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THE MIDDLE YEARS
A neglected population regarding domestic violence and abuse?

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Introduction
DV is a complex issue perpetrated by and against both men and women, often occurring bidi-
rectionally (i.e. perpetrated by both intimate [ex-]partners), although the dynamics of violence
can vary significantly across genders. The same men and women as parents may also maltreat
their children, either by way of neglect, exposure to parental violence, or even direct physi-
cal, emotional, or sexual abuse (Keiski, Helminen, Lindroos, Kommeri, & Paavilainen, 2018).
DV causes suffering to individuals and families, sometimes resulting in the intergenerational
transmission of violence (Hughes et al., 2017), while also resulting in an economic burden for
societies (Peterson et al., 2018). DV is generally considered to be an adverse childhood experi-
ence (ACE) with a sustained impact throughout the life-course of those affected (McGavock &
Spratt, 2017).

For the purposes of our discussion, DV will be used to refer specifically to the issue of
intimate partner violence (IPV) and its variants, although we acknowledge that the term can
encompass many wider forms of abuse (for example, certain definitions include so-called ‘hon-
our’ violence, female genital mutilation/cutting, and forced marriage; Crown Prosecution Ser-
vie, 2017). The aim of this chapter is to bring DV in the middle years (from about 30 to 65)
into the discussion and explore the experiences and perspectives of this age group. Due to a
limited focus in the literature on the unique characteristics of this age group, we argue that
it is important to explore issues pertaining to the prevalence and impact of DV among this
demographic in more depth, in addition to professionals’ identification of and responses to the
issue. In a recent analysis of longitudinal records in the UK, focusing on childhood maltreat-
ment and DV against women, Chandan et al. (2020a) concluded that maltreatment and abuse
continue to be significantly under-recorded within primary care records. The study found that
the incidence rate of DV was highest among those aged 18–34, with incidence gradually declin-
ing with age. That said, given the study’s focus on recording, its figures may serve to indicate a
reduced recognition and/or reporting of abuse which coincides with increasing age, rather than
a decrease in actual incidence.

The Middle year person (MYP) may be busy at work, having and raising children, and possibly
taking care of their own parents who require additional help and care. Acting as an official caregiver to
family members may even directly cause or exacerbate DV (Latomäki, Runsala, Koivisto, Kylmä, &
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Paavilainen, 2020). Individuals in this age group also frequently utilise health and social care services, as clients or patients in different settings, with a multitude of health problems of their own. It is important therefore that their experiences of DV as a (very diverse) group are not neglected by researchers and policy-makers.

As already noted, DV researchers and service providers often focus their attention on specific perpetrator/victim subgroups, including children, pregnant women, or the elderly as victims, and men as perpetrators. However, violence perpetrated towards men (by both male and female intimate partners or family members) continues to be an issue and, as with violence against women, often goes unreported (Bradbury-Jones, Appleton, Clark, & Paavilainen, 2017). The National Intimate Partner Violence Victimization Survey notes that any focus on differences between men and women should not obscure the fact that nearly 16 million men [in the USA] have experienced some form of severe physical violence by an intimate partner during their lifetimes and over 13 million men have experienced intimate partner violence during their lifetimes that resulted in a negative impact.

(Breiding et al., 2014)

In Finland, we undertook a survey in one large hospital (across different clinics and wards) to ask adult patients whether they had been victims or perpetrators of DV at some point during their lifetime. Twenty-two percent reported having been victims and 11% reported perpetrating DV on at least one occasion (Leppäkoski & Paavilainen, 2015). These mostly middle-aged patients had been hospitalised for various reasons not connected to their current hospital stay, indicating that adults among this age group could be found across all settings of a hospital, many of them potentially suffering from long-term effects of DV. Yet the issue of DV would likely be overlooked in most cases.

This chapter, based on our experiential knowledge and theoretical understanding of DV, will present an exploration of current literature and ideas. Eija Paavilainen has for a long time worked with a family violence research team focusing on various DV issues, particularly child maltreatment and IPV as perpetrated by both men and women, and together with colleagues has written a national guideline concerning the identification of child maltreatment. Tanja Koivula has studied violence perpetrated against children by mothers. She is currently piloting a domestic violence risk assessment model from Sweden called iRiSk in Finnish shelters. Earlier in her career, Tanja worked as a nurse on a child psychiatric ward with children who had experienced DV, and alongside her research continues to work as a part-time psychotherapist. Together we have noticed that certain aspects of DV have been studied to very different extents among different disciplines. However, the incidence of DV continues to be high despite ongoing research and public health efforts to address it. Much is known about the risk factors for DV and methods to facilitate identification, yet interventions to reduce its prevalence have not been so effective. A review of the literature has shown us that the MYP as a specific group has not received much research attention, with these individuals often being included among (and hidden behind) other specific subgroups. We present here an example of DV in the MYP.

**Scenario: Terry’s story**

Terry is a 35-year-old woman living in a small city. She has recently divorced Michael, her husband of 15 years, with whom she has three children (two of school age and one of preschool age). Terry has a lower-level degree and previously worked in a traditional ‘woman’s occupation’.
which paid a low income, though she has been out of work for several years in order to look after her children. Michael has a high income, high social status, and a senior position at work. Terry doesn’t have close friends and only remains in touch with a few former colleagues from her previous workplace. After several years of consideration she decided to divorce her husband, though her parents were against her decision and no longer support her in any way. One of the main reasons behind the decision was Michael’s behaviour towards the children, and Terry’s recognition of its negative effects on the children’s wellbeing. Michael often outwardly blamed the children for various perceived wrongdoings, and even began using physical violence against their eldest child, Thomas. This included pushing, slapping, or hitting Thomas with a belt when he came to Terry’s defence during Michael’s violent episodes.

Terry often thinks that she is unworthy because of Michael’s sustained affront to her confidence and sense of self. After a diagnosis of depression, Terry began using alcohol as a coping mechanism. Michael’s abuse extended to denying Terry access to their shared finances throughout the marriage, forcing her to have sex with him against her will, and openly having affairs with other women. He also insisted on knowing her whereabouts at all times, both before and after their divorce, which involved digitally stalking her via her mobile phone.

Terry has never disclosed this abuse to anybody. She is in a precarious financial situation post-divorce, requiring expensive legal support from a lawyer because of Michael’s aggressive affronts to her freedom. This has recently involved attempts to alienate the children from their mother, telling them that Terry does not love them, and threatening to take them permanently away from her. Terry now suffers with insomnia and has begun to experience panic attacks. However, she has started wondering whether she should go back to Michael who continues to tell Terry that he loves her and that she will not be able to cope without him. He also insists that he is going to change and will be a better husband and father.

While reading this chapter, we would like you to pay attention to two things: firstly, consider how gender inequality impacts on the incidence of DV, and secondly, consider the association between DV and other physical and mental health problems. Once you have read Terry’s story, consider your own attitudes or preconceptions about DV and how these might manifest when discussing the issue with others. Do you anticipate any differences in your approach to talking about DV with women and men? The chapter will also discuss DV services and consider how reporting and recording of DV might be improved. We will start with an overview of DV, as experienced by the MYP, and then continue with suggestions for the actions required for addressing DV among this group.

**Overview of DV as experienced by the middle years population**

A 2018 multilevel study across 28 European Union (EU) countries by Sanz-Barbero et al. found that 4.2% of ever-partnered women (aged 18 and older) had experienced DV within the last year. The study’s objective was to establish whether a relationship exists between a country’s gender equality (measured by Gender Equality Index [GEI] score) and political responses to women who experience physical and/or sexual DV. The authors concluded that countries with higher gender equality and with anti-gender-based violence legislation had an overall decreased prevalence of recent DV. Women who had suffered abuse by an adult before the age of 15 were the most likely to have experienced recent DV. However, other recent studies (see Alsaker, Moen, Morken, & Baste, 2018) have discovered what is now termed the ‘Nordic paradox’, a phenomenon seen in Nordic countries, where gender equality is typically high, and where paradoxically women are known to suffer from DV at a disproportionally high level compared with other countries with comparable levels of gender equality.
In the USA, the association between DV and gender inequality has been explored by Wil-llie and Kershaw (2019). Their study found that the lifetime prevalence of DV ranged between 28–45% for women and between 18–39% for men. Across states, high Gender Inequality Index values (note this is a different index to the GEI mentioned earlier; United Nations Development Programme, 2018) correlated positively with the prevalence of any form of either physical or psychological DV among women. In a cross-sectional study focusing on the relationship between DV and quality of life, Alsaker et al. (2018) found that quality of life (as measured by a 12-item questionnaire called the SF-12) among abused women was significantly lower than the norm for the female Norwegian population.

Associations between DV and mental health problems have been widely studied across the MYP. Nationally representative data have been collected in Korea by Soyeon Oh, Kim, Jang, and Park (2019) from women (n=3732) and men (n=1040), with the aim of studying associations between DV and depression. In this study, 40% (n=415) of men and 23% (n=866) of women had suffered from DV, and both groups also suffered significantly more from depression both in terms of prevalence and severity. Furthermore, Miltz et al. (2019) explored DV among a group (n=410) of gay, bisexual, and other men who have sex with men, and found a 40.2% lifetime prevalence of DV, with a past-year DV prevalence of 14.7%. As with the findings from Oh, a history of DV was strongly associated with recent depressive symptoms.

Ruiz-Perez, Rodriguez-Barranco, Cervilla, and Ricci-Cabello (2018) explored the associations between DV and ‘mental disorders’ (MD) (as diagnosed via the ‘Mini-International Neuropsychiatric Interview’) in Spain, from the perspective of both women and men. In their community-based study (n=4507) the prevalence of DV was 9.4%, and the prevalence of MD cooccurring with DV was 4.4%. Poor health status (measured via the SF-12) was associated with MD and with DV-MD in both men and women. Their paper concludes that there is a strong association between DV and MD in both women and men, although the prevalence is typically higher in women than in men, which has a relevance in terms of long-term health inequalities (this will be discussed later on). Van Deinse, Wilson, Macy, and Cuddeback (2019) similarly found that severe mental illness and DV are connected: women with severe mental illness who experience DV face additional challenges that perpetuate behavioural ill-health and DV issues, ultimately putting these women at greater risk for continued victimisation.

DV and physical illnesses such as cardiovascular disease and type 2 diabetes are also connected. This link has been described in a retrospective cohort study from the UK where a large group (n=18547) of women with experience of DV were matched to women without such experiences (n=72231) by age and lifestyle factors (Chandan et al., 2020b). The paper describes how women with a history of DV suffer higher incidence rate ratios (IRR) for cardiac events (IRR=1.31), type 2 diabetes (IRR=1.51) and all-cause mortality (IRR=1.44). These numbers demonstrate that women exposed to DV have a disproportionate risk for adverse health outcomes across the lifespan. There are considerations surrounding the directionality of violence in intimate relationships, as this has a bearing on the severity of violence that women suffer. According to Behnken, Duan, Temple, and Wu (2018), in their study focusing on low-income women (n=763), women in relationships with bidirectional DV were more likely to experience severe physical violence and severe DV-related injury compared with women in the unidirectional DV relationships. These findings highlight the importance of approaching the issue of DV with a non-judgemental attitude so that all involved parties can access the support they need in order to remain safe.

Gibson et al. (2019) collected data from women between 40 and 80 years of age (n=2016). The authors undertook a cross-sectional analysis to examine the association between lifetime experience of DV, sexual assault, and post-traumatic stress disorder (PTSD) and the development of menopausal symptoms (difficulty sleeping, hot flushes, night sweats as well as vaginal
symptoms). The authors conclude that individuals with a history of DV are statistically more likely to experience more menopausal symptoms than those without exposure, with the number rising more steeply in those with diagnosed PTSD. Seeking medical care for menopausal symptoms is common, and the findings from this study present an argument for DV screening among women reporting menopausal symptoms in primary care settings.

Hughes et al. (2017) discuss how the presence of multiple ACEs leads to an increased risk of developing long-term health conditions: for example, obesity, diabetes, numerous cancers, heart conditions, respiratory disease, and mental health issues. Their systematic review and meta-analysis also found that individuals with multiples ACEs have worse self-reported health scores. Again, these findings have a relevance across multiple health and social care settings, and highlight the importance of holistic professional assessment.

Despite the negative impact of DV, many couples in relationships characterised by violence remain together, and to date we know little about the factors affecting violence desistance (i.e. how individuals come to abstain from violence within their relationship). Using grounded theory methods, Merchant and Whiting (2017) aimed to find out more about the process of desistance in formerly violent couples. The authors describe three stages in the process of desistance: (1) the ‘Turning Point’, described as a ‘conscious decision to change’; (2) the ‘Decision to Change’, where both partners become committed to improving their relationships or overall lifestyles; and (3) ‘Doing Things Differently’, which involved a multicomponent change in the participants’ lives. An awareness of these three stages might enable professionals to have a more nuanced understanding of the desistance process, and thus allow for more targeted and optimised treatment for individuals experiencing and perpetrating DV.

To conclude this section, we argue that taking steps to address gender inequality at a societal level is important to meeting the goal of reduced overall prevalence of DV. In turn, these efforts can lead to improved physical and mental health outcomes across populations. Given that ACEs are known to transmit intergenerationally, together with accumulating evidence which suggests that violence is likely to cooccur with multiple ACEs (see Hughes et al., 2017), reducing DV on a wider scale can contribute to an overall reduction in the prevalence of certain health problems for future generations.

**Actions needed to tackle DV in the MYP**

Healthcare services often provide the first formal support opportunities for many individuals experiencing DV. However, in addition to addressing immediate healthcare needs, professionals are required to signpost service users to other specialist services who can meet their needs appropriately. These can be both professional services or voluntary organisations. Emergency departments are important points of contact for many individuals experiencing DV, particularly those currently suffering (or with a history of) physical abuse. DiVietro et al. (2018) tested a dual screening method for DV, which involved the combination of a tablet-based questionnaire and a face-to-face assessment, and found that the combined methods were more successful in identifying DV than either method in isolation.

In a retrospective cohort study across two Hong Kong hospitals, Choi et al. (2018) found that of 980 DV victims (157 male, 823 female), 69.9% accepted on-site counselling when offered during visits to the emergency department (following a confirmed incident of DV). The authors also explored associations between help-seeking and demographic- and injury-related factors. Rates of acceptance of on-site counselling were significantly lower for victims with mental illness, while victims who had experienced more than two abuse incidents were more likely to seek and/or accept help than those visiting for the first and second time. Rates
of help acceptance were also lower among those who attended the emergency department alone, with the authors suggesting that the presence of family, friends, or professionals (such as police officers or paramedics) may increase the motivation to seek help. The article concludes by stating that healthcare professionals require formal training on how to promote help-seeking behaviour, and specifically, on how to provide individualised support for both male and female victims of abuse. Chandan et al. (2020a, 2020b) similarly argue that clinicians should have a good awareness of DV in order to improve physical and mental health outcomes for patients, in addition to enabling better recognition and management of risk factors for abuse. DiVietro et al. (2018) stress the importance of utilising various different techniques and approaches to asking patients about DV, rather than relying solely on a single method.

A study of 42,000 women across the EU (European Union Agency for Fundamental Rights; FRA, 2019) found that only one-third of individuals experiencing DV contacted either the police or other formal support services following the most serious incident of violence. Reasons for not reporting violence are similar across different contexts: these include fear of retaliation from abusers, pressure from families to maintain privacy, lack of awareness of rights or available support, economic dependency, and a perception that authorities will fail to take adequate action. It is clear that more effort is needed to facilitate access to legal remedies and justice in the case of DV. Lack of coordination between agencies and organisations responding to DV, including health and social services, the police, forensic services, and the judicial system, is also a common problem globally. Some countries have established specific structures to increase coordination, such as cross-sectoral taskforces operating with specific protocols for case referrals. However, more efforts are needed to make sure that individuals’ safety is not compromised due to the failure of agencies to coordinate with one another (United Nations; UN, 2019).

Previous studies have shown that many parents who are subjected to DV contact social services without talking about the violence they experience (Stanley, 2011). In Finland in 2019, 1052 adults (attending shelters) came without children compared to 1825 who brought children with them. The typical age of those seeking refuge from DV is 25–34 years, with an overwhelming majority being women (males represented only 267 [9%]; Finnish institution for health and welfare (THL 2020). In contrast, individuals over the age of 45 are less likely to seek refuge at a shelter when compared to 25–34-year-olds Finnish institution for health and welfare (THL 2020). Evidence also suggests that women with younger children are often in contact with social services more regularly than childless individuals in the MYP Finnish institution for health and welfare (THL 2020). After the age of 29, IPV prevalence rates begin to decrease according to data for 53 countries. Sixteen and a half percent of women in the oldest age group analysed (aged 45–49) reported a history of some form of IPV within the year preceding the survey, compared with 22.8% among the age group of 20–24-year-olds. Unfortunately, data on violence experienced by women above the age of 50 are limited because most population-based surveys use the 15–49 age range (UN, 2019). We argue that it is important to fill this data gap given the MYP’s underrepresentation in DV literature, in addition to the fact that older women are more susceptible to abuse and neglect than their male counterparts (United Nations Department of Economic and Social Affairs, 2013). In the 2002 Madrid International Plan of Action on Ageing, the increased susceptibility of older women to abuse and neglect was acknowledged:

Older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the nonrealization of the human rights of women. Some harmful traditional practices and customs result in abuse and violence directed at older women, often exacerbated by poverty and lack of access to legal protection.

(UN, 2003; para. 108)
Again, this points to the wider issue of gender inequality on a societal level.

When it comes to supporting male individuals experiencing DV, many professionals’ lack of knowledge and experience are compounded by the overwhelming ‘female focus’ of the majority of models designed to facilitate health and social care responses to DV. Shelter programmes have also historically been gender-specific, and in many areas are still segregated by gender identity in an effort to protect the safety and security of women and girls. Males can typically be accommodated in off-site hotels or partner shelters (for example, homeless shelters). These options likely intensify feelings of isolation, potentially even exposing individuals to further harm or resulting in limited access to additional supportive services. Hotel stays are generally short term and lack the constant staff presence and support needed to help male DV victims fully process their experiences, ultimately resulting in heightened feelings of loneliness and vulnerability (Stiles, Ortiz, & Keene, 2017).

The accessibility of services for women who experience multiple and intersecting forms of violence also remains a major challenge. Significant gaps exist, for example, in the accessibility and reach of violence against women (VAW) services for rural and remote areas (UN, 2013). Older women, indigenous women, immigrant women, lesbian, bisexual, and transgender women or women with disabilities may also face additional barriers to accessing mainstream services. These can include language barriers, cultural discrimination, physical barriers, or a lack of competency from service providers to respond appropriately to particular circumstances. In response, many countries have established group-specific services (UN, 2019).

Previous research has mainly focused on men as perpetrators of violence within intimate relationships. As such, the majority of DV risk assessment instruments assume a male perpetrator and female victim. Additionally, Axberg, Broberg, Eriksson, Hultmann, and Iversen’s (2018) review of the literature showed that there were no domestic violence risk assessment instruments which focused on a male perpetrator’s role as a father. Therefore, these instruments fail to take into account some important perspectives, for example, the feelings of remorse or abusers’ understanding of how their own behaviour is affecting the victim or the child (Hultmann, 2020). Hultmann and his team are currently undertaking a study to test the structured iRiSk interview for use by professionals within child welfare investigations, focusing on fathers who have used DV and who are in contact with crisis centres and child welfare. Their project is being funded by the Swedish National Board of Health and Welfare.

Use of ICD-10 coding (International Classification of Disease) for domestic violence injuries in healthcare settings is problematic for a number of reasons. This coding system was developed by the World Health Organization (WHO) and is used internationally for statistical purposes to monitor diseases, injuries, symptoms, and other issues which impact health status across populations (WHO, 2020a). Partner- or spouse-related perpetrator coding has been shown to be particularly poor, with a 2019 Finnish study finding that only 11% of DV-related hospital visits were coded appropriately (Kivelä, Leppäkoski, Ruohoniemi, Puolijoki, & Paavilainen, 2019). The insufficient (or inappropriate) use of perpetrator codes contributes to an underestimation of the incidence of DV and reduces the coding system’s usefulness for DV monitoring. Similar results have also been found in other countries (see Btoush, Campbell, & Gebbie, 2008; Schafer, Drach, Hedberg, & Kohn, 2008). This is a huge problem for international researchers and policy-makers who seek to compare DV prevalence across different countries.

Sanz-Barbero, Corradi, Otero-Garcia, Ayala, and Vives-Cases (2018) argue that the introduction of a consolidated legislative framework to address VAW, together with the assumption of state responsibility for responding to VAW, could decrease overall prevalence of DV in Europe. The authors also suggest that responses to DV in Europe require an integrated
approach which protects women during their youth. Bradbury-Jones et al. (2017) conclude in their focused mapping review and synthesis on VAW research in Europe that researchers should be explicit about the gendered nature of violence, for both women and men, and that more research should be conducted between countries. This could contribute to addressing the enduring gendered inequalities across Europe and worldwide, and may also draw needed attention to the perspectives of men who experience DV. Writing from the USA perspective, Willie and Kershaw (2019) recently concluded that structural changes to gender inequality may help to reduce the overall incidences of DV and improve women’s overall wellbeing. To illustrate this, they suggest: “Creating an egalitarian environment that supports the wellbeing of women may weaken gender power dynamics and reduce the incidence of IPV” (p. 262).

Lilley-Walker, Hester, and Turner (2018) reviewed 60 evaluation studies relating to DV perpetrator programmes across Europe, involving over 7000 participants across 12 countries. The study assessed the design, methods, input, output, and outcome measures used across the evaluations in order to identify the possibilities and challenges of a Europe-wide evaluation methodology that could be used to assess future perpetrator programmes. The authors conclude that a standardised approach to evaluating DV perpetrator programmes would facilitate smoother comparisons across countries. They suggest that a standardised approach should include the following:

A mix of quantitative and qualitative methodologies; larger and more varied participant samples; some form of control group design; a wider range of potential outcome measures (including perpetration of controlling and coercive behaviours as well as all other types of domestic abuse) assessed over a longer period postintervention; a focus on the role and quality of programme facilitation; and outcome data triangulation (e.g., including reports of those women/partners in a position to reliably assess change).

(p. 879)

In a Finnish follow-up study, the effectiveness of a psychodynamic group intervention developed for female perpetrators of family violence was evaluated (Keiski et al., 2018). The participants (n=134) voluntarily sought help after perpetrating violence against a partner, child, or both. The study, whose sample included only women without acute mental health or substance abuse problems, concluded that the intervention led to an improvement in women’s knowledge and a reduction in violent behaviour. The study also discovered that both of these positive outcomes continued after six months. However, given that perpetrator programmes are mostly utilised in situations where participation is mandatory, it is important to consider that motivation to engage will likely be quite different when participation is voluntary, as it was in Keiski et al.’s study.

According to Dias et al. (2019), social support may safeguard individuals against some of the negative effects of violence on physical and mental health. They conducted a cross-sectional study across eight European countries to assess the association between social support (referring to support from friends, family, or other reciprocal networks) and DV victimisation. The study found a statistically significant association between low levels of social support and DV victimisation. The authors conclude that although further research is needed, the presence of both formal and informal networks seems to correlate positively with a reduction in prevalence of DV.

In a systematic review, Tol et al. (2019) examined the relationship between ‘mental health treatments’ (referring to a range of interventions designed specifically for individuals experiencing mental health problems) and rates of DV perpetration and victimisation in middle-income
countries. The authors concluded that the existing literature is too limited in scope for reliable conclusions to be drawn. They propose that future research should maintain a strong theoretical focus, particularly with a view to exploring which specific mechanisms of DV (both perpetration and victimisation) are impacted by mental health interventions. Other research suggests that individuals who disclose their abuse and receive appropriate support are at a significantly reduced risk of experiencing mental ill-health (e.g., Dias et al., 2019). However, these positive outcomes are to an extent dependent on a prevailing ‘informed’ or non-judgemental attitude towards DV among formal and informal support networks. For example, professionals, friends, and other reciprocal networks who endorse the belief that DV is a private or family matter are unlikely to offer the same level of support as those who would encourage a disclosure. According to Dias et al. (2019), women seek support more easily than men. However, another important finding from their cross-sectional study was that most individuals who reported being victims of violence also reported having perpetrated violence at some point. This echoes an earlier finding from a study by Leppäkoski and Paavilainen (2015), and reiterates the importance of asking about DV in a non-judgemental and open-minded manner.

According to Peterson et al. (2018), DV prevalence can only be reduced if prevention is prioritised and if prevention strategies are also evaluated and continuously improved. In addition, as highlighted by Bellis et al. (2019), millions of adults across Europe and North America are living with the burden of multiple ACEs. In their study, the authors suggest that a 10% reduction in ACE prevalence could result in annual savings of 3 million DALYs (Disability-Adjusted Life Years, which represent “the loss of the equivalent of one year of full health”; WHO, 2020b). Programmes for reducing the prevalence of ACEs are already available (e.g., Chen & Chan, 2016). One possible intervention would be to implement routine ACE-history-taking to identify those who are at risk of poor health outcomes. Alternatively, universal implementation of trauma-informed approaches (e.g., fostering trust, transparency, and empathy with families) may be sufficient (see Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). Ereyi-Osas, Racine, and Madigan (2020) argue that professionals in health and social care services should be more aware of the potential for adversity such as DV to transmit intergenerationally. Adequate resources, multidisciplinary collaborative work, and adequate trauma training are undoubtedly needed for professionals. Furthermore, as noted earlier in the chapter, checklist approaches such as ICD-10 coding can cause more harm than good if not used appropriately.

Conclusions

In conclusion, we argue that actions are needed to educate professionals of different fields to appropriately discuss, identify, and support individuals experiencing DV in their middle years. Current evidence suggests that multi-professional collaboration lacks coordination and is ineffective. For example, in social services, the topic of DV is seldom discussed (Stanley, 2011). Documentation and recording of DV requires development, and DV perpetrator programmes similarly require ongoing improvement. Due to inconsistent professional training, both women and men experiencing DV often go unidentified and therefore unsupported.

DV is common among the MYP and often impacts children, perpetuating the intergenerational transmission of adversity. Multiple ACEs (including those which manifest as a direct result of DV) are a major risk factor for many health conditions, regardless of the type of violence experienced. The true prevalence of DV on a global scale is unclear for a number of reasons, including (but not limited to) underreporting and poor documentation and/or monitoring methods. This also makes it difficult to compare statistics relating to the prevalence of DV across different countries.
A number of long-term conditions such as heart disease, diabetes, cancer, respiratory conditions, and mental health problems can be directly linked to exposure to DV. Moreover, DV often correlates with heavy alcohol use, smoking, poor self-rated health, and sexual risk taking. Quality of life among abused women has been found to be significantly lower when compared to women who have not suffered DV, and there is ample evidence linking exposure to DV with mental ill-health in both men and women. Although this link is stronger for women, men who experience DV are also at a heightened risk of depression, PTSD, and other mood disorders. It is important for health and social care professionals to bear these issues in mind when working with individuals who have experienced violence of any sort.

DV causes significant suffering to individuals and families, and incurs vast costs for societies worldwide. Systemic improvements in training for health and social care professionals are required to enable them to better advocate for victims and develop a more tailored and individualised response. Formal and informal social support may buffer the negative effects of violence on physical and mental health, while the provision of better treatment for mental health conditions may likewise contribute to a reduced prevalence of DV across populations. Structural changes to gender inequality are also incredibly important in tackling this issue at its roots. Researchers and policy-makers should be explicit about the gendered nature of violence, though a focus should also be maintained on improving research into and opportunities for men who suffer DV. Furthermore, an increased effort to conduct research cross-nationally is needed to ensure a more coordinated response to tackling gender-based inequalities on the global scale.

Critical findings

- DV among the MYP is common and often impacts on children. Children can be affected directly by witnessing or overhearing violent episodes, becoming injured while intervening, or may themselves become the targets of abuse. Children also suffer indirectly by way of the intergenerational transmission of ACEs.
- The association between DV and gender (in)equality requires more global attention.
- The MYP have been included in a great deal of DV research, yet as a group they are rarely singled out for the purposes of analysis.
- DV causes suffering to individuals and families and incurs significant costs for societies worldwide.
- DV among the MYP causes innumerable short- and long-term health problems, regardless of the type of violence experienced.
- The specific needs of the MYP experiencing DV are not sufficiently well established or studied. This group experiences multiple burdens due to competing demands on time and energy from work, childcare, and, in many cases, acting as an official caregiver to older family members.
- DV continues to be poorly identified, documented, and responded to across health and social care settings.

Implications for policy, practice, and research

- DV among the MYP requires an improved research focus across all levels of society.
- Global action is needed to improve gender equality.
- Individuals experiencing DV often don’t disclose their abuse for a number of reasons, including (but not limited to) fear of retaliation from abusers, economic dependency, and
lack of awareness of the support services available. Asking about DV, particularly by those working in health and social care settings, is important.

• The needs of individuals experiencing abuse can be addressed by multiple different services, and professionals across sectors (including health and social care and police services) should have a good awareness of DV.

• While approaches to identifying and responding to DV have been well studied, further research, evaluation, and dissemination are required to continue improving our understanding of what ‘best practice’ looks like.

References


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