

Domestic violence, spouse abuse, and battering all refer to the victimization of a person with whom the abuser has or has had an intimate relationship. Domestic violence may take the form of physical, sexual and psychological abuse, is generally repeated, and often escalates within relationships.

Most evidence indicates that domestic violence is predominantly perpetrated by men against women. Some evidence suggests that women are just as likely to use violence against male partners as men are against female partners. It is clear that the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims.

Medical ethics require doctors to intervene in cases of domestic violence. Some may argue that the doctor's ethical obligations to patients who are battered are limited to treating the bodily injuries and other manifestations, and in doing more, physicians will step out of their medical role. Treating only the injuries and symptoms of abuse will not address the ongoing family violence that is at the root of its victims' health problems. When doctors do not diagnose abuse, it is most likely to continue and will often escalate. When a diagnosis of abuse is missed, treatment is likely to be inappropriate and potentially harmful. The most common drugs prescribed are analgesics and tranquillizers and this increases the risk of suicide in desperate cases. Further, such drugs may hamper the victim's alertness, making her more vulnerable to assault.

Failing to diagnose abuse may also further the victim's sense of entrapment and thereby contribute to victimization. Often when battered women seek help from others including the police, health care providers, friends and family, they are met with denials of the seriousness of the abuse. Inability to find help often causes victims to feel that there is no escape from the violence. These feelings of helplessness are associated with the psychosocial problems caused by abuse.

Physicians are particularly well situated to intervene in cases of domestic violence because persons who are in violent relationships often visit doctors for injuries and other symptoms caused by ongoing abuse. Battered women also often visit primary care physicians for a variety of medical complaints, such as abdominal pain, headaches and sleep disorders. Pregnancy appears to be a high risk factor for abuse.

Although the solutions to domestic violence extend into social and legal domains, in which doctors have limited influence, we can still provide a number of important interventions. Protocols for the detection and management of domestic violence should be developed; why not by the College itself, as they are the primary care physicians in association with other related bodies.

Probably the most important contribution doctors can make to ending abuse and protecting the health of its victims is to *IDENTIFY* and *ACKNOWLEDGE* the abuse. Identifying domestic violence can initiate the process by which people may get the necessary

assistance to find safety. Other primary responsibilities include providing sensitive support, clearly documenting the abuse, providing information about options and resources and with the patient's consent making necessary referrals. Doctors must also assess the level of danger faced at home and if present must participate in efforts to secure a safe place, including offering hospitalisation, if necessary, for patients when there are no available shelters. Doctors in other clinical situations would not discharge a patient from the emergency department with a potentially life threatening condition. I remember two cases where women preferred being admitted to Mt Carmel Hospital rather than going back home to the violence.

A number of studies have shown that doctors often fail to diagnose abuse when signs and symptoms are present. One barrier to detecting and treating family violence is a lack of knowledge and training. This is a glaring omission in our curriculum at medical school. As a result physicians share a number of pervasive societal misconceptions about domestic violence that undermine the medical response to battering. The most harmful of these misconceptions include the following:

- 1 *domestic violence is rare;*
- 2 *violence does not occur in relationships that appear 'normal';*
- 3 *domestic violence is a private matter that should be resolved without outside intervention;*
- 4 *battered women are responsible for their abuse.*

1 The belief that domestic violence is rare stems from the traditional view of the family as a safe haven from the troubles of the outside world. From our experiences in casualty we have discovered the hard way that families and other intimate relationships are often anything but safe. Doctors' lack of awareness of the prevalence of domestic violence contributes to their reluctance to consider abuse in the differential diagnosis and to disbelieve that abuse has occurred even when the signs are evident.

In 1992 out of an annual 100,000 cases seen in the casualty department only 40 cases were of alleged wife beating. We are only seeing the tip of the iceberg.

2 The attitude that domestic violence does not occur in seemingly 'normal' relationships causes physicians to miss diagnoses of abuse. In particular, it is often assumed that abusers can be easily identified as pathological and excessively violent. Doctors may be especially likely to disbelieve that abuse has occurred when they know the suspected abuser as a friend. They appear especially concerned or attentive when they accompany their partner to receive medical attention either because they feel remorseful or they do not want to be suspected of abuse or more probable they do not want the patient to be seen alone.

At any rate, one thing we have noticed is that domestic violence cuts across racial and class categories.

3 Another common misconception is that domestic violence is a private matter and should be resolved within the relationship with the advice to try to work out their

difficulties together. Unfortunately, without assistance, continuing to live in an abusive relationship can be the most dangerous course for the victims, since abuse is usually repeated and the injuries increase in severity.

4 Another societal misconception is that women are responsible for their victimization. They may be blamed for provoking the abuse by not leaving the relationship and not pressing charges. Many barriers prevent victims from leaving their spouse including the presence of children at home, fear of retaliation, not having a safe place to go to, financial dependency and/or lack of job skills, emotional ties; some hope that the situation may improve.

One of the primary aims when treating such victims is to bring them into contact with resources such as social services, legal assistance support groups and shelters. Unfortunately these shelters are almost always filled to capacity and the time has come to expand to other homes.

Physicians have an ethical obligation to maintain patient confidentiality so that patients feel free to make full disclosure of relevant information about their health. The need for the patient's trust in the physician is especially important since patients may feel embarrassed, ashamed or afraid that they have been battered. Spouses, partners or other third parties including the police should not be notified about an abuse diagnosis without the expressed consent of the patient.

### **Dynamics of Violence Against Wives**

Types of partner abuse against

women seen in casualty range from being slapped, punched, kicked or thrown bodily to being scalded. Shocked, smothered or bitten. Typical assaultive episodes often involve a combination of physical attacks, verbal abuse and threats. The repetition of aggression in families is facilitated by the fact that victims are readily available, the amount of time at risk is high, assaults can be carried out in private, and wife assault is relatively a low-risk behaviour for the aggressor.

... a sort of "if there is nothing on the telly why not beat up the wife" attitude.

### **Impacts on Psychological and Social Well-Being**

During assaults the woman's primary reaction is one of self protection and survival. Reactions of shock, denial, withdrawal, confusion, psychological numbing, and fear are common. After the assault especially if this is repetitive, a victim may offer little or no resistance, in an attempt to minimize the threat of injury or renewed aggression. These effects of trauma are exacerbated by the fact that the aggressor is someone they may love, trust and depend on. There is a high prevalence of depression and suicide. Violence at home typically leaves no place in which defences can be let down by the victim.

### **Marital Rape**

Marital rape is an integral part of marital violence however it is the least likely to be reported by victims. They suffer many of the same reactions of other rape victims.

### **Recommendations for Policy**

1 The Hospital Authorities, College of Family Doctors working with other relevant bodies undertake a campaign to alert the health care community to the widespread

prevalence of violence against women, and to sensitize them to the needs of victims of violence.

- 2 That doctors routinely incorporate screening leading to identification of female patients who are victims of violence. This could be done at the entry points of contact between women and medical care: primary care, emergency services, obstetric and gynaecological services,

psychiatric and paediatric care.

- 3 That doctors give due validation to the experience of victimization and of observed symptomatology as possible sequelae in their differential diagnosis
- 4 That doctors record a patient's victimization record, observed trauma potentially linked to the victimization. These are useful to assess progress or to

indicate the need for more intensive interventions at a later contact with the patient.

- 5 That doctors, after diagnosing a violence related problem, refer patients to appropriate medical and community based resources as soon as possible.
- 6 That training on interviewing techniques, risk assessment, safety planning and protocols for help, be incorporated into undergraduate and continuing medical education programs.