WHEN HOME IS NOT A PLACE OF SAFETY

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INTRODUCTION

This paper addresses the concept of the *place* that home is, how it is normally considered a *place* of safety, and when this *place* is no longer a *place* of sanctuary as a result of violence. Intimate Partner Violence (IPV) is discussed with particular reference to the *place* of IPV in rural areas. Implications for nursing practice are considered with reference to home being an unsafe *place*. The effects of IPV has a devastating impact on victims as they experience trauma. Women living in rurally isolated areas are at an increased risk of being victims of IPV. Additional complexities are considered for victims of IPV living in rural areas, including a lack of resources and an assumed lack of privacy. Finally, nursing considerations are discussed including routine enquiry for IPV and how nurses manage disclosures of violence.

Background

Home for most people should be, or is usually thought of, as a place of safety and refuge. When you think about home, people think about where they grew up, their parents/whanau and other relatives that they have strong links to. The concept of home as a place gives a feeling of belonging and helps build a sense of who you are as a person (Peter, 2002). However if the home is not a safe place, then the sense of who you are as a person can be affected. Home should be the place that is safe. It should not be a place of fear and loathing.

This paper addresses the concept of the *place* that home is, how it is normally considered a *place* of safety, and when this *place* is no longer a *place* of sanctuary as a result of violence. Literature on family violence (often referred to as intimate partner violence or IPV), is reviewed with particular reference to the *place* of IPV in rural areas. Implications for nursing practice are considered with reference to home being an unsafe place.

Place

The concept of place is complex, dynamic, culturally based and fluid, and has several meanings including geographical location, setting, relationship to people, individual or groups, and local (Giesbrecht,; Lovell, Gray & Boucher, 2017; Crooks & Stajduhar, 2014; Carolan, Andrews & Hodnett, 2006; McGarry, 2004; Peter, 2002). The meaning, or how people create their understanding of place, is through their experience; and their experience is the key to understanding the importance of place (Lovell, et al., 2017; Giesbrecht et al., 2014; Bender, Clune & Gurunge, 2009; Gavin et al., 2006; Andrews & Moon, 2005; Williams, 2004). Peter (2002, p. 65) quotes the 1994 seminal work of Liaschenko as:

> Places are symbolic constructions reminding us of our connections to others, to the natural world and animals, and to projects – they give meaning to our lives. Thought of in this way, we can see place is important in shaping our identities and in fostering (or depleting) our sense of self.

In this paper, I consider the context of place as being in the home or place of residence.

Home as a context of place

Home is a subjective experience and therefore significant to those who live there (Williams, 2004). Williams (2004) discusses the different meanings of home as being; home as familiar, centre, protector and locator. These concepts refer to:

> Home as familiar – where the person is comfortable, and where routines are established
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> Home as centre – where the everyday experience of interaction and social activity occurs;
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> Home as locator – takes a wider perspective of the context of the home and includes the socio-economic status, community and service involvement, and geographical location, and,
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> Home as protector – where privacy, identity, safety and security are guaranteed.

'Home as a protector' is the focus for discussion. When home is not a protective place, then rather than seeing home as a protector (Williams, 2004) it can be viewed as home as a place of persecution or as a place of fear and un-safety. When home is an unsafe place due to partner or family violence, victims of that violence report living in fear of saying or doing the wrong thing (Williams, 2004). They report that it is "like walking on eggshells", that their feelings or even thoughts are not validated, or are told they are stupid or worse where insults are used to demean and put them down (Campbell, 2004; Women's Refuge, 2017). People outside the relationship wonder why people stay living in violent relationships; but for victims of IPV, leaving is the hardest thing to do. The term 'the devil you know is sometimes better than the devil you don't know' is common. Features of many victims are that they are estranged from their families and friends, or they have so little self-esteem and they are frightened that people will not believe them. Or it may be because the perpetrator controls every aspect of their lives including access to resources and money. Subsequently, living in and with fear is a prescript for mental health issues, including depression, anxiety and drug and alcohol abuse, and the ability to make decisions about leaving the relationship is often impossible (Campo & Tayton, 2015; Women's Refuge, 2017).

Family violence

Recent changes to the New Zealand (NZ) legislation (currently known as the Domestic Violence Act, 1995, the first reading of the Family and Whanau Violence Legislation Bill was introduced to the NZ Parliament in March 2017, and will amend the Domestic Violence and other Acts) has defined family violence as "violence inflicted against a person, and by any other person with who that person is, or has been, in a family relationship" (Section 3, Family and Whanau Violence Legislation Bill, 2017, p. 3). Violence means physical, sexual and psychological abuse which includes a pattern of behaviour including coercive or controlling behaviours that cause or may cause cumulative harm (Fanslow, Kelly & Ministry of Health, 2016). This Bill and current Ministerial (Ministries of Health, Justice and Social Development) documents (for instance Fanslow, et.al., 2016) show a clear indication that the New Zealand Government is taking active steps in reducing and preventing the effects of family violence and intimate partner violence in NZ.

Intimate Partner Violence

Intimate Partner Violence (IPV) is recognised as a public health issue (Fanslow et al., 2016; World Health Organisation, 2012 Hughes, 2010; Campbell, 2002). It is defined as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm" (WHO, 2012, p.1) and includes threats of harm, intimidation, stalking and controlling behaviours. It includes any form if violence perpetrated by a family member, intimate partner or significant partner. It is also known as family violence, battered women, spousal abuse and violence against women. IPV occurs in any configuration of family, across all socio-economic and ethnic groups (Campbell, 2002).

The result of IPV affects all bodily systems, and includes both physical injuries (including unwanted pregnancy and death) and emotional/psychological injuries including forms of mental illness and substance abuse, the effects of Post-Traumatic Stress Disorder (Campbell, 2002). It also includes the effects of financial abuse for example controlling money that prevents the person (victim) from working or having access to appropriate housing, work or essential items including food and sanitary items (Women's Refuge, 2017; Fanslow, et al., 2016). People (more often they are women) who experience IPV are more likely to visit health care settings including emergency department, women's health services and primary health care for example general practices, more frequently than non-abused people (Campbell, 2002).

New Zealand Statistics on IPV

It is evident that 1 in 3 (35.4%) women in NZ who have had a partner, reported experiencing physical and/or sexual abuse in their lifetime, with approximately 1 in 20 women having experienced IPV in the last year; compared to 18% of men in their lifetime and 6% in the previous year (Fanslow, et al., 2016; NZ Family Violence Clearinghouse, 2016). However when emotional abuse is considered this rates increases considerably to 55% of women reporting IPV in their lifetimes. Those at an increased risk of IPV are women, Maori, people with disabilities and those who identify as gay, lesbian, bi-sexual and transgender (Fanslow et al, 2016). Herbert, Hill and Dickson (2009) claim that there are particular groups of women in NZ and society that are more likely to be targets of violence and abuse, and these women are more likely to have limited resources, less support and are often living in contexts where violence is normalised. Combinations of factors that may increase women's vulnerability include, ethnicity where young Maori women are more likely to be abused than non-Maori, and where there is intergenerational abuse (Fanslow et al., 2016). Women are not strangers to perpetrating violence on men, however, violence by women against men is reported as being less prevalent and with less severe consequences (Fanslow et al., 2016).

Rural women and IPV

Although the research on the place of IPV in rural areas is not well researched in New Zealand, international literature does show that women living in rural places are at a greater risk of being victims of IPV and are more likely to be killed by their partner than women living in urban areas (Campo & Tayton, 2015; Peek-Asa, Wallis, Harland, Beyer, Dickey & Saftlas, 2011; Riddell, Ford-Gilboe & Gilboe, 2009).

Riddell, et al., (2009) provides a comprehensive understanding of women's experiences of living in unsafe rural places in Canada. This research clearly identifies that rural dwelling women are more to be at risk of being victims of IPV, and that rural cultures may prevent many women from leaving abusing relationships (Riddell, et al., 2009). Rural culture can be described as patriarchal and masculine, where gender roles are clearly identified and are unequal (Campo & Tayton, 2015). The physical isolation of rural communities can be seen as attractive to abusive

men and that they intentionally relocate to these places to isolate their partners which may contribute to the higher incidence and severity of the abuse (Riddell, et.al, 2009). For those women growing up in rural areas, they may have seen first-hand that violence is a means of social control. The societal norms may restrict women from speaking out, which reinforces the message *'what happens at home, stays at home'*. This attitude serves to silence women and reduces the likelihood and opportunity for them to disclose or to talk about the violence (Campo & Tayton, 2015).

Furthermore, the lack of services (health and social including police) in rural places, means there are fewer opportunities for women to talk about their experiences of violence in their home (Peek-Asa, et.al., 2011). Disparities of services have been identified by the Australian Institute for Family Studies as issues that contribute to inequalities for women living in rural places in the following way;

> *Fear of stigma, shame, community gossip, and a lack of perpetrator accountability deter women from seeking help.*
>
> *- A lack of privacy due to the high likelihood that police, health professionals and domestic and family violence workers know both the victim and perpetrator can inhibit women's willingness to use local services.*
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> *- Women who do seek help find difficulty in accessing services due to geographical isolation, lack of transportation options and not having access to their own income.*
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> (Campo & Tayton, 2015, p.1)

These issues are equally relevant in rural places in New Zealand. Not only are victims of IPV live in rural places geographically isolated, but they are also socially isolated. There is a disparity of the provision of and access to primary health care and social services in rural places in New Zealand, including early detection and screening procedures, for instance breast and cervical screening and other women's health services (Fernley, Lawrenson & Nixon, 2016). These services are places that routinely enquire about IPV and provide women with the opportunity to talk about or disclose IPV in their home.

Discussion and implications for nursing practice

With gender inequalities for women living in rural areas, there are recognised barriers and less opportunities for women to leave abusive relationships (Hughes, 2010). These barriers include having less resources available, including the lack of guaranteed anonymity and this means that the option for some women to leave their home is decreased. Therefore nurses and other health professionals working in rural areas need to be mindful that for many women they work with, it is a distinct possibility that their home is not a safe place to be. Additionally, nurses are more likely to be the recipient of disclosures of IPV during everyday health care if they enquire about safety issues in a non-judgemental way.

Disclosure may be solicited (direct) as in screening or enquiry for IPV, or unsolicited (indirect) where disclosure might occur without asking or prompting of the client (Fanslow et al, 2016; Hughes, 2010). Although routine enquiry for IPV is recommended (Fanslow, et al. 2016), this does not always occur in primary health care (Sundborg, Saleh-Stattin, Wandell & Tomkvist, 2012). Barriers for primary health care nurses enquiring about IPV and therefore to provide adequate or appropriate care for women in this situation, have been identified as a lack of organisational support (in the form of guidelines and policies), the nurses discomfort in asking about IPV, the lack of resources or knowledge of what to do when a positive disclosure is made, their own personal experience and their attitude towards IPV (Koziol-McLain, Giddings, Rameka & Fyfe, 2008; Sundborg, et.al., 2012). However, women who have experienced IPV have reported that they welcome being asked, giving them an opportunity to talk about their trauma in a safe environment (Koziol-McLain et.al., 2008)

In New Zealand routine enquiry asking client's if they have experienced or are experiencing IPV has been in place for nurses for well over a decade now, with Plunket nurses first introducing this in 2003 (Vallant, Koziol-McLain & Hynes, 2007). This practice was followed by nurses in other areas, including public health, emergency department, women and children's health and mental health. The place (locality) that IPV is enquired about by nurses includes clinics or health care settings and in people's homes, and Williams (2004) identifies that home is a place that is suitable for primary care nurses to be enquiring about IPV.

Nurses provide care for clients/patients and whanau in the home routinely. The majority of the literature on the setting or environment of primary health nursing practice has usually been referred to as nurses working in the community rather than the home environment. Community nursing has been explored in depth over the last two-three decades, of note is the construct of the home environment where nurses provide care. Some research has found that the relationship between nurse and client is seen as being different when the place or environment where the care is being provided is the home (Giesbrecht, et al., 2014). This relationship is reported as being of greater equality, or less of a power-differential between the nurse and client as a result of the nurse feeling as though they are a guest in the client's home, or because of the social nature of the locale of the care being provided (Giesbrecht, et al., 2014; McGarry, 2004; Peter, 2002). Nurses feel as though a greater sense of trust is developed when care is provided in the home setting. This sense of trust places nurses working in the home environment in a unique position to be enquiring about what they see in the home including the relationships of the client's they are caring for (Giesbrecht, et al., 2014, Jack et al, 2012). Indeed the therapeutic relationship between the client and nurse can be viewed as significant enough to be considered a place in itself (Gavin et al, 2006).

However, these crucial relationships in rural places may cause a disparity in how rurally based nurses enquire and respond to IPV disclosures, because they are more likely to know or be related to the victim and/or perpetrator of violence. However Murphy and Fanslow (2012) suggest that professionals working with women who are victims of IPV in rural areas have well developed networks based on trust and social networks. The nurse-client relationship based on trust, acceptance and rapport provides an inimitable opportunity to support women in disclosing and talking about IPV, regardless of the 'place' (of disclosure) this relationship occurs in. When the client-nurse relationship occurs in the home, this may prove to be more difficult where the relationship is not built on trust (Jack, et al, 2012). Jack and colleagues (2012, 2016) identified that structured IPV screening used by nurses does not promote disclosure, however when the nurse 'enquires' about the client's exposure or experience of violence in the home, within the context of parenting, safety and relationships, women are more likely to discuss their experiences.

CONCLUSION

For the majority of people, their home is considered a place where relationships are formed and maintained. However when home is not a place of safety, it becomes imperative that nurses working with clients in the home are able to provide appropriate care and support for the client. Increasingly home is also a place where health care is provided and nurses working in the home environment are in a privileged position to establish trusting relationships at a different level from other environments. More specifically nurses working in rural areas may be the only people working with clients in the home and or the health care environment and may be in a position of having IPV disclosed to them. Yet research has also shown that the relationships and community dynamics inhibits IPV disclosure.

Rates of IPV in urban, rural and remote places has been identified as being higher than in urban areas. Geographical factors and social norms and attitudes that are common to life in rural environments shape the experience of IPV and victims access to services and support. Nurses should have a good understanding if the cycle of abuse, the forms that violence takes particularly within intimate and family relationships, and the impact that IPV has on the victim cannot be underestimated.

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