



This is a repository copy of *Researching domestic violence and abuse in healthcare settings: Challenges and issues*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/105868/>

Version: Accepted Version

Article:

McGarry, J. and Ali, P. orcid.org/0000-0002-7839-8130 (2016) Researching domestic violence and abuse in healthcare settings: Challenges and issues. *Journal of Research in Nursing*, 21 (5-6). pp. 465-476. ISSN 1744-9871

<https://doi.org/10.1177/1744987116650923>

Reuse

Unless indicated otherwise, fulltext items are protected by copyright with all rights reserved. The copyright exception in section 29 of the Copyright, Designs and Patents Act 1988 allows the making of a single copy solely for the purpose of non-commercial research or private study within the limits of fair dealing. The publisher or other rights-holder may allow further reproduction and re-use of this version - refer to the White Rose Research Online record for this item. Where records identify the publisher as the copyright holder, users can verify any specific terms of use on the publisher's website.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Journal of Research in Nursing

Title Page: Researching Domestic Violence and Abuse in Health

Care Settings: Challenges and Issues

Author details

Dr Julie McGarry, DHSci, MMedSci, BA (Hon), RN (adult and mental health) Associate Professor, School of Health Sciences, University of Nottingham, A Floor Queens Medical Centre, Derby Road, Nottingham NG7 2HA, UK Tel: 0044+(0)115 82 30516

Email: Julie.mcgarry@nottingham.ac.uk

Biography

Dr Julie McGarry is Associate Professor within the School of Health Sciences, University of Nottingham, UK. Julie's clinical background is in adult and mental health fields of nursing practice working with vulnerable adults both in hospital and community settings. Julie's field of research expertise centres on domestic violence and abuse (DVA) – her recent work has included exploring narratives of abuse among older survivors, barriers to the recognition of DVA among healthcare professionals and the development of effective health and social care professionals' working practices with survivors and families. Julie's work synthesises research, education and practice and she has recently been awarded the title of Senior Fellow of the Higher Education Academy.

Dr. Parveen Ali, PhD, MScN, RN, RM

Lecturer, School of Nursing and Midwifery, University of Sheffield,
Barbarhouse Annex, 3a Clarkhouse Road, Sheffield, S10 2LA

Tel: 0114 222 2046

Email: parveen.ali@sheffield.ac.uk

Biography

Parveen is a Lecturer within the School of Nursing and Midwifery, University of Sheffield. Parveen is a registered nurse, Registered Nurse Teacher, and a Fellow of Higher Education Academy. She is interested in exploring gender based violence, and inequalities in health care experiences and health outcomes. Parveen have been involved in studies exploring how preparation and training of health professionals such as doctors, nurses, and allied health professionals can contribute to tackling such inequalities and improving patient experience.

Abstract

Domestic violence and abuse (DVA) is now recognised as a significant global health and societal issue. DVA encompasses many different forms of violence and abuse including physical, sexual, emotional, psychological and financial abuse. A number of approaches have been used in healthcare contexts to explore the issue of DVA. Every methodology has its own opportunities and challenges, however, conducting DVA research in healthcare contexts requires and understanding of various methodological and ethical issues. Based on our experiences of working as clinicians and researchers, this paper aims to explore pertinent issues and challenges associated with DVA research conducted in healthcare settings involving patients and/ or healthcare professionals or both. A number of methodological challenges, particularly those associated with research design and data collection and ethical challenges related to participants and researcher are explored.

Keywords Domestic violence and abuse, research, ethical issues, methodological challenges

Key points:

- Domestic violence has a significant impact on the health of those who experience abuse and is a national and global concern.
- Effective recognition, management and support is now acknowledged as a key priority for healthcare professionals at a policy level.
- As DVA research continues to evolve within healthcare it is important that nurses and healthcare professionals are able to recognise the tensions that are inherent on carrying out research in this field.
- Consideration of the practical, ethical and professional challenges to DVA research enables nurses and healthcare researchers to conduct research that is both rigorous and cognisant of the safety of all participants within the research process.

INTRODUCTION AND BACKGROUND

After all, violence is preventable. The more we gather knowledge about it, the better we are to contribute to its minimisation in society (Stanko & Lee, 2003)

Domestic violence and abuse (DVA) is now recognised as a significant global health and societal issue (World Health Organisation, 2015). Traditionally, DVA has been conceptualised as encompassing a number of different forms of harm including physical, sexual, emotional, verbal, psychological and financial abuse. However, more recently there has been a greater recognition of the inherent complexity that underlies DVA and in the United Kingdom (UK) the definition of DVA has now been revised by the UK Home Office to include:

any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse among those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The definition also includes so called 'honour' based violence, female genital mutilation (FGM) [cutting] and forced marriage (United Kingdom Home Office, 2013).

The potential consequences of experiencing DVA are far reaching and DVA is not defined by gender, age, social class or ethnic group. The impact of DVA on the lives and health of those affected is now well documented within the literature and this includes increased mortality and morbidity, both physical and psychological ill-health, effecting both short and longer term health and wellbeing (Rose et al., 2011, McGarry, et al., 2011). DVA also exerts a

detrimental impact on the health and wellbeing of wider family members, especially children (Holt et al., 2008).

In the UK, DVA has recently been identified as a key national priority at a policy level for all healthcare professionals. This has been crystallised through the development and subsequent publication of The National Institute for Health and Care Excellence (NICE) (2014) guidance entitled *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*. A core component of the NICE (2014) guidance centres on the development of strategies to support the effective recognition and management of DVA among healthcare professionals with a key focus towards education and training.

Alongside the increasing emphasis on the role of healthcare professionals in terms of effective support and management of DVA, there has been a growing body of research which has focused on some of the key challenges associated with DVA within healthcare environments more generally. For example, research has been conducted to explore the issues related to the accurate recording of the incidence and prevalence of DVA in specific settings (Boyle, et al. 2004), identification and effective facilitation of education, training and support needs of healthcare professionals (Feder et al., 2011; Larijani & Guggisberg, 2015; Leppakoski, et al., 2014), barriers and enablers to the effective identification and management of DVA across a range of settings (Rose et al., 2011; Taft, Broom, & Legge, 2004), the impact of DVA on the health and wellbeing of survivors (Campbell, 2002) and the experiences of DVA survivors within healthcare systems (Yam, 2000).

A number of methodological approaches have been utilised to investigate these phenomena within healthcare settings, ranging from surveys (Bradley, Smith, Long, & O'Dowd, 2002; Leppakoski et al., 2014; Ramsay et al., 2012) to randomised control trials (RCTs) (Husso et al., 2012) and thematic analysis (Rose et al., 2011) to grounded theory (Chang, et al. 2005).

While the use of quantitative approaches to explore DVA are not uncommon, certain research questions may be best answered by qualitative approaches. Certain methodologies such as discourse analysis and ethnographic observations may prove to be very useful in exploring questions such as how healthcare professionals assess DVA risk and explore patients' experiences in healthcare setting.

Moreover, in addition to the wider 'system' type research questions, many of the salient questions that DVA researchers have sought to address within healthcare settings are qualitative in nature, concerned with 'exploring', 'examining' or 'explaining', and are rooted in experiential or the lived experience of an individual for example, questions which ask *what is the impact of DVA for survivors?* (Sarkar, 2008; Yamawaki et al., 2012) or questions which ask *what are the barriers to healthcare professionals undertaking enquiry about DVA?* (Baig et al., 2012; Jenner et al., 2015; Rose et al., 2011; Sprague et al., 2012). Given that DVA is largely hidden these approaches are arguably also particularly valuable for example in enabling otherwise marginalised or 'silent' voices to be heard (author, 2016 in press).

Overall, DVA research entails a number of particular opportunities and challenges for researchers. For instance, general considerations at the onset of the research may be associated with identification and recruitment of

appropriate participants, negotiating access, ensuring safety of the participants while maintaining confidentiality and anonymity and issues relating to response or recall bias (Kelmendi, 2013). Other issues include the lack of appropriate description of the context in which DVA occurs, impact of the research on researcher and researched and vice versa (Dowson, Watkins, Khan, Dasgupta, & Sahai, 2012; Watts, Heise, Ellsberg, & Ellsberg, 2001).

Irrespective of the methodological approach undertaken the subject of DVA itself also warrants careful consideration and planning in terms of any safeguarding issues that may emerge during the process of enquiry (Nursing and Midwifery Council, 2015). Such issues are relevant to researchers generally but are particularly pertinent to researchers who are healthcare professionals themselves such as nurses, midwives, physicians, as they are bound by the code of conduct of their respective registration regulators. As such researchers with such dual responsibilities need to be cognisant of the range of important methodological and ethical difficulties intrinsic to investigating DVA in healthcare settings (Bacchus, Mezey, & Bewley, 2003).

AIM

Utilising existing literature, alongside the collective experience of the authors in undertaking DVA research, the aim of this paper is to explore pertinent methodological, ethical and practical challenges and responses that DVA researchers need to consider when designing and conducting research in healthcare settings involving patients and/ or healthcare professionals or both.

METHODS

This paper was developed through a narrative review and synthesis of a range of relevant literature and is set within the broader context of our personal

reflections, experiential knowledge and the learning that we have developed as a result of working as clinicians and researchers in the field of DVA.

FINDINGS

Methodological Challenges

Design related issues

While clinical presentations of DVA may occur across a wide range of healthcare settings, the emergency department (ED) and primary care settings have often been frequently as common places in the healthcare context where DVA research is conducted. These and similar settings are often very busy with brief episodes of patient/client contact, thus making availability and engagement with participants, who could be healthcare professionals or patients, a challenge. Therefore, while planning a study in such a setting, a researcher has to clearly think about the design and research methodology. It is important to ensure that the design is appropriate to answer the research question and that the data collection instruments and tools, especially questionnaires used are easier to understand, efficient, relevant and not burdensome.

i) Study design and data collection

Defining DVA and the potential lack of conceptual clarity

The design of a study is directly related to the methods to be utilised for the collection of data. A number of issues can arise at the outset, before data collection has commenced, and include fundamental challenges around the lack of shared understanding with regard to how DVA is defined. Schwartz (2000) has highlighted this by asking "*if we want to study something called family*

violence, is this possible when we do not have an agreed-on definition of family and are not even close to determining the definition of violence” (p816). Issues related to the lack of conceptual clarity around the definition of DVA are further echoed by Boyle (2004) within the context of the emergency department (ED) in terms of potential validity and reliability when attempting to compare findings of DVA research across and within populations.

While a clear definition of DVA is central for researchers in terms of study design, it is crucial that collaborating healthcare practitioners and study participants themselves are able to identify with and recognise the terminology used (Schwartz, 2000). The researcher also has to be very self-aware of their own thoughts, feeling and views to ensure that these do not impact the design and conduct of the study.

Working alongside practitioners as research partners

A sizable proportion of DVA research, in the healthcare context, requires direct collaboration or working alongside practitioners and clinicians in a number of different ways including the collection of data. There may be challenges in terms of engaging clinical staff and managers within a particular setting. This might be especially relevant where there has been little in the way of training or prior awareness-raising around the significance of DVA within a particular clinical area (Bacchus et al., 2003). In a study that explored the development and use of a screening tool for DVA within midwifery services Bacchus et al. (2003) identified a number of practical issues associated with the execution of the study in practice. These issues included for example, the quality of the data collection by midwives in the study who had limited research experience. Midwives also had

limited commitment to research due to the demands of their everyday workload issues. These observations arguably highlight the possible tensions when carrying out research in healthcare contexts and are not specific to DVA research. However, such issues of engagement are of greater importance when set within the particular context of DVA research, as *"enquiry about domestic violence takes time and if the midwife appears hurried or distracted, the woman may be alerted to this and will be less likely to reveal that she is being abused"* (Bacchus et al., 2003, p. 202). One way of dealing with these issues is co-joint study development with practitioners from the outset of the project. Such involvement ensures that practitioner's concerns are listened to and a sense of ownership of the project can be developed.

Engaging with survivors of DVA

Within DVA research, the voice of study participants is central to the process of enquiry and may include survivors or perpetrators of abuse, healthcare professionals and specialist agencies providing services. As previously identified, there are a number of approaches to data collection that may be used however, it is important to consider which approach will be most appropriate for any given situation. For example, the use of focus group discussions is helpful in addressing issues relating to asymmetry of power or discomfort between researcher and participants, especially those who may not feel comfortable in a one-to-one interview (Wilkinson, 1998) or feel they do not have anything valuable to contribute (Kitzinger, 1995). Use of focus groups provides a safe environment for discussion (Owen, 2001) whereby the perspectives of the participants are dominant over the agenda of the researcher (Wilkinson, 1998) (author, in press). However, given the sensitive nature of the DVA and the

healthcare context, individual interviews, participant observation or document review may be other useful data collection methods.

ii) Methodical Challenges

Undertaking sensitive research

Within the literature, there has been considerable discussion with regard to what constitutes sensitive research (Sampson, et al. 2008). The definition of sensitive research may range from that which is defined as an intrusive topic (Renzetti & Lee, 1993) to an activity with physical and emotional consequences for both researcher and researched and has serious implications for practice and research (Dickson-Swift et al. 2008). Many of the broader challenges surrounding researching sensitive subjects has been explored in an earlier paper within the context of undertaking nursing research around sensitive issues generally (author, 2010). Various ethical and safety recommendations (Table 1) proposed by World Health Organisation (Watts et al., 2001) are very useful in this respect. There are also a number of issues and challenges that are arguably specific to DVA within the context of healthcare. There are various ethical issues not only related to participants but the researchers themselves that should be considered while designing DVA research.

Participant's safety

In DVA research the safety of the participant is of paramount importance. One such issue is the potential for so called 'double disempowerment' of DVA survivors during research "first as research subjects and second as part of a stigmatised and marginalised community" (Malpass et al. (2015, p2). Such risk can potentially be minimised by ensuring ethical issues related to an individual's

capacity to consent, the right to appropriate information about purposes, processes and outcomes of the study, provision of enough time and space for individuals to enable them to make an informed decision about their participation are considered.

Participants also need to be aware of their rights to privacy, confidentiality, anonymity and their right to refuse to participate or withdraw from the study any time without any negative consequence. All of this information should be detailed in an information sheet, which (along with a copy of consent form) is usually given to the participant to keep.

However, in the context of DVA, the potential participant may not feel safe keeping a copy of information sheet or consent form with them. This is even more relevant to healthcare context, where a participant may recently have experienced violence and may still feel terrorised or unsafe. At the same time, the perpetrator may also be very alert and observant to a survivors actions. DVA researchers need to consider if such documents are there to protect participants or researchers and institutions (McNutt et al., 2008; Riessman, 2005). The researcher really needs to think clearly of the need, usefulness and potential impact of giving information sheets and copies of consent forms to participants. Asking the potential participants if they feel comfortable in keeping a copy and respecting their preferences may help.

Survivors may feel more comfortable in giving verbal consent to avoid recognition associated with written consent (Bacchus et al., 2003). In our own practical experience of conducting research focus group participants have felt more comfortable in signing a group consent sheet or giving a verbal consent. Involvement of collaborating practitioners, in this regard, can be helpful as the

possibility of incorporating consent requirement in to existing institutional routine consent process can be explored.

DVA research is undoubtedly emotive and personal and has the potential to bring up emotionally disturbing and painful memories for victims as participants (Davis et al, 2001, p337). Malpass, et al (2015) for example use the term 'symbolic violence' (Bourdieu, 1996) "*as it relates to the research process itself, something which may arise in any encounter where there is a power imbalance between the researcher and the researched*" and further highlight the need to be cognisant of "*how we carry out any research with human beings, but particularly with vulnerable populations*" (p3). In a recent study that sought to explore narratives of DVA survivorship with older women the authors worked closely with a specialist DVA agency in the development and execution of the project and specialist staff from the agency were present during the project workshops and available afterwards in terms of follow-up support for participants.

There is a concern that contributing to DVA research is associated with increased risk of violence if the perpetrators come to know about it. However, it has been suggested that this concern to some extent has been based in assumptions, anecdotal evidence (Griffin, Resick, Waldrop, & Mechanic, 2003; Kuyper, de Wit, Adam, & Woertman, 2012) or "...worst case scenarios of research atrocities" (Sikweyiya & Jewkes, 2012, p. 1). On the contrary, such participation can be beneficial and cathartic (Edwards, Kearns, Calhoun, & Gidycz, 2009; Sikweyiya & Jewkes, 2012) and may prove empowering (Downes, Kelly, & Westmarland, 2014). However, the safety of participants is paramount and we have worked with specialist agencies throughout the research process to ensure that the necessary safeguards are in place. This has included seeking advice and

guidance with regard to recruitment and how and where to advertise a study to ensure participants safety. In a recent study, the authors were requested by participants not to audio-record a focus group. While this presented challenges in terms of traditional research methods and reporting, we have argued that to exclude these narratives from subsequent reports further 'silences' the voices of survivors (author, 2016 in press).

Ethical Challenges: Researcher's Safety

As previously identified, the intrusive and sensitive nature of DVA research means that it has the potential to bring up emotionally disturbing and painful memories to those involved (Davis et al, 2001, p337). Research participants, however, are not unique to such experiences. There is an increasing recognition that nursing and healthcare research especially DVA research is associated with several physical and emotional risks to researchers themselves (Taylor & Bradbury-Jones, 2011). However, the potential impact of DVA research for researchers has not always been sufficiently accounted for by researchers and *"considering how many studies have been conducted on VAW [violence against women] it is remarkable how little has been written about the impact on researchers"* (Fontes, 2010, p168).

Within DVA research and especially qualitative research, the very nature of engagement with participants or informants necessitates a degree of proximity between the researcher and the researched. *"Proximity is most clearly articulated through the respective constituents of reflexivity which acknowledge the role of the researcher in "the actual production" of the data (Davies, 1999), the motivations guiding the researcher and the way in which 'the field of study is*

filtered through the very particular interpretive lens of the researcher' (Allen, 2004) and the impact of the field of research upon the researcher and vice versa in terms of personal and emotional encounters (Coffey, 1999)" (author, 2010, p14).

Moreover, other challenges associated with such research have been described as including issues surrounding the maintenance of appropriate boundaries, the development of rapport, developing friendships, physical and emotional safety, managing emotions and leaving the field (Dickson-Swift et al. 2007, p328).

Accounts within the wider literature include the actual physical proximity of undertaking research as described by McClennen (2008) in her paper entitled *Researching Gay and Lesbian Domestic Violence*. For McClennen, one of the key issues of proximity related to the process of 'immersion' and the "personal and professional costs of being identified with the population under study" (p41) which included the potential impact in terms of social identity. The impact of physical proximity has also been highlighted in terms of issues relating to personal safety by Coles et al (2014) in their study that explored 'researcher trauma' surrounding researching sexual violence. Sort out this sentence

Proximity however may not necessarily be defined in terms of physical proximity and there are implications for all those involved in research process such as data collectors, transcribers, transcribers, supervisors, readers/viewers of publications and presentations, practitioners and professionals (Downes et al., 2014; Johnson & Clarke, 2003; McCosker, Barnard, & Gerber, 2001). Etherington (2007) also highlights how the process of reflexivity requires researchers to "*emerge from behind the secure barrier of anonymity*" (p611) in terms of presenting their

subjective position and dilemmas within the research reporting process which again involved emotional proximity to the data.

As well as 'reliving' narratives there are also issues related to notions of 'powerlessness'. Researchers are often placed in a position where they are privy to deeply personal accounts of violence, but unlike professionals for example, clinicians working in practice, they did not feel in a position to be able to provide direct support (Coles et al, 2014).

Due to the nature of DVA research, especially qualitative research, it can be difficult to anticipate fully the way in which the research will unfold. This includes possible disclosure beyond the original scope of the study. For example, during a recent study the authors of this paper encountered a deeply personal disclosure of historical rape by a participant. This disclosure was unexpected within the context of the discussion. However, the participant felt that this was a safe space to disclose and the researchers were able to offer support and also to ensure that we as team members were well supported. Appropriate debriefing exercises, discussions and reflections are some strategies that can help researchers and the research team manage the emotional and psychological impact of DVA research. However, it is important to recognise the possible emotional impact of a study at the onset and to ensure that mechanisms are planned and in place to support all members of the research team.

CONCLUSION AND IMPLICATIONS FOR NURSING RESEARCH AND PRACTICE

DVA is now clearly acknowledged as a significant concern for those working across a range of healthcare settings. As healthcare professionals such as nurses

and clinicians continue to engage in DVA research it is also necessary to consider the practical issues that impact on the design and delivery of DVA research for all participants, both researcher and researched. It is further acknowledged that as nurse researchers we are bound by the ethical code of conduct expected of all of those engaged in research. However, in addition we are also professionally bound and accountable to our respective professional boards, for example in the UK the NMC Code (2015). The aim of this paper, therefore, was to explore pertinent issues and challenges that DVA researchers need to consider when designing and conducting healthcare research involving patients and/ or healthcare professionals or both. As highlighted in this paper there are a number of particular challenges for those researching DVA within healthcare contexts, and while these should not be underestimated, they should not deter the continued pursuit of empirical enquiry around DVA.

References

Allen, D. (2004). Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry*, 11(1), 14-24.
doi: 10.1111/j.1440-1800.2004.00201.x

Bacchus, L., Mezey, G., & Bewley, S. (2003). *Researching domestic violence in a maternity setting: problems and pitfalls*. Oxon: Routledge.

Baig, A. A., Ryan, G. W., & Rodriguez, M. A. (2012). Provider barriers and facilitators to screening for intimate partner violence in Bogota, Colombia. *Health Care for Women International*, 33(3), 250-261.

Bourdieu, P. (1999) Understanding, In Bourdieu, P. and Balazs, G. (eds.) *The weight of the world. Social suffering in contemporary society*. Stanford: Stanford University Press.

Boyle, A., Robinson, S., Atkinson, P. (2004) Domestic violence in emergency medicine patients. *Emergency Medicine Journal* 21: 9-13

Bradley, F., Smith, M., Long, J., & O'Dowd, T. (2002). Reported frequency of domestic violence: Cross sectional survey of women attending general practice. *British Medical Journal*, 324, 271.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359(9314), 1331-1336.

Chang JC, Cluss PA, Ranieri L, Hawker L, Buranosky R, Dado D, McNeil M, Scholle SH. (2005) Healthcare interventions for intimate partner violence: what women want. *Women's Health Issues*. 15(1):21-30.

Coffey, A. (1999) *The ethnographic self: Fieldwork and the representation of identity*. London: Sage

Coles, J., Astbury, J., Dartnall, E., Limjerwala, S. (2014) A qualitative exploration of researcher trauma and researchers responses to investigating sexual violence. *Violence against Women* 20(1): 95-117

Davies, C.A. (1999) *Reflexive Ethnography: A Guide to Researching Selves and Others*. Oxon: Routledge

Davis, K., Taylor, B., Furniss, D. (2001) Narrative accounts of tracking the rural domestic violence survivor's journey: a feminist approach. *Healthcare for Women International*, 22: 333-347

Dickson-Swift, V., James, E., Liamputtong, P. (2008) *Undertaking Sensitive Research in the Health and Social Sciences: Managing Boundaries, Emotions and Risks*. University Press: Cambridge

Dickson-Swift, V., James, E.L., Kippen, S. and Liamputtong, P. (2007) Doing Sensitive Research: What Challenges Do Qualitative Researchers Face? *Qualitative Research* 7(3): 327-53

Downes, J., Kelly, L., & Westmarland, N. (2014). Ethics in Violence and Abuse Research - a Positive Empowerment Approach. *Sociological Research Online*, 19(1), 2.

Dowson, C., Watkins, J., Khan, M. S., Dasgupta, P., & Sahai, A. (2012). Repeated botulinum toxin type A injections for refractory overactive bladder: medium-term outcomes, safety profile, and discontinuation rates. *Eur Urol*, 61(4), 834-839. doi: 10.1016/j.eururo.2011.12.011

Edwards, K. M., Kearns, M. C., Calhoun, K. S., & Gidycz, C. A. (2009). COLLEGE WOMEN'S REACTIONS TO SEXUAL ASSAULT RESEARCH PARTICIPATION: IS IT DISTRESSING? *Psychology of Women Quarterly*, 33(2), 225-234. doi: 10.1111/j.1471-6402.2009.01492.x

Etherington, K. (2007) Ethical research in reflexive relationships. *Qualitative Enquiry* 13(5): 599-616

Evans, C. (2005) Toolkit for targeted HIV/AIDS prevention and care in sex work settings. Geneva: HIV Prevention Unit, World Health Organisation.

Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Ramsay, J. (2011). Identification and Referral to Improve Safety (IRIS) of women

experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*, 378(9805), 1788-1795.

Fontes, L.A. (2004) Ethics in violence against women research: The sensitive, the dangerous, and the overlooked. *Ethics of Behaviour*. 14:141-174

Griffin, M., Resick, P., Waldrop, A., & Mechanic, M. (2003). Participation in Trauma Research: Is There Evidence of Harm? *Journal of Traumatic Stress*, 16(3), 221-227. doi: 10.1023/A:1023735821900

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child abuse & neglect*, 32(8), 797-810.

Husso, M., Virkki, T., Notko, M., Holma, J., Laitila, A., & Mäntysaari, M. (2012). Making sense of domestic violence intervention in professional health care. *Health & social care in the community*, 20(4), 347-355.

Jenner, S. C., Etzold, S. S., Oesterhelweg, L., Stickel, A., Kurmeyer, C., Reinemann, D., & Oertelt-Prigione, S. (2015). Barriers to Active Inquiry About Intimate Partner Violence Among German Physicians Participating in a Mandatory Training. *Journal of Family Violence*, 1-9.

Johnson, B., & Clarke, J. M. (2003). Collecting Sensitive Data: The Impact on Researchers. *Qualitative Health Research*, 13(3), 421-434. doi: 10.1177/1049732302250340

Kelmendi, K. (2013). Violence against Women: Methodological and Ethical Issues. *Psychology*, 4(07), 559.

Kitzinger, J (1995) Qualitative Research: Introducing focus groups. *British Medical Journal* 311:299

Kuyper, L., de Wit, J., Adam, P., & Woertman, L. (2012). Doing More Good than Harm? The Effects of Participation in Sex Research on Young People in the Netherlands. *Archives of Sexual Behavior*, 41(2), 497-506. doi: 10.1007/s10508-011-9780-y

Larijani, H. H., & Guggisberg, M. (2015). Improving Clinical Practice: What Dentists Need to Know about the Association between Dental Fear and a History of Sexual Violence Victimization. *International Journal of Dentistry*, 2015, 12. doi: 10.1155/2015/452814

Leppakoski, k. T., Flinck, A., & Paavilainen, E. (2014). Assessing and Enhancing Healthcare Providers Response to Domestic Violence. *Nursing Research and Practice*, 2014, 8. doi: 10.1155/2014/759682

McClennen, J. (2008) Researching gay and lesbian domestic violence. *Journal of Gay and Lesbian Social Services*. 15 (1-2): 31-45

McCosker, H., Barnard, A., & Gerber, R. (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All Participants. *2001*, 2(1).

McGarry, J., Simpson, C. and Hinsliff-Smith, K., 2011. The impact of domestic abuse on the health of older women: a review of the literature *Health and Social Care in the Community*. 19(1), 3-14

Malpass, A., Sales, K. and Feder, G. (2015), Reducing symbolic-violence in the research encounter: collaborating with a survivor of domestic abuse in a qualitative study in UK primary care. *Sociology of Health & Illness*. doi: 10.1111/1467-9566.12352

McNutt, L.-A., Waltermaurer, E., Bednarczyk, R. A., Carlson, B. E., Kotval, J., McCauley, J., Ford, D. E. (2008). Are We Misjudging How Well Informed Consent Forms are Read? *Journal of Empirical Research on Human Research Ethics: An International Journal*, 3(1), 89-97. doi: 10.1525/jer.2008.3.1.89

National Institute for Health and Care Excellence (2014) Domestic violence and abuse: how health services and the organisations they work with can respond effectively <http://guidance.nice.org.uk/PHG/Wave20/60> (accessed 5.10.15)

Owen, S. (2001) The practical, methodological and ethical dilemmas of conducting focus groups with vulnerable clients. *Journal of Advanced Nursing* 36, 5, 652–658

Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G. (2012). Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *British Journal of General Practice*, 62(602), e647-e655.

Renzetti, C. & Lee, R (eds). (1993) *Researching Sensitive Topics*. Newbury Park: Sage Publications

Riessman, C. K. (2005). Exporting ethics: a narrative about narrative research in South India. *Health*., 9(4), 473-490. doi: 10.1177/1363459305056414

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*, 198(3), 189-194.

Sampson, H., Bloor, M., Fincham, B. (2008) A Price Worth Paying? Considering the 'Cost' of Reflexive Research Methods and the Influence of Feminist Ways of 'Doing' Sociology 42(5), 919-933

Sarkar, N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics & Gynecology*, 28(3), 266-271.

Schwartz, M. (2000) Methodological issues in the use of survey data for measuring and characterizing violence against women. *Violence Against Women*, 6(8): 815-838

Sikweyiya, Y., & Jewkes, R. (2012). Perceptions and Experiences of Research Participants on Gender-Based Violence Community Based Survey: Implications for Ethical Guidelines. *PLoS ONE*, 7(4), e35495. doi: 10.1371/journal.pone.0035495

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. (2012). Barriers to screening for intimate partner violence. *Women & health*, 52(6), 587-605.

Stanko, E. & Lee, R. (2003) Methodological reflections. In Lee, R & Stanko, E. (eds) *Researching Violence*. Oxon: Routledge

Taft, A., Broom, D. H., & Legge, D. (2004). General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ*, 328(7440), 618.

Taylor, J & Bradbury-Jones, C. (2011) Sensitive issues in healthcare research: The protection paradox (Guest editorial) *Journal of Research in Nursing* 16 (4): 303-306

The Nursing and Midwifery Council Code (2015). Retrieved 5th October 2015 from <http://www.nmc.org.uk/standards/code/>

United Kingdom Home Office (2013) Domestic Violence and Abuse. Retrieved 5th October 2015 from <https://www.gov.uk/guidance/domestic-violence-and-abuse>

Watts, C., Heise, L., Ellsberg, L. H., & Ellsberg, M. (2001). Putting women first: ethical and safety recommendations for research on domestic violence against women . Geneva.

Wilkinson, S. (1998) Focus Groups in Health Research: Exploring the Meanings of Health and Illness. *Journal of Health Psychology* 3(3) 329-348

World Health Organization (2015) Violence Against Women. Retrieved 5th October 2015 from http://www.who.int/topics/gender_based_violence/en/

Yam, M. (2000). Seen but not heard: Battered women's perceptions of the ED experience. *Journal of Emergency Nursing*, 26(5), 464-470. doi: <http://dx.doi.org/10.1067/men.2000.110432>

Yamawaki, N., Ochoa-Shipp, M., Pulsipher, C., Harlos, A., & Swindler, S. (2012). Perceptions of Domestic Violence The Effects of Domestic Violence Myths, Victim's Relationship With Her Abuser, and the Decision to Return to Her Abuser. *Journal of Interpersonal Violence*, 27(16), 3195-3212.

Table 1

ETHICAL AND SAFETY RECOMMENDATIONS FOR DOMESTIC VIOLENCE RESEARCH
1. The safety of respondents and the research team is paramount, and should guide all project decisions.
2. Studies need to be methodologically sound and to build upon current research experience about how to minimize the under-reporting of violence.
3. Protecting confidentiality is essential to ensure both women’s safety and data quality.
4. All research team members should be carefully selected and receive specialized training and on-going support.
5. The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
6. Fieldworkers should be trained to refer women requesting assistance to available local services and sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
7. Findings should interpreted and used to advance policy and intervention development.
8. Violence questions should only be incorporated into surveys designed for other purposes when ethical and methodological requirements can be met

Adapted from Watts C, Heise L, Ellsberg LH, Ellsberg M. (2001) Putting women first: ethical and safety recommendations for research on domestic violence against women. World Health Organization: Geneva.