was staying on and seeing me because she wanted to support me but she didn't need to, you know she wasn't worried about the children and we were safe. That was nice, she wasn't there because she had to be, she was there because she wanted to be. So she said when she came after I was home, she said that she would be stepping back but would give me a message every now and then, and that's how it was. A text about a month later, 'Hi, it's me, how are you and</p> | <p>empowerment will never come.</p> <p>Planning</p> <p>Present the options.</p> <p>Empowerment is knowingness, not actual doing.</p> <p>Solidarity</p> <p>Connection</p> <p>Having to do something 'VS' wanting to do something. Wanting involves empathy.</p> |
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| <p><b>children?’ that sort of thing. And then before I knew it she was back for the next baby!</b></p> <p>And when the health visitor contacted you about coming to see the new baby did you chat through everything with your husband, and how your relationship was?</p> <p><b>Yeah, but not like a direct thing, just a really nice conversation about the family, how things were, what I was thinking, how I was feeling you know. I suppose the first visit it was tricky because he was there, so we didn’t really chat much about that, but when she came again a month later we talked more. Just how it had been, nice and friendly. She wasn’t worried and I wasn’t worried.</b></p> <p>Is there anything you would have liked to have been said, or if you change anything about that period of working with the health visitor?</p> <p><b>Change? No. I don’t think much about what’s happened, but thinking about it all, it was right for what was happening at the time. The conversations were never too deep into the actual events with him, but it was as if they didn’t need to be because that’s why she referred me to the support worker, you know. Her focus was the children, but she was there. That’s what I remember the most, just a nice person who listened and was there.</b></p> | <p>connection</p> <p>priorities</p> <p>Parents sense the HV’s sense and instinct.</p> <p>connection</p> <p>“...she was there.”</p> |
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SU11 Transcript

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| <p>So can we start by you telling me about the contact you had with the health visiting service.</p> <p><b>So, I think from what I know, you know, talking to mates and what they had, I would say standard, not much really. I think when the baby was born, and then maybe once more and that was it.</b></p> <p>OK, and those contacts, can you remember where they at your home? In a clinic?</p> <p><b>Yeah, at home and then at a centre. The baby one, they came to my flat, and then the one year one at the children's centre.</b></p> <p>Any how old is your child now?</p> <p><b>They're coming up to 3 years old now.</b></p> <p>OK thanks. Can I ask in those contacts with the health visitor, can you remember what you talked about? Any of the topics?</p> |  |
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| <p>my bidding number and helped me look for properties and bid, so yeah, that's how I got my own place, it's not massive, but it's mine you know, which is so important to me. And yeah, just got me coming to some of the groups, like the stay and play groups, meeting some other mum's, and they supported me with my ex. I don't have a relationship with my ex, baby's dad, anymore. We had a bad time together, a lot of fighting and really controlling behaviour. He would make sure I couldn't do anything on my own, or he would fight with me for no real reason, or he would get into fights with other blokes at the pub, or out you know and then come back bang on the door and tell me it was my fault. He caused a lot of problems between me and my stepdad which is part of the reason I had to get my own place. My stepdad told me enough and I had to go, so it was either move in with the ex or get my own place. So yeah, my support worker helped me with the housing, and just you know, getting me onto this program (domestic abuse intervention program). This is my second time finishing the program, the first time I joined late and missed some sessions, but this time I've stuck with it. It's been great, you talk about all the elements of the control and stuff and how they make you feel, and they get you to think about it all because of them, and it's not because of you, you know. It's amazing, there are so many other</p> | <p>had to take. A feeling to call this complexity, but does that add negative bias? More a sense of multiplicity.</p> <p>Patterns of abuse</p> <p>Part of the control and pattern of behaviour is to make the victim believe they are to blame.</p> <p>That they too are complicit in the abuse.</p> <p>Truth(s)</p> <p>Empowerment</p> |
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| <p>about that. I know it's bad, but I wish he wasn't on the birth certificate, I wish that my child didn't have to know anything about him, he doesn't deserve to be a dad you know. But yeah, she asked me, and I think I said something that we were off and on, and we weren't together then, we'd had a bust up or something. I said something along those lines. I think she could tell I wasn't telling the whole story, you just can right? I mean especially as I'm sure she'd seen lots of things, and so just knew from what I was saying. I think I could tell, I think women we can sense it, you know... but yeah so we chatted about it for it a while. She asked me if he'd been violent, and I'd said no, I just didn't want to get into it all, probably because my parents would have been coming home soon or something, and then if they'd have heard they would have got involved and gone on and on. It had got to the point my ex and stepdad was arguing and it wasn't even to do with me anymore, you know, just blokes. I didn't want to talk about it then. So yeah, we chatted and that's when she said about him contacting me, and where I was living and that I could get support and she would ask someone to call me. Maybe she knew, maybe that's why she got someone to call me and help with the housing cause she knew. But if she knew, why didn't she help? It's stupid isn't it, you don't want to tell someone, but then you think they may know, and then you</p> | <p>Truth(s)</p> <p>The unsaid moment between people. I know you know...</p> <p>Connection</p> <p>Our sense of help is individual. Perhaps professionals need to be clearer, more frank. Say what they feel?</p> <p>Stuck</p> <p>See me</p> <p>..If you do know, why aren't you saying so?</p> |
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get mad because if they do know, they should do more, but you don't want to talk about it. It's a mad cycle.

It sounds like they were heavy conversations during that visit though. Thinking back, and considering what you've experienced, would you change your answer now? Would you have said more if you could go back to that moment?

You know what, no I wouldn't. And that isn't because she seemed rubbish, she was nice, you know kind, but I couldn't, not then. I'd just had a baby, how could I then? You know I was in a place that I would just do whatever and say whatever to shut his agg up, so I can concentrate on the baby. You know, I can't deal with him and us right now, it's all about my baby, that's my focus, so even if they've had visited everyday and asked, I still wouldn't have chatted much about it. You know, I didn't say anything to my support worker until like 4 or something months later, then I wanted to talk, but not before. You speak to these women who do all this work in refuge and stuff right after the baby, and I don't know how they do it, their strength to have a brand new baby and make these changes, it's so much, so big, I just couldn't. Maybe if she'd come back afew months later and it was her I would have done. I dunno, it's hard isn't it.

Victims stuck in the abusive cycle, and professional cycle. They can never sit in their own bubble. ...Perpetuates their sense of 'I am not enough'.

containment

New parents need time. Transition to parenthood requires time and readjustment.

Consider when is the right time to routine enquire?





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| <p>need to be able to do it. So yeah, listening I suppose and chatting it through. I don't know maybe there are some things you need answers to, but they aren't like <i>right now</i> answers with babies. It's like with anyone know if they talk about those early months, and a baby crying a lot and not sleeping, I always say like the baby will sleep, so you tell them they will sleep, eventually, but you can't say when, and sometimes you just have to do what you can do to get through. And that's it with a baby, you can't fix it. Just be in it, and to have someone say, yeah that's hard, it doesn't make you feel so alone.</p> <p>Do you think that, when you felt ready to discuss what was going on with your ex, you wanted this kind of support then? Or did you need more a 'fixing' solution?</p> <p>Support still. As I said, like the practical stuff, help me with getting a home, that's fixing a problem, I get that. I suppose if I hadn't been able to get a council flat, god knows, maybe a mother and baby place or something... but I wasn't picky with a particular area, so that helped. But yeah, with the thinking about his behaviour and actually realising it was nothing to do with me, that's not someone fixing for me. <b>You have to let someone find their own answers in their own lives you know? If someone else is doing it for them, then the person will never really get it. You know, this</b></p> | <p>Solidarity She was there so I wasn't alone.</p> <p>Empowerment.</p> <p>Let me answer my own questions.</p> |
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| <p>me. I don't know, so with her, it's better she doesn't know. I still trust her with other things, but yeah, I don't know what she would do with it, or say.</p> <p>You mentioned about being a good mum, do you care what other people think regarding that, particularly professionals? Like the health visitor, would that influence what you said to them?</p> <p>Yes and no. Like I do care, especially if someone was to say I wasn't a good mum I would argue back, and say well prove it. Everything I do is for my little girl you know. But then other times I don't care. Maybe more about if I want to be with her and things like that, things to do with how we are together, like she's my best friend and I don't care what people think about that. But with the health visitor, there is a part where you want to say the right thing, I don't know, like do they work close with social services, but like they have that power more to tell other professionals' stuff, but I do know they have to tell you what they're doing first I guess. So for that, you care what they think, because they have the power to get people involved. At the end of the day though, all I'm bothered about is if someone is doing anything to help my daughter and me that's fine. I've realized that, you can talk abit more, because actually it's not all your fault when things can go bad. That's what you know we talk about in the group, like actually saying to other</p> | <p>priorities</p> <p>Relationships are not equal. One person always holds more power. Perhaps you have to understand the power they have first before you decide what information you give them?</p> <p>boundary</p> <p>We all fall into the trap of good and bad....even the researcher has!</p> <p>Truth(s)</p> |
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Do you think there is anything you would say to a health visitor if they were worried about a mum and their relationship, and if there were controlling behaviours...?

**You know that's what I want to do when I'm able is give back and help with this sort of program, you know talk to people. I think when you start to talk that's like when you see it more in your head for what it is. Like I always think, what would I say to my**

We are so much kinder to others than we are to ourselves.

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| <p>daughter, I would tell her to tell someone, tell me. But we don't let ourselves do that do we?</p> |  |
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SU12 Transcript

Can you start by telling me about the contact you have with the health visitor. I would say I have quite regular visits with them now. It's like up and down, but yeah, quite abit. OK, and if we go back to when you first started seeing them, was that when the baby was born? Or before? It was before, maybe a month or so before the baby was born. Right, and can you remember how they came to get in contact with you? Was it a referral to them, or did they come as a routine visit? Yeah so, I have been seeing my support worker for a while and the midwife and they said they would let the health visitor know I was having a baby and they would be part of the visits. I	Visits tailored to this woman.

think then the health visitor called me and arranged to come over, and then came again after that for the visits. Whenever there was like a visit with the support worker or something. It's mostly home visits, and sometimes she just calls me, depends. OK, can you tell me abit more about these visits that you have with the health visitor and support worker...? Yeah, so I started working with my support worker a while ago, I was pregnant and there had been some issues with my ex, there had been an incident when I was in hospital and the midwives referred me to social services and from there, I started working with the support worker. So, like the visits were about how things were with my ex, getting me some support...housing and benefits, and how things were at home, and how I was with him (ex-partner) and him seeing the baby. Right, and so have these visits been pretty constant with professionals? Or have there been periods when you don't see them? Pretty constant, yeah. Probably like every month or so, sometimes I have had to cancel because of being busy with the baby.	Team working... individualised Truth(s)The incident is the thing...this is why there was social care... a one off.... Or is it easier to see it that way? Shows how DA is never just about <i>that</i>, there is a whole life...

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Yeah it can be busy with such a little one. Can you tell me in these visits what does the health visitor do, or what does she talk with you about? Umm. As I know she is there for the baby, so she will weigh him and asks about his sleep and feeding and stuff. He's had a milk allergy so she helped sort out some cream and new milk for him which was good. But yeah, I suppose she makes sure the baby is good. I know she works with my support worker on other things and stuff and she does talk about how things are with the baby's dad and stuff. Would you say that you feel able to chat with the health visitor about the baby's dad? Yeah. Maybe not at the start, if she asked me something I would say what happened and things, but not like talk about it in details and things. Over time though, I think they know more of what's gone on, like sometimes they chat with my Dad about things before he heads out. I don't know, it's still not something that I go about chatting about, but I don't mind talking with people who see me and I feel know me and I know them. Yeah, I understand that, do you think then, say if the health visitor's colleague was to come to one of the visits if yours	Priorities There is a sense of prioritizing the baby with mum and HV. Baby first, then me. See me There is a sense of being seen before there is a willingness, or ability to open and share. If you want the privilege of knowing, you must know me first. connection

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but they knew about it. And with the health visitor she has been there to help with the baby, and let me know he is growing and things which is good, like she talks about ways I know he is growing and she tells me about things I can do to help with his brain growing, and you know I see all the things she would talk about, like if you smile and chat to the baby, he goo's back and is talking to me, and like he watches me and he loves his grandad, he just knows us and things. She (health visitor) would talk about how I know he's happy, and its looking at those things. It was hard in the start because he was a real sickly boy, because of the milk and he would scream and scream, and you just don't know what to do and you think it's me... he's just not happy. But then we knew why, and it got better and that's when I could see those moments better of when she would say that's how we know baby's are happy. It's been good because when I do take him (baby) to see his dad and his gran you know, I will say (to the dad) talk to him and look at him you know, and he (baby) will smile back. It sounds like you've got a lot of knowledge about parenting and things. Would you say you feel confident with being a parent? Yeah, like just knowing that stuff helps. And I've learnt that even if I pop to do a bottle in the kitchen, I will talk to him	Consistency. The HV sees this woman and the good parent. The HV is a supporter as well as a teacher. HV helped to unpick the most important issue – my baby is suffering. She focused on that when I needed to focus on that. Knowledge is power to demonstration self ability and resilience. I am capable. HV can give information and knowledge that infiltrates life in every way. Wisdom shared... age old parenting (some

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(baby) and it helps him to know I'm there. You know she (health visitor) told me about how he gets scared if I go, but he can hear me cus he's always been able to hear me even when he was inside my belly. So would you say the health visitor has helped with this? Yeah yeah. Like my dad is really good. I know he was shocked when he found about the baby, and things, but he's been great, and my older brother is good. It was hard early on cus he (ex-partner) and my dad don't get on. He isn't allowed at the house, but my dad has been good with helping in the evening. But yeah, the health visitor just helped with talking about how things affect him (baby), like the allergy and we've chatted about me starting weaning in a month and what do I give him, she's going to do me a food list of things to start with and stuff. Her telling me about holding the baby, talking to him, and those things is good. I think I've got on fine with it all, but I didn't know about babies before him you know, so to have someone just chat with you has been good. I've got one other friend who has a little baby as well and we talk about this stuff. Do you feel that what happened with your ex, or how things are going with him has impacted your confidence with parenting?	may say anecdotal, but still evidenced). Sharing We forgot that part of the transition of parenthood is walking into the unknown for so many. You cannot be expected to know something you don't know! HV tailor information. Strength

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I don't think so too much. Like he has his issues, and he smokes too much weed, and got into heavier stuff when we were together, and it was all a lot for a while. I think us separating was something that happened over time, we've been on and off since I was 15, I love him, but he's been such a dick, I don't want his rubbish in my life right now. When I found out I was having a baby we were staying in a room in a house, and it was more about how we would fit a baby in. My Dad did not want me with him (ex-partner) so we couldn't stay there, I would come home for abit and then go back, and then it all got bad over afew weeks, and he pushed me so I went in (hospital), and he was just kicking off on the ward which is why they called social services. I suppose I knew I needed to properly leave, because this (the baby) was it for me, but he mostly just made it harder. You know, since the baby, I'm the one showing him and he asks me, it wasn't like that before, he was the big man with me and I just wanted the quiet life. But it's reversed now. I think it was more he just affected me rather than me being a mum. He's abit lost now, these big men, they're little boys really. You sound like you've spent some time reflecting on how you were together...?	There is compassion is her explanation of him. A sense that their story is far from over? Can DA be a premature close (or pause) for some? There is a blaze explanation to this. "it got bad..." What can be so bad that it would make one push another (who's pregnant)? The breaking point of it impacting the most important thing to the mum (the child). Victims can recognise those who hurt are hurting themselves. Fear

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Yeah, you have too. I've got my dad and brother so I have them for him (baby). Maybe I knew for ages it wasn't good and having all that happened was good, it was the thing. Like they said, "if you go back then there will have to be a plan with more people involved..." I would never choose him over my baby, that was never going to happen. And then doing the (intervention) program was time as well to think. I had no idea what to expect and you just want to go and get it over with to start, but so quickly you start saying things, even things I had forgot that happened, but when you are with other people it makes you think. Don't get me wrong there is a lot of love there still, and maybe we might be together, but he acts like a lad at the moment, and like I know he is on tinder and whatever, seeing whoever, so yeah, right now whatever. How has it been co-parenting with him? Up and down. He didn't bother for the first few weeks. Well he came once just after he was born. My Dad let him in, but he isn't allowed here so it was difficult and me and my Dad did argue about that, but I get it now. It was just a rule he has. I get on with his (ex-partner) mum, she's good, so that's where we go. He's not taken him out on his own, he will do bottles and stuff at the house with his mum, but I just don't think he knows him	Priorities Do professionals sometimes not realise that women know. The fear of the unknown was the driver. Women need time. There is sense and clarity in time. Control So much knowing. And importantly an acknowledgement of the unknown... boundary

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well enough yet. So maybe soon, but he's my baby. Sometimes we've had some arguments, over messenger but I will block him. It's hard sometimes, I think just cus he isn't prioritising us, but whatever right now. Do you talk about how you and him, your ex, are, and how you feel about it and him to the health visitor? Um, yeah, like they will ask "how's it going?" like with him. And they know the set-up. They've never met him, or his mum. We had a bad time a month or so ago with agg, and my dad was here and told them that he had been calling and stuff. He hadn't come round, he wouldn't, but calls and messages, so they said I needed to block him else if it carried on they would have to escalate it, just for my safety. But I did, I don't take it off him anymore. So yeah, we talk about it. It's probably more with both of them (health visitor and support worker), but if either asks, we chat. Does it make any difference to how you feel chatting with them? Umm, yeah. I think I don't mind too much, but also I want them to know what's going on so they can't say I'm not protecting him (baby), you know, that was the thing before... him or the baby, so I know it's a thing. But if they know everything then it's	We all have our drawn lines... empowerment This woman is empowered to prioritise herself and baby over it all. There are still some things not shared... no matter the trust. We all have the privacy to our conversations... to expect someone to say everything is more than anyone could expect?

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all out there. I suppose maybe the reminder of what it all is, because you do forget bits. Can you say more about 'what it all is'... Like he hurt me, and he wasn't bothered about having a baby, like he could hurt me, and then kick off on the maternity ward. You forget, or I would think 'shit, it's something I've done', but it was just him you know. So do you think talking about it with them helps you to remember what it all is? Yeah it does. I know I can be aggy at him, especially when I know he's messaging other people, but they tell me directly what he's done. They know about the weed and the issues he's had growing up, but they still say "yeah, but he should never have hurt you, especially being pregnant", so yeah they say it like that. Whereas my dad just hates him and won't talk about him. Sometimes you need to talk about it all, I need to say rather than my dad just saying No, not talking about him... or whatever. It sounds like they've said some honest things to you over the visits, what is that like speaking in that way? Yeah fine. I know why they're there and at least I know what they think. I say things that have happened, and they will say	This woman will open up, but not freely? simplicity It becomes apparent here. I am open with you because I have to be. I understand the power you hold. Contradictions - honesty When you've lived through it, within the bubble, you need the moments and time to step outside the bubble and view it. honesty There appears to be a directness in the exchanges between woman and

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to have someone in your corner. It takes the worry of having a support worker away when you know that they just want to help you. Do you think if you were worried about how things were with your ex in the future, you would feel able to speak to your health visitor about it? Errr, yeah. I think if it was something I couldn't deal with, probably. Like her, I don't think I would just call up an office or anything. But that's the thing I know what it was now, and I think I can handle things. Everything changed with him (baby), so he (baby) always comes first. I know I'm a good mum. Lets just say I would rather speak to them again than anyone else.	take and take in a relationship... 'I give, you give. I take, you take...' This woman senses the reassurance of knowing someone is there... consistency You've proven yourself to me. Professionals need to demonstrate their intention. The scaffolding and foundational work to empower women has the ability to be life affirming and life changing.

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So can you tell me about the support and contacts you've received from the health visiting team. So I've had the health visitor since I had the baby, they've been there. And how old is your baby now? She's 9 months old now. I think I first saw the health visitor when she was about 2 weeks old, I had her back again, and then a bit of a break. And recently I've been seeing her quite regularly. OK, can you tell me a bit more about the amount you've seen the health visitor, like the reasons they saw you and your daughter. Oh yeah, ok. So they started seeing me when she was first born, she came with the midwife and met us. I knew she was coming, I had the midwife and they had explained about them stopping now the baby was born, and the health visitor being there instead. So yeah, when she first came to the house it was like to meet me. The midwife weighed the baby and stuff and the health visitor talked to me about all stuff to do with the baby, feeding, sleeping, colic, and then about what was happening with my husband and my husband's family, and why I had moved out. So yeah, I saw her quite a bit in the first few months, she was	Consistency Continuity. Reflects universal provision and then increases. A reflection of transition of care! Caseload management! 'my husband's family...' sensing isolation. Help and isolation

a big support for me. We get on well, she's about my age and she has young children as well. She really helped me early on, and then again more recently she's been helping with being supported for my visa and housing. OK thank you. Can you explain a little more about those early months, you mentioned the health visitor supported you. Can you tell me abit more about how you feel she supported you? So this is my first baby and I arrived in the UK last year, pregnant. I came over on a spousal visa. I moved in with my husband and his parents and younger brother. From the moment I arrived it became really difficult. It was a difficult few months. I was told by my parents in law to just deal with his behaviour, that it was allowed for him to go and out and disrespect me. I wasn't allowed out, and then I found I couldn't even speak to his parents because they began being unkind. I found out he had another baby with someone else and it devastated me, it still does. It became an incredibly difficult situation, and I had my husband being so cruel to me, and his mother hurting me. She would burn me, scald me. I'm still scared down my legs. My sister is here with her family so I came here. I came here afew weeks before the baby was born. When the health visitor first came my brother-in-law (sister's husband) was talking with my husband	connection Limited recourse to public support. Vulnerability ...deal with it... as if it should be accepted and tolerated. Isolation and betrayal. Punishments to isolate further and maintain power. Family norms... the men sort... belonging

Emotional. Listening. My sister was growing tired of trying to settle her husband and look after her family, and I was a burden. To begin with we all believed my husband would see sense and start being a husband to me and looking after me. They were talking for weeks. My husband refused to see me and wanted a divorce. I think his parents had decided it had been a mistake. But I was here and I had his daughter. He didn't want anything to do with us. It was incredibly hard. What did I have here without him? I mean I had my daughter, and she is such a blessing, everything is for her... but I had nothing here (in the UK), and I could not go home. I think early on she (health visitor) said 'you can do this...' I remember thinking 'I can't' and just wondering how she could even say that. She only said it once early on, maybe she saw my reaction, and then we talked a lot how all this made me feel, how I felt awful. You know I didn't believe her when she said I could do it, but her listening to me, she was the person I didn't feel a burden too. I didn't feel I was draining her. That sense supported me through abit. She was good as well because she helped me, she got me support from the local centre with food and nappies. She would bring me formula as well. I think she got this (steriliser) for me from the shop, I couldn't ask if she did, but I knew she did. But her kindness, I felt it. We	Truth(s) empowerment Someone had belief in her. There is a time for affirmations... the HV sensed this wasn't the time. containment The privilege of talking to someone who's job it is to listen. No revelation is too hard. Acts of kindness empower. solidarity

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money. So again I didn't mind, it was all for me and my daughter so I would never argue with that. And through out those early months did you see the health visitor much? Yes. She said she would see me every month, but her kindness.... She would drop formula off, or some baby clothes she said her colleagues had been donated. Her work was only a short walk, so we would go to the well baby clinic, she was sometimes there, or her colleagues. It was a place to go for us. She would text message me, and if I needed something, or was worried I called her. It's lovely to here about the small things she, and the team did to support you... Yes, and I know it was more than her role. I believe that in this life what we do impacts the next paradise, it was more than her job, she was a good person, is a good person! We talked about all of that as well. We are very different in what we think, and she had said to me she does not have a religion, but she is respectful. We have recently celebrated Eid and she would talk to me about fasting and how we celebrated. It was more than her job as I say. Can you tell me a little about the contact you have with her now?	There is an informal warmth to this working relationship. A connection that isn't quantified. empathy The HV got to know this woman. See her for her in everyway... recognizing the cultural differences.

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Do you feel the health visitor has helped you to feel more how you do now?

Yes, she is part of it definitely. The early times of feeling very low, to know there is someone coming, there is someone who smiles and says that you are doing a good job at parenting helps with your belief in yourself. You can feel alone, but to have someone to listen and share with, lessens that feeling. I do not know if I would be in this same situation without her, without her help. There are many times I feel sad, but in prayer I think on this. She cannot take this, no person can, but what she has done has been to help to get me to this point.

See me

Sit alongside me.

Solidarity

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DISCERNING CURIOSITY. Wondering and knowing, how things can contradict and compliment at the same time.					LOVE AND JUSTICE, connection and care					MOMENTS AND OPPORTUNITIES			
Power and priorities	Safety	Acceptance		Humanity in the home	Multiplicities of life	Embrace	Moving between awareness, understanding and empowerment	To sit alongside	My values, your values, our values	Managing and changing	Accountability	Help and support	Weight of the past

Acceptance	Containment	Fuel
Safety of home	Boundary	Fear
Protection	Listen with humility	Breaking point
Priorities	Solidarity	Pattern of abuse
Team working	Approachability	Protection
Individualised	Safe	Team working
Children	Connection	Responsibility
Instinct	Honesty	Blind
Wonder	Who am I?	Simplicity
Privacy	Consistency	The systems
Knowing	Help and isolation	Time
Truth(s)	Shame	'That's it?'
Questions	Martyrdom	Opportunities
Planning	Love/hate	Breakdown
	See me	

	Vulnerability Transcendence Belonging Anger Empathy Respect Blame Stuck	

Themes and codes