Airing Pain 126: Domestic Violence and Chronic Pain

This edition of **Airing Pain** *has been funded by the Women's Fund for Scotland.*

The Coronavirus pandemic has been long and isolating for everyone, but particularly for those who experience abuse. The pandemic and subsequent lockdowns have seen an increase in the level and severity of domestic abuse.

In this episode of **Airing Pain***, our host Paul Evans discusses the isolating effects of Covid-19, trauma and how this can contribute to the development of debilitating chronic illnesses, such as fibromyalgia and chronic fatigue syndrome. Throughout the episode Paul speaks candidly with Kath Twigg, senior lecturer in social work, trainer, mentor, writer and domestic abuse survivor, about her experience of abuse and pain.*

An article by Kath Twigg will accompany this extended episode of **Airing Pain***, and her book, The Hall of Mirrors, How to Change Life Patterns and Avoid Toxic Relationships, is available in Kindle and paperback versions on Amazon.*

Paul Evans: This is ***Airing Pain***; a programme brought to you by Pain Concern. The UK charity providing information and support for those of us living with pain and for those who care for us. I'm Paul Evans, and this extended edition of ***Airing Pain*** has been funded by the Women's fund for Scotland.

Joht Singh Chandan: If we think even in a pre-Covid world, domestic abuse is unfortunately an experience which affects one in three women globally. In the UK we're thinking about one in four women, but there's always a hidden burden of domestic abuse which is not being reported to services or through surveys. So, if anything, the number could be much higher.

Caroline Bradbury-Jones: When we went into lockdown in the spring of 2020 there was speculation about how lockdown and isolation would impact on the numbers of domestic violence incidents that were taking place. There's very clear evidence that it's increased dramatically.

Evans: As we record this edition of ***Airing Pain*** in the week leading up to Christmas 2020. [Due to] the discovery of a new variant of the COVID-19 virus along with a sharp increase in infections, The UK's devolved governments have imposed new stricter social isolation lockdown rules to try and stem infection rates whilst we wait upon a full vaccine rollout. For women, because it is mostly women, lockdowns and social isolation heighten the level and severity of domestic abuse. A 2019 study by the University of Birmingham showed that UK domestic abuse victims are three times more likely to develop severe mental illnesses. A

further study by the University of Birmingham at Warwick found a link between women who are subjected to domestic abuse and the long-term conditions fibromyalgia and chronic fatigue syndrome. Dr Caroline Bradbury-Jones is professor in Gender Based Violence and Health at the University of Birmingham. She is a co-author of the study.

Bradbury-Jones: What the study found was that there was an association between fibromyalgia and chronic pain amongst women who had had domestic violence experiences. We found in separate studies, associations with poor mental health [and] dental issues. Also, in other work that I've undertaken, and more recently interviews with women who've experienced domestic violence, the narrative about the experience of pain is a really strong one. So, when you're hearing about survivors talking about their experiences, they talk about pain.

Kath Twigg: I was constantly in pain all the time.

Evans: This is Kath Twigg. She's a survivor of two abusive marriages. In her book, *The Hall of Mirrors How to Change Life Patterns and Avoid Toxic Relationships*, she chronicles her abuse and the pathway through it. We'll be hearing her story throughout this edition of ***Airing Pain***.

Twigg: I remember just before I left my long-term job, I'd been in it for 26 years, I was doing quite a senior role and asked to go down to London one day, to Bristol the next day, up to the northeast another day literally. And I remember, on one occasion, going on a train up to Durham from the Peak District, where I live, and not being able to sit down on the train, I was in so much pain. I had to stand up and move around as much as I could, I was in so much pain. And on another occasion, I remember coming back from London, and I've got to go somewhere else the next morning and leave about six o'clock, and all I could do was go and lie on the bed. I was in so much pain, it was awful, and this didn't get much better. I had all kinds of ailments and illnesses and rashes and all sorts of odd things [for] about two years after I left that job, and I think it was because of the pushing and pushing and pushing. I had bacterial meningitis and very nearly died. My family were told that I had no higher brain function and the life support machines would need to be turned off, and it was just miraculous that I came out of that. And I put that down to an accumulation of pain and stress, psychological pain as well as physical pain.

Evans: Kath Twigg. Dr Joht Singh Chandan is a specialist Registrar in Public Health, and he's an academic Clinical Lecturer at the University of Birmingham, and he too is co-author of that study showing the relationship between domestic abuse and chronic pain.

Singh Chandan: When you sort of experience abuse or maltreatment or traumatic experiences on a regular basis. There's a huge body of research which is showing that actually these experiences can result in a dysregulation of the hypothalamic pituitary adrenal axis. In simple terms, that axis, that system that I'm referring to there, is our central stress response system. When we see that disruption of that system, we can actually see that these effects alter our normal functioning of the immune system, of our metabolic system, neuroendocrine system, and actually quite a few bodily systems. So, the knock-on effect of having alteration in these areas can lead to our bodies sort of being in a heightened state of, what I described as, a very inflamed state. And actually, that's very visible even if we just sort of do blood sampling from survivors of abuse and trauma. There are a few blood tests that we use in hospital, for example, which check for inflammation. We normally use them in cases of infection or if somebody comes into hospital acutely unwell, but we also see in survivors of abuse is some of these levels are just raised at baseline. So, there's something going on, an inflammatory process being proven, actually from experiencing abuse. So that's just one element to it. That's one reason why there could be an association with ill health and domestic abuse.

Evans: Dr Kate Gillan is a Clinical Psychologist within the Acute Psychology Service, and working in the NHS Greater Glasgow and Clyde Pain Service. She has a particular interest in the relationship between trauma and pain.

Kate Gillan: There's a multitude of predisposing factors that are linked to chronic pain, but we like to look at a term called 'central sensitization'. What we like to see it as is a sort of persistent alarm system that's going off in the nervous system. We think about it in terms of two main characteristics: this heightened sensitivity to pain and the sensation of touch, so you would get people who might say that there's pain even though somebody is touching them lightly; or they have a sort of persistent state of heightened reactivity. So, the brain isn't producing a mild sensation as it should, but it's more of this kind of hyper-sensitised nervous system. It's more like this sort of high reactivity, that the nervous system is in this persistent state of pain being amplified.

Evans: A pain that shouldn't necessarily be painful is turned up.

Gillan: That's exactly it, the alarm system is going off but it's not necessary. It's something that you don't need to actually act on, but the alarm system is telling you that there is something wrong. So, it's a different part of your nervous system that's being activated with chronic pain.

Evans: Now, here's the big question: What does activate it?

Gillan: There's a lot interlinked: the biological, the psychological and environmental predisposing factors. A lot of what, as a psychologist, we're interested in is the stress response; what are the links to do with pre-existing anxiety or something that has predisposed somebody to have this heightened state of their nervous system.

When we see people in the clinic, we usually have two sessions that are focusing on assessment and formulation. Formulation, from psychological point of view, is pulling together the information, the patient story, that has been discussed in those two sessions and hypothesising about what is keeping difficulties going for somebody, and forming the basis for a treatment plan.

Twigg: When I was a young teenager, relationships, particularly with my father, became soured, having been very, very special and close when I was little. And I got stuck in something I would call a 'traumatic bond', which means that you keep trying to put relationships right when you can't anymore. And I tried to do that with my father, and he wouldn't listen to me, and then we lost each other. He died early and I became pregnant when I was a teenager, and got married very early, which was a great disappointment to him. So, I felt I'd lost him many times during my life, and I'd let him down. That was kind of the pattern so that my first marriage was not good, that was characterised sometimes by violent relationships, and [I] thought that I'd escaped and got married again in my late thirties, and that turned out to be disastrous. That was a really, really damaging relationship, which had all the hallmarks of coercive control and some violence as well, and was deeply hurtful. I, again, got stuck for 12 years in that relationship, and instead of walking away, which I should have had the capacity to do as someone who knew about these things, I still tried to put it right. So that's been my pattern; instead of recognising when something is wrong, and is never going to go back to the vision you had of that relationship in the first place, like many people I know would do, they would walk away. But in terms of my pattern and the way that I habitually dealt with damaging relationships, I tried to stay, and I tried to argue my case, and I tried to put things right. So, that meant that for most of my adult life, until my late 40s, I'd been in a really damaging pattern of relationships.

Gillan: So, we would really want to pull together this developmental history right through to what's a typical day like for you so that we can find out, obviously it's crucial to find out, is somebody experiencing ongoing trauma, and are there safety concerns that you would need to work with that person on alerting them to that and to seek safety.

Evans: But you can't take away those earlier experiences.

Gillan: But we can help people reframe what's happened to them. There's a huge sense of shame that's attached to complex trauma. If you think about somebody coming in and

probably feeling highly vulnerable in a clinical situation. You're reframing things to not what is wrong with you, but what's happened to you? That can have a huge impact on somebody's well-being and ability to adhere to other aspects of the pain service.

Evans: I haven't counted them, but there's an awful lot of use of the word shame in your writing. Explain to me, and others, who might not understand why you should be ashamed of domestic abuse.

Twigg: People who get stuck, like I do, tend to have quite a lot of baggage and damage in their relationships right back from childhood. What I found myself doing is comparing myself to other people. I come from a family of stable relationships, where people have been together for a long, long time. My friends had long-term stable relationships, and I had this feeling of being inside a goldfish bowl and looking at the world and everyone else had shining lives and perfect relationships, and that wasn't the case for me. So, I felt like I couldn't tell people because that would expose the fact that I didn't, and it would make me feel even more wretched.

Evans: Kath Twigg. ACE, the Adverse Childhood Experiences study, was a research programme in California in the 1990s, in which thousands of people received a physical examination, and completed confidential surveys about their childhood experiences to do with physical abuse, neglect, witnessing domestic abuse and other social factors. These, the researchers found, were predictive of health problems in later life. Kate Gillan.

Gillan: The study was quite pivotal because it showed that almost two thirds of participants reported at least one ACE. Now we're continuing to gain insight into how that impacts people later in life. Within the pain clinic, the psychology team are very involved in assessing people for a type two PTSD. So, we have type one PTSD, which people are familiar with, but there's a different presentation when you have a type two PTSD, and we kind of link that to the central sensitization, the prolonged stress related to adverse events.

Evans: PTSD is post-traumatic stress disorder. Now, I associate that with military veterans, or people who've been through terrible things like that. I assume that is what you're talking about with type one PTSD. So, what is type two?

Gillan: You're right military veterans, we sometimes have people that we would refer to organisations such as combat stress to receive trauma therapy, but complex trauma, there are military veterans that would experience complex trauma as well. It's very much about, you know, if you think about traumatic events like a physical or sexual assault, a road traffic accident, a natural disaster. Traumatic events experienced is highly distressing, leaving us feeling out of control, overwhelmed, leaving us with this emotional shock or psychological

trauma. And the symptoms are this kind of triad of unwanted memories, flashbacks, nightmares, avoiding any reminders of event, feeling unusually tense, irritable, on edge. These are kind of key indicators that we would be looking out for, for active type one PTSD.

There's something different with complex trauma, and complex PTSD. You would have the same presentation as type one, but you would have additional difficulties. The reason for that is that with complex trauma, it's cumulative experience of multiple traumas over long periods of time. Often, they can start in childhood, not always, we might have people who have experienced these events later in life, but it's this multiple traumatic impact that they've had. So, if you think about child physical, sexual, emotional abuse, child neglect, domestic abuse, torture. These events can be especially difficult because they're all of that interpersonal nature. If you think about where some of the situations that I've talked about that are linked to complex trauma, they're particularly difficult because they might be by people that we should have been able to trust. There's that kind of power and control dynamic. If people have experienced these events, they are likely to have difficulties with controlling overwhelming feelings, difficulties in relationships, difficulties with sense of self and needs that we all have, as children. We've got basic needs, and as adults, basic psychological needs: to feel safe; to feel supported; to have routine and structure; to feel loved and accepted. If we don't get that we have a challenging upbringing or challenging adulthood, then we're more likely to develop safety strategies in order to survive. All this is linked to this 'central sensitization'. In the pain clinic we know that if somebody has PTSD, research has shown that there can be about 80% of people with PTSD are likely to have physical health difficulties as well, such as chronic pain. We know in the pain clinic that if somebody is presenting, particularly with things such as widespread pain, or a pain that you're thinking 'why is this person experiencing this persistent unexplained pain?', we do want to check out for a history of complex trauma. And we know that you're more likely to have that presentation in a clinical setting with chronic pain than in a non-clinical setting with chronic pain because obviously, we know that chronic pain is common in the general population.

Evans: Kate Gillan. Of course, domestic abuse is not carried out in the clinic, it's carried out behind the closed doors of a family home. Dr Caroline Bradbury-Jones's preacademic experience was as a Nurse, Midwife and a Health Visitor.

Bradbury-Jones: The health visiting role in particular takes you into people's homes. Going into people's homes in any role is really very interesting, because you then assume the role of a professional visitor, if you like, and the health visiting also is a service whereby you have quite a lot of regular contact with families and with people. That gives the opportunity to build

up trust. So, what I was seeing as a health visitor was women disclosing to me about their experiences of domestic violence, but more frequently me being concerned about them in some way and gently asking them, were they okay?

Evans: It occurs to me that going into a home like that, a woman isn't going to open up straightaway and say ‘I am experiencing violence from my husband’, you have to work out what is going on.

Bradbury-Jones: Absolutely right, for most women in most circumstances. So, through understanding this problem of domestic violence, and through my contact with women and families over the years, and all of the evidence, I've read from, really good research on the subject, it's highly unlikely that women will present at a clinical encounter, whether it's in the home or whether it's not, very rare that they would say in an initial contact, ‘I'm experiencing domestic violence’. That's why that repeated contact with women, the relationship building that I talked about before, is so crucial. They need that in order to feel safe to disclose what's happening to them. They need that in order to know, or to hope, that when they do disclose that they're not going to be disbelieved, that they're not going to be criticised in some way, that they're not going to be traumatised by what's going to happen to them. Because women who've experienced domestic violence have lived through being controlled, through being coerced, through being told that if they ever tell anybody about what's happening to them the consequences are going to be such that they may have their children removed, that they're not going to be believed anyway, that they're going to be made homeless, they're going to be judged as being a really bad mother. So, they don't disclose because of really sound rational judgments and they don't disclose because of those misbeliefs and misinformation that they've been given over a period of time, kind of ‘gaslighting’ as it's referred to. Understandably, they would very rarely present, or say to somebody who's going into their home on a one-off encounter, ‘I'm experiencing domestic violence’. It often takes many, many attempts, and they often try it out. You know, when we're disclosing anything in life, we test out, we drop little hints so that we can get a sense of how this person is going to react, and it's no different domestic violence,

Evans: I suppose also going into somebody's home, you're also going into the home of the perpetrator of violence, who may even be sitting in the next room, or even in the same room.

Bradbury-Jones: Absolutely, because part of the ability to be a perpetrator is based on that coercion and control and the very tight control, physically, of a person's space. And so, within that home a perpetrator will often be there, deliberately so, so that they can hear what's going on. So, they can make sure that that woman is not going to disclose. They prohibit it through their very presence. So, for the women who've ever disclosed to me, they

waited till the perpetrator was out. That's very important thing for health professionals to understand, and I think most do when they're dealing with domestic violence. That you would never broach the subject with anybody if there was a risk that the perpetrator could know that you've had that conversation, if you have a sense that somebody might be experiencing domestic violence, and that can be really tricky. For example, in maternity care and midwifery practice where there is an encouragement to ask all women who are coming into contact with maternity services, they are to ask a question about domestic violence, and to document that you've asked that question. It can be really tricky when you have another person there, and to try and get that woman alone. So, midwives will often say to a partner, 'would it be okay if I just, I'm going to do a bit of a personal examination now. I just need just need to have this discussion in privacy.' And then while that perpetrator is out of the way to then quietly ask the woman 'is everything okay with you? Are you feeling safe at home?' Those kinds of questions, just with that minute of the window of opportunity to ask about it.

Evans: I would assume that the process of getting somebody to open out in something as personal as that may take many consultations.

Bradbury-Jones: Absolutely, and that's why it's so helpful if you are fortunate enough as a health care practitioner to have an opportunity to see the same woman on repeated occasions, because it takes that incremental testing out of the woman to see what the reaction is going to be. And it also takes the opportunity for the health care practitioner to be able to gently probe to be able to say 'I'm going to come and see you next week', or to develop strategies to have time for that woman to feel safe to disclose. And then, of course, because disclosure does not necessarily mean leaving, in fact it often doesn't, women will say that they're experiencing domestic violence and have no intention of leaving the perpetrator, again, for myriad reasons. But they want to tell, and they want to hear about what their options are, it's a process. Just earlier on I was talking about the fact that women would rarely disclose a kind of one-off event. The only time when that's likely to happen is in the most extreme situations, where they are literally fearing for their life, or fearing for the life of their children. It's on those occasions, an absolute crisis situation where they would present as a kind of one-off. I refer to it, and have written about it as being a crisis event. Where women have often experienced, in those cases, serious physical abuse and are literally fearing for their lives.

Twigg: On one occasion, my husband threw me onto the bed and put his hands around my throat and was banging my head against the pillow. And there were many times when I was afraid to push too far because I knew that he might have just snapped.

Evans: The mental abuse and the physical abuse, which was the worse?

Twigg: Oh, the mental abuse, definitely. That was devastating. Even when I left that relationship, eventually when it ended, I told myself 'Whoopie I'm out of it. I am okay now, and I'm happy and all the rest of it'. But again, I didn't stop and give myself time to heal. There were signs that I was becoming very depressed. It could have been Post Traumatic Stress Disorder as well, I think. I wouldn't open letters for instance, I wouldn't open bills or I wouldn't be able to cope with day-to-day things properly and at work. I was late for everything, just not functioning properly, but driving myself forward thinking I must be okay now, but not having that space to stand back and think I'm probably not okay, and I need to get myself some help.

Evans: Dr Lene Forrester is a Consultant Clinical Psychologist at Albyn Hospital in Aberdeen. She, along with a physiotherapist, created the pain management programme for Grampian Pain Service and a peer support group in Aberdeen for people with pain. She has a particular interest in interpersonal violence, and the link between post-traumatic stress disorder, that's PTSD, and chronic pain.

Lene Forrester: Interpersonal violence is a particular type of trauma, it's very intimate, it's very predominantly female, it's about 80/20. The psychological trauma of that, you know, pain is produced by the brain, it's in the brain. It doesn't mean that we're making it up, it just means that we have susception, we have signals to the brain, and the brain makes sense of it and sends the signals back to produce pain. And that process in the brain is incredibly complex, you know, it's affected by memory and mood and attention and personality. So, the trauma is relevant in that part, but also otherwise, and in terms of the psychological aspects of trauma. So, there are more physical trauma that'll have a psychological component in terms of helplessness, like if you have a car accident, say. Of course, there's psychological aspects of that run helplessness and lack of control, when an accident is an accident. And then you have more deliberate forms of trauma inflicted upon you, like people who have been victims of terrorist attacks or particularly vicious attacks in war, or whether it's deliberate intent to hurt you, which adds another psychological component to it. And then you have interpersonal violence, where the one person who's the closest to you in your life, and is meant to provide you with a safe space as an adult, is the person who's the most dangerous to you.

Evans: Did you have forewarning, if you like, before you married this person that he was like that?

Twigg: Yeah, I rationalised it away. You know, there was jealousy, there was criticism, coldness, very typical things that you get from someone who might be described as a narcissist, I think in the field of domestic abuse. Very little emotional warmth, just wanting to

control me and change me into someone I wasn't, and didn't want to be. But because of this feeling I've had that I couldn't be alone, and I didn't know myself and I couldn't respect myself enough, I felt that I had to be with someone else.

Forrester: I'm using the language ‘domestic violence’ today but often I use ‘domestic abuse’, because ‘violence’ has connotations of being physical, and that's really unhelpful because a lot of it is not. So, when we look at the imagery around domestic violence, it's often showing women with black eyes, and yet that is just an unhelpful image because a lot of domestic violence is not physical in nature, but emotional, financial, sexual, coercive, controlling. All domestic violence is underpinned by coercion and control - all of it, and most of it is emotional in nature. Those different forms of domestic violence often intersect, so a woman would experience a number of them. So that's not to say for one minute that physical violence doesn't exist, because it absolutely does, but there's so many women who don't experience physical violence and therefore are left wondering whether their experiences are really domestic violence. ‘He's only telling me that I'm not good looking.’ ‘He's only stopped me from having money.’ ‘That's not really domestic violence, is it? Because what I've seen about domestic violence is women with black eyes. So that can't really be domestic violence that I'm experiencing.’ But all domestic violence is based on coercion and control.

Twigg: Criticism, jealousy, not liking my friends or my family, criticising my job and my career which was deeply hurtful because that really kept me going. Not wanting me to say much about myself when friends were around, not wanting me to have phone calls with people, becoming aggressive when I was on the phone so that I then didn't answer the phone at home. Didn't speak to anyone anymore, moved away from my family incrementally and felt very lonely. This person incrementally took away everything that made my life worth living.

Forrester: Women report that the psychological abuse is worse because it targets yourself and who you are. But, also, it doesn't have a beginning and an end, and the unpredictability of it is very relevant in terms of development of chronic pain. I've seen women who've been abused in a very predictable manner, like somebody whose husband, every time his football team lost, he would get drunk and he would come home and he would abuse her. Of course, that was terrible, it was predictable, and she found him pathetic. She could see that it had to do with him and his behaviour, nothing to do with her, and so it didn't affect her in the same psychological manner. Whilst other women and men, if it's a real unpredictability around it you never know what's going to set them off, you never know what will spiral, you never know what's wrong or what's right. You're always on guard, you're always walking on eggshells, and always tense. And if you live like that, always tensing your muscles, of course

something's going to happen. In fact, I saw a woman many years ago and she told me: ‘of course I developed fibromyalgia, because I lived like this. I was always tensing my body, waiting for the next blow.’

Evans: A friend of yours said ‘he would only have to hit me once, and I'd be gone.’ Why did you stay?

Twigg: It goes back to this phrase ‘traumatic bonding’, the way that you get trapped by distorted thinking, by telling yourself that you can have a decent relationship with this person, you can go back to what you thought you had in the first place. And people like me, with that pattern of relationships into which they get a meshed, tend not to think logically in that way. So ‘traumatic bonding’ is where you have this distorted little bubble around yourself that makes you see the world slightly differently than other people. And you don't always see the danger with the perspective that other people have. The friend who said it to me very definitely would not have stayed, and I have many friends who I know would not have stayed, but I also know a lot of people who have stayed and do stay. And when I talk to people who are in situations that I was in, there is kind of a glaze that comes over people. When you talk about, you know, how they could remove themselves and make themselves safe. You know when the shutters have come down and they can't take in what you're saying. It's very hard for people who've not experienced this kind of syndrome to understand how that works.

Evans: Kath Twigg. The NICE guidelines for trauma and PTSD recommend either cognitive behavioural therapy, that is CBT, prolonged exposure, or eye-movement desensitisation and reprocessing (EMDR), or a combination of the two. Lene Forrester.

Forrester: The CBT prolonged exposure is a very verbal way of processing trauma. So, what happens in trauma is that something happens that is too awful, really, for the brain to let it in, and maybe because of high amygdala involvement, a lot of stress. So, it's stored in the rear sort of left part of the brain, may be the less verbal part, and it stays there because you try to push it away and not integrate it. And that's why it leads to flashbacks, or come back in your nightmares, or affect you in other more physiological ways, like in pain. The CBT prolonged exposure is a verbal way of recounting, closing your eyes, recording it and recounting the events and listening back to them every day, which can be quite harrowing of course. Which helps with processing in the brain and perspective, I suppose, maybe we can be a bit more compassionate for the person on the tape than we are to ourselves.

Whilst EMDR is a much more physical and visceral emotional kind of processing and less verbal. So, it involves that the person brings to mind and a traumatic event and the feelings associated with that and cognitions that they have. And they hold that in mind and body

whilst they follow your finger back and forth with their eyes really fast. Hence the name, which is to do with alternating stimulation of the left and right brain hemisphere. It helps the brain to process trauma. So, you can see on functional MRIs that the activity goes from the rear right to the higher functioning. From the sort of reptilian part to the basic part, the primal part to the higher functioning left prefrontal cortex, the verbal parts. So, it's integrated as a normal memory, rather than bad memory, but still a normal memory.

Evans: Clinical psychologist Dr Lene Forrester. As always, I'll remind you that whilst we in Pain Concern believe the information and opinions on ***Airing Pain*** are accurate and sound based on the best judgments available, you should always consult your health professional on any matter relating to your health and well-being. He or she is the only person who knows you and your circumstances, and therefore the appropriate action to take on your behalf.

Now, it's particularly important to reiterate that this edition of ***Airing Pain*** is being recorded just a few days before Christmas 2020. Please bear in mind that between then and whenever you're listening to this programme, public guidance for dealing with COVID-19 may have changed. So, do keep up with the current NHS and government advice. However, the content of this programme is relevant regardless of the current crisis. Dr Caroline Bradbury-Jones.

Bradbury-Jones: When we went into lockdown in the spring of 2020, there was speculation. I speculated myself about how domestic violence would be exacerbated or how lockdown and isolation would impact on the numbers of domestic violence incidents that were taking place. And since that time, and it's a relatively short time, there's very clear evidence that it's increased dramatically.

When it comes to domestic violence services, they have responded very well to the current situation, and have developed safe ways of engaging with women in a way that is remote and is over the telephone or using Zoom, Skype, etc. So, face to face contact within the domestic violence sector is remote. Similarly, consultations between GPs, between health visitors, midwives, those kinds of clinicians who typically have face to face contact with women are no longer the case. And obviously that's problematic, because there were opportunities for finding that physical space, finding the closeness are missing, and now that is really very important. When it comes to having a screen, there's so much about human interaction that you can't capture. So, for health practitioners who would normally pick up on little cues about something that would be uncharacteristic for a woman, are very difficult in this situation. So, when it comes to offering a service or offering support, the current working from a distance or practising virtually is an additional layer of complexity, and really extends the isolation that a lot of survivors and victims of domestic violence feel.

Evans: Over the telephone or over a Zoom link or a video link, you have no idea who is sitting within a couple of feet of the person you're dealing with, or tapping into the conversation. You have no idea who's there.

Bradbury-Jones: No, absolutely, no, you have no idea.

Gillan: The impact of lockdown has not caused the domestic abuse, only the people who abuse are responsible for their actions, but we do know that things have escalated. But, you know, prior to this year we've had situations where people, you know, we've just actually had to try and signpost them to seek refuge or to contact the police, social services. There are situations that you think 'this is not the job of the pain clinic', all we can do is direct that person because if somebody is in quite a dangerous situation, certainly in terms of a traumatic framework, we will look at what we call a window of tolerance. This optimal zone where somebody is able to tolerate emotions and integrate information. They're curious, they're able to take on board new learning. When people have a traumatised history, they can present with quite a narrow window, so they might be quite likely to go up into the, what we call the, hyper arousal zone, this fight or flight response, very emotionally reactive, hyper vigilant, all the PTSD symptoms that we're talking about in the most extreme sense. Or they might be called a hypo arousal zone. So, you've got the red zone and the blue zone and they might quite quickly go back and forth, and in this blue zone you might have people that are very quiet, there's a kind of numbing of emotions, reduced physical movement. And I think in our clinic situation, if you think about going into a busy outpatient service, this kind of over reactivity or under reactivity, people need to be aware of that. As health professionals, we need to be aware of that. And, you know, if you're running late for an appointment, you need to be able to go and tell that person 'look, I'm running five minutes late. Are you able to wait?' You need to be aware that this window of tolerance could result in somebody leaving.

Bradbury-Jones: In GP practices in the UK, there is a wonderful intervention called IRIS (the Identification and Referral to Improve Safety). It is like a national program, it is research-based. For a woman who presents to a GP and discloses domestic violence there is a really clear pathway for referral. So, that GP or the member of the practice staff would know exactly what to do and would know exactly where to refer that woman to for help. They would have, as part of their surgery, a named expert called an 'advocate' who can help that woman. That is not in place right the way across the UK, GP practises sign up for it. The benefits being they receive training, all the practise staff get training in how to identify domestic violence, how to ask about it and they have that named person, that named expert, as a point of referral. Which the practise staff, mainly GPs I would say, a really good grounding in what they are looking for and what they dealing and how to deal with it and

then it gives that important point of referral. So, they, in some ways, they are not the one who are then having to deal with the situation or finding that support. That is very different to other areas where they don't have this particular intervention. Where the person asking about the domestic violence or the disclosure situation is then, I've heard it being referred to 'opening a can of worms' because practitioners are left holding that situation, responsible for it. Often, with very little idea of where to go for help and how to support that woman. Often, quite frankly, not having the confidence or the knowledge on how to deal with it in a helpful way. From listening to women talking about their experiences over the years that I have, reporting that health professionals often get it wrong. Unwittingly, most health professionals want to help that why they're in that business, but they just do not have the resources internally and professionally to be able to deal with it and they often don't have the resources physically to refer to, because resources as regards services for domestic violence survivors are under resourced and there were not enough of them.

Evans: That was Dr Caroline Bradbury-Jones, Professor in Gender Based Violence and Health at the University of Birmingham. Dr Joht Singh Chandan, Specialist Registrar in Public Health and academic Clinical Lecturer, also at the University at Birmingham.

Singh Chandan: What we've seen in the pandemic is, it was even described by the United Nations as, a shadow pandemic of violence against women and children. So that is referring to things like domestic abuse. It's very likely that following the pandemic, due to the mental health consequences of the pandemic [and] due to the problems of isolation, there will very likely be an increase of fibromyalgia [and] more demand for services. So, what we've got is the perfect storm here brewing away because of the pandemic. We've got more people who might be exposed to domestic abuse, hence we've also got a greater burden of individuals who may go on to experience symptoms relating to pain or fatigue and dysfunction. As a public health doctor, we are quite worried about the public health burden. What does this mean to greater society? What does this mean to the burden on our services as well? How can we actually plan and restructure services to consider this? This going to be the real challenge for 2021 and beyond. It is very clear in my mind, actually, how do we solve a complex problem such as this? And the only real way to do it is to take a public health approach. It is not something we've done before it is something we've been campaigning for a very long time but it is very clear that now is the time to do something about it.

What does a public health approach to abuse or maltreatment look like? Well it's very simple, there are 4 steps to it. A lot of this is being pre-documented by the World Health Organisation, but it is not an approach that we necessarily take in the UK or within Europe. The first element being improving surveillance. That really means defining the violence

problem that we have, the abuse problem that we have, through systematic data collection on the prevalence of abuse, how common it is. These figures are not very reliable. Who does it affect? We don't really have very reliable statistics on this because we have issues in the way that data is collected around this topic. We've shown ourselves in a lot of research we've done, healthcare data really only captures the tip of the iceberg, police data only captures those who encounter police services and charity data only captures those who are willing to go and engaged with these services, or were aware of them. So, we've got a huge problem with under recording. There is a secondary problem with that, which is if we don't the burden it is hard to plan services going forward, and secondly, it's hard to understand the risk and protective factors for domestic abuse, unless we've got a good population or a good understanding of who's being affected we can't really get to the bottom of why they are being affected. Is domestic abuse during the pandemic affecting certain subgroups of people? Is it women between a certain ages or different ethnic groups? An area we really don't understand is what does domestic abuse look like in different ethnic groups, and that's something which worries me quite a lot.

So, the Covid-19 pandemic has been disproportionate in the way that is affecting people, particularly different ethnicities. We have no understanding of what that's meant different ethnicities in term of rates of domestic abuse during this period. So, unless we improve surveillance we won't get to the second step of understanding risk and protective factors very well.

Also, when it comes to understanding risk and protective factors, because we don't really have many mechanisms of capturing all this information on people, it is actually very hard to undertake risk assessments. There is a lot of research saying that actually clinicians, even police officers, you know, these professions have the best will in the world, they only really ever want to help people, but this is a very tricky topic to bring up. It is a very difficult conversation to have with someone when we suspect them to be at risk. Can we improve the training in these areas to make sure people feel confident to do so? A lot of research has been published and people don't necessarily feel confident in asking these questions because they don't really know what to do next. So, there is clearly something about improving the way we have referral pathways. Then actually the third step really comes into its own which is, can we develop and evaluate interventions that work during this period where we apparently in a state where face-to-face interventions are not being supported in the same way that they would have been? What other sort of services do we have. There is a vast area for remote services that are available, but a lot of these have not been created or developed in conjunction with survivors of domestic abuse, and very few of them have been evaluated. So, to be completely honest, we are a bit stuck in what population-based remote

measures we can implement during this time and that's something which we really need to get to the bottom of. We need more research very urgently. The bit that worries me the most is that we are essentially in month 9 of the pandemic and we still haven't taken these actions forward. Unless we get good interventions very soon, I think all that we are doing is basically saying that we are not supporting the survivors in the way that they really need. The final step of any good public health approach is, once you identifying and evaluate some of these good interventions, we need to scale them up in policy and to mandate certain actions to happen in areas. But we are very far from that because charities, healthcare services, administrative services, public sector services are definitely doing the best they can but equally there is still a long way to go until we really nail this area, and really just support the survivors the best way possible.

Evans: Did you confide with friends at all?

Twigg: Not for a very long time. I kept to everything to myself. I was ashamed because I'd gone through one marriage that ended. I did not want to be seen as a failure. I got a professional job so I needed to put on a persona and go out and do that. It just didn't feel right to tell anyone. It took a very long time and the help of some special people before I realise, I needed to do that. Even then it was still hard to go. It is hard to leave what you work for; it is hard to leave your home. Also, the distorted thinking still draws you back and makes you think that somehow, I could put things right and I could take it back to what I thought I had in the first place, which was never real.

Evans: What sort of advice would you give to somebody who feels their friend or family member is undergoing violence at home. How can they get involved? What should they do?

Bradbury-Jones: They can do some practical things and they can do some emotional support things. From the practical point of view, they can find out and get details of resources and points of referral, there is a domestic violence helpline for example, get the details of that and right it down, have something physical. The most they can do is ask when it's safe. We've talked about safety and we've talked about the lingering presence of perpetrators, but they not around for ever, you know, perpetrators go to the toilet. Finding the opportunity to ask, that's just such a crucial thing, and it doesn't actually matter if you get the wording wrong. It doesn't really matter if you feel you might have said the wrong thing. The point of asking quietly, gently and in a supportive way is a key to showing that member of the family, [or] showing your sister or your friend that you're concerned about them and that you're brave enough to ask. Even though the answer might be 'of course I am fine. No, no, no I am absolutely fine', opening up the opportunity to have that discussion again and

showing that person that you are there to listen to them and there to help should they need it.

Evans: It is so easy to be judgmental or ‘he’s doing this to you, this that or the other’ You are under his thumb. ‘I told her to get it sorted, she wouldn’t do it, there we are, leave it there.’

Bradbury-Jones: That’s right. Again, referring to some of the women that I’ve spoken to recently, a number told me that after they’d disclosed, after they got help and after they left that relationship that friends and family would say ‘you know I am so glad that you are not with him anymore because we always thought that something going on’, but never, ever mentioned it. Women are angry about that, because they think they have been in the presence of members of their family and their friends who they thought cared for them and yet they couldn’t find the words, and couldn’t find the wherewithal to actually ask them. That, for a lot of women, they find very upsetting.

Evans: It is easy to judgmental and to say ‘what I would do in these circumstances.’

Bradbury-Jones: It is easy to be judgmental and survivors talk about that. They talk about the unhelpful advice they get, often by well-meaning people. Well-meaning friends and family, but also well-meaning professionals as well. Those judgmental elements are hard to contain, and a lot of well-meaning helpers would say that ‘you need to get out of this situation, you need to leave now.’ Which seems like a rational piece of advice, but as I’ve said before a lot of women who disclose domestic violence don’t want to get out there and then. They often do eventually but it takes time and that’s not always the helpful action, and it is not what they want to hear and in some sense that’s why they don’t talk about it or say what is happening to them. They pre-empt that judgmental stance of the person who’s there, but health professionals have the same response as well. I am thinking of one particular study that we conducted a few years ago: health professionals expose a real frustration sometimes, when women are remaining in a relationship they don’t understand it, they don’t get it. You know, ‘you are experiencing domestic violence, get out, leave.’ It’s not that simple, we know it’s not that simple. Frustration, when we know that somebody close to us is enduring something that’s so terrible and yet they’re still there. ‘Why are you still there?’ Is a common question, but it’s not a sensible one. We can talk about the helpful things that one can do, the practical and the emotional support, but we can also talk about the things not to do. The ‘not to do’ are really about not asking when there is any risk that the perpetrator can find out that you’ve asked. Also, withholding more of the advice that you would want to give and just take more of the hearing, listening stance than an advisory one.

Forrester: It is very important to seek professional help, psychological help, for what you’ve been through. This is a massive event or series of events. You’re not going to be okay

immediately, in a psychological way, more often than not. Maybe some people are, but most people are not. To struggle on with that because there are other priorities, you don't value yourselves enough to do something about it, or you think that you can leave it behind and that it won't affect you, is a dangerous prospect. You do deserve help for your trauma and preventing secondary illnesses to evolve.

Evans: Clinical Psychologist Dr Lene Forrester. There is a list of professionals and third sector resources on Pain Concern's website, which is painconcern.org.uk.

I'd just like to highlight some important organisations for immediate help. One is Refuge, at refuge.org.uk and the 24-hour National Domestic Abuse Helpline phone number is 0808 2000 247 and Woman Aid office 24/7 Domestic Abuse and Forced Marriage support. Each of the UK nations has its own website with specific information in Scotland is womensaid.scot.

Kath Twigg whose accounts of abuse we've been hearing throughout this program runs therapeutic writing courses for survivors of domestic abuse, and workshops for those who wish to escape destructive life patterns and abusive relationships. Visit her website at kathtwigg.co.uk for more details of her work and her book *The Hall of Mirrors, How to Change Life Patterns and Avoid Toxic Relationships*. Kath is spelled with a 'k' and Twigg ends in double 'g'. She'll have the last words.

Twigg: You have to find a way of loving yourself. Remember the person that you lost along the way, because in all of this pattern and fluff that you lived through; you forget who you are. So, I married the wrong people.

Evans: Are you in a relationship now?

Twigg: Yes, yes, I am with an old, old friend who I've known for 37 years. He was always on my wavelength, who is my soul mate.

Evans: Do you argue or is everything lovey-dovey and sweet and nobody says anything bad about each other.

Twigg: We argue, yes. We have different point of view about things, we get on each other's nerves. It's normal, that's what normal relationships do. People don't have, you know, a kind of going off into the sunset. We have a normal, up and down relationship, and we're very happy.

Transcribed by Oliane-Newman Savey

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