Chapter 2
Intimate Partner Violence in the United Kingdom

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2.1 Introducing Ourselves to You

I, Arlene, am a clinical psychologist, and I, Jan, am a former psychiatric social worker. We are both systemic psychotherapists, trainers, and supervisors. Later in this chapter, we describe our independent family violence intervention service, founded in 1996, in the town of Reading, in the south of England. Here we shall say a little bit about ourselves and how we met. Prior to this, we knew each other for years, meeting at the annual conference of the UK Association for Family Therapy. During that time, I, Arlene, was working as a clinical psychologist in adult mental health services in the National Health Service, and I, Jan, was working for a major children's charity. So we would meet up at the conference and talk about our frustration at not being able to persuade our respective employers to let us focus on working directly with violence in family relationships. We could see the intergenerational impacts on child and adult development and in particular the impact in family culture of unresolved complex trauma. Thus, in 1996, we said to each other, "enough is enough, we need to do something about this!" So we stepped outside our paid employment to establish and work together in an independent service. As the reader of this chapter, you will not be surprised to hear that once we had taken this step, our previous employers looked at our service with interest and invited us back to work for them. We looked at each other in this moment, as it was tempting to go back to paid employment, but we decided to continue as two women, working in our local community. Looking back, we are both grateful we did this. We had to learn fast as we did not have an agency to protect us. We had to be highly visible, transparent,

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and completely accountable for our beliefs and practices around safety in family relationships (Cooper & Vetere, 2005; Sammut Scerri et al., 2017). We shall write more about this later in this chapter.

2.2 United Kingdom (UK) Overview

The United Kingdom of Great Britain and Northern Ireland is an island nation in NW

Europe, which includes the four nations of England, Scotland, Wales, and the province of Northern Ireland. The UK population totals nearly 67 million and is considered an aging population as 18% are over the age of 65. London, the capital city, is in England and has a population of 8,800,000 in Greater London. It was in London, during the 1970s and early 1980s, that Erin Pizzey's work established the need to take domestic violence generally, and IPV in particular, seriously in how we as a society, in our social, health, political, and economic organizations, responded to the need (1974). In 1971, she established the first domestic violence shelter in modern times, Chiswick Women's Aid, now called Refuge.

Currently, Refuge provides a UK wide helpline. Locally, in the town of Reading, in the south of England, our first shelter was established in 1974 with Jan Cooper as one of the founding members.

2.3 Intimate Partner Violence in the United Kingdom

Walby (2009) estimated the economic and social costs of domestic violence for 2008 in the United Kingdom to be £16 billion. The UK Department of Health (1995) estimated that over 750,000 children a year witness domestic violence in England. The Crime Survey for England and Wales (Home Office, 2019) estimated that at least one third of all violent crime was domestic assault, with women much more likely to be assaulted and harmed by their male partners. The survey for 2019 recorded that 5.7% of 16–74-year-old people (2.4 million) experienced domestic abuse in the past year, with little change reported from the previous year. However, the recent Covid-19 pandemic has seen a rise in divorce rates and reported incidents of IPV, probably as a result of increased internal and external stressors for couples, as reported by commentators, but at the time of writing, accurate data are not available. The most common age at which women experience domestic violence is 18–24 years (38.6%), followed by age 11–17 years. For men who experience domestic violence, the most common age is 18–24 (47.1%) followed by age 25–34 (30.6%). Such findings led the Home Office for England and Wales to include 16–17 year olds in the definition of domestic violence and to enlarge the definition further to include coercive control. Earlier, in 2005, the definition had been expanded to include forced marriage, "honor crimes," and female genital mutilation. Interestingly, it is important to note that all the definitions of the UK nations speak

of what people do to harm others, i.e., acts, whereas they do not include omissions. The original Council of Europe's Council of Ministers (1986) definition of physical violence in the family is still the only definition that speaks of both acts and omissions. When considering safety in families and working toward safety in family life, it is important to consider what people do as well as what they do not do.

In 2004, the UK government via the Department of Health and Department of Education and Skills published the National Service Framework for Children, Young People and Maternity Services. The report emphasized that IPV starts or escalates during pregnancy and is associated with a greater incidence of miscarriage, fetal injury, and prematurity. In addition, the report called for domestic violence awareness training to be delivered within these public sector services to all staff, including the identification of appropriate referral pathways. However, therapeutic provision remains patchy, as discussed below. In 2005, the child protection category of emotional abuse was expanded to include seeing or hearing the ill treatment of another. This change was based in van der Kolk's (2005) developmental trauma research that showed that children were as adversely affected when they were exposed to other's violence as when they were physically assaulted themselves.

The Domestic Violence and Matrimonial Proceedings Act (1976) provided police with the powers of arrest for breaches of injunctions in circumstances of IPV and gave women the legal right to stay in the marital home. The Family Law Act 1996 Part IV provided remedies under civil law criminal offences, including sexual and physical assault, harassment, and homicide. The government strategy toward domestic violence and IPV is built on the three pillars of prevention, protection and justice, and support (Blunkett, 2003). In practice this means that police domestic violence units, housing services, probation, health and social care services, legal professionals, and voluntary agencies all work together at a local level. The Domestic Violence, Crime and Victims Act (2004) was enacted to aid in providing resources and legal protection to victims of IPV across the United Kingdom. Broadly speaking, there are few notable differences between the four nations in their definitions of IPV and provision of support, although, the North of Ireland was the first to include financial abuse in their definition, and Scotland was the first to include marital rape in law. The Women's Aid Federation is one of a group of charities in the United Kingdom that provides safety, assistance, and support to women and children. There are four main federations for each nation in the United Kingdom. Their main aim is to end domestic violence against women and children. They address the main needs of women through providing shelter and outreach work, for example, with housing, health, finance, and their children (Women's Aid Charity, England, 2020). The Women's Aid service is widely advertised throughout the United Kingdom, with all family doctor services, hospital departments, social work departments, etc. displaying posters, with leaflets and online links. In England, the Samaritans organization provides a phone link to the Women's Aid service. Shelters are available in all UK counties, and many in our metropolitan centers are organized to reflect the needs of women and children from different cultural and ethnic groups.

2.4 Challenges and Issues in IPV Services in the United Kingdom

A number of challenges confront us at this time of austerity politics and deep funding cuts in our public sector services. Research and practice identify a number of issues for our consideration here. The long-standing and mainstream focus on violence against women in intimate partner relationships has inadvertently downplayed the violence perpetrated by women in both same and different gender relationships. Downplaying violence against men strengthens some heteronormative assumptions in the gender paradigm and risks overlooking the needs of LGBTI+ couples (Eckhardt et al., 2013). The tendency to focus on single explanations for IPV, such as how it is rooted in patriarchal assumptions and entitlements to treat women, has meant that integrative formulations for the causation, maintenance, and cessation of IPV, which also include trauma theory, attachment theory, family psychology and sociology, etc., have been slower to develop. Similarly, dominant paradigms such as patriarchy do not help us explain women's violence, and for us it is an ethical position to draw on all available theory and research. Finally, the focus on men as perpetrators of IPV against their partners somewhat overshadows men's other roles in the family and community, such as fathers, sons, brothers, etc. This raises a level of analysis issue, i.e., how explanations for IPV can fit and adapt to the level of the individual, the couple, the family, community groups, and wider social institutions.

Therapeutic responses to IPV in the United Kingdom, as opposed to or in conjunction with legal responses, are still patchy (Hester & Westmarland, 2006). Probation services have traditionally offered perpetrator group programs to men and partner groups to women. Forensic psychologists and forensic services based in prisons provide individual and group therapeutic treatments for those people incarcerated as a result of perpetrating violent crime. Charities, such as the Women's Aid Federation, provide support and outreach to women as victims, as described above. They rely on grants and external funding, rather than a central government core funding program. Adult psychiatric and psychological services in the UK National Health Service are still diagnostically organized, and although staff may be aware of unresolved trauma responses as a result of IPV, they are often uncertain how best to respond, and the interventions offered generally follow the diagnostic categories (Turner et al., 2017). IPV in the relationships of older couples is addressed less frequently. Despite some notable exceptions, relationship-based therapeutic services, grounded in safety methodologies, are rarer still (Sammut Scerri et al., 2017). The impact of deep government funding cuts to the public sector services these past 10 years has made the provision deficit worse.

2.5 Situating Ourselves: The Reading Safer Families Service

The Reading Safer Families independent family violence intervention service, established in 1996, in the south of England, is an example of a community-based practice that did not need additional funding from the statutory sector (Cooper & Vetere, 2005). Reading Safer Families provided an affordable family violence prevention service, which was accessible for all family members and those living in close relationships, across the family life cycle, where violence was of concern. With this project, we aimed to explore both how systemic thinking and practice could make a contribution to family safety and to establish a safety methodology for safe relationship therapy practice. The question of how to make therapy safe enough to meet family members together, and to offer relationship support and therapy when violence has taken place, has vexed the field for decades. The Reading Safer Families systemic safety methodology is published extensively (see Sammut Scerri et al., 2017, for a full list of references). The methodology is based in the triangular relationship between the assessment of the risk of future violence, helping people take responsibility for safety and for behavior that harms others, and collaborative practice. The risk of future violence is managed from the outset of a referral with a no-violence contract and a careful, tailored safety plan to help predict, prevent, and de-escalate unhelpful arousal during relationship conflicts. The safety plan explores the internal and external relationship factors that trigger unhelpful arousal into dangerous arousal, such as attachment fears, relational traumas, etc. on the one hand and, on the other, stresses arising from debt, employment, wider family and community conflict, etc. It also explores resources, i.e., confiding relationships, those times when relationship conflict did not become dangerous, etc. The safety plan is supported with the help of a "stable third" person who knows the family and, if children are involved, can visit the family home. The "stable third" could be the referrer but needs to be someone who can think about the likely success of the safety plan, can help corroborate what family members are saying about the ending of their violent behavior toward others, and can participate in regular reviews of the safety plan. If the safety plan is effective, then it can be considered sufficiently safe to continue with relationship therapy, including the exploration of the developmental impact of the traumas and legacies of intergenerational violence and abuse (Vetere, 2015). We are writing this chapter in the post-Covid-19 world of online therapeutic work and are pleased to report that, thus far, safety planning with the help and support of the stable third person can be managed online.

The management of risk takes place alongside the assessment of the risk of future violence and includes consideration of the contexts of violent behavior, severity, frequency, etc., empathy for the victim, reflective functioning, and internal motivation for change. Commonly used psychometric measures include as follows: the Spousal Assault Risk Assessment (Kropp & Hart, 2000), the Conflict Tactics Scale 2 (Straus et al., 1996), and the Controlling Behavior 32 scale (Sleath et al., 2017). Responsibility for safety and for behavior that harms others is addressed at all times and involves the deconstruction of the use of language that minimizes

violent behavior and its impact and that blames others. If, in our opinion, a family member has an untreated substance use problem, we insist on them using our local addiction service, with consent for liaison, in parallel with our work. Collaborative practices include the use of reflecting processes; in-room consultation; transparency at every level about our thinking, intentions, and actions; recognition of our own moral dilemmas around the use of violence; and our commitment to help families find and maintain a resolution to the violence.

2.6 Defining Success and Good Outcomes

An interesting challenge is how we define success and good outcomes in IPV perpetrator programs and, in particular, from the perspectives of the different stakeholders, for example, the men and women who behave with violence, the funders and commissioners of perpetrator programs, and the practitioners. In the United Kingdom, commonly used outcome measures include the Couple Satisfaction Index 32 (Funk & Rogge, 2007) and the SCORE 15 (Carr & Stratton, 2017). A pilot study by Westmarland and Kelly (2013) attempted to map the complexity of successful outcomes from the four different perspectives, described above. Although the meaning of success held similarities across all the four perspectives, such as safety and empowerment, enhanced awareness of self and others, respectful/improved relationships, and so on, the differences for the funders and practitioners resided in safer parenting practices and increased well-being for all family members and their communities and, for the funders, quantifiable measures of success. Herein lies the rub, as a successful outcome can be defined as a safe separation, and this is where the theory-research gaps loom larger (Sammut Scerri et al., 2017). There is a higher risk of physical violence for women during the processes of separation, divorce, and contact handover when safety is not being monitored or maintained within public sector services (Johnson & Hotton, 2003).

2.7 Working in Multicultural Contexts

Multicultural work in the context of IPV continues to be a focus. The challenges lie in the integration of developed understandings of cultural differences with the need to work through language translators. Many local authorities, particularly in London, aim to meet the cultural diversity of their communities. There is often an educational focus to their work, which is based on the differing beliefs and understandings that their client population may hold based on their gendered roles in their country of origin, yet living within the context of UK legislation. There are very few specialist units; however, an exception is the NEWday Project in the London Borough of Newham where they work toward effective and sustained change with a culturally diverse community (Infanti-Milne & Walton, 2020). The NEWday

domestic abuse intervention project was funded through the Department of Education Innovation Fund in 2017 to assist families where domestic violence, including couple violence, was the main reason for Children's Services involvement in the family across the contexts they live in – home, school, and community. The NEWday team consists of social workers, family therapists, teachers, and parent support practitioners. They adapted the Reading Safer Families model and the work of Alan Jenkins (1990) for the development of social work practice in their urban context where they often rely on the help of interpreters

2.8 The Future

The challenges for the United Kingdom and for services in the future remain as above, including the further development of online practice, but in addition, there is a need to develop services for women who behave with violence in their intimate relationships, such that they receive help with understanding and managing their dangerous arousal. The evaluation of domestic violence perpetrator programs continues to be a vexing methodological issue, and early findings suggest that these programs continue to need improvement by tailoring the programs to the characteristics of the participants and their family and community contexts (Akoensi et al., 2012).

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