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Family violence across the life cycle

Background

Family violence covers a range of abuse including child abuse and neglect, intimate partner violence and elder abuse. Each form of abuse has a significant negative impact on health and wellbeing, and patients present to general practice with varying physical and psychological issues. General practice is unique in that it often works with an entire family, which can be challenging and needs to be actively managed.

Objective

This article aims to address clinical questions that general practitioners (GPs) may have in identifying and responding to patients experiencing family violence. It takes into account the different types of abuse victims experience and how to respond to perpetrators. The recommendations in this article can also apply to same-sex relationships.

Discussion

Managing family violence requires a whole-of-practice approach to encourage a safe environment in which families can disclose abuse and where GPs can respond appropriately. Abuse can be inter-generational and GPs have a role in identification, management and referral.

Keywords

domestic violence; general practice

Case

Novak family

Mary is 37 years of age and is married to John, an electrician aged 39 years who has his own business. They have been married for 3 years. Mary has a son, Lachlan, aged 12 years, from a previous marriage. Mary and John have a daughter, Caitlyn, who is now 13 months. Mary's mother, Alice, also lives with Mary and John. Alice is 69 years of age and was diagnosed with early dementia 4 years ago.

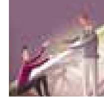
Mary has presented with low back pain, which she has had for the past year. She also has symptoms of depression and disrupted sleep. One month ago she brought Lachlan in as she was concerned about the change in his behaviour, in particular, that he was becoming aggressive at school and was not sleeping.

John drinks heavily and has presented over the last month with increasing frequency of headaches and stress at work.

Mary has also previously accompanied her mother, Alice, to the practice, explaining that Alice has a cough that will not get better. There appeared to be some bruises on Alice's left arm. When asked how she got them, Alice said she couldn't remember and did not seem to want to discuss it any further.

Family violence includes child abuse, intimate partner violence and elder abuse. It also includes abuse that occurs between other family members, for example siblings, uncles, aunts, cousins, grandparents and in-laws. Abuse is not only physical, but can be sexual, emotional (eg humiliation, harassment), economic (eg restricting access to money) and social (eg isolation from family and friends).[1] While many families have fights, abuse incorporates elements of fear and control by one family member over another. For children, witnessing family violence can also be considered child abuse.

Family violence can have a major adverse impact on health and wellbeing. Intimate partner violence is a significant cause of mortality and morbidity for women of child-bearing age.[2] Exposure to childhood abuse, either directly or by witnessing family violence, is a risk factor



for many health issues in adult life, such as obesity, high-risk sexual behaviour or mental health issues and can lead to a range of health problems such as heart disease, suicide and cancer.[1,3]

The recently updated Royal Australian College of General Practitioners (RACGP)'s manual *Abuse and violence: working with our patients in general practice* (the White Book, 4th edition) is a practical resource that outlines the role of health practitioners in prevention, appropriate identification and response.[4] It presents 'the nine steps to intervention – the 9Rs' (*Table 1*), providing health practitioners with an overall guide. Using the 9Rs as a framework, this article provides examples of practical clinical responses to the case study.

Recognising and asking about family violence

General practitioners (GPs) may not be aware of the number of patients experiencing abuse because they often present for other reasons.[4] Full-time GPs may be seeing up to five women per week who have experienced underlying partner violence, one or two of whom will have experienced severe abuse (*Table 2*).[5]

GPs are in a unique position because they often see an entire family. The case study of the Novaks reflects the complexity of abusive family relationships and typical presentations of underlying abuse and violence (*Table 3*). Managing the care of a family such as the Novaks would require several consultations with each family member. *Table 4* outlines suggested ways of asking about family violence within the consultation.

Child abuse

Trauma experienced by very young children shapes brain and psychological development, which can make them vulnerable to a range of mental health problems.[3] Growing up in an abusive environment can affect children's relationships in adulthood,[6] and abused women and perpetrators are more likely to have experienced abuse as a child.[7] By recognising and working with families, GPs can help break the cycle of inter-generational abuse.[4]

Certain changes within a family, for example, separations and additions to the family, work stress or moving, may increase the risk of child abuse. A child is at greater risk in families that experience substance abuse, mental illness or partner violence.[8] Children under 1 year of age are particularly vulnerable.[9]

Intimate partner violence

GPs should ask women and men who present with clinical indicators of abuse and violence about their experiences.[4,10] Depression or anxiety are the most prominent indicators, as well as multiple physical symptoms.[7,11] The majority of female patients do not object to being asked about abuse,[12] and providing that communication skills are good, the gender of the GP does not affect disclosure.[13]

Elder abuse

Elder abuse includes any type of abuse or neglect of a person aged 65 years or over, whether they are in a residential aged care facility, private care or living independently. It can be a single or repeated act, or lack of appropriate action that causes harm or distress, occurring in any relationship where there is an expectation of trust.[14] Risk factors can be cognitive impairment, stress due to a past relationship between the abused and caregiver, or crowded living conditions.[1] If the patient has capacity, a history can be taken in the absence of caregivers, and differing stories may raise suspicion.[15]

Case continued…

On speaking with Lachlan it becomes clear that he is afraid of his stepfather and has been subject to emotional abuse while also witnessing physical abuse towards his mother, Mary.

Table 1. The Nine steps to intervention – the 9 Rs

Health practitioners need to understand their:

- **Role** with patients who are experiencing abuse and violence
- **Readiness** to be open to
- **Recognise** symptoms of abuse and violence, ask directly and sensitively and
- **Respond** to disclosures of violence with empathic listening and explore
- **Risk** and safety issues
- **Review** the patient for follow-up and support
- **Refer** appropriately and also
- **Reflect** on their own attitudes and management of abuse and violence
- **Respect** for patients, colleagues and themselves is an overarching principle of this sensitive work

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Table 2. Family violence is very common

- 17% of all women and 5.3% of all men aged ≥18 years have experienced violence from a partner[22]
- From 2008–2010 there were 185 domestic homicides (an incident involving the death of a family member or other person from a domestic relationship) in Australia[30]
- From 2011–2012 there were 37 781 substantiated reports of child abuse and neglect (suspected to be an underestimate).[9]
- Internationally, 20% of women and 5–10% of men report childhood sexual abuse, and 25–50% children report being physically abused[31]
- Each year, 25 Australian children are killed by their parents[32]
- 2–14% of older people may be experiencing abuse[33–37]

Mary discloses that John has become increasingly aggressive and controlling towards her since the birth of Caitlyn. She also describes how it has been very stressful having her mother living with them, particularly as Mary is looking after Caitlyn. She discloses that she has very mixed feelings about her mother, Alice, who was unable to protect Mary from abuse as a child from her father.

Alice has lost capacity and is unable to give you a clear story. However you are aware of her increasing distress and notice the bruising.

Responding to partner violence and exploring risk and safety

The World Health Organization (WHO) recommends that GPs should provide first-line support to patients who disclose partner or sexual violence. This includes listening, inquiring about their needs, validating women's disclosure, enhancing safety and providing support.[10] When women disclose, they want GPs to give them time, to listen and respond non-judgmentally, while supporting and believing them. They want their experiences to be validated, their decisions to be respected, to be given safety advice, information about appropriate services, and freedom to make their own decisions.[16] A GP needs to be aware at what stage a woman may be, which can range from being unaware that what she is experiencing is abuse, to taking action or returning to an abusive relationship. These stages are rarely linear and any response needs to be flexible and supportive of the woman's choices.[4] There may be several reasons for a woman not wanting to report abuse or to leave her partner (*Table 5*). The police can take out an intervention order independently of the woman if they perceive she is at risk.

Risk assessment and safety planning are important aspects of responding.[10] Initially, GPs can assist in assessing whether it is safe for a woman and her children to return home by asking the questions listed in *Table 6*.

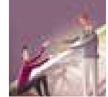
For women who feel unsafe, crisis referral and an urgent safety plan may be required. If they are under immediate threat of harm, a GP can consider calling the police on their behalf. If they feel safe to return home, detailed safety planning can be postponed until subsequent consultations (*Table 7*).[4] It is important to remember that women and children are at greatest risk of harm when separating from abusive partners. This time should be planned carefully, taking into account their safety.[17]

Responding to child and elder abuse and exploring risk and safety

Reporting child abuse is mandatory across Australia. In cases of indirect abuse, the RACGP suggests that GPs consider referring to an organisation for vulnerable children.[4] For children at risk, the RACGP recommends referrals to parenting or home visitation programs.[4,18–20] Interventions to reduce alcohol use, which has a strong link to child abuse, are also recommended.[21] In the long term, children exposed to

Table 3. Psychological and physical clinical indicators of abuse

	Psychological	Physical
Child abuse and neglect[25,38,39]	• Insomnia • Bedwetting • Behavioural/conduct issues in adolescents: – depressive/anxiety symptoms – suicide ideation – drug and alcohol use – sexual/risky behaviour	• Unexplained or inconsistently explained bruises or injuries • Dirty, poor hygiene, inappropriately dressed
Intimate partner violence[40]	• Depressive/anxiety symptoms • Suicidal ideation • Drug and alcohol use • Insomnia • Somatoform disorder • Post-traumatic stress disorder • Eating disorders	• Obvious injuries (particularly to head and neck) • Bruises in various stages of healing • Sexually transmissible infections • Sexual assault • Chronic pelvic pain or abdominal pain • Chronic headaches • Chronic back pain • Numbness, tingling from injuries • Lethargy
Elder abuse[41]	• Depressive/anxiety symptoms • Insomnia • Rigid posture and avoidance of contact (including eye contact) • Reluctance to talk	• Injuries such as skin trauma • Signs of restraint • Poor hygiene, bad odour, urine rash



family violence can be referred to psychotherapeutic counselling or small group therapy.[10]

In cases of elder abuse, capacity can be an issue. Check the patient's medical record to see if there is a legal power of attorney or someone designated to give medical consent. If the person recorded is also the suspected perpetrator, then the public guardian, public advocate or appropriate state/territory body should be contacted.[4] Any criminal act, such as assault, should be reported to the police. If the older person is in a residential aged care facility, the Australian Government Department of Health Office of Aged Care Quality and Compliance can be contacted.[4]

Responding to men who use violence against their partner

Women can be perpetrators but most perpetrators of partner violence are men.[22] There are no defining characteristics to predict whether a man will be violent towards his partner,[4] but GPs should suspect potential for violence if substance abuse issues are present.[23] Prevalence figures for perpetrators of violence are around 20–25% of the population.[1]

It is inappropriate to provide counselling to both the woman experiencing abuse and the perpetrator.[24] If the perpetrator is unaware that the abuse has become known, the GP may continue to see him as a patient. However, where the abuse has been acknowledged, the perpetrator should be encouraged to see another GP. There are several reasons for this,[4] including that the GP may inadvertently reveal information and that perpetrators can convince themselves and others that they are not responsible for the abuse.

The RACGP recommends referral to men's behaviour change groups. These groups are not anger management programs but focus on the use of power. If the perpetrator is not ready to accept such a referral, mental health or substance abuse services may be appropriate. Ongoing support in assessing progress and the safety of the family will be required.[4]

Table 4. Asking about family violence

Children[4]

- Sometimes children are good at keeping secrets. What type of secrets do you think children are good at keeping?
- Sometimes I see children I worry about. I saw another child who was sore like you, what do you think happened to them?
- Some children can get scared at home. What do you think makes them scared?
- Sometimes kids worry about lots of things, like when they have a fight with their friend, or they feel their teacher was mean to them. Kids also worry about things in their homes, maybe about mum and dad fighting or when their mum or dad was mean to them. Sometimes kids are scared and don't know what to do. Do you sometimes worry about things like that?
- Does anything happen that makes it hurt for you to wee?
- Questions you can ask older children:
  - How good are the good days? What makes them so good?
  - How bad are the bad days? What makes them bad?
  - Where do you feel safe? Where do you feel unsafe?

Intimate partner violence*

- Has your partner ever physically threatened or hurt you?
- Is there a lot of tension in your relationship? How do you resolve arguments?
- Sometimes partners react strongly in arguments and use physical force. Is this happening to you?
- Are you afraid of your partner? Have you ever been afraid of any partner?
- Have you ever felt unsafe in the past?
- Violence is very common in the home. I ask a lot of my patients about abuse because no-one should have to live in fear of their partners.

Elder abuse (from the elder abuse suspicion index)†

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

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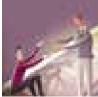

Reviewing and making appropriate referrals

GPs have a key role in ongoing support. There are many resources available for GPs and their patients. For a detailed list of resources in your state or territory, see the Resources section of the White book,[4] which can be found on the RACGP website (www.racgp.org.au/your-practice/guidelines/whitebook/tools-and-resources/7-resources/).

For women who have experienced partner violence there are several interventions and referrals that can be made. For example:

- helping women discuss detailed safety plans
- counselling for post-traumatic stress disorder and trauma-informed cognitive behaviour therapy
- empowerment counselling and advocacy support.

Ongoing care of an older person may include several options:

- involving a home nursing service, home help, day centre, carer support groups or other local services
- seeking help from an aged care assessment team
- respite care
- admission to a residential aged care facility
- sending the older person to a hospital to ensure immediate safety
- accessing further information about services and management by ringing the relevant state Elder Abuse helpline.

Ongoing review is important, and adjustments to care may be appropriate if the situation does not improve.

The case study highlights the experiences of Mary as a child. Adult survivors of child abuse can experience ongoing health problems and a high incidence of comorbidity.[25] The RACGP recommends a trauma-informed approach.[4] Providing a safe place for survivors of child abuse to talk about their needs is important and referrals to appropriate specialist services can be made (*Table 8*). Adult Survivors of Child Abuse (ASCA) have produced guidelines that focus on:

- what has happened to the patient rather than what is wrong with them
- establishing safety as the core to any therapeutic work.[26,27]

Reflection and respect

Dealing with complex sensitive issues can adversely affect the wellbeing of the GP and practice staff. Working with patients who have or are experiencing family violence, particularly if the GP has experienced abuse, can lead to vicarious traumatisation.[28] To enable excellent patient care, the RACGP recommends self-care, working with others and a reflective approach.[4,28,29]

Case continued

Ongoing management of the whole Novak family

The GP was able to support Mary and her children as they sorted out how they could best be kept safe and move away from the violence. Mary's main priorities were to stay in the relationship and keep her children safe and healthy. Mary eventually, with GP support, sought help and advice from a domestic violence service, once she

Table 5. Why a woman may not wish to report abuse or leave a relationship[4]

- Fear of reprisal or counter charges being laid by their partner
- Too worn down to seek help
- Living in fear of severe violence
- Fear their children will be taken away
- Unable or to recognise the cycle of abuse
- Social isolation
- Financial dependence
- Emotional dependence and fear
- Poor self-esteem
- Cultural or religious issues

Table 6. Questions to assess safety

- What does the patient need in order to feel safe?
- Has frequency and severity increased?
- Is the perpetrator obsessive about the patient?
- How safe does she feel?
- How safe does she feel her children are?
- Has the patient been threatened with a weapon?
- Does the perpetrator have a weapon in the house?
- Has the violence been escalating?

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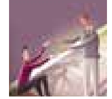
Table 7. The elements of safety planning[4]

- Developing a list of emergency numbers
- Removing weapons from the home
- Identifying a safe place to go to and how to get there
- Identifying family and friends who can provide support (and establishing a signal for help)
- Ensuring availability of money
- Providing a safe place to store valuables and important documents, such as:
  - Medicare and tax file numbers
  - rent and utility receipts
  - birth certificates
  - ID and driver's licence
  - bank account and insurance policy numbers
  - marriage licence
  - valuables, such as jewellery
  - hidden bag with extra clothing
  - extra set of house and car keys



had recognised that she was being abused. Lachlan saw a counsellor through the school. Alice was sent to hospital for assessment of her dementia and as a way of keeping her safe and to give time to sort out her care. John saw another GP in the practice for his chronic headaches but did not see his drinking as an issue affecting his family. The GP did not ask him directly about any use of violence, which was a missed opportunity.

This is a work in progress as the GPs in the practice discuss this case and reflect on ways they can improve their management of family violence. Confidentiality is absolutely essential in these cases, unless child abuse is occurring. The Novaks live in a region where witnessing or experiencing partner violence does not require mandatory reporting.

Conclusion

Family violence is a common hidden problem requiring a whole-of-practice approach, including recognising clinical indicators, asking questions, appropriate immediate response and ongoing care that supports the patient. The GPs were able to identify and assist the Novak family because they had received training in family violence, which WHO and RACGP recommend, so that all GPs provide a safe, non-judgmental and empathic response to patients experiencing family violence.

Key points

- Family violence refers any abuse within a family and includes physical violence, emotional, sexual, economic and social abuse.
- Abuse and violence have a significant negative impact on health and are very common in clinical practice.
- GPs are in a unique position to recognise, ask and appropriately respond to families who are experiencing violence.
- Dealing with complex sensitive issues can adversely affect the wellbeing of GPs, and self-care is important to ensure best, ongoing care for patients.

Table 8. Referrals in cases of adult survivors of child abuse[4]

- Another GP with training and experience in supporting adult survivors
- Psychiatrist, psychologist or psychotherapist experienced in working with adult survivors
- Specialist social worker or counsellor
- Sexual assault service
- ASCA Professional Support Line 1300 657 380 for details of therapists who have been trained in trauma informed care
- Living well on 1300 114 397 or at www.livingwell.org.au, a national service that assists men who have experienced childhood sexual abuse or sexual assault abuse or sexual assault

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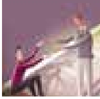

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