

# Domestic violence: a hidden problem for general practice

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**SUMMARY.** *Domestic violence is a common problem that may affect more than a quarter of women. It is a complex area in which to undertake research. Studies often focus on selected populations and exhibit a diversity of design, making comparison difficult. This review focuses on physical violence by men against women partners or ex-partners, and exemplifies important issues for general practitioners. Domestic violence frequently goes undetected. This may be the result of doctor's fears of exploring an area perceived as time-consuming, where knowledge is lacking and where they feel powerless to 'fix' the situation. Women may not reveal that they are experiencing violence, sometimes because doctors are unsympathetic or hostile. Nevertheless, women wish to be asked routinely about physical abuse and want to receive immediate advice and information about their options if necessary. Women experience a range of health and social problems in association with domestic violence, including depression, anxiety, substance abuse and pregnancy complications. However, none of these features is specific enough to be useful as an indicator of violence. Therefore, doctors should routinely ask all women direct questions about abuse. This recommendation can be incorporated into guidelines, which should be implemented widely in the UK, to improve the care of women experiencing domestic violence. In parallel with this, the educational needs of general practitioners should be addressed. Further research is needed to establish the prevalence of domestic violence in women presenting to general practice and to investigate how the problem is currently being addressed. If progress is to be made in tackling domestic violence, action within primary care is just one part of this: a fundamental change in the attitudes of men towards women is required.*

**Keywords:** *violence in the home; women's health; missed diagnosis; doctor-patient relationship; patient's attitudes.*

## Introduction

DOMESTIC violence against women is a worldwide problem with extensive repercussions.<sup>1</sup> According to the most commonly used definitions, it may comprise physical, emotional, sexual and economic abuse occurring in an adult relationship between intimate or formerly intimate partners with a pattern of controlling behaviour by the abusing partner. Physical violence is frequently ongoing, and associated with increasing entrapment, injury, medical complaints, psychosocial problems and unsuccessful help-seeking.<sup>2</sup>

This review focuses on physical violence by men against

women partners or ex-partners. Our aim is to increase awareness among general practitioners of the prevalence of domestic violence, to explore why it is underdetected and to review good practice that may lead to improved identification and care of women. Suggestions are also made for research that needs to be undertaken in general practice.

## Search method

We searched the *Medline* bibliographic database from 1976 to April 1995 for English language articles, using the search terms 'domestic violence' and 'spouse abuse'. In this review we focus on five aspects of domestic violence: prevalence; attitudes of doctors to women experiencing domestic violence; views of women about doctors and their role; indicators; and guidelines. We did not independently assess the numerous prevalence studies, predominantly from the American literature, but relied on review articles to summarize these data. Not all of the many published guidelines were obtained. Guidance on important literature was made available from those working in the field, particularly with regard to unpublished reports and journals not referenced on *Medline*. Social science databases were not searched.

## Overview of research on domestic violence

Domestic violence is a complex area in which to undertake research. Consequently, studies exhibit a diversity of design and often focus on selected populations, making comparison difficult and of little value. Definitions of domestic violence vary considerably, including different personal relationships and different degrees or types of violence. This particularly affects the results of prevalence studies. Whether or not data are collected face to face from women has a considerable impact when studying such a sensitive area. In-depth studies are often of small, selected samples and response rates are frequently low, particularly to questionnaire surveys. Well-designed, methodologically rigorous studies are notably absent. Taken overall, therefore, research evidence in the areas reviewed is patchy and incomplete, and for this reason we felt it was not appropriate to undertake a formal classification of studies according to strength of design. It is worth noting that most of the literature originates from the USA, with a few papers from the UK, Canada, Australia and New Zealand. Domestic violence is an under-researched area in British general practice.

## Prevalence

Population studies in the USA indicate that as many as 20–25% of adult women have been abused by a male intimate,<sup>2</sup> suggesting a large 'clinical iceberg'. The position may be similar in the UK. A community survey in north London<sup>3</sup> found that 27% of women responding to a questionnaire said that they had suffered physical injury from their partners in their lifetime. Eight per cent had been injured in the previous 12 months, with more than a quarter of these women being injured at least six times during the year. However, the British Crime Survey (BCS) of 1992,<sup>4</sup> a national survey, found that only 0.9% of women overall reported at least one incident of domestic violence in the previous year. Domestic violence is defined in the BCS as wounding or com-

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mon assault involving partners, ex-partners, and other relatives or household members. The strict definition of violence may account for some of the difference between this and the north London study, as well as possible reluctance to admit to being a victim of domestic violence in a face-to-face interview. The BCS also investigated lifetime prevalence of domestic violence: overall, 11% of women who had lived with a partner said that there had been some degree of physical violence in their relationship(s).<sup>5</sup>

In a classic study in an urban American emergency room,<sup>6</sup> retrospective medical records analysis found that up to a quarter of women presenting with an injury were definitely or probably experiencing domestic violence. The researchers' criteria included no record of the perpetrator or an inadequate explanation of the injury. By contrast, the physicians who had treated the women identified only 2.8% as battered. McLeer *et al*<sup>7</sup> studied female trauma patients in another emergency department in the USA. Introduction of a protocol for detection of injuries caused by battering increased the identification of battered women from 5.6% to 30% of female trauma patients. These studies show that, when evidence of domestic violence is actively sought by direct questioning or examination of medical records, the documented prevalence rises considerably: doctors are failing to identify many women who have been abused.

Research in American primary care shows a range of prevalence of physical abuse from 7.3% (women in a family planning clinic in Texas) to 44% (women attending two South Dakota family practice clinics).<sup>8-11</sup> Again, different definitions of violence are used. No studies of the prevalence of domestic violence among women presenting to general practice in the UK were found during the course of this review.

### Women experiencing domestic violence and their doctors

Attitudes held by doctors may affect how frequently women experiencing domestic violence are identified; one influence on this is the medical model of care.<sup>12</sup> Standard medical language and an emphasis on objective findings, such as physical trauma, may result in the true cause of a woman's symptoms being obscured. In a study of emergency room charts of women who were deliberately injured by another person,<sup>13</sup> the problem of ongoing domestic violence was mentioned in the discharge diagnosis in only 1 out of 52 cases in which abuse was explicit or strongly indicated. In three-quarters of cases, the physician failed to record the relationship of the assailant to the woman. Warshaw<sup>13</sup> suggests that this lack of recognition recreates the dynamics of an abusive relationship in which the needs of the woman are reduced to categories that meet the needs of the clinician. Frustrated help-seeking is a feature of ongoing violence.<sup>2</sup>

Other studies have explicitly investigated the attitudes and responses of doctors to women who may be experiencing domestic violence. Fears that domestic violence disclosure may be time-consuming were expressed by general practitioners in one small study.<sup>14</sup> Lack of time was also seen as a barrier to identification in a survey of a selected group of American primary care physicians,<sup>15</sup> with a fear of 'opening a Pandora's box' were they to ask about violence in the home. Worries about offending the woman and jeopardizing the doctor-patient relationship, feelings of powerlessness in the face of a situation the physician cannot 'fix', loss of control when attempts at intervention are useless and identifying too closely with patients from a similar background may also impede identification. Other problems raised in a study of 32 Canadian family doctors<sup>16</sup> included lack of medical school training about 'wife abuse' and lack of knowledge about community resources. Fears were expressed about possible threats to the doctor from the perpetrator of the violence.

Despite ambivalence towards disclosure and its consequences, in one American study of 27 primary care physicians<sup>17</sup> most thought that they would be able to assist patients with problems arising from physical abuse. Australian general practitioners perceived themselves as capable of playing a preventative role through vigilance for indicators of violence.<sup>18</sup> Women may hold more sympathetic attitudes than men: one study of physicians' and nurses' attitudes to domestic violence found that gender was more important in this respect than profession.<sup>19</sup>

### Women's views of doctors

*'He only talked to me as if it were my fault'*<sup>21</sup>

A number of studies have explored the responses women received when seeking help. In a study in a refuge, Pahl<sup>20</sup> found that 32/50 women had talked to their general practitioner about the violent behaviour of the man with whom they were living. Over half had found the response helpful, characterized by listening, being sympathetic and offering appropriate advice. General practitioners who were said to be 'unhelpful' frequently prescribed antidepressants and tranquilizers. A later study<sup>21</sup> found that 89% of women in refuges had consulted their general practitioner in the previous year, but nearly half of these had concealed the fact they were being battered, mostly because they were ashamed or were afraid their partner would find out, but also because of the hurried, unsympathetic or hostile attitude of their general practitioner. Other studies have reported similar findings, with women not revealing that they had been beaten.<sup>22</sup> According to women interviewed in Northern Ireland,<sup>14</sup> general practitioners apparently did not see obvious signs of injury and did not ask directly about the cause of injuries.

Women seem quite clear about what they want from their doctors: recognition of their plight and immediate advice and information about what they can do and where they can go.<sup>14</sup> Three-quarters of American women interviewed in a questionnaire survey in primary care<sup>17</sup> favoured being asked routinely about any history of physical abuse, and 97% of male and female respondents stated that they would answer truthfully if asked directly. Only 7% stated that they had ever been asked about a history of physical abuse. In another American survey,<sup>11</sup> women stated that physicians are responsible for making the diagnosis of abuse. Two-thirds of a group of women questioned in Northern Ireland thought that doctors should ask directly about violence.<sup>14</sup>

### Improving identification: are indicators useful?

In many cases a woman's general practitioner may be the first person outside family and friends to be informed of domestic violence.<sup>23</sup> Behavioural aspects such as a woman appearing nervous if her partner is present or an inconsistent account of the cause of an injury may raise the suspicion of violence. However, in the absence of disclosure, when should the general practitioner consider the possibility of domestic violence?

There are a number of features which are associated with domestic violence, but most are so common in general practice that they are not specific indicators. One American study based on a medical chart review found that a combination of all variables analysed in the study could only predict lifetime injury in about 50% of cases and violence in the past year in about 20%.<sup>10</sup> The presence of certain features in a woman's past history raises the likelihood of her experiencing domestic violence. More significantly, domestic violence is associated with an increased risk of health and social problems that may be presented to the general practitioner.

A detailed review of risk markers in husband to wife violence found that only witnessing violence in the wife's family of origin

as a child or adolescent was consistently associated with being victimized by violence.<sup>24</sup> Other studies have shown that early and repeated sexual abuse in the family of origin may be associated with later domestic violence.<sup>25</sup>

The pattern of a woman's injuries when presenting to general practice or an accident and emergency department may indicate possible domestic violence. Battered women are 13 times more likely than non-battered women to be injured in the breast, chest and abdomen.<sup>2</sup> Multiple injuries, injuries in different locations, and injuries located on the face, head and neck are highly indicative of abuse.<sup>25</sup> Bruising may be in different stages of healing: abuse is typically ongoing and repeated.<sup>2,23</sup>

Women experiencing domestic violence are at increased risk of drug and alcohol abuse. Rates of substance abuse rise considerably after the first battering episode has presented, and this seems to be largely as a consequence of domestic violence.<sup>2,25</sup>

There is little doubt that psychiatric illness, particularly depression and anxiety, is greater among physically abused women.<sup>25</sup> Suicide attempts are more common and seem to be a consequence of domestic violence: the increased rate is not noted before the first reported episode of abuse.<sup>2</sup> A study in New Zealand of a randomly selected group of women found that those who identified themselves as victims of physical abuse as an adult were significantly more likely to be identified as psychiatric cases than non-abused women (all had been abused by a male partner).<sup>26</sup> In a study of American psychiatric inpatients, 64% of women disclosed a history of physical abuse as an adult.<sup>27</sup>

Pregnancy is a high-risk period. Battered women are three times more likely to be pregnant than non-battered women presenting with injuries.<sup>2</sup> Studies show reports of abuse during pregnancy ranging from 3 to over 20%, depending on the definition used.<sup>28,29</sup> Injury to the abdomen, breasts and genital area is common during pregnancy.<sup>9</sup> Abuse may increase during pregnancy, and in one informal questionnaire study of pregnant American teenagers, 26% were being battered, with 40–60% reporting that battering had begun or escalated since becoming pregnant.<sup>30</sup> Miscarriage is more frequent among battered women,<sup>6</sup> and low-birthweight babies have been reported as more common.<sup>29</sup> One study of a selected group of women<sup>31</sup> found the number of incidents of abuse to be highest in the 3 months after delivery.

Other associations are recognized. A history of sexual abuse or rape is more common among women who have experienced physical abuse.<sup>2</sup> Some studies suggest a high risk of child abuse among the children these of women.<sup>25</sup> In a review of the notes of mothers whose children were suspected of being abused or neglected, 45% of the women had a trauma history that indicated battering.<sup>32</sup> Children may suffer in other ways when their mother is being abused, psychological and behavioural problems being more common.<sup>2,25</sup>

Demographic features are not useful aids to identifying women experiencing domestic violence: they are not specific. Only younger age and being divorced or separated are consistent risk factors.<sup>25</sup>

In summary, none of these factors can do more than raise a clinician's suspicion of domestic violence, and is no substitute for direct questioning in a sensitive and appropriate way.

### Improving identification: guidelines

Domestic violence guidelines and protocols were used in health care settings in America by the late 1970s.<sup>33</sup> Guidelines may increase the identification of women experiencing domestic violence,<sup>7</sup> but without ongoing commitment to their implementation and staff training, identification drops sharply. The potential value of guidelines lies in the standardization of good practice,

which, in the absence of intervention studies around domestic violence, must be based on local consensus rather than evidence of effectiveness. This consensus will need to embrace social and police as well as health care services. In 1992, the American Joint Commission on the Accreditation of Healthcare Organizations required that all emergency and ambulatory care services adopt written policies and procedures relating to adult and child victims of alleged or suspected abuse or neglect.<sup>33</sup>

Sheridan and Taylor<sup>33</sup> have made recommendations for content areas which should be covered in a health care protocol on domestic violence. There should be: a definition of domestic violence, including heterosexual, gay and lesbian relationships; a statement of 'facts versus myths'; a list of common indicators of abuse; culturally sensitive assessment questions; a legal overview, advice on medical record documentation, forensic evidence collection and advocacy with police and court systems; a review of safety issues for patients and staff; information about community agencies for referral; and a selected bibliography. Five areas should be specifically assessed as regards the woman (or man): suicidal ideation; sexual abuse/rape; risk of homicide; substance abuse; and abuse of any children. These recommendations provide a useful starting point for agencies considering implementing guidelines, although 'indicators' may be more appropriately described as 'associations'.

#### WHAT TO INCLUDE IN GUIDELINES

- Definition of domestic violence
- Background facts and information
- Features associated with domestic violence
- Assessment questions
- Key aspects of history-taking
- Advice on accurate record keeping
- Legal overview, including role of police
- Review of safety issues for women/staff
- Information about community agencies (e.g. Women's Aid)
- Selected bibliography

There is general consensus that helping to empower women by affirming their right not to be abused and informing them of help available is more appropriate than health professionals trying to take control of the situation and making referrals for them.<sup>34</sup> Domestic violence interventions within accident and emergency departments may best be coordinated by a clinical nurse specialist, which avoids untrained staff unwittingly making the situation worse,<sup>33,34</sup> although this is not a solution for general practice.

The American Medical Association guidelines and others state that the physician should routinely ask all women direct, specific questions about abuse.<sup>35</sup> This recommendation amounts to universal screening and emerges from the failure to detect women at risk from consideration of other factors.

### The future

In the UK, the problem of wife battering was brought to particular public attention in the 1970s by campaigners including Erin Pizzey.<sup>36</sup> Domestic violence has recently re-emerged as a media issue via soap operas and the quashing of murder verdicts against two abused women.<sup>37,38</sup> However, it remains an area that attracts relatively little attention within the National Health Service and even less within general practice.

In 1992, Victim Support published the report of a national interagency working party on domestic violence.<sup>39</sup> The report recommends that each health professional group should agree guidelines to good practice in the identification and care of women experiencing domestic violence, that domestic violence

should be specifically included in training curricula for all members of the primary health care team, and that local multi-agency forums on domestic violence should be set up, including general practitioners. The extent to which this has happened is patchy: guidelines for general practitioners, published by the Royal College of General Practitioners, exist<sup>40</sup> but are rarely implemented. Forums exist in some parts of the country but not others. When the government responded to the Home Affairs Committee third report on domestic violence, which had studied the Victim Support report, no specific recommendations were made regarding health care.<sup>41</sup>

Further research is needed to establish the prevalence of domestic violence in women presenting to general practice and to investigate how the problem is currently being addressed. A consistent definition of domestic violence needs to be used and women sampled randomly from all groups as well as from those presenting for specific reasons, such as antenatal care.

Action research is needed which could be linked to the more widespread introduction of guidelines on good practice in domestic violence with training and educational input at all levels, including undergraduate. In particular, the educational needs of general practitioners should be addressed. The Royal Australian College of General Practitioners has produced a teaching package to enable general practitioners to care for women who have experienced domestic violence.<sup>42</sup> This model could be adopted here, incorporating the guidelines already produced by the British College. Audit of guidelines is required, and this could focus on specific aspects, such as the effectiveness and appropriateness of universal screening. The form screening questions should take needs further investigation. Commissioners of health care can support the implementation of domestic violence guidelines by including a requirement in contracts with providers.

We do not claim that action within primary care will solve the problem of domestic violence. Sadly, there continues to be acceptance of the use of violence against women: two-thirds of boys in a survey in Edinburgh believed that there was some likelihood that they would use violence in future relationships.<sup>43</sup> Progress in reducing domestic violence will require a fundamental change in attitudes of men towards women.

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