

Domestic Violence

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A thirty-two year old woman presents herself at your surgery with multiple bruising to her arms and legs and a black eye. She has no injuries apart from this bruising, which appears to be at different stages of resolution. Clinically she has no fractures.

In the course of the consultation she says that this has happened before throughout her ten years of marriage and that the injuries were caused by her husband. She is concerned about her current injuries and worried that a similar incident may happen again, either to herself or her five-year-old daughter.

How would you manage the consultation and follow-up?

Introduction

Domestic violence in the form of spouse abuse and child abuse has been a feature of Maltese society throughout the centuries. Spouse abuse has been documented even in the late eighteenth century as a common cause for conjugal separation. Between 1780-1798, there were 36 applications for injunctions against husbands molesting their wives.

In the last decade of the twentieth century, the average number of cases of wife battering reported to the Police Authorities during 1989-92 was 165 annually; a figure which amounts to about 2.06 per 1000 marriages. Between 1995-1999 an average of 283 cases annually were referred to Appogg compared with 357 cases annually between 2000-2004. Of the



latter cases an average of 2.2% were male. From an anonymous questionnaire on 393 pregnant women in 2001, it results that spouse abuse in the Maltese community has a prevalence of about 11.7%, with physical abuse being reported in 2.3% of women.¹⁻⁶

The term domestic violence, now commonly called intimate partner abuse, is used to describe the physical, emotional and mental abuse of women by male partners or ex-partners. The manner in which the general practitioner responds to a woman's first tentative attempt to seek help to change her situation can make an immense difference to that woman's life and those of her children.⁷

While many of the causes of domestic violence are complex, acknowledgement by health professionals and society that it is unacceptable may well be the first step towards tackling it. Public health officials have a strong advocacy role. People listen to public health professionals when they point out that something is a problem in a way that they may not listen to other sectors.⁸

The roots of domestic violence are embedded in our social structures and customs and a co-ordinated community response is needed to bring about change.⁹ There should be a multidisciplinary and inter-agency approach to the problem of domestic violence: the refuge movement, women's groups, mental/medical health personnel, educators, clergy, the media, social workers, as well as the civil and criminal justice system.⁹ Dealing with domestic violence should not be the sole responsibility of the general practitioner.

Important contact numbers

Appogg Support Line	179
Childrens' Helpline	112
Domestic Violence Unit	21249995/6
DVU Service for Abusive Men	21227067

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Table 1: Indicators of the possibility of domestic violence²⁰⁻²⁷

History	Past or present abuse Substantial delay for presentation for treatment Past Psychiatric illness, attempted suicide or depression	Repeated “accidental” injuries Alleged ‘accident’ described in hesitant, embarrassed or evasive manner Past Alcohol or drug dependence
Examination Findings	Extent or type of injury inconsistent with explanation offered Injuries to areas hidden by clothing; injuries to face, chest, breast and abdomen	Evidence of sexual abuse Unexplained bruising, areas of erythem a consistent with slap injuries or multiple injuries in various stages of healing
Social Circumstances	Pregnant Intrusive partner, trying to answer questions during examination	Past history of miscarriage

Table 2: Examples of direct questions which may be asked if the professional suspects intimate partner abuse

1. I have noticed a number of bruises. Can you tell me how they happened? Did someone hit you?
2. You seem frightened of your partner. Has he ever hurt you?
3. Many patients tell me they have been hurt by someone close to them. Could this be happening to you?
4. *You mention your partner loses his temper with the children. Does he ever lose his temper with you? What happens when he loses his temper?*

Intervention

In the past, general practitioners have often failed to respond because of lack of confidence in their ability to intervene effectively¹⁰, sharing the sense of helplessness of the victims in the face of society’s apparent ambivalence.¹¹ However, attitudes have altered considerably and society is now beginning to make clear its determination to treat domestic violence as seriously as any other form of violence.

Without appropriate intervention, violence usually continues and escalates in frequency and severity.¹² By the time the woman’s injuries are visible, violence may be a long-established pattern. On average, a woman will be assaulted by her partner or ex-partner 35 times before actually reporting it to the police.¹³

Early detection and appropriate intervention can help to prevent future violent incidents and the consequent psychiatric morbidity, and can help to save and salvage lives. As with much

else in general practice, the most important aid to diagnosis is a high index of suspicion. Table 1 lists the situations when the possibility of domestic violence should be considered. It is also worthwhile considering other causes of bruising besides injury such as haemorrhagic disorders which can either be congenital or acquired.

While carrying out the consultation/s, it is important to ask direct questions in a non-threatening and non-judgmental manner. Each professional needs to work out the language and questioning style that best suits the person suffering the abuse (Table 2). To ignore the offered ‘calling card’ is to collude with the continuing concealment of domestic violence behind closed doors. Much can now be done to protect women and empower them to change their situation. Much still remains to be done, but all general practitioners should be aware of what services are available to their patients locally e.g. Appogg, shelters etc.

Finding oneself a repeated target of someone else’s violence is intensely demeaning and demoralizing. Women attempting to survive domestic violence tend to lose their self-esteem and begin to accept the counter-accusation that they themselves are somehow to blame.¹⁴ If a woman is to extract herself from an abusive situation she must often pay a high price in terms of loneliness and disrupting her children’s relationship with their father. The violent relationship may be the only intimate relationship that she has and this is a lot to lose. For many women, there is also an economic price to pay with the decision to leave a violent home bringing with it a substantial fall in income, and even the risk of homelessness. All this goes some way in explaining why so many women return again and again to face the risk of repeated violence to the amazement and sometimes the exasperation of the police, doctors and others trying to help. Effective help must be directed towards enabling the woman to retake control of her own life, to offer her realistic

choices while accepting that the decisions are hers alone and are always valid in her particular situation. No woman should be condemned for a decision to return to her abuser. It can take a very long time for a woman, demoralized by years of violence, to find the confidence and courage to choose a different life for herself and her children.

In the above-mentioned situation, a set of guidelines should be followed which are underlined below. Only in very exceptional and grave circumstances will it be appropriate for these guidelines to be followed in their entirety on a single occasion in general practice. Much more commonly it can be used to provide a framework for the care of patients over a number of consultations over several weeks, months or even years as, in common with many other conditions, the diagnosis of domestic violence emerges over time.

If intimate partner violence is confirmed, as in this case, the following steps provide a practical management template:

- A. Emphasizing confidentiality
- B. Documentation
- C. Photographing
- D. Assessing present situation
- E. Providing information
- F. Devising a safety plan

A. Emphasizing confidentiality

Fear is often one of the reasons why a woman remains in a violent relationship. *Always interview the patient alone. Remind the patient that anything she chooses to talk about is confidential.* The only exception to this arises if the doctor becomes aware that a dependent child is at risk.¹⁵ Be aware that the patient may prefer to talk to a female health worker if one is available. The concept of medical confidentiality may be unfamiliar to many first generation immigrant women and the protection it offers will need to be very carefully explained and emphasized. Provided the patient gives consent, it would be highly recommended to involve a chaperon and maybe involve translators, advocacy workers or ethnic community link-workers as appropriate.

B. Documentation

Accurate documentation, over time at successive consultations, may provide cumulative evidence of abuse, and is essential for use as evidence in court, should the need arise.¹⁶

Record clearly:

1. Data from previous medical record which is suggestive of prior abuse.
2. Time, date and place and witnesses to assault or accident.
3. If patient states that abuse is the cause of injury, preface patient's explanation by writing: "Patient states . . .".
4. Avoid subjective data that might be used against the patient (for example, "It was my fault he hit me because I didn't have the kids in bed on time.").
5. If patient denies being assaulted, write: "The patient's explanation of the injuries is inconsistent with physical

findings" and/or "The injuries are suggestive of battering."

6. Record size, pattern, age, description and location of all injuries. If possible, make a body map of injuries. Include signs of sexual abuse.
7. Record non-bodily evidence of abuse, such as torn clothing.

C. Photographing

Photographs can convey the severity of injuries much more effectively than verbal description and, whenever possible, photographs should be taken of all patients with visible injuries. If this is not possible, advise the patient to have photographs taken elsewhere.

1. Explain to the patient that photographs will be very useful as evidence if she decides to prosecute the abuser now or in the future.
2. Explain to the patient that photographs will become part of the patient's medical record and, as such, can only be released with the patient's permission.
3. Obtain written consent from patient to take photographs. (Written informed consent should include the statement, "These photographs will only be released if and when the undersigned gives written permission to release the medical records.").
4. Use a good Polaroid camera with colour film flash bulbs. (It should be noted that digital photography is not permissible in a court of law.)
5. Photograph in brightest light possible.
6. Attempt to take close-up of injury but try to include an identifiable feature of the patient. If this is not possible, a long shot should be followed by a close-up.
7. The photographer should sign and date the back of each photograph.
8. Place photographs in a sealed envelope and attach securely to the patient's record. Mark the envelope with the date and the notation "Photographs of patient's injuries".
9. Bruising is often more obvious two or three days after the injury. If this is likely to be the case, the patient should be advised to return at a later date, or to have more photographs taken elsewhere.
10. Always show all photographs taken to the victim after consent is given.

D. Assessing present situation

Let the patient tell you her story. Gather as much information as possible. Try to include the following:

1. History of abuse (include past and present physical, emotional and/or sexual abuse).
2. Attempts by patient to remedy her situation (for example, through police, courts, separation, refuges, and so on).
3. Sources of emotional support.
4. Current living situation. Is there some place, other than home, where she can go to recuperate if it is dangerous for her to return home?

Table 3: “Stages of change” for women affected by domestic violence as reflected in the words that are used to portray their situation

Stages of change	Patient’s belief	Physician “nudging” strategies
Pre-contemplation	“My relationship is not a problem”	Learn about the relationship.
Contemplation	“I know the violence is a problem, but I need to stay in the relationship.”	Discuss the ambivalence. “How would you change things if you could?”
Preparation	“The violence is a problem, and I’m planning some changes.”	Offer support and encouragement Clarify plans List community resources Provide anticipatory guidance
Action	“I am making changes to end the violence.”	Offer support and encouragement List community resources Provide anticipatory guidance Review coping strategies
Maintenance	“I have adapted to the changes.”	Offer support Review need for community resources Discuss coping strategies
Relapse	“I cannot maintain this change.”	Remain positive and encouraging Discuss lessons learnt from the effort Review Safety Plan Remain open for future discussions

5. Present danger:

- Is abuser verbally threatening her, frightening friends and relatives or threatening to use weapons?
- Does abuser have criminal record or is intoxicated?
- Are the children in danger?

Assess the woman’s “readiness for change”, using Prochaska’s model¹⁷ (Table 3) Tailoring conversation to the stage of change is likely to be most helpful.

E. Providing information

This step is particularly important since it is the gateway to open this situation to a multidisciplinary approach by having other people involved e.g. social workers.

1. Explain to the patient that violence in the home is as illegal as violence on the street and that she is the victim of a crime and has legal rights.¹⁸
2. Explain the physical and emotional consequences of chronic battering.
3. Provide written information about legal options and help offered by:

- Police domestic violence unit
 - Women’s refuges
 - Social work agency
 - Housing department
 - Department of Social Security
4. Offer help in making contact with other agencies.
- Provide *card* with useful phone numbers namely 179 (support line) and 112 (emergency number) bb
 - Provide *Patient Information Manual* “How to protect yourself from domestic violence” produced by local Domestic Violence Unit.

F. Devising a safety plan

No patient should ever be pressurized into following any particular course of action. Only the patient can decide what is right for her in her particular situation. Her individual autonomy, self-esteem and self-determination should be encouraged and respected. Even if the patient decides to return to the violent situation, she is not likely to forget the information and care given and, in time, this may help her to break out of

the cycle of abuse. Beware of the danger of the needs of some ethnic minority patients being ignored under the guise of 'respect' for different cultures.

1. If she does not wish to return to the abuser, advise her on the services available from local agencies and offer help with contacting them.
2. If she chooses to return to the abuser:
 - a) Discuss a Protection Plan¹⁹ (see below).
 - b) Give her the phone number of the local women's refuge and of the Appogg (Domestic Violence Unit) Supportline.
 - c) Advise her to keep some money and important financial and legal documents hidden in a safe place, in case of emergency.
 - d) Help her to plan an escape route in case of emergency – Where will she go? How will she get there? What will she take with her?
3. If children are likely to be at risk, seriously consider referral to social services, if possible with the patient's consent.

Protection Plan

- When abuse is occurring, curl up into a ball to protect the abdomen and head
- Remove potential weapons from the home
- Shout and scream loudly and continuously while being hit
- If possible, arrange with a sympathetic neighbour to phone 112 if they hear loud screams
- Teach the children how to dial 112 if they feel unsafe

Conclusion

This paper suggests a line of interventions which the GP could take in a situation of domestic violence. It should be emphasized that such situations often require protected time and subsequent consultations may be necessary especially if the initial consultation occurs during a busy surgery. Training in interviewing and listening skills and working in the context of a multidisciplinary approach is most necessary for the success of these interventions.

Much can be achieved in this potentially frustrating situation by simply recognizing the reality of a victim's situation, endurance and courage. This can be the beginning of rebuilding a woman's confidence and putting her in touch with agencies who can provide detailed advice, practical help and refuge.

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