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Aims and objectives. The aim of this paper is to discuss critically the theoretical concepts of awareness, recognition and empowerment as manifested in intimate partner violence (IPV) and to show how these can be translated into a practice framework for improving nurses' response.

Background. IPV is a universal problem and is considered a significant public health issue. Nurses are in an ideal position to recognize and respond to IPV but many lack confidence in this area of practice. In our previous empirical work we identified three concepts through which nurses' responses to IPV can be understood: Awareness, Recognition and Empowerment. In this paper we advance nursing knowledge by showing how these concepts can form a practice framework to improve nurses' responses to IPV.

Design. A discussion paper and development of a practice framework to improve nurses' responses to IPV.

Discussion. The framework comprises three principal needs of women and related three key requirements for nurses to meet these needs. Arising from these are a range of practice outcomes: enhanced understanding of IPV, increased confidence in recognising IPV, establishment of trusting relationships, increased likelihood of disclosure, optimized safety.

Conclusions. Nurses sometimes lack confidence in recognizing and responding to IPV. Awareness, recognition and empowerment are important concepts that can form the basis of a framework to support them. When nurses feel empowered to respond to IPV, they can work together with women to optimize their safety.

Relevance to clinical practice. Access to adequate and timely IPV education and training is important in improving nurses' responses to IPV. Getting this right can lead to enhanced safety planning and better health outcomes for women who experience IPV. Although difficult to measure as an outcome, nurses' improved responses can contribute to higher rates of referral for help and a reduction in IPV rates.

What does this paper contribute to the wider global clinical community?

- A new practice framework shows how the concepts of awareness, recognition and empowerment can be translated into IPV-related practice outcomes.

- The simplicity of the framework makes it a practical resource that might assist nurses in unravelling the complexities of IPV and it can be used as a clinical or pedagogical tool.

- IPV is a global public health issue and the framework presented in this paper should have transference to multiple settings and countries.

AIMS

The aim of this paper is to discuss critically the theoretical concepts of awareness, recognition and empowerment as manifested in intimate partner violence (IPV) and to show how these can be translated into a practice framework for improving nurses' responses.

BACKGROUND

Violence against women is pervasive and encompasses a range of practices that threaten women's liberty, health and life, including human trafficking (Oram et al. 2012), early or forced marriage and female genital mutilation (The Lancet 2015). Another form of violence against women is Intimate Partner Violence (IPV). IPV consists of partner abuse, family abuse, sexual assault and stalking, and can be understood as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty (World Health Organization (WHO) 2013). IPV tends to be under-reported which makes assessment of its prevalence problematic, but it is estimated that almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (WHO 2013).

In Britain, the Office for National Statistics (ONS 2015) reported that young women were twice as likely as men to have experienced IPV, with 8.5% of women and 4.5% of men having experienced abuse in the last year, which equates to an estimated 1.4 million female victims and 700,000 male victims. IPV occurs in different relationship configurations, irrespective of gender or sexuality (Home Office 2012). Lesbian and bisexual women experience IPV at a similar rate to women in general (1 in 4), although a third of this is associated with male perpetrators. Compared with 17% of men in general, 49% of gay and bisexual men have experienced at least one incident of IPV since the age of 16. This includes IPV within same-sex relationships (ONS 2015). While accepting the serious impact of

violence perpetrated against men, we situate IPV within a broader Violence Against Women framework and thus most of this article focuses on women as victims of IPV.

The fiscal costs of IPV are considerable. In Europe, an estimated €226 billion is spent annually on IPV, including €45 billion on services and €25 billion in lost economic output (Walby 2014, Walby & Olive 2013). But it is the cost to human life that has far more weight than financial loss. IPV carries risk of physical and sexual harm and domestic homicide. It is also associated with suicide risk (Devries et al. 2011). IPV is invariably associated with psychological and emotional harm. It impacts directly upon the mental health of women and children, resulting in poor functioning and compromised health over the life-course (Symes et al. 2014). Overall, the negative health impact on women contributed by IPV is greater than other risks such as smoking or obesity (Humphreys et al. 2008) and it is recognized as a considerable public health issue (Bacchus et al. 2012).

Nurses are ideally placed to recognize and respond to IPV, but there is significant evidence that some lack confidence in this area (Taylor et al. 2013). In previous empirical work we suggested that increasing nurses' awareness, recognition and empowerment in relation to IPV may positively influence their responses to it (Bradbury-Jones et al. 2014). In this paper we advance nursing knowledge by showing how these concepts can form a practice framework to improve nurses' responses to IPV as shown in Table 1. The framework comprises three principal needs of women and related three key requirements for nurses to meet these needs. It shows the practice and public health outcomes that can arise from the synergy of 1) women's needs and 2) requirements for nurses, being met. In developing the framework the intention is to bridge theory and practice by turning a solely conceptual framework, into a practice based one that has relevance for clinical nursing.

{Table 1}

DESIGN

This is a discussion paper that builds on and refines the conceptual framework arising from our previous IPV research (Bradbury-Jones et al. 2014).

DISCUSSION

Clarification of concepts

Awareness, recognition and empowerment are complex concepts and to attempt a full concept analysis of each is beyond the scope of this paper. Besides, we are seeking practical transference rather than further theorization. But for the sake of clarity, some explanation of what we mean by these concepts is required (Table 2). These will be explained in brief before moving to a fuller analysis of how they relate to nursing practice.

{Table 2}

'Awareness' can be understood as familiarity, knowledge or understanding of something. Our interpretation of awareness in this paper is that it remains at a conceptual and theoretical level. We might know that something exists, but that doesn't necessarily mean that we can recognize it, in much the same way as most nurses know that confusion can occur in patients for a number of reasons (dehydration, trauma, medication, dementia etc.) but they might not always be able to recognize its existence or cause among patients in their care. In relation to a nurse's awareness of IPV, this can be expressed as 'I know about IPV and I may, or may not be able to recognize it in practice'. 'Recognition' is defined as detection, acknowledgement and realization and is concerned with personalization and application. In other words, it is where a conceptualized and theorized understanding of IPV is applied to a person. Hence, 'I

know about IPV and I recognize that it may be happening to you'. Empowerment is a nebulous term, but our interpretation is that of enablement and sharing of power. It can be expressed as: 'I know about IPV, I recognize that it may be happening to you and I am confident in how to respond' (Table 2). How each of these three concepts might be translated into an IPV framework is presented in Table 1 and importantly, their relevance for nursing practice is highlighted.

Awareness of IPV

An important phenomenon to understand in relation to IPV is that women do not always see their situation as abusive (Taylor et al. 2013). This is particularly the case among women who experience emotional or coercive abuse. Bradbury-Jones and colleagues (2014) described how abused women in their study relied on nurses to help them to 'see' the abuse and to recognize is at such. One woman who took part likened this to having an x-ray image explained – it looks messy and complicated at first, but once explained it looks much clearer. Table 1 therefore shows that 'naming the abuse' is a principal need of many women who experience IPV. Talking about IPV creates an environment in which women can reflect on their own experiences, and begin to name their experiences as abusive. Nurses are crucial in this process and can be catalysts in supporting women to re-frame their experiences.

Regarding nurses, evidence suggests that in general, their theoretical knowledge in relation to IPV is good (Taylor et al. 2013). For example, they understand that IPV occurs in many forms and that it can often be a combination of physical, sexual, emotional or financial. In this respect, their knowledge aligns with existing evidence, regarding the co-existence of different forms of abuse (WHO 2009). Sound understandings of IPV appear to be formed

early in nurses' careers and Bradbury-Jones and Broadhurst (2015) reported that student nurses have a good theoretical grasp of the issue.

Despite the sound knowledge of IPV among many nurses, some prevailing stereotypes exist, for example that IPV only happens to certain 'types' of people or that some women are to blame for their abuse (Taylor et al. 2013). Such misconceptions mean that nurses may be alert to the risk of IPV only among certain women who fit their stereotype; ignoring the fact that while economic hardship is a complex feature of IPV (for example, Renzetti 2009), women's gender is a more significant risk factor that crosses socio-demographic boundaries. Taylor and colleagues' study also highlighted the mistaken belief among some nurses, that women are upset or insulted by being asked about IPV. This supports earlier research regarding midwives' fear of offending women (Salmon et al. 2006). There is plenty of evidence however, that women are not offended (Koziol-McLain et al. 2008, Robinson & Spilsbury 2008, Feder et al. 2009, Bradbury-Jones et al. 2014).

Overall in relation to IPV awareness, apart from some erroneous beliefs, many nurses appear to possess sound theoretical understandings of the issue. The problem is a tendency towards being unable to transfer this knowledge to practice. With reference again to Table 2, nurses may understand IPV in theory but may - or may not - be able to apply this in practice. Evidence suggests a particular paralysis around discussing the issue of IPV with women (Sundborg et al. 2015). These authors reported that district nurses in Sweden often fail to ask women about IPV and they suggested that this 'hesitation process' was partially attributable to limited awareness.

Education and training have been identified as crucial in improving health professionals' responses to IPV (NICE 2014). This level of the framework (Table 1) shows that access to such training is a key requirement for nurses because it is the catalyst to improved IPV responses. There are key messages here for nurse educators and providers of IPV training. Drawing on evidence as discussed, the framework highlights the need to focus less on the manifestations and types of abuse, and more on myth-busting and bolstering nurses' confidence in addressing the issue of IPV in practice. It is important also, that education and training meet the needs of nurses from different clinical environments, such as emergency contexts (Rahmqvist Linnarsson et al. 2015). It is through this that they can be equipped to recognize and respond to IPV appropriately.

Recognition of IPV

Another important IPV related phenomenon is the propensity among most women to conceal abuse from health professionals. There are complex reasons why this is the case, but among other things, concealment is underpinned by shame (Ahmad et al. 2009) and fear of removal of children (Peckover 2003). Robinson and Spilsbury (2008) identified fear of further abuse as a considerable – and real – concern among women. They also reported that concealing abuse arises from women's perception that many health professionals do not understand IPV nor respond appropriately. There is evidence that this may be the case. Health professionals, including nurses, have been found to lack empathy and sensitivity (Reisenhofer & Seibold 2012, Walker & Allen 2014); appear to be uncaring (Ormon et al. 2013, Shoqirat 2014) or have ambivalence about their IPV role (Sundborg et al. 2015).

Interestingly, while disinclined to disclose, as discussed already, women *do* want the issue of IPV raised. Whether experiencing abuse or not, most women are not offended (Koziol-

McLain et al. 2008). Indeed, women who had experienced IPV in the study by Bradbury-Jones and colleagues (2014) were angry with the nurses that they had encountered who avoided talking about IPV with them, and who failed to provide opportunity for disclosure. It is important therefore that nurses are able to offer support with disclosure (Table 1). There needs to be a safe time and place for this, but asking about IPV provides an indication to women that it is an issue to be discussed, making it less of a taboo subject. Importantly, when nurses discuss the issue of IPV openly and confidently, they create opportunity for disclosure.

However, nurses find discussions about domestic abuse difficult and many avoid the issue. Therefore, as shown in Table 1, a key requirement for nurses at the recognition level is support for having what has been termed 'difficult conversations' (Bradbury-Jones 2015). This can be achieved in part, through education and training and as discussed, the framework gives direction and focus to this. But the framework can also be used in practice as a discussion aid among nurses (for example as part of clinical supervision) or between registered nurses and students. It is envisaged that as a reference point, it might create dialogue regarding ways to make difficult conversations easier. Understandably, non-judgemental attitude is important in facilitating the disclosure process (Feder et al. 2006, Ahmad et al. 2009). Thus as shown in Table 1, in order to facilitate disclosure, establishing trusting relationships is important and particularly those that facilitate open discussions about abuse (Bradbury-Jones et al. 2014). But this is not an end in its own right. The purpose is to optimize the safety of women and any children. This is achieved through nurses being empowered to act appropriately when faced with the act of disclosure.

Empowerment and IPV

Empowerment is a nebulous term, but our interpretation is that of enablement. As a definition we appreciate the simplicity of Chandler's (1992 p.65) definition of empowerment as 'to enable to act'. Control is a significant issue for people who have experienced abuse. From a woman's perspective then, empowerment is concerned with choice and relationships between nurses and women need to be based on a philosophy of shared power. Part of the control needs to be a shared control – that is, empowering the woman to act for herself and have control over safety choices (Table 1). Wilson (2015) discussed the need for nurses to use both 'hearts and minds' when enabling women to identify and secure their own means to safety. This hinges on respect for autonomy and knowing and accepting that not all women are ready to leave an abusive relationship. 'Why doesn't she just leave?' is over-simplification and there are multiple, complex reasons why the only choice for a woman is to stay (Murray 2008). The role of nurses in this context is to support women through the immediacy of the abusive situation and plan towards safety. As captured in Table 1, this is contingent upon developing trusting relationships and acknowledgement that the development of autonomy takes relational time and skill.

Sundborg et al. (2015) identified a lack of preparedness among nurses for managing the disclosure event. As a nurse, to be empowered is to respond appropriately to IPV and this hinges around confidence in nurses 'response. Working in partnership for safety planning is important (Table 1). Public Health England (2013) produced guidance for multi-agency working to reduce the harms associated with IPV. Abuse rarely presents as a stand-alone risk to personal safety; multi-agency approaches must incorporate public health and primary care strategies if harm reduction strategies are to succeed (Smith et al. 2014, PHE 2013). Making every contact count is crucial; for example, as smoking behaviours are tentatively linked with women who are more at risk of abuse (Smith et al. 2014) a common-sense approach to

empowerment could involve nurses' integration of IPV awareness and recognition within smoking cessation strategies and other public health focused interactions.

There are clear reporting duties for vulnerable children and adults (Department of Health 2013, HM Government 2015), with women experiencing domestic violence being classed as vulnerable in this context. The threat of immediate danger, although not always easy to ascertain, requires and emergency response. In the UK there are clear referral pathways for IPV (NICE 2014, CAADA & IRIS 2012). Nurses need to be familiar with such pathways and other guidance and legislation. Highlighting this in the framework serves as a prompt for nurses to ensure that they are aware of such guidelines. In particular they need to know how to give a more nuanced response where the threat level is less immediate or intense. This is crucial because it has been shown that health care professionals do not always recognize the child protection side to IPV (Taylor et al. 2013). Yet it is increasingly recognized that living with IPV experience, even if not directly physically hurt, is harmful to children's social, emotional and physical development (Buckley et al., 2007). Children's safety needs to be factored into a response and where children are present within an IPV situation a child protection concern should be raised.

Finally (and importantly) optimized safety (Table 1) is not unique to women; it is crucial that nurses are also safe. Physical safety is important and nurses must be vigilant in terms of following policies and practices that protect them. There is emotional safety too, and it is acknowledged that dealing with the issue of IPV is associated with emotional labour (Taylor & Bradbury-Jones 2011). The NSPCC (2013) have laid out the potential implications for professionals when working with traumatized children and families, warning that vicarious trauma, compassion fatigue and burnout are considerable threats. They argue that if the emotional consequences of this work are not mitigated a professional's wellbeing and ability

to work effectively will be affected. There is an argument that to be empowered, one has to first be empowered themselves. So in striving to support and ensure the safety of abused women in their care, nurses must first keep themselves safe emotionally. Self-care is important and as recognized by the NSPCC, one way to manage vicarious trauma is with rigorous supervision and peer support (NSPCC 2013). The IPV framework highlights an important lesson for nursing practice then, in reminding us all to better support each other.

CONCLUSIONS

Although there has been significant progress in tackling violence against women, there is still a long way to go (The Lancet 2015). In this paper we have explored IPV as a significant threat to women's health and liberty and the important part that nurses play in addressing IPV. Bacchus and colleagues (2012) argued that it is necessary to create a 'domestic abuse aware' culture in healthcare. We hope that the practice framework supports this, particularly with its emphasis on 'awareness raising' for nurses through education and training. In producing the framework, we have attempted to move from concept, through to strategies and outcomes. The extent to which this bridges theory and practice will be for the judgement of readers and will be demonstrated by the test of time. But at least there has been an attempt to advance nursing practice through moving beyond theory.

It is acknowledged that the cost of prevention of IPV is substantially less than the cost of legal and public health service(s) to reduce the burden (Walby 2014, Walby & Olive 2013). The far right column of the practice framework shows the long-term public health outcomes of increased rates of IPV referral and reduction in IPV rates (Table 1). It may be a leap to suggest that the practice framework presented here can bring about such significant public health outcomes. However, with an eye to the fuller picture, small upstream actions such as

those suggested in this paper, have at least some potential, albeit very modest, impact on downstream outcomes.

RELEVANCE TO CLINICAL PRACTICE

Nurses' knowledge of IPV is variable with a reported lack of awareness about abuse and lack of confidence in responding effectively to disclosures of abuse. Although many nurses claim some knowledge about the issue of IPV, training and education for practice appears insufficient (Bradbury-Jones et al. 2014, Sundborg et al. 2015, Taylor et al. 2013). Adequate and timely education and training is important in improving nurses' responses to IPV. Additionally, supporting each other to deal with the potential trauma of working with IPV is crucial. Getting these things right can lead to improved safety planning and better health outcomes for those with IPV experiences. In our framework we have juxtaposed the needs of abused women with the requirements of nurses. We hope that nurses and nurse educators use it as a clinical or pedagogical tool and it may be displayed visually or used as a reference point. IPV knows no boundaries and women across the world experience it, which means that the framework should have transferability to many countries and contexts.

Table 1: A practice framework for improving nurses' responses to IPV

Concept	Principal needs of women	Key requirements for nurses	Practice Outcomes	Public Health Outcome
Awareness	Naming the abuse	Access to appropriate IPV education and training	Enhanced understandings of IPV Increased confidence in recognising IPV	Increased rates of IPV referral and reduction in IPV rates
Recognition	Support with disclosure	Support in having difficult conversations	Establishment of trusting relationships Increased likelihood of disclosure	
Empowerment	Control over safety choices	Working in partnership for safety planning	Optimized safety	

Table 2: Clarification of terms, definitions, interpretations and expressions

Term	Definition	Interpretation	Expression
Awareness	Cognizance, consciousness, familiarity, knowledge and understanding	Conceptualization and theorization	'I know about IPV and I may, or may not be able to see it in practice'
Recognition	Detection, discovery, acceptance, acknowledgement, realization	Personalization and application	'I know about IPV, I recognize that it may be happening to you'
Empowerment	To enable, to act	Enablement and control	'I know about IPV, I recognize that it may be happening to you and I am confident in how to respond'

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