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The hidden epidemic of domestic violence: when to ask and how to respond

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Domestic violence underlies many psychosomatic presentations in women. To help prevent major, enduring health effects, GPs need to ask directly about abuse and respond with ongoing support.

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Intimate partner violence is a hidden problem in general practice, with women presenting with a wide range of psychological and chronic physical symptoms. GPs need to ask direct, nonjudgemental questions about abuse, as well as provide appropriate follow up and ongoing support.

WHAT IS DOMESTIC VIOLENCE?

The World Health Organization defines domestic violence as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.[1] It may include physical violence (e.g. slaps, punches, kicks, use of a weapon and homicide), sexual violence (e.g. forced sex or participation in degrading sexual acts), emotionally abusive behaviours (e.g. stopping a person from seeing family and friends, ongoing belittlement, humiliation or intimidation), economic restrictions (e.g. preventing from working) and other controlling behaviours (e.g. monitoring movements and restricting access to information or assistance).

Rates of isolated violent acts within relationships are comparable between men and women, but repeated, coercive, sexual or severe physical violence is largely perpetrated by men against

POTENTIAL PRESENTATIONS OF DOMESTIC VIOLENCE

Psychological

- Insomnia
- Depression
- Suicidal ideation
- Anxiety symptoms
- Panic attacks
- Post-traumatic stress disorder
- Eating disorders
- Drug and alcohol abuse

Physical

- Multiple unexplained physical symptoms
- Chronic pelvic or abdominal pain
- Chronic headaches
- Chronic back pain
- Somatic complaints such as dizziness and chest pain
- Numbness and tingling
- Lethargy
- Obvious injuries, especially to the head and neck or to multiple areas
- Bruises in various stages of healing
- Sexual assault
- Sexually transmitted diseases

POSSIBLE QUESTIONS TO ASK IF YOU SUSPECT DOMESTIC VIOLENCE

- Have you ever been afraid of your partner/ex-partner?
- Has your partner ever physically threatened or hurt you? Or have you been kicked, hit, slapped or otherwise physically hurt by your partner/ex-partner?
- Within the last year, have you been forced to have any kind of sexual activity by your partner/ex-partner?
- Sometimes partners use physical force. Is this happening to you?
- Have you felt humiliated or constantly put down by your partner/ex-partner?

RESOURCES FOR MANAGING DOMESTIC VIOLENCE

- Police
- State crisis services (24-hour, 7-day crisis line). Usually provide crisis counselling, referral, support and advocacy. Act as a contact point for women's refuges and referral to other short-term crisis accommodation
- Immigrant or migrant women's domestic violence service
- Telephone interpreter service
- Community legal services
- Child First services
- Child protection services
- Sexual assault services or rape crisis centres
- Men's referral service
- Local domestic violence services
- Private counsellors and psychologists
- Women's information services
- Women's community health centres
- Lifeline (24-hour counselling)
- Relationships Australia

women.[2] This article concentrates on the needs of women as victims of domestic violence.

WHY IS IT IMPORTANT?

Domestic violence is the leading contributor to death and ill health for women of childbearing age, with a major effect on mental health.[3]

HOW AND WHY DOES THE PATIENT PRESENT?

GPs need to be aware of the many and varied potential indicators of domestic violence. A full-time GP has up to five women attending per week (about 10%) who have experienced domestic violence in the past year.[4] Women usually do not present as victims of domestic violence but rather with multiple psychosocial complaints.

Somatic and psychological symptoms, including depression and post-traumatic stress disorder, often mask domestic violence (see the box on this page): one-quarter of currently depressed women have experienced domestic violence.[5] Underlying signs and symptoms include:

- chronic pain
- gastrointestinal issues
- cardiac symptoms
- neurological symptoms
- mental health diagnoses.

It is more common in younger (less than 40 years of age) and separated or divorced women. It is estimated that about two-thirds of women killed by abusive partners are killed after leaving the relationship.

Identifying domestic violence is a challenge for all GPs because women rarely present directly with the issue unless they need their injuries documented. However, women usually disclose the information when GPs ask in an empathic way.

WHEN AND HOW SHOULD GPS ASK?

GPs should have a low threshold for asking direct questions about abuse. The main trigger for women disclosing abuse is in simple communication that helps the patient sense that the doctor will listen, be sympathetic, help them and not tell anyone.[6] It is very unlikely that you will offend patients by asking about this area of their life if you ask sensitively (see the box on this page).

HOW SHOULD GPS RESPOND TO DISCLOSURE?

Women understand that there are limits as to how GPs can help them; they realise that GPs cannot fix their lives but they have some well-defined needs and expectations when seeking help.[7]

POSSIBLE RESPONSE STATEMENTS IF A WOMAN DISCLOSES ABUSE

- Everybody deserves to feel safe at home.
- No one deserves to be hit or hurt in a relationship.
- I am concerned about your safety and wellbeing.
- Abuse is common and happens in all kinds of relationships. It tends to continue.
- Abuse can affect your health and that of your children in many ways.

Prior to disclosure or questioning, women want clinicians to understand the issue and to have knowledge of appropriate community services and useful referrals (see the box on page 55). It is useful to include brochures and posters in the practice waiting rooms. They want to be assured about privacy, confidentiality and safety, and when the issue of domestic violence is raised they want a nonjudgemental, compassionate and caring questioning and response.

Women want to be believed and acknowledged and to have their concerns and the decisions they make respected (see the box on this page). They may be at various stages of change with regard to naming the violence and taking action; motivational interviewing techniques may be helpful (Table).[8,9] Women want their doctors to take the time to listen, provide information and offer referrals to specialist help if needed.[10] GPs may need to ask about abuse several times because there are many barriers to disclosure.

GPs can find it difficult to support women who stay in abusive relationships. However, doctors manage to support patients who continue to smoke, are noncompliant or who continue in stressful jobs when it affects their health. It is extremely difficult for women to leave abusive relationships for a variety of reasons, including:

- the woman does not see it as abuse
- she hopes for change
- she stays for the sake of the children or for financial reasons
- she may still love the abuser.[5]

DOES THE PATIENT REQUIRE IMMEDIATE REFERRAL TO A SPECIALIST SERVICE?

It is vital that doctors address safety issues and concerns both for the women and for their children (see the box on page 57). This may include urgent referral to a crisis service or to child protection services.

TABLE. STAGES OF CHANGE AND RESPONSES TO WOMEN[9]

Stage	Description	Health provider response
Precontemplative	The woman is not aware that she has a problem or holds a strong belief that it is her fault.	Suggest the possibility of a connection between symptoms, feelings of fear and problems at home. Try to use terms the woman uses when referring to her problems.
Contemplation	The woman has identified a problem but remains ambivalent about whether or not she wants to or is able to make any changes.	Encourage the possibilities for change should she decide to do anything. Point out that you are available to help and support her on the journey.
Preparation/decision	Some catalyst for change has arisen (e.g. concern for children, realisation that partner will not change, getting a new job).	Explore resources within the woman's network and the local community. Respect her decision about what she wants to change (e.g. talking to family and friends or counsellor, leaving the relationship, taking out a restraining order, reporting to the police).
Action	Plan devised in the previous stage is put into action.	Offer support to carry out plan and ensure safety planning is in place.
Maintenance	Commitment to above actions is firm.	Praise whatever she has managed to do and support her decision.
Returning/relapsing	The woman may feel compelled to reverse the above action. Reasons include finding life without the partner too stressful, no access to children or resources.	Need to support her whether she does or does not return to the relationship, see a counsellor or report abuse. Reassure that this pattern of behaviour is common for many women.

ASSESSING SAFETY OF WOMEN AND CHILDREN

- How safe does she feel?
- What does she need in order to feel safe?
- Has the frequency and severity of violence increased?
- Is he obsessive or excessively jealous about her?
- Has she been threatened with a weapon? Does he have a weapon in the house?
- Has he a history of drug or alcohol abuse, psychiatric problems or trouble with police for violence?
- Does he ever directly hurt the children?
- Does she think the children hear or see any of the violence and abuse?

In some states of Australia, witnessing domestic violence by children is included in the definition of child abuse and neglect. As direct child abuse is common when there is adult family violence, it is crucial that GPs consider all members of a family to be at risk.

IS THERE A NEED FOR FOLLOW UP OR PREVENTION?

GPs need to understand the chronic nature of the problem and provide follow up and continuing, nonjudgemental support. Respecting the woman's wishes (even if that includes staying with the abusive partner) and not pressuring her into making any decisions are key to this support.

CONCLUSION

Intervening with women experiencing domestic violence is vital to the prevention of major health effects on women and their children who witness the violence and abuse. GPs should have a low threshold for asking directly about abuse, in a nonjudgemental manner, and need to respond to disclosure by acknowledging the abuse, stating that violence is unacceptable behaviour in any relationship and following up with ongoing support.

GPs also need to check that women and children are safe and refer them to specialised services if the woman wishes, and child protection services if GPs suspect direct child abuse. GPs are often the first professional that women disclose domestic violence to, so it is important that their response provides a pathway for these women to access support and services. MT

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