3rd edition

Abuse and violence

Working with our patients in general practice

The Royal Australian College of General Practitioners

Abuse and violence: Working with our patients in general practice (3rd edition)

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Foreword

Welcome to this third edition of *Abuse and violence: Working with our patients in general practice* (previously published as the *Women and violence manual*). In this edition, health practitioners and researchers with expertise in specific areas of sexual and other intimate violence were invited to share their knowledge by contributing to individual chapters.

This publication has been designed for the purpose of assisting general practitioners and their staff in recognising women, men and children who are survivors of abuse and violence, or who are currently involved in violent situations. This is a sensitive issue, both for patients and GPs. However, this guideline may assist GPs to intervene in a positive and empowering manner.

In the context of this guideline, abuse and violence refers to:

- intimate partner abuse (domestic violence)
- perpetrators of intimate violence
- child abuse
- bullying
- adult survivors of child abuse
- sexual assault, and
- elder abuse.

This guideline encompasses issues experienced by specific groups, for example, Aboriginal people and Torres Strait Islanders, same sex couples, those with a disability, and cultural and linguistically diverse people.

Rigorous debate surrounds screening and mandatory reporting and there is scant evidence regarding effective interventions for those experiencing violence. There is a danger that the patchy evidence base for how GPs should respond to issues of abuse and violence can result in inaction by GPs. However, it is possible to articulate an appropriate response for GPs when faced with disclosure of abuse, or when they suspect that abuse is occurring. This will empower GPs to act appropriately when dealing with patients suffering past or present abuse.

The issue of violence and abuse involves many services in our community, including children's services, education, health, and police, as well as the legal and court systems. This is an issue that is often difficult to confront and discuss. It is reflected in the difficulties GPs have in asking about violence and abuse, and the difficulties our patients have in telling their stories. It could be said that at times abuse and violence is a hidden part of the consultation. Because evidence suggests that abuse and violence may have a very damaging effect on patients' health, this guideline will help GPs play their part in responding to abuse and violence within the community.

This third edition of *Abuse and violence: Working with our patients in general practice* has been funded by The Royal Australian College of General Practitioners and produced with the generosity of the many contributors who gave freely of their time.

Dr Elizabeth Hindmarsh, Dr Gwenneth Roberts

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What is interpersonal abuse and violence?

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Key messages

- Interpersonal abuse and violence includes intimate partner abuse, adult survivors of child abuse, sexual assault, child abuse and elder abuse.
- Violence is not just physical; it includes emotional, sexual, economic and social abuse.
- The main perpetrators of interpersonal abuse and violence are men, but women can also be perpetrators.

Introduction

When we speak of abuse and violence in this guideline, it encompasses:

- Intimate partner abuse (domestic violence) – any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship.[1] An intimate relationship may refer to a victim's current or previous partner or living companion
- Perpetrators of intimate violence – a person who commits, or knowingly allows, acts of abuse, neglect or exploitation to occur
- Children in violent families – children who are members of a family in which abuse and violence occurs, whether or not they themselves are abused
- Child abuse – any type of abuse that involves physical, emotional, sexual, or economic abuse or neglect of a child under 18 years of age (16 years of age in New South Wales, 17 years of age in Victoria)
- Adult survivors of child abuse – adults who experienced physical, sexual, or emotional abuse or neglect during their childhood or adolescence
- Sexual assault – any sexual activity with a child or any type of sexual activity with another adult without their consent
- Elder abuse – any type of abuse (physical, emotional, sexual, economic) or neglect of people 65 years of age or over, either in a residential aged care facility (RACF), in private care, or living independently.

While we acknowledge that not all survivors of violence are female and not all perpetrators are male, research supports that men are the perpetrators in the majority of cases for child abuse, sexual assault and intimate partner abuse. Intimate partner abuse incidents that are reported show that the majority of the subjects of this abuse are women.[2]

Any form of abuse and violence has implications for the health of our patients, both physically and emotionally. Health outcomes may also be affected by the quality of care received, which in turn will affect the health of the entire family. Recent research shows that children who live in abusive families suffer effects on their health, wellbeing and ongoing relationships.

Types of abuse and violence

Abuse and violence can take many forms. The violence can be severe and leave obvious injuries. However, some victims may be subject to more subtle abuse that may not leave physical injuries. Some victims may not even recognise that what is perpetrated against them is abuse. Abuse and violence may be any of the following:

- Physical abuse – injuries may range from minor trauma, that may or may not be visible, to broken bones and lacerations, head injuries and injuries to internal organs. For many victims, the abuse occurs regularly. Some victims are threatened with weapons such as knives, and household items such as a hot iron, cigarettes, a length of rubber hose
- Emotional abuse – may include subtle or overt verbal abuse, threats or any behaviour aimed at scaring/terrorising the victim. The victim may lose their confidence, self esteem or self determination. Emotional abuse can take many forms such as smashing property, or killing or hurting family pets
- Child sexual abuse – for children, sexual abuse may involve forcing or enticing them to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or nonpenetrative acts. The abuse may include noncontact activities such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways
- Adult sexual assault – involves any type of sexual activity to which there is no consent. This may or may not involve penetration or physical contact with the victim (eg. exposure). It is important to note that with the elderly, they may have lost their ability to consent (eg. those with dementia)
- Economic abuse – restricting access to money and essential needs, fraudulently using another's money for personal gain, or stealing from the victim; the illegal taking, misuse, or concealment of funds, property or assets
- Social abuse – isolating the victim from family and friends and other contacts in the community
- Neglect – the persistent failure to meet the basic physical and/or psychological needs of a person for whom you are caring, such as failing to protect from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, the other person's basic emotional needs.

Intimate partner abuse – not just an argument

So if I argue with my partner and we push each other around, that's intimate partner abuse?

Not always. Some couples have arguments that may involve some physical contact without an imbalance of power in the relationship. Generally, intimate partner abuse occurs where one partner is being abused by the other partner and lives in fear of being exposed to that abuse again (*Figure 1*). Fear experienced by the abused partner may be constant or episodic. Regardless of the frequency that abuse occurs, it is still abuse.

About one-third of intimate partner abuse victims say that arguments did not precede the violent episodes. In other incidents, the perpetrator had often provoked the confrontation deliberately.

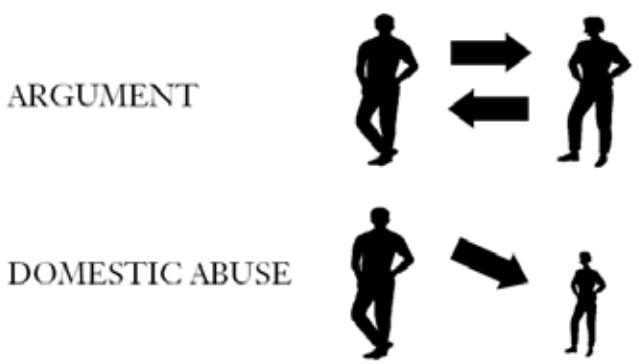


Figure 1. Domestic abuse: power imbalance in an abusive relationship

The Australian Medical Association's[3] position statement on intimate partner abuse is clear about this issue of intent:

'Domestic violence [sic] is an abuse of power. It is the domination, coercion, intimidation and victimisation of one person by another by physical, sexual or emotional means within intimate relationships'.

Abuse and violence can take many forms in intimate relationships, and is often not recognised as such by the victim.

'At the time I felt that it was not really abuse but the longer I thought about it the more that I felt it was abuse. Emotional abuse is more severe than physical abuse as there is no outward marks or bruises. When this was realised by myself [sic] I got out. Living alone is far better than what was happening in the relationship'.

The cycle of violence

One model used to explain the pattern or dynamic of intimate partner abuse is the 'cycle of violence' (*Figure 2*). Exploring this cycle to highlight the pattern of abuse in a relationship can be useful to assist general practitioners in understanding what may be happening in a patient's relationship. It may also help the patient to accept that the situation is unlikely to improve.

This model has limitations, and is not useful if used in such a way as to blame the patient for staying in the relationship or for not preventing the violence.

By applying the cycle of violence to the patterns of a violent relationship, it is possible to see how a patient becomes stunned and confused. As the partner changes from a loving person to a terrifying and forceful one, the patient swings between hope and despair.

People outside a violent relationship find it hard to understand why the victim stays. Love and hope for change play a strong part in keeping a person in an abusive relationship. Added to this is fear, which paralyses the victim and coerces them into staying. Homicide statistics verify that this fear is justified.[4]

This model will have as many variations as there are patients in your practice. Although the cycle of violence does not exist in all abusive relationships, it can provide insight into the nature of the violence.

The cycle of violence has five phases:[5]

- Build up phase – tension builds within the perpetrator (for various reasons, eg. family pressures, work stresses). Other couples will have a range of reactions to this tension which do not include violence, but in the abusive relationship it leads to the stand over phase
- Stand over phase – because of the imbalance in perceived physical strength and frightening threats to harm, the victim feels under their partner's control. Verbal attacks will weaken them further. This is when the 'explosion' (eg. physical or emotional attack) happens. After the assault or other abusive act, the perpetrator enters the remorse phase
- Remorse phase – the perpetrator often feels ashamed and may be afraid of the consequences, or will deny and play down their actions. The perpetrator may say: 'She knows I get mad when she does that', 'It was only a bit of a shove'. The victim may go along with this; or otherwise they will have to confront how dangerous the situation is for themselves and/or others, including any children
- Pursuit phase – the perpetrator will try to buy back their partner with extravagant gifts and promises. If the victim does not cooperate, threats and more violence continue – so the victim often forgives. The couple then move into the honeymoon phase
- Honeymoon phase – having come so close to separation and destruction, the partners cling to each other for comfort.

Unfortunately, the cycle inevitably continues. The relationship, still bearing all its original problems, weakens again under the growing weight of tension.

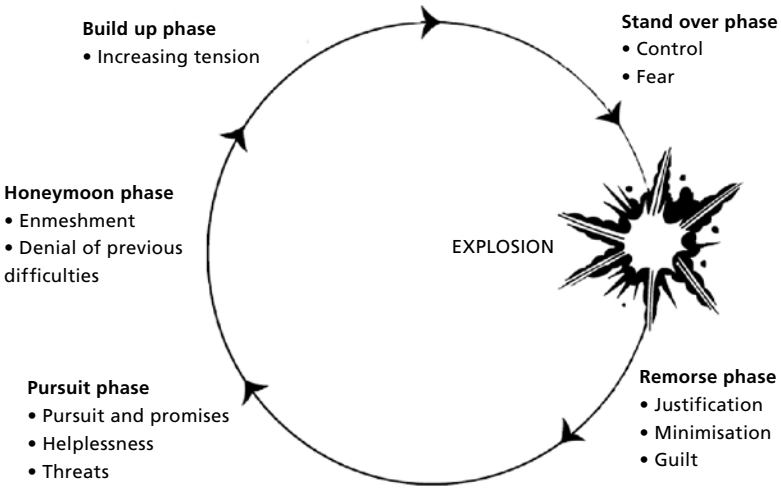


Figure 2. The cycle of violence

What part does the community play?

Society condones violence in overt and subtle ways by failing to recognise and acknowledge that intimate partner abuse, child abuse, sexual assault and elder abuse exist. We turn a blind eye to family violence, preferring not to be involved. (This has been described as a 'conspiracy of silence'.) Unfortunately, this has meant that the problem often seems to be no-one's responsibility. Health practitioners need to understand the nature of violence and abuse so that they can help break the cycle.

Communities that experience high rates of unemployment, poor health, overcrowding, alcoholism and few support services are most at risk.

In community surveys, women are more likely than men to be aware that intimate partner abuse can consist of both psychological and physical abuse. Women also tend to attach a greater degree of seriousness to such abuse. Both men and women identify men as more likely to be perpetrators.

What other factors influence our response?

- We expect the family to nurture, protect, guide and provide refuge for all its members
- Family violence forces us to acknowledge that for some families this is not the case, and that for some, the greatest danger lies in the home itself
- As a community, we believe that the family is the basis of a good community and a strong nation. The existence of family violence challenges our sense of security
- The high level of violence we tolerate as a society (eg. some sports, in film and television) can be seen as normalising this behaviour.

Changing attitudes

A 2006 survey commissioned by VicHealth,[6] as compared to a survey undertaken in 1995,[7] displays the changing attitude toward violence in Australia:

- in 1995, 20% of Australians regarded intimate partner abuse as a private matter; in 2006 this had decreased to 14%
- in 1995, 10% of Australians condoned the use of physical force by a man against his wife; in 2006 this had decreased to 4%.

Sampling and methodological issues mean that these figures are not directly comparable, but they do give us a crude indicator of change in the community. There is a developing awareness that intimate partner abuse and violence is a crime and is not acceptable. While there has been education of health professionals about the management of those who have suffered violence, we still have a long way to go.

Resources

- The Australian Domestic and Family Violence Clearinghouse – a national organisation providing high quality information about domestic and family violence issues. A range of information and services is available (eg. newsletters and forums). Available at www.austdvclearinghouse.unsw.edu.au/
- The 'Community attitudes to violence against women survey' – this report presents findings from a community survey conducted by VicHealth in 2006. It provides an interesting insight into community attitudes toward violence and how this has changed over the past decade. Available at www.aic.gov.au/publications/reports/2006–11–violenceAgainstWomen.pdf
- Intimate partner abuse and health professionals: New approaches to domestic violence by Roberts G, Hegarty KL, Feder G, editors. London: Churchill Livingstone Elsevier, 2006 – this book gathers together and presents an overview of the literature in the field of abuse and violence in primary health care. It explores prevalence and the barriers faced in health professionals addressing some of these challenging issues
- Domestic violence in Australia: Definition, prevalence and nature of presentation in clinical practice by Hegarty KL, Hindmarsh ED, Gilles MT – this article outlines the domestic violence debate in Australia. Available at www.mja.com.au/public/issues/173_07_021000/hegarty/hegarty.html.

02 Abuse and violence – confronting the myths

Key messages

- It is important to address our own attitudes and assumptions about abuse and violence as they can affect the way we respond to patients who have experienced abuse and violence.
- There is an assumption that abuse and violence only occurs in certain groups. This is not the case. Abuse and violence can happen within any group or strata of society.
- Blaming the victim has been given as a reason for abuse and violence. The victim is not responsible.

Introduction

This chapter challenges some of the myths and beliefs commonly held in society about women and men who have suffered violence.

Myth – only a small percentage of women and men are victims of violence

It is difficult to determine the exact incidence of violence against women and men in our society because violent incidents are under-reported to police and other authorities. Research from a community survey reports that 20% of women have experienced at least one unwanted sexual experience by the age of 16 years.[8] Other research shows that 39% of women sitting in general practice waiting rooms reported at least one unwanted sexual experience before the age of 16 years.[9] While this research focuses on the experiences of women, it is also noted that many men have negative experiences by this age. However, the health burden of intimate partner violence is experienced predominantly by women, with men more likely to suffer violence at the hands of a stranger than within a close relationship.[1]

It has been estimated that as many as one in three households experience intimate partner abuse (domestic violence) at some stage;[10] with almost all violence perpetrated on women and children. For many thousands of women, violence is a regular part of family life.

Research findings

- General practitioners in full time practice see up to five women per week who have experienced some form of abuse by their partner in the past 12 months[11]
- Approximately 80% of perpetrators of intimate partner abuse are men[12]
- Male offenders are reported as responsible for 94% of all female homicide, with the majority occurring between intimate partners (current or ex-partners)[13]
- Children who live in a family where partner abuse is occurring are considered to be experiencing abuse. They may also be experiencing direct abuse
- It was estimated that in New South Wales the annual cost in 1995 of domestic violence was $1.5 billion.[14]

Myth – women and children frequently lie about sexual assault

This is not true. Most people do not lie about assault. They are more likely not to speak about it.

Myth – women enjoy being assaulted

There is a myth that when a women says 'no' she means 'maybe'. This is not true. When a woman says 'no' to sexual or other violence she means 'NO'.

Myth – only poor women are abused

Numerous studies, both in Australia and internationally, show that both victims and perpetrators are found in all social classes and across all ethnic groups.[15] The abuse may be more hidden in higher socioeconomic groups.

A study completed in Brisbane, Queensland, suggested that abuse was not significantly associated with income or education level.[11] Another study of American medical staff and medical students found that of the 787 respondents, 12.6% reported physical and/or sexual abuse by a partner during their adult life; and 15% reported child physical or sexual abuse. The authors concluded that:

'Family violence is a pervasive problem that crosses into the personal experience of medical professionals. The conservative estimate of partner abuse for female medical students and faculty appears comparable with the general population national estimates. The acknowledgment by physicians that family violence is a potential risk for everyone, physicians and patients alike, is a step toward enhancing the identification of abuse and initiating interventions on behalf of survivors of family violence'.[16]

Myth – women deserve to get raped and beaten. They provoke the assault by their behaviour and clothing

Violence is never an acceptable method for resolving conflict. Partners do not have the right to physically assault one another. Most abused women try exceptionally hard to please their partners and avoid further violent episodes. In cases of sexual assault, victims do not invite the assault by their behaviour or by how they are dressed. Belief in this myth allows us to shift the blame for the violent assault from the perpetrator to the victim.

Myth – if there are no visible injuries then the assault cannot have been so bad

Frequently there are no visible signs of assault or rape in domestic violence presentations. This does not mean that the emotional or psychological effects of the assault are minimised or that the effects will be any less devastating to the victim. Some victims say physical abuse is easier to bear because scars heal. Emotional and psychological scars are often more resistant to treatment.

Post-traumatic stress disorder (PTSD) is recognised as being likely to manifest itself following a 'psychologically distressing event that is outside the range of usual human experience'.[17] Sexual assault and intimate partner abuse are recognised as being events that can result in PTSD due to the assaults and/or abuse being experienced with feelings of terror, fear for one's life, loss of control and a sense of helplessness. Abuse and assault are also associated with other symptoms such as phobic avoidance of similar situations to where the assault happened, anxiety, fear, withdrawal, isolation, depression, appetite and sleep disturbances, as well as problems with intimate and sexual relationships. Any life threatening situation can result in long term responses. (See *Appendix 1* for the DSM-IV criteria for PTSD.)

Myth – abused women can always leave if they wish

Abused women are usually constrained from leaving home by a number of factors. These may include:

- fear of reprisals. Many women are subjected to threats of injury and violence to themselves or their children if they leave. Approximately 40–45% of women killed by their spouse are separated or in the process of separating[13,18]

- social isolation. A number of social factors contribute to why women feel they cannot leave, such as having dependent children, being deliberately isolated from friends and family by the perpetrator, and shame relating to injuries. Abused women often have no-one to turn to and are unaware of available services
- financial dependence. Women generally do not have equivalent earning capacity to men. To leave their partner condemns many women, and their children, to a substantial decline in their standard of living
- emotional dependence and fear. Many abused women are committed to their relationship, love their partner and are hoping for a change in the relationship. Some abused women are fearful that their partner will not cope with a separation and/or the partner may be threatening to suicide if she leaves
- poor self esteem. After years of physical violence and verbal abuse, many victims lose their self confidence and doubt their ability to cope on their own.

Myth – perpetrators of violence against women are mentally ill and cannot control their violence

Clinical studies of men who abuse their partners or sexually assault women do not support this view. It has been noted that there may be three main types of abusers:

- the 'family only' group who predominantly engage in abuse within the family
- the 'borderline dysphoric' group who are violent outside the family
- the 'generally violent antisocial' group who have the most extra-familial violence and criminal behaviour.

The latter group includes psychopathic perpetrators and great care should be taken when consulting with such a perpetrator of violence. Perpetrators of violence against women mostly do not meet the criteria of having a mental illness.[19] The majority of perpetrators (approximately 60%) do not perpetrate violence outside the family unit.[19,20]

Myth – men who abuse their wives do not display love to their partner

A cycle of violence has been described as occurring in some intimate partner abuse (see *Chapter 1*). This results in an unpredictable series of violent episodes, punctuated with love, affection and possibly promises to change. Men who abuse women can appear to be loving.

Myth – alcohol misuse causes violence

Alcohol appears to be involved in about 45% of incidents of intimate partner violence.[10] However, 55% of cases involve sober perpetrators. Abuse of alcohol is a risk factor that contributes to spousal abuse by lowering inhibitions; but alcohol does not cause intimate partner abuse, sexual assault, child abuse or elder abuse, nor is it an excuse for these behaviours.

Intimate partner abuse 03

Key messages

- Research shows that, in heterosexual relationships, the majority of intimate partner abuse victims are women and the majority of perpetrators are men.[21] However, intimate partner abuse also occurs in same sex relationships.
- General practitioners have a role to play in identifying and supporting patients who are suffering the effects of intimate partner abuse.
- The gender of a patient's GP does not affect disclosure of intimate partner abuse.[22]

Introduction

Intimate partner abuse (or domestic violence) is the most common form of assault perpetrated against adult women in Australia today.[23] Because it occurs in the privacy of the home and those involved are often reluctant to talk about it, intimate partner abuse remains a hidden problem in all strata of society. Research supports that intimate partner abuse occurs in both heterosexual and homosexual relationships, by both men and women. However, as intimate partner abuse is perpetrated more often against women, this chapter focuses on women as the victims and survivors. However, the overarching statements and recommendations in this chapter relate to both genders *(see Chapter 4* for information on perpetrators and *Chapter 10* for information on same sex couples).

Identifying and naming intimate partner abuse is the first important step in breaking the silence. The Australian Public Health Association employs a broad definition that includes abuse of a physical, sexual or emotional nature (*Figure 3*):[24]

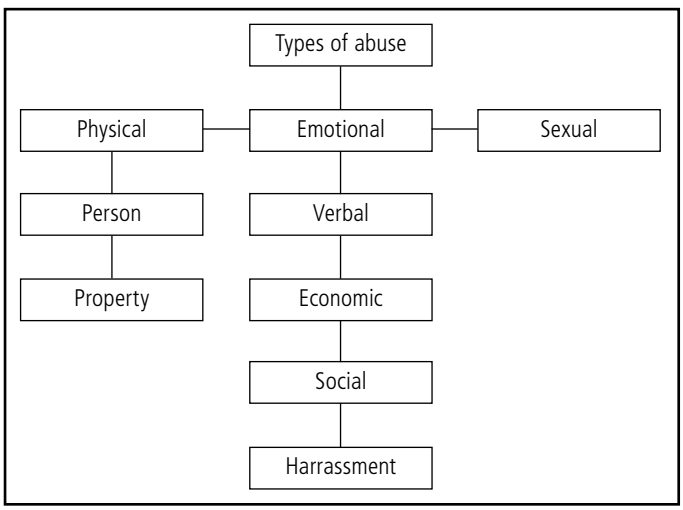


Figure 3. Types of abuse

Forms of violence

Violence used by perpetrators of intimate partner abuse can take many forms:

- punching, hitting, slapping, shoving, throwing objects, pulling hair, twisting limbs, choking and other forms of physical assault
- use of weapons; murder
- threats to injure or otherwise harm adults, children, pets, or an elderly person
- sexual abuse or assault
- harassment – by telephone or at the workplace
- deprivation of basic human needs – food, money, sleep, medical care
- erosion of self esteem through humiliation and verbal abuse
- social isolation through denial of outside contact with friends or relatives.

Physical abuse

Many victims of intimate partner abuse suffer physical abuse. Most victims say that the constant fear of the next episode is as bad as the actual violence:

'You don't know what the limit is when he's attacking you. It is very frightening. Each time you think: "This will be the last. He's going to kill me".'

Emotional abuse

Physical injuries heal. Emotional abuse, if not dealt with, can cause long term suffering for the victim. Emotional abuse can involve:

- verbal abuse – 'You're lucky to have me, no-one else would have you'; 'You're a hopeless mother'
- threats – 'If you leave, I'll kill you'; 'I'll smash your face in if you do that again'; 'If you leave, you'll never see the kids again'
- the destruction of property, killing or maiming pets, isolation from friends and family, and deprivation of essential personal needs (eg. sanitary items and food).

Sexual abuse

Many domestic violence survivors undergo forced sexual contact, but sexual abuse is rarely an isolated form of abuse. In most cases, it takes place within relationships where physical assaults and emotional abuse are occurring.

Economic and social abuse

In some situations victims are isolated from family and friends and have either no access or very restricted access to money (see *Case study*).

When does it start?

People don't enter relationships expecting that the relationship will become violent.

'I'll never forget when he hit me for the first time... the pain of split lips and blackened eyes was outdone by the shock I felt. I just couldn't believe it had happened'.

Violence erupts in many relationships in the first year of that relationship, often involving a pregnancy, and setting off a cycle of abuse that may last years.

Who are the victims of intimate partner abuse?

A victim of intimate partner abuse reported:

'People say to me, "I just can't believe an intelligent woman like you could be in such a situation. You just aren't the type I picture tolerating such madness". My answer is this. It can happen to anyone.'

Victims of intimate partner abuse come from all social, cultural, economic and religious backgrounds. We know this from telephone surveys, phone-ins, mailed questionnaires and household surveys, as well as research conducted in hospital accident and emergency departments and general practice consulting rooms.

What about culturally and linguistically diverse women?

The problems for women from a non-English speaking background are often compounded by social isolation, language barriers, the migration experience, cultural differences and for some, their religious beliefs. They may be less aware of the resources that exist within the community and how to access them. They may also need help in their own language and support which is culturally appropriate.[25] Migrant women often feel economically and socially marginalised and need support to seek services and to understand the Australian legal system (see *Chapter 10*).

Prevalence

In 1996, the Australian Bureau of Statistics conducted a survey of 6300 women (78% response rate) – the Women's Safety Survey[4] – which had a specific focus on physical and sexual violence against women. It showed that one in 14 women had experienced physical or sexual abuse in the 12 months before the survey. Abuse and violence were experienced predominantly (19%) by women in the 18–24 years age group. The 25–34 years age group experienced 10%, decreasing to only 1.2% of incidents experienced by those over 55 years of age.

Using the Women's Safety Survey figures and extrapolating them to the community, 104 600 women experienced violence by their current partner, 75 800 by a previous partner, and 67 300 by a stranger.

In 2005, the Australian Bureau of Statistics Personal Safety Survey found that 13.5% of women felt unsafe at home alone after dark, compared to 3.8% of men.[26] This survey, of both men and women, showed that the majority of physical assaults on women were in the home by a partner or ex-partner, whereas for men, assaults were in a public place by a stranger.

What is happening in general practice?

General practitioners will often say that they do not see many patients who have suffered violence. It is true that violence doesn't necessarily present in an obvious way, and it may not be identified by the patient as their reason for presenting.

Despite this, it has been estimated that full time GPs are seeing up to five women per week who have experienced some form of intimate partner abuse (physical, emotional, sexual) in the past 12 months.[21] One or two of these women will have experienced severe intimate partner abuse (eg. raped, attacked with a weapon, locked in their home or not allowed to work). These figures are from a survey of 1836 consecutive women attending 20 randomly chosen Brisbane general practices (response rate 78.5%).[21] One in three women in current relationships had experienced partner abuse in their lifetime. Abused women were more likely to be younger, separated or divorced, to have experienced child abuse, and to have come from a violent family. It is important that GPs have an idea of the level of abuse and violence in general practice populations. This heightened awareness may help GPs identify health issues related to abusive episodes.

What is happening in other health settings?

Research on women presenting to the Accident and Emergency Department of the Royal Brisbane Hospital (Queensland),[27] and the Royal North Shore Hospital (New South Wales)[28] showed around one in 5 women and just under one in 10 men surveyed disclosed a history of intimate partner abuse. The greatest risk for being an adult victim of intimate partner abuse was being female and having experienced abuse as a child.

Intimate partner abuse in pregnancy is also common, with a rate of 9% in women attending the Royal Women's Hospital (Queensland), with violence tending to escalate during pregnancy.[29] In the Women's Safety Survey,[4] approximately 700 000 women who experienced violence by a partner in a previous relationship were pregnant at some time during the relationship. Some 42% of these women reported that violence occurred during a pregnancy and 20% experienced violence for the first time when they were pregnant. This is an important finding for general practice, as GPs are often involved in the provision of antenatal and postnatal care to women through shared antenatal care programs.

TIP

Consider asking about intimate partner abuse in the antenatal period. Evidence suggests that 4–9 women in every 100 pregnant women are abused.[30] The Abuse Assessment Screen will give you an idea of how you may wish to construct questions when in a consultation with a pregnant patient who does not have her partner present (see *Appendix 2*).

Types of presentations in general practice

Studies show abuse is associated with depression, anxiety, other psychological disorders, drug and alcohol abuse, sexual dysfunction, functional gastrointestinal disorders, headaches, chronic pain and multiple somatic symptoms (*Table 1*). Sexual abuse has also been linked with chronic pelvic pain.[31]

A study in primary health care settings in the USA showed that currently abused patients were significantly more likely to be younger than 35 years of age, and to be single, separated or divorced, compared with women who had not recently experienced intimate partner abuse.[32] The currently abused women had more physical symptoms and higher scores for depression, anxiety, somatisation and low self esteem. They were more likely to have attempted suicide and to be abusing drugs or alcohol. Depression appears to be one of the strongest clinical predictors of intimate partner abuse. One in five currently depressed women attending Victorian general practice experienced severe physical, emotional and sexual abuse by a partner or ex-partner in the past 12 months.[33] Similarly, in-depth interviews of 367 women at Royal Brisbane Hospital who had been victims of domestic violence showed an increased likelihood that abused women will experience depression, post-traumatic stress disorder, anxiety and somatisation (*Table 1*).

Table 1. Potential presentations of intimate partner abuse

Psychological	Physical
• Insomnia • Depression • Suicidal ideation • Anxiety symptoms and panic disorder • Somatiform disorder • Post-traumatic stress disorder • Eating disorders • Drug and alcohol abuse	• Obvious injuries (especially to the head and neck) • Bruises in various stages of healing • Sexual assault • Sexually transmitted infections • Chronic pelvic pain • Chronic abdominal pain • Chronic headaches • Chronic back pain • Numbness and tingling from injuries • Lethargy

Table 2. General clinical indicators of partner abuse

- Delay in seeking treatment or inconsistent explanation of injuries
- Multiple presentations to general practice
- Noncompliance with treatment and attendances
- Accompanying partner who is overattentive
- Identifiable social isolation
- Recent separation or divorce
- Past history of child abuse
- Age less than 40 years
- Abuse of a child in the family

What happens to pregnant women who are abused?

Abused pregnant women are twice as likely to miscarry than nonabused pregnant women. An abusive partner will often target the breasts, stomach and genitals of their pregnant partner.[28]

For many women, pregnancy exacerbates the violence and threats within their relationship. For some, pregnancy may even provoke it. A violent and jealous partner may resent the pregnancy because he is not prepared to 'share' her. There may be financial or sexual pressures, which are compounded by the pregnancy.

Often the abuse will start with the first pregnancy, and as a result the woman may avoid prenatal check ups. It has been suggested that screening in antenatal care and clinics for intimate partner abuse is appropriate. Women who do not seek antenatal care until the third trimester should raise suspicion.

General practitioners involved in obstetric or shared antenatal care need to be aware that pregnancy is a risk factor for intimate partner abuse. As GPs, we ask pregnant patients about smoking, alcohol, and breastfeeding – we may also need to screen for intimate partner abuse.

Identification – do abused patients want to be asked?

In one overseas study, the majority (78%) of female patients (n=164) attending family practices stated that they would not object to being asked about physical abuse, although they had rarely been asked (7%).[34]

Women disclose abuse to their GPs in significant numbers. In a Brisbane study, 36.7% of abused women had told a GP about the abuse, while only 13.2% had been asked by a doctor.[22] Women were significantly more likely to disclose if they had been asked by their doctor about the abuse. The gender of the GP did not affect disclosure.

The women in this study identified four main barriers to disclosure:

- they see the abuse as their own problem
- they think the abuse is not serious enough
- they prefer to deal with it themselves
- they perceived the doctor might not be able to help.

General practitioners said they did not inquire about abuse because of lack of time and appropriate skills, and a perception that they were unable to help abused women.

Studies show that there is a need for patients to be encouraged to see abuse as impinging on their health; they also need to be able to discuss it. General practitioners also need to have a high level of suspicion and to be able to ask direct questions in a sensitive way. There is insufficient evidence for screening in clinical settings, with the possible exception of antenatal care, however, there should be a low threshold for asking about abuse, particularly when the GP suspects underlying psychosocial problems (*Table 2*). Possible questions to ask and statements to make are listed in *Table 3*.

Table 3. Questions and statements to make if you suspect domestic violence[2]

- 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?
- 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.

Why don't women want to report the abuse?

Most people do not report their partner to the authorities for intimate partner abuse or child abuse because of fear of reprisals or counter charges from their partner. Abused women are often:

- too terrorised to be able to always protect their children, and too worn down by repeated violence to seek help
- living in fear of violence with the use of weapons
- in real fear of losing their children to authorities whom they fear will disapprove of their home life and take the children into care
- at greater risk themselves of abusing their children.

Management

In a meta-analysis of 25 qualitative studies of women's expectations and experiences when they encounter clinicians, there were consistent messages about how doctors can respond appropriately to the issue of partner violence (*Table 4*).[35]

Even if a woman does not choose to be referred to specialist intimate partner abuse services, a GP's validation of her experience (*Table 5*) and the offer of support is an act that may contribute to the woman being able to change her situation. In addition to offering support, the clinician needs to make an initial assessment of the patient's safety (*Table 6*). This may be as simple as checking if it is safe for her (and her children) to return home. A more detailed risk assessment will include questions about escalation of abuse, the content of threats, and direct and indirect abuse of any children.

These questions are applicable for both male and female victims.

TIP

The stages of change model can be very helpful in understanding a patient's current position within the journey of change (see *Chapter 14*).

The use of weapons in violence

A report by the Australian Institute of Criminology (AIC)[13] states:

'In general, women are at a relatively low risk of homicide victimisation, but when they are killed, it is most likely that they will be killed by an intimate partner. This [the report] sheds light on the more unpleasant aspects of gender relations and, in particular, intimate relations'.

It is important to note that homicides tend to occur when a partner in a relationship is leaving or threatens to leave.

The availability of guns in the home is a significant factor in domestic violence. One-third of domestic homicides involve the use of firearms. In Victoria, two-thirds of murder/suicides involve guns. This is an important issue in relationship to gun ownership and gun laws in Australia. In some states, the police have the power to remove firearms where intimate partner abuse is present.

Table 4. What abused women say they want from clinicians

Before disclosure or questioning

- Understand the issue, including knowing about community services/appropriate referrals
- Ensure that the clinical environment is supportive, welcoming, and nonthreatening
- Place brochures/posters in the clinical setting
- Try to ensure continuity of care
- Be alert to the signs of abuse and raise the issue
- Use verbal and nonverbal communication skills to develop trust
- Assure abused women about privacy, safety and confidentiality issues
- Be compassionate, supportive and respectful toward abused women

When the issue of intimate partner abuse is raised

- Be nonjudgmental, compassionate and caring when questioning about abuse
- Be confident and comfortable asking about intimate partner abuse
- Do not pressure women to disclose, as simply raising the issue can help them
- Consider asking about abuse at later consultations because patients may disclose at another time
- Ensure that the environment is private and confidential, and provide time

Immediate response to disclosure

- Respond in a nonjudgmental way, with compassion, support and belief of experiences
- Address safety concerns
- Acknowledge the complexity of the issue, respect the patient's unique concerns and decisions
- Put patient identified needs first, making sure social/psychological needs are addressed
- Take time to listen, provide information and where appropriate offer referral for more specialised help
- Validate experiences, challenge assumptions and provide encouragement
- Assist patients to make their own decisions

Response in later interactions

- Be patient and supportive, allow the patient to progress at their own pace
- Understand the chronicity of the problem and provide follow up and continued support
- Respect the patient's wishes and do not pressure them into making any decisions
- Be nonjudgmental if patients do not take up referrals immediately

Table 5. Possible validation statements if a patient discloses intimate partner abuse

- Everyone deserves to feel safe at home
- You don't deserve to be hit or hurt and it is not your fault
- I am concerned about your safety and wellbeing
- You are not alone; I will be with you through this, whatever you decide. Help is available
- You are not to blame; abuse is common and happens in all types of relationships. It tends to continue
- Abuse can affect your health (and that of your children)

Table 6. Assessing the safety of patients experiencing intimate partner abuse

- 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?
- Has the patient been threatened with a weapon?
- Does the perpetrator have a weapon in the house?
- Has the violence been escalating?

What finally prompts women to take legal action, leave or change?

Most victims have to begin to reject their own reasons for staying in the relationship. The abused woman needs to stop believing that violence is normal. This may be a greater problem with women whose own parents have been violent. In order to be able to leave or take legal action a woman needs to:

- stop excusing her partner as being sick, mentally ill, alcoholic, unemployed or under great stress
- stop blaming herself, and stop believing she is bad, provocative or responsible for the violence
- stop believing and hoping that if she is good her partner will not abuse her
- stop pretending that nothing is wrong, and hiding or minimising her injuries
- stop believing her children would be disadvantaged if she and they were to leave
- stop believing that their partner will change
- start believing that there are other options.

What happens to women after they leave?

Some women receive help from family and friends. Women's shelters are available, although this support may be limited depending on location and whether a bed is available.

Problems experienced by women once they leave an abusive partnership include:

- risk of further abuse
- financial – many women experience a dramatic fall in living standard (eg. may be on the Supporting Parent's Benefit)
- loneliness – the need for companionship and a sense of belonging is important to most women
- the need to rebuild their lives and those of their children.

Do women ever get over the abuse?

Some women re-partner. However, the longer a woman stays in an abusive relationship, the harder it becomes to leave and re-establish a normal life. Some women carry the scars of physical, sexual and emotional abuse into the future. Anecdotally, around 50% of women who leave a relationship will return to that relationship. Many enter another abusive relationship. Few will truly recover from the experience. As reflected in the Women's Safety Survey[4] and Personal Safety Survey,[26] many women fear their partners, even when they have managed to leave.

Conclusion

General practitioners are often the only health professional seeing the victim, the perpetrator and the children, which can create difficulties for doctors. The major principles of management remain safety and confidentiality within legal limits (see *Chapter 4* and *Chapter 12*).

Resources

Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians. This guide outlines information relating to management of the whole family. Developed by an international group, it explores the evidence surrounding identification and management of those experiencing intimate partner abuse. Available at www.racgp.org.au/guidelines/intimatepartnerabuse.

Organisation	Telephone	Website
National		
Lifeline	13 11 14	www.lifeline.org.au
Australian Capital Territory		
Domestic Violence Crisis Service	02 6280 0900	www.dvcs.org.au
Canberra Rape Crisis Centre	02 6247 2525	
New South Wales		
Domestic Violence Line	1800 656 463	www.community.nsw.gov.au/
Domestic Violence Advocacy Service	1800 810 784 02 9637 3741	www.dvas.org.au
Rape Crisis Centre	02 9819 6565 1800 424 017	www.nswrapecrisis.com.au
Dympna House	1800 654 119 02 9797 6733	
Northern Territory		
Domestic Violence Counselling Service	Darwin 08 8945 6200 Alice Springs 08 8952 6048	
Crisis Line	1800 019 116	
Sexual Assault Referral Centre	08 8922 7156	www.nt.gov.au
Women's Information Centre	Alice Springs 08 8951 5880	
Dawn House	08 8945 1388	
Ruby Gaea House	08 8945 0155	
Queensland		
dvconnect womensline	1800 811 811	www.dvconnect.org.au
dvconnect mensline	1800 600 636	www.dvconnect.org.au
Brisbane Domestic Violence Advocacy Service	07 3217 2544	www.dvrc.org.au/advocacy-service.html
Statewide Sexual Assault Helpline	1800 010 120	www.health.qld.gov.au
Zig Zag Young Women's Resource	07 3843 1823	www.zigzag.org.au
South Australia		
Domestic Violence Helpline	1800 800 098	www.ucwadel.org.au/domesticviolence/
Domestic Violence Crisis Service	1300 782 200	
Crisis Care	131 611	
Women's Information Service of South Australia	08 8303 0590 1800 188 158	www.wis.sa.gov.au
Tasmania		
Domestic Violence Crisis Service	03 6233 2529 1800 633 937 (north) 1800 608 122 (statewide)	
SHE (Support, Help & Empowerment)	03 6278 9090	www.she.org.au
Yemaya: Women's Support Service (Launceston)	03 6334 0305	
Victoria		
Women's Domestic Violence Crisis Service of Victoria (24 hour crisis support)	03 9373 0123 1800 015 188	
Centre Against Sexual Assault	1800 806292	www.casa.org.au/
Women's Information and Referral Exchange	1300 134 130	www.wire.org.au
Immigrant Women's Domestic Violence Service	03 9898 3145	www.iwdvs.org.au
Action Centre	03 9654 4766 1800 013 952	www.fpv.org.au/1_5_5.html
Domestic Violence and Incest Resource Centre	03 9486 9866	www.dvirc.org.au
Western Australia		
Women's Council for Domestic & Family Violence Services WA	08 9420 7264	www.womenscouncil.com.au
Women's Domestic Violence Helpline	08 9223 1188 1800 007 339	
Crisis Care Unit	08 9325 1111 1800 199 008	
Men's Domestic Violence Helpline	08 9223 1199 1800 000 599	
Women's Council for Domestic and Family Violence Services	08 9420 7264	

Case study

This story started in the mid 1980s as I was preparing to study an Arts degree. My husband at first encouraged this, but after marriage he decided it was unnecessary for me to study. The first physical violence occurred within 6 months of the marriage, around the issue of my studying. I was shocked and confused when he first hit me. I didn't tell anyone. I went to the doctor because I was tired and unwell and he prescribed antidepressants.

My husband was very critical of my using antidepressants and insisted that I cancel my driver's licence and stopped me spending time with family and friends.

We moved away from Sydney and bought an old house, which I was primarily responsible for renovating. My health became worse, I became more isolated. I had arranged a visit to Europe, which my husband did everything in his power to prevent. It was a time when I could reflect on my life, my health improved and I met a family who were very supportive. They recognised that things were not right and encouraged me to talk. Meanwhile, my husband was demanding my return and achieved this by reporting my Visa card stolen. It was cancelled and I had no access to funds.

I arrived home with not a friend anywhere. My husband had turned my family and friends against me. He insisted I write to my friends overseas and cut off contact. They were alerted by this and wrote to my family. My husband continued to abuse me, ranting that I was selfish and ungrateful. He accused me of being lazy and careless and criticised everything I did. He also accused me of having affairs. He kept knives in his bedside table and I was totally intimidated. I couldn't sleep at night – I only slept 2–3 hours a day when he was out of the house. I lost weight and started smoking.

The letter to my family alerted them and I was able to explain things to my parents and break my husband's hold on them. I began to see a counsellor, Karen, who would prove to be very helpful to me.

Why didn't I leave earlier?

The only way for women to leave domestic violence is to leave the house. When people say: 'Why don't you leave?' I ask them how would they feel if tomorrow morning they were to walk out of their home, leaving everything behind and in the evening they would not come back or the next night or ever again. Just leave everything behind and try to find a new life.

To walk out into the unknown is very hard for someone who has lost all confidence and belief in themselves. It's hard to believe you can manage alone. Also, there is the terrible fear of the husband and what may happen if he catches up with you. Some women not only have to leave, but also have to go far away to be safe. I had to go to Darwin. The logistics can be very daunting.

I was slowly helped, so that I was able to go to a solicitor for advice, make a plan to leave, go to a distant place for safety and arrange for an AVO.

This is only a very small part of the story as it has involved divorce, trying through the Family Court to get a settlement and slowly, very slowly, rebuilding my life. The most difficult times were going to court for the AVO (I could not have done this without a court support worker), and the meetings at the Family Court where they tried to force me to be in the same room with my husband. (Karen insisted that we be kept separate as there was an AVO and it was not possible for any negotiations with my husband.) It is as if my husband has been able to continue his abuse through the court system.

Why have I told my story?

I do it in the hope that it will enable you to understand what may be going on behind closed doors; why it is so hard to leave; how intimidated and exhausted one can become; how leaving needs to be planned and carefully done; and how leaving is only the beginning of much more that needs to be organised.

I appreciate the support I have had from my counsellor, family and doctors. I hope to prevent this happening to other women.

04 Perpetrators, children and the nonabusive parent

Key messages

- Perpetrators are not a homogenous group; they come from all socioeconomic, cultural and social groups and can be classified into different types.
- While some perpetrators are depressed and may have substance abuse problems, relatively few have serious mental illness.
- Children and adolescents living with abuse and violence in the home exhibit a range of symptoms.
- Parenting support for nonabusive parents is an important issue.
- Confidentiality and safety are paramount for all family members, particularly for the victim.

Introduction

While it is important to focus on the victims of abuse and violence, it is equally important to acknowledge the entire family when considering care. General practice, unlike other health services, may come into contact with the victim, the perpetrator and/or the children. It is not possible for one general practitioner to counsel both the victim and the perpetrator. This may be managed within the practice or by referral to another agency. Doctors in rural areas may find this particularly difficult.

TIP

Doctors in small rural towns may need to refer patients to services in neighbouring towns where available. This can help to protect your patient's safety and/or confidentiality.

Intimate partner abuse affects all members of the family. Most perpetrators of intimate partner abuse will be men, but it is also possible for women to be the abuser.

Men who abuse their partners

Perpetrators of intimate partner abuse come from all social, cultural and religious backgrounds. One of the main problems in acknowledging the extent of abuse and violence is the fact that there is no distinguishing characteristic of a man who will be violent toward their partner.

Research also shows that perpetrators present to general practice for health care needs and may be presenting more often than nonabusive men. This can include a range of issues from injuries to anxiety and depression. They can also have low self esteem as an outcome of the abuse and violence.[36]

In order to understand why particular men become perpetrators, it is important to understand that there are larger community and societal issues (norms, expectations) that create a complex framework in which perpetrators operate (*Figure 4*). Personal, situational and sociocultural factors all play a part in shaping perpetrators; so it is important for GPs to view a clinical intervention as only one tool in a wider response. Legislation, policing, social sanctions and community attitudes are also critical to ending the violence.[19]

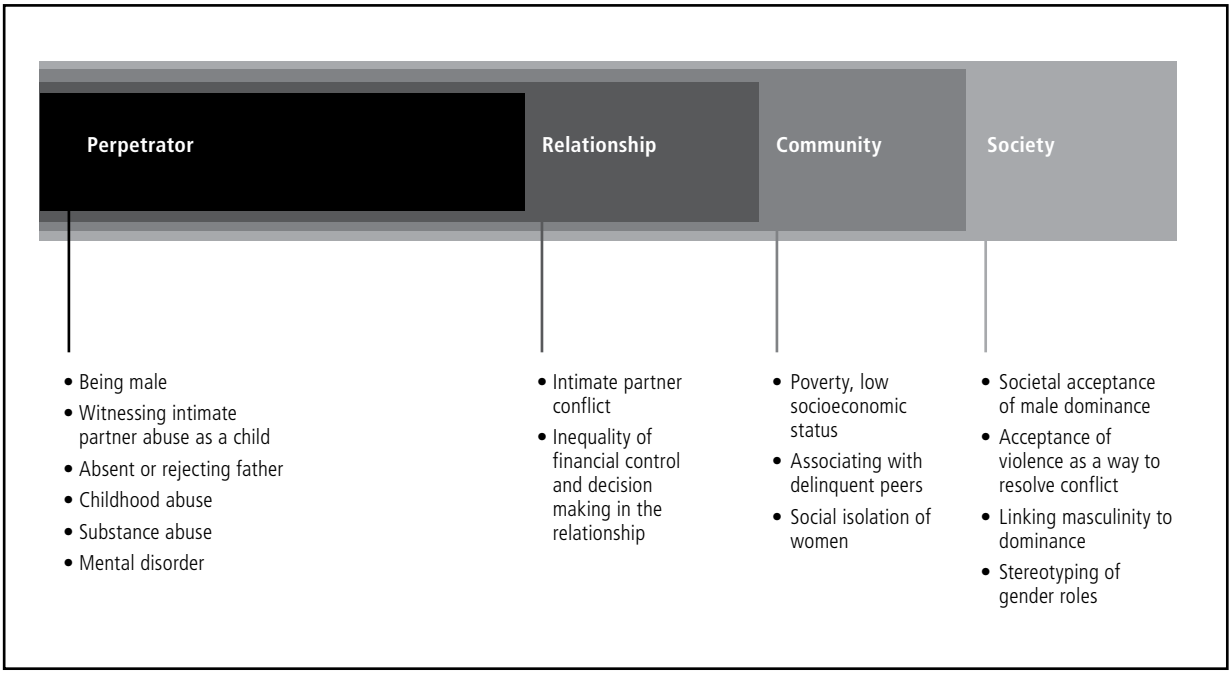


Figure 4. Factors associated with intimate partner abuse[37]

Figure 4 outlines other factors that have been linked to intimate partner abuse such as mental disorders[38] and substance abuse.[39,40] These have also been correlated with more significant risk of injury to the victim.[41,42]

It is extremely important to qualify here, that while some of the factors outlined above may be risk factors for intimate partner abuse, they are not causal. It cannot be assumed that perpetrators are mentally ill and/or substance abusers. Profiling the characteristics of perpetrators is a new field of research.

Due to the heterogeneity of perpetrators, they may require different forms of management. Recent research has suggested that perpetrators can be divided into three types of offender:[43]

- The family only group – who predominantly engage in abuse within the family. Acts of abuse within this group are generally lower in severity, but not necessarily frequency. This group also engages in the least criminal behaviour of all three groups. They have developed a pattern of escalating tension leading to aggression toward their partner, followed by a period of regret
- The borderline dysphoric group – whose violence is moderate to severe, who are violent outside the family, psychologically distressed with some borderline personality characteristics, and may have problems with substance abuse
- The generally violent antisocial group – who are moderately to severely violent against partners and with the most extra-familial violence and criminal behaviour. This group is more likely to have antisocial personality and substance abuse problems. Perpetrators who come under this category can be dangerous, and GPs should not engage in attempting to manage the violence of this type of perpetrator.

TIP

GPs should not engage in attempting to manage the violence of the generally violent antisocial group. This type of violence is best managed by the police and the legal system.

Prevalence

In research conducted with perpetrators self reporting mechanisms are often used. This has led to fundamental issues of underreporting;[44] with the most consistent evidence coming from reports by victims. These figures place prevalence rates of perpetration of violence at 20–25% of the general population.[1]

Types of presentations in general practice

The GP needs to be aware that any patient within their practice may be a perpetrator. However, many of these patients are reluctant, unwilling or unable to identify themselves as being perpetrators of intimate partner abuse.[45]

While not all those who have mental health issues or substance abuse problems will display abusive tendencies, GPs need an index of suspicion of the possibility of abuse among this cohort.

While there are links with mental illness and substance abuse, it is important for GPs to not over pathologise the perpetrator. Abandoning generalisations and negative attitudes, along with being open to providing support to perpetrators, is important in providing successful treatment.[46]

Management

Immediate safety of the victims (ie. the partner and any children) should be the predominant concern when a perpetrator is identified. Management objectives also include:

- taking a history – especially suicidiality, substance abuse, mental health, weapon ownership
- reinforcing that abuse and violence are not okay – condemn the actions, not the person
- encouraging ownership – help the perpetrator take responsibility and encourage active change.

General practitioners often find broaching the subject of violence with perpetrators difficult for a number of reasons including:

- trouble viewing the patient as violent
- damaging the patient/doctor relationship for ongoing care
- being at risk from added stress[47]
- invading the patient's privacy
- managing confidentiality and privacy issues when managing the entire family.

Remember, addressing the issue may help reduce risk for other members of the family.

Broaching the subject of abuse with perpetrators is possible with the use of funnelling questions.[45,48] This requires starting with a broad subject and becoming more specific. The efficacy of these queries is increased if the GP asks the questions in a caring, rather than accusatory, tone. Initial questions may include:[45]

- How are things at home?
- Have you or your partner ever been injured?

Then, after you have established some trust you may wish to move onto more specific questions, such as:

- What do you do when you get angry?
- How do your children react when you get angry?

Keep in mind the stages of change model (see *Chapter 14*) and try to identify the most appropriate time to refer to an adequate program. This may be a specific behaviour change group for perpetrators run by an accredited agency (also providing support for the victim), drug/alcohol rehabilitation or mental health specialist. Check your local area for counselling and accredited groups available to perpetrators and record this information in *Appendix 4*.

TIP

Many experts have noted that couple/family counselling is not appropriate until the abusive behaviour has ceased[45] as it is not possible to provide couple/family counselling where there is such a power imbalance.

Note that providing the perpetrator with a referral is not the end of your involvement. Supporting the perpetrator's change and monitoring the safety of the family is an important, and ongoing task. If the GP is seeing both the victim and the perpetrator for medical care (not counselling), it is important for the GP to check with the victim as to how they perceive the perpetrator is progressing.

A resource for GPs managing these issues 'Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians' can be found in the resources list.

Children involved in intimate partner abuse

Children may be in the position of 'witnessing' intimate partner abuse. However, even if the child has not seen or heard the abuse, you cannot assume that they are not aware of it. Children may be exposed to their abused parent's distress, injuries, depression, or police involvement. Many children survive without harm because of a secure attachment to a nonviolent parent or other significant carer. However, it is important for GPs to be aware that exposure to any intimate partner abuse can be harmful to a child.[19]

Evidence suggests that the effects on children who are exposed to intimate partner abuse are similar to behavioural and developmental problems of those who have experienced direct abuse.[49,50]

TIP

Patients involved in intimate partner abuse often deny their children know about it or are affected by it.

Prevalence

Statistics of children exposed to abuse are usually under-reported. Australian Bureau of Statistics data from women's experiences of abuse shows:[4]

- 61% of women who experienced violence at the hands of their current partner reported having children in their care
- 38% of women who experienced violence at the hands of their current partner reported that the children had witnessed the violence
- of those women who experienced violence in a previous relationship, 68% had children in their care
- of those women who experienced violence in a previous relationship, 46% reported that the children had witnessed the violence.

One woman said:

'My son is only 2 years old and he has seen his father bashing me on many occasions. I'm sure it was just as painful for him as it was for me. He'd scream. I didn't know what was going through his little head, but I'm sure he knew it was wrong. Maybe it was fear, I just don't know'.

Another said:

'The kids just sat there like statues and I prayed: "Don't scream or he'll hit you too".'

Types of presentations in general practice

Children experiencing exposure to intimate partner abuse may have behavioural, emotional and social competence issues, developmental or mental health problems.

Children engaging in 'over rehearsed' or 'overly competent' behaviours may also live in abusive households. This type of 'perfect' behaviour in certain situations (eg. being perfectly quiet so as not to anger the abuser) may be a sign of trying to halt or lessen abusive episodes. Indications of exposure to intimate partner abuse generally change with age as outlined below.[19]

Infants and young children

- Growth and developmental problems (eg. growth retardation, failure to thrive, developmental delay)
- Irritability, disruption to sleeping or eating behaviours
- Disrupted attachment, separation anxiety
- Evidence of fear or terror (eg. screaming, stuttering, hiding).

School aged children

- Aggressive behaviour and language
- Acting out or delinquent behaviours (eg. cruelty to animals)
- Attention deficit hyperactivity disorder
- Anxious, withdrawn or hypervigilant behaviour
- Depression, negative self concept
- Learning problems or disability
- Bedwetting, psychosomatic problems.

Adolescents and young adults

- School failure or refusal
- Running away, homelessness, substance abuse, delinquent or antisocial behaviours
- Anxiety or depression, self harming or suicidal behaviours
- Being protective of parent and/or younger siblings
- Child-parental violence.

Long term effects

Research suggests that children exposed to intimate partner abuse may retain adverse effects in their adult life. These effects include:[19]

- Aggression
- Depression
- Trauma related symptoms
- Low self esteem
- Victimisation or perpetration of intimate partner abuse.

Management

Management of children exposed to intimate partner abuse is difficult as there may be no direct disclosure or injury that alerts you to what is happening at home. Consultations will usually be conducted with the child's parents, either perpetrator or, more commonly, victim.

Broaching the subject in this situation is difficult and will generally require a trusting relationship between the doctor and the parent. Using broad questions and grounding intimate partner abuse as a normative topic for discussion when relating to childhood development could be used to approach the subject. General practitioners may also want to educate the attending parent about the effects that intimate partner abuse in the home can have on children. This may encourage the parent to take action.

Once the subject is successfully introduced, open discussion about the experiences of the child needs to be promoted. Safety issues for both the child and the adult are paramount and a management plan may follow. Children who have been exposed to intimate partner abuse may benefit from individual or group therapy once they are in a safe and stable situation. Groups aimed specifically at children exposed to violence do exist; explore your local services to see if any exist in your area. Mandatory reporting must be adhered to where required (see *Chapter 5* and *Chapter 11*).

The nonabusive parent

The cumulative impact of abuse can increase health damage to children and young people, but such damage is not inevitable. The role played by the nonabusive parent is important as it may enable the child/children to survive without harm. A number of studies have found that children report that their mothers are a significant source of support.[51]

However, being abused may also directly affect the victim's ability to care for their children in several ways such as:

- being rendered less effective through tranquilising medication
- constantly 'walking on eggshells' to avoid violence
- depression
- unable to keep themselves or the children safe
- being more likely to abuse the children themselves
- children being more difficult to manage
- any older children becoming abusive to the nonabusive parent.

We need to be cognisant of the fact that lack of confidentiality of the disclosure, referral for joint counselling and medicating the victim is not the way to deal with intimate partner abuse.

However, offering the following support could be helpful:

- believing the story being told by the nonabusive parent
- addressing safety issues
- maintaining confidentiality within the parameters of the law (eg. mandatory reporting of child abuse)
- providing information and links to community services (eg. police, legal services, intimate partner abuse services)
- making the parent aware of the connection between intimate partner abuse and their children's behaviour, health and wellbeing.

Resources

- Guidelines for doctors on identifying and helping their patients who batter – discusses the identification of perpetrators in general practice. Available at www.amwa-doc.org/index.cfm?objectid=5CDDAE24–D567–0B25–5119B0D21D103D02
- Identifying and responding to family violence – produced by the Victorian Community Council Against Violence. Provides information for GPs. Available at www.dvirc.org.au/TrainingHub/GPsKit.htm
- Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians – outlines information relating to management of the entire family. Developed by an international group, this document explores the evidence surrounding identification and management of those experiencing intimate partner abuse. Available at www.racgp.org.au/guidelines/intimatepartnerabuse
- Intimate partner abuse and health professionals: New approaches to domestic violence by Roberts G, Hegarty KL, Feder G, editors. London. Churchill Livingstone Elsevier, 2006 – provides an overview of the literature in abuse and violence in primary health care. Explores the prevalence and barriers faced by health professionals addressing abuse and violence
- Health impact of domestic violence – explores the health impacts felt by perpetrators of abuse and violence. Available at www.btinternet.com/~Negativecharisma/dv/gerlock.pdf.

Perpetrator support	Telephone	Website
National		
Relationships Australia	1300 364 277	www.relationships.com.au
Mensline Australia	1300 789 978	www.menslineaus.org.au/
Child Abuse Prevention Service	1800 688 009	www.childabuseprevention.com.au/
Australian Capital Territory		
Men's Centre	02 6230 6999	www.menscentre.com.au/
Domestic Violence Crisis Service	02 6280 0900	www.dvcs.org.au/
New South Wales		
Relationships Australia	02 9635 9311	www.relationships.com.au
Northern Territory		
Crisis Line	1800 019 116	www.crisisline.org.au
Queensland		
dvconnect mensline	1800 600 636	www.dvconnect.org.au
South Australia		
Domestic Violence Helpline	1800 800 098	www.ucwadel.org.au/domesticviolence/
Tasmania		
Centacare	03 6278 1660	www.hobart.catholic.org.au/centacare.html#wel
Victoria		
Men's Referral Service	03 9428 2899 1800 065 973	www.ntv.net.au/ntv_two.htm
Western Australia		
Men's Domestic Violence Helpline	08 9223 1199 1800 000 599	
MensTime	1800 812 511	www.menstime.com.au/
Children's support	**Telephone**	**Website**
National		
Kids Help Line	1800 551 800	www.kidshelp.com.au
Australian Childhood Foundation	1800 176 453	www.childhood.org.au www.stopchildabuse.com.au
The Child Abuse Prevention Service	1800 688 009	www.childabuseprevention.com.au/
Australian Capital Territory		
Family Services (protection of children from abuse)	02 6207 1069 (northern) 02 6207 1466 (southern)	www.dhcs.act.gov.au/
New South Wales		
DoCS Helpline	132 111	
Northern Territory		
Dawn House	08 8945 1388	
Family & Children's Services (child protection)	1800 700 250	www.health.nt.gov.au
Queensland		
Child Protection Crisis Care, Department of Child Safety	1800 811 810 1800 177 135	www.childsafety.qld.gov.au
South Australia		
Family & Youth Services (child abuse report line)	131 478	
Tasmania		
Child Protection Advice & Referral Service, Child and Family Services	1300 737 639	
Victoria		
Child Protection Crisis Line	131 278	
Action Centre	03 9654 4766 1800 013 952	www.fpv.org.au/1_5_5.html
Western Australia		
Child Protection	08 9223 1111 1800 199008	http://community.wa.gov.au/

Case study – Gabby

Gabby married her husband Nick after a long relationship and shortly thereafter moved to her husband's family farm. The couple were happy at the farm and soon had their first child. During the pregnancy Nick's behaviour began to change and by the time their daughter was born the relationship did not 'feel' as it had before.

Nick's behaviour became threatening and controlling, especially in relation to money and social contact. He was increasingly aggressive in arguments and would often shout and throw objects around the room. Gabby thought that because he wasn't physically hurting her, his behaviour did not constitute abuse. Nick did not show much interest in their daughter, Jane, except when in public, where he would appear to be a doting and loving father.

Jane was generally a well behaved child, however, Gabby found that she was unable to leave her with anyone else. Jane would cry and become visibly distressed when Gabby handed her to someone else to be nursed. This was stressful for Gabby and also meant that her social activities were further limited.

Jane took a long time to crawl, walk and begin talking. Her sleeping patterns were interrupted and Gabby did not often sleep through the night, even when Jane was over 12 months of age. When Jane did begin to talk, she developed a stutter and this further impeded her speech development. Gabby worried about Jane a lot. Their family doctor told her that this was normal for some children and if the speech problems persisted, that she could always send Jane to a specialist at a later date.

After a number of years, Nick's behaviour became unacceptable to Gabby. During arguments he had taken to holding the rifle that he had for farming purposes, and Gabby found this very threatening. On a number of occasions, items that Nick threw hit Gabby and she was increasingly afraid for their daughter. Gabby decided to leave.

Once Gabby had taken Jane away from Nick her behaviour changed. Jane's development seemed to speed up and Gabby couldn't understand why. As part of her counselling at a local women's service she discussed this issue and her counsellor recognised the developmental delay, stutter, irritation and separation anxiety as effects of Jane's having lived in an abusive situation.

Child abuse 05

Key messages

- Most child abuse is perpetrated by someone within the family, or by a person known to the child.
- General practitioners need to be aware of their legal obligations under the mandatory reporting requirements in their state or territory when they suspect child abuse may be occurring.
- General practitioners need to be aware of services that help to prevent child abuse, and to refer families at risk to the appropriate services.

Introduction

Child abuse refers to any physical, emotional, and/or sexual abuse, and/or neglect of a child. Within this definition there are a wide range of behaviours. These may include:

- **physical abuse** – shaking (especially a baby), hitting, grabbing, slapping or threatening a child physically
- **emotional abuse** – threatening, yelling, taunting, debasing (eg. 'you're worthless', 'you're dumb', 'no-one likes you')
- **sexual abuse** – touching a child inappropriately, exposure to pornography, an adult exposing themselves to the child, sexual intercourse or other sexual activity
- **neglect** – not allowing the child adequate access to health care, education, social activities, food, shelter and/or clothing.

Child abuse is a significant issue for all of society, and specifically for services such as the police, education, child protection services and health systems. It is an important issue facing general practitioners as they care for children and their families.

Child abuse is an issue that is grappled with internationally, with a number of treaties and agreements attempting to set the world standard in dealing with this difficult topic. (See *Resources* for more information on the Convention on the Rights of the Child.) In Australia, the Northern Territory Government report, 'Ampe akelyernemane meke mekarle – Little children are sacred' outlines the changes that the enquiry identified needed to be made to protect children in the Northern Territory. It has implications for all Australian children (see *Resources*).

Prevalence

In 2006–2007 there were 58 563 substantiated reports of child neglect and abuse made to Australian state and territory community services departments.[52] These reports involved children aged less than 1 year to 17 years of age.

The highest proportion of hospital admissions due to neglect or abuse are for children under 4 years of age.[53] Between 1999–2001, 17 children in Australia died from neglect, abandonment or other maltreatment syndromes.[53] There are no recently published statistics for hospitalisation due to abuse.

Research on child abuse in Australia also indicates that both reporting and substantiation rates are higher in younger children (*Figure 5*).[53] This could be an indication of the age at which more children are abused, or may indicate when this abuse is more likely to be reported.

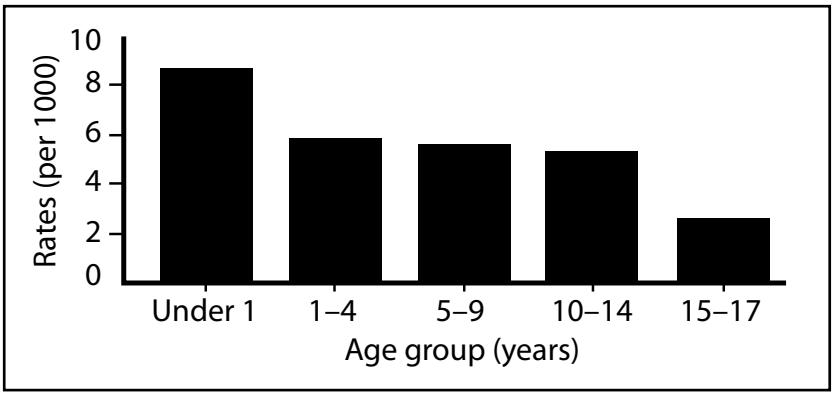


Figure 5. Children with substantiated abuse (rates per 1000 children, 2001–2002)

Types of presentations in general practice

All people, including GPs, function from the perspective that children are wanted and cared for within their families. When considering the possibility of child abuse, that belief is challenged. It is important for GPs to remain aware of the possibility of abuse when caring for children in their practice.

Some children may present with bruising or injuries that raise suspicion. Within a consultation it can be very difficult to know definitively that the root cause of the presentation is abuse or neglect. The family may also be actively trying to hide the abuse or neglect.

Child abuse can present in myriad ways and these effects vary from child to child. Some of the physical and behavioural effects outlined below could be due to child abuse.[54]

Possible effects of physical abuse:[55]

- bruising, sprains, dislocations, cuts
- broken bones, especially at ages when this does not generally occur (eg. in infants)
- burns (eg. cigarette burns)
- brain damage (eg. from shaking a baby)
- anxiety or low self esteem
- being overly friendly or overly wary of strangers
- fear of returning home or being around parents.

Possible effects of emotional abuse:

- difficulty making friends or relating to peers and adults
- difficult or demanding behaviour
- being withdrawn or passive
- low self esteem
- being anxious, tense and worried
- developmental delays (eg. walking, speech)
- bedwetting behaviours at an inappropriate age.

Possible effects of neglect:

- malnutrition or poor weight gain
- poor health, infrequent visits to the doctor
- missing school or alternatively staying at school after hours
- physical or intellectual developmental delay
- dressed inappropriately for the weather

- child, or their clothes, dirty and unwashed
- child left alone for long periods of time
- stealing food
- drug taking behaviours.

Possible effects of sexual abuse:

- headaches or stomach pains
- sexual behaviour or knowledge too advanced for a child's age
- sudden avoidance of familiar adults or places
- fear of having nappy changed or being bathed
- difficulty in trusting others or relating to peers
- confusion about sexual identity (ie. if the abuser was the same gender)
- abuse of alcohol, food or drugs
- depression or suicidiality
- sexually transmitted infections (STIs), genital or urinary infections, pregnancy.

Sexual abuse

Sexual abuse can remain undisclosed by the child. The perpetrator is likely to have 'groomed' or threatened them, which makes it difficult for them to reveal the abuse. Younger children may not be able to identify what is happening to them as abuse. Some older children think that what is happening to them happens to everyone, as they may have little contact with other families in order to make a comparison.

In identifying sexual abuse, the GP must remember the underlying thread of 'lack of consent'. The child or young person may be forced to participate or cannot properly judge what their participation means. The display of pornography, or an adult exposing themselves to a child is considered abuse, despite the fact that this act may not contain any physical contact with the perpetrator.

TIP

Children living in families where intimate partner abuse occurs are considered to be victims of child abuse, whether directly or indirectly abused. Therefore the GP needs to ensure where possible, that the child or children and the nonabusive parent are in a safe environment. This may not be easy to achieve (see *Chapter 4*).

Management

General practitioners can work on managing issues related to child abuse at two levels:

- prevention – a GP may identify environments in which it could be possible for child abuse to occur and offer preventive support and referral, and
- identification – a GP may identify child abuse that they suspect is already occurring.

Preventive measures and identifying families at risk

Family situations change over time and GPs are often aware of these changes and the potential stress that it places on families. Because of this awareness, GPs are well placed to monitor families for a potential situation that may give rise to child abuse. These situations may include family break up, work stress, additions to the family, or moving location. Families in these situations may benefit from support and other preventive measures.

As the highest incidence of abuse and neglect happens in the first year of life,[53] families with infants and toddlers may require specific attention and support. For children in this age group GPs may want to consider preventive action such referral to support services such as early

childhood services. This may help break down the isolation that is often felt in families with younger children. The provision of information in the practice waiting room (eg. posters, brochures, books) could be helpful, and identify that the practice is willing to talk about such issues (see *Resources*).

Research on adequate prevention techniques and coping mechanisms for children and their families is relatively scarce. Cochrane data on prevention of sexual abuse programs for school children displayed an increase in knowledge and protective behaviours, but it was inconclusive as to the effects of anxiety in the children participating.[56] Another meta-analysis of 40 family support prevention programs for those with children at risk of physical abuse and/or neglect displayed similar positive, yet modest results.[57] This analysis displayed reduction in manifestation of abuse, along with an increase of positive risk reducing behaviours such as parent-child interaction.

These studies show that prevention of child abuse or neglect can give positive results. Local services are useful to identify and have on hand to refer patients to. (Enter details on the local directory template, *Appendix 4*.)

Identifying suspected child abuse

This is a very sensitive issue in general practice consultations for a number of reasons:

- children do have accidents, and frequently have bruising on their bodies
- children often attend with other family members (eg. parents)
- children may present for a reason unrelated to abuse, but you may suspect abuse for other reasons.

Where the GP is unsure if abuse is taking place, but concerned about a child or their family, they may need to seek external assistance from an appropriate service which safeguards the GP or assists if the GP is troubled by doubts as to whether the relevant circumstances call for mandatory reporting. In some Australian states there are resources that may be accessed by the person abused, or by the GP (see *Resources*).

Advice from an experienced colleague or child abuse service can also be helpful and this sharing of information may resolve the dilemma in circumstances of doubt. Provided there is no disclosure of patient identity, there is no impediment to seeking assistance, in confidence, without patient consent. Where the child is at risk, mandatory reporting is required as a matter of law.

Mandatory reporting

In some circumstances you may have a responsibility to report child abuse or neglect to the authority in your state or territory. The laws are different in every state and territory and it is advisable that you speak with your medical defence organisation for help and advice. See *Table 7* on mandatory reporting for further general information.

The family, or the child's needs, may require services additional to medical assistance such as counselling or family services, or they might be managed appropriately in another way. Mandatory reporting does not affect the GP's continuing professional obligation to the patient.

Table 7. Mandatory reporting requirements in each Australian state and territory

State/ territory	Are doctors mandated?	For children under	What is to be notified?	Legislation
Australian Capital Territory	Yes	18 years	A reasonable suspicion that a child or young person has suffered or is suffering sexual abuse or nonaccidental physical injury Criminal sanctions for failure to report. Criminal sanctions if report made other than in good faith. Six months gaol sentence	*Children and Young People Act*, 1999 Section 159 www.legislation.act.gov.au
New South Wales[58]	Yes	16 years	Current concerns that a child aged under 16 years is at risk of harm. This includes: • basic physical or psychological needs not being met or are at risk of not being met • necessary medical care not being met • physical or sexual abuse (or risk thereof) or ill treatment (or risk thereof) • exposure to domestic violence in their home and, as a consequence, the child or young person being at risk of serious physical or psychological harm • caregiver behaviour causing, or potentially causing, serious psychological harm • child was the subject of a pre-natal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report – criminal sanctions – fine – protection for informant – yes. Identity cannot be disclosed without consent of person making report	*Children and Young Persons (Care and Protection) Act,* 1998 Section 23 through 27 www.legislation.nsw.gov.au/
Northen Territory	Yes	18 years	• Reasonable grounds to believe that a child has suffered or is suffering maltreatment – criminal sanctions – fine – protection for informant – yes	*Community Welfare Act*, 1983 Section 14 www.nt.gov.au/dcm/legislation/current.html
Queensland	Yes		• Aware of or reasonably suspects a child has, is, or is likely to suffer harm	*Child Protection Act,* 1999
South Australia	Yes		• Reasonable grounds that a child has been or is being abused or neglected – carries criminal penalty	*Children's Protection Act,* 1993 Section 12
Tasmania	Yes		• Suspicion of knowledge of abuse or neglect • Reasonable grounds to believe or suspect that a child is suffering, has suffered or is likely to suffer abuse or neglect. Current reforms include exposure to domestic violence – carries criminal penalty	*Children, Young Persons and Their Families Act,* 1997 Section 14
Victoria[59]	Yes	17 years	• Reasonable grounds that physical injury or sexual abuse is occurring	*Children, Youth and Families Act,* 2005 Section 181 through 186 www.legislation.vic.gov.au/
Western Australia	No		• Mandatory reporting is the subject of a Bill to amend existing legislation to bring WA in line with other states. At the time of publication this has not occurred	• *Child Welfare Act,* 1947 • *Community Services Act,* 1972

Note: The GP has a statutory obligation in all Australian states and territories, other than Western Australia, to report suspected abuse. Failure to do so is a criminal offence. The extent to which doctors are protected from identification is not uniform in each state and territory

Organisation	Telephone	Website
National		
Australian Institute of Family Studies provides contact telephone numbers for each state and territory to report incidences of child abuse		www.aifs.gov.au
Australian Capital Territory		
Mandated reporters	1300 556 728	
General public	1300 556 729	
Crisis service	1300 556 729	
Office for Children, Youth and Family Support	133 427	www.dhcs.act.gov.au/ocyfs/
New South Wales		
Department of Community Services	132 111 (24 hours)	www.community.nsw.gov.au
	02 9716 2222	
Northern Territory		
Department of Health and Community Services	1800 700 250 (24 hours)	www.crisisline.org.au
	08 89411644	www.health.nt.gov.au/
Queensland		
Departmental Head Office	07 3224 8045	
Crisis care	07 3234 9999	
Rural areas	1800 177 135	
Department of Child Safety	1800 811 810	www.childsafety.qld.gov.au/
Child protection information After hours crisis service	1800 811 810	• www.families.qld.gov.au/childprotection/publications/documents/pdf/cpbill 98 explan.pdg • www.childsafety.qld.gov.au/legislation/child-protection-act-1999.html
South Australia		
Department for Families and Communities	131 478	www.families ad communities.sa.gov.au/
After hours	131 611	
Tasmania		
Child Protection Advice and Referral Service	1300 737 639	
Child Abuse Prevention Service	1800 688 009 (24 hours)	www.dhhs.tas.gov.au/services/view.php?id=657
Commissioner for Children	03 62334520	www.childcomm.tas.gov.au
Victoria		
Child Protection Crisis Service	131 278 (24 hours)	www.ntv.net.au/ntv_two.htm
Department of Human Services Children, Youth and Families		www.office-for-children.vic.gov.au/
Western Australia		
Department for Child Protection		www.community.wa.gov.au/DCP/
To report instances of child abuse: Department Head Office	08 9222 2555 08 9223 1111 (after hours)	
Commonwealth Agency		www.disabilityhotline.org

Resources

- 'Ampe akelyernemane meke mekarle – Little children are sacred' is available at www.nt.gov.au/dcm/inquirysaac/pdf/bipacsa_final_report.pdf
- McCutcheon LK, Chanen AM, Fraser RJ, Dew L, Brewer W. Tips and techniques for engaging and managing the reluctant, resistant or hostile young person. Med J Aust 2007;187(Suppl 7):S64–7
- Never shake a baby – the Children, Youth and Women's Health Service have produced this guide that explains why you shouldn't shake a child and gives alternative methods to quieten a child. Available at www.cyh.com
- Resources are available for families with small children wanting to help them understand 'safe touch'. The book, 'Everyone's got a bottom' by Tess Rowley and illustrated by Jodi Edwards is available from Family Planning Queensland at www.fpq.com.au/pdf/Bottoms. It could also be a good book to consider having in the practice waiting room
- Specific information for children of Aboriginal and Torres Strait Islander descent, and their communities is available. 'Through young black eyes': A handbook to protect children from the impact of family violence and child abuse is available from the Secretariat of National Aboriginal and Islander Child Care at www.snaicc.asn.au
- The Convention on the Rights of the Child is an interesting example of international responses to child abuse. You can read the convention at www.unhchr.ch/html/menu3/b/k2crc.htm.

06 Child bullying

Key messages

- Bullying is a common factor in the life of many Australian school students.
- Extensive research confirms that bullying is physically harmful, socially isolating and psychological damaging.
- General practitioners need to ask young patients about their experience of bullying and be prepared to provide advocacy for effective interventions.

Introduction

Bullying is widely regarded as a particularly destructive form of aggression. It can be defined as a 'physical, verbal or psychological attack or intimidation that is intended to cause fear, distress or harm to the victim'. This occurs where the intimidation involves an imbalance of power in favour of the perpetrator. Typically, there are repeated incidents over a period of time.[60] Cyber bullying is now emerging as a significant new form of bullying as bullies move from 'behind the scenes to behind the screens'.

Bullying is characterised by at least three criteria:[61]

- there is a social interaction between a child or a group of children (the 'bullies') who intentionally cause hurt to another child (the 'victim')
- this relationship is based on an imbalance of power (of a physical, psychological and/or social type) so that the bully is stronger than the victim, or is perceived to be stronger
- this aggressive and imbalanced relationship occurs repeatedly and over time.

A number of longitudinal studies provide strong support that victims of bullying suffer poorer health and wellbeing; and that the effects can last into adulthood.[62–65] Perpetrators of bullying are more likely to demonstrate subsequent antisocial and violent behaviour.[64]

Bullying also can occur in families and is a form of family violence and child abuse.

Prevalence

Australian research based on a sample of 25 000 students from year 1 to year 8 indicates that over 20% of males and 15% of females report being bullied 'once a week or more often'.[66] Up to a quarter of students can be caught up in the bully-victim cycle either as bullies, victims or bystanders. In more recent Australian surveys, 50–61% of students reported being bullied[62,67] and 10% reported regular bullying and are bothered or negatively affected by it.[64] In particular, research highlights that children with special needs are particularly vulnerable to school bullying.[68]

Bullying can have a short and long term impact on the victim. In one study of high school students, self report of victimisation and physical health revealed that students who were most frequently bullied ('once a week or more often') were significantly more likely to suffer poorer health.[69] Another study revealed indications of suicidal ideation and attempts at self harm were significantly associated with self reports and peer reports of school bullying.[66] In a further

longitudinal study of adolescents over 3 years, it was found that students who reported a relatively high incidence of physical health complaints (eg. headaches, stomach aches) had been victimised more frequently by their peers in the first 2 years at school.

Types of presentations in general practice

Acute problems related to bullying include: depression, anxiety, bedwetting, headaches, sleep problems, abdominal pain, poor appetite, vomiting, school phobia/refusal and feelings of tension or tiredness.[63,70] Long term impacts include substance abuse, and psychosocial complaints including substance abuse, depression and anxiety; and a range of psychosomatic problems and psychopathological behaviour.[62,65,71–73]

Children often cover up the fact that they are being bullied and don't tell their parents. Australian research shows that only about one-third of students will tell someone that they are being bullied.[74] They often feel ashamed and embarrassed and fear being singled out for recriminations. Parents often do not recognise the signs of bullying, or simply label it as teasing by another child at school, or by a family member.

Characteristics of children who are being bullied include:[75]

- overly quiet or sensitive
- low self esteem/insecurity
- fear of going to school
- attempted self harm
- deterioration in school performance and/or behaviour
- sense that they 'deserve to be bullied'.[76]

Management

Case finding

The general practitioner needs to ask the child direct questions and to believe the child's story. A range of psychosomatic symptoms are commonly associated with bullying. In a United Kingdom sample of 2962 children age 7–10 years who were interviewed about bullying and symptoms, common associated complaints included:[70]

- headaches
- tummy aches
- feeling sad or very sad
- bed wetting, headaches
- sleeping difficulties.

An Israeli study of 921 teenagers aged 12–15 years showed that more than half the children involved in some form of bullying had behavioural problems in the borderline/clinical range.[77] In victims, look for evidence of anxiety and depression. In perpetrators, conduct disorders, hyperactivity and antisocial personality disorders are relatively common.

Children identified as suffering the effects of bullying may need individual psychological assessment and treatment (see *Case study*).

Family involvement – the role of parents

Resilience to bullying is enhanced by involving caring adults, teaching appropriate cognitive and social skills and the presence of strong social support systems such as whole-of-school programs to deter and deal with bullying.[75,78]

Advocating for the child at school

Over the past 2 decades the steady accumulation of evidence of the prevalence and harmfulness of school bullying has led educators and health professionals to recognise that peer victimisation in schools is a serious problem. General practitioners often see the acute consequences of bullying. As a result, they should strongly encourage the parents of both bullies and victims to contact the school regarding the implementation of school wide antibullying policies.

Case study

The human misery of bullying is strongly conveyed in this clinical story of an 11 year old boy.

As the boy described it: "One thing that happened to me was that I was bashed up at school by one of the kids in my class. This kid kicked me in my legs and body. The teasing and bullying started in the first week of term 1. It started with name calling – 'idiot', 'carrot head', 'freckle face', 'stuff head', 'dickhead', 'loser'. The kids excluded me from groups. If I tried to play basketball with them at school they would tell me to 'get lost'. I hated that so much I spent more and more time in the library."

The boy was finally physically assaulted which resulted in referral to the GP. The GP arranged for the boy to receive psychological counselling. Parental and school involvement in the management of this bullying was also arranged.

Resources

- National Safe Schools Framework – the framework contains a set of nationally agreed principles for a safe and supportive school environment. It includes guidelines to assist schools in addressing issues of bullying. Available at www.dest.gov.au/sectors/school_education/publications_resources/profiles/national_safe_schools_framework.htm
- Bullying No Way – this website provides practical resources for students, caregivers, teachers and health care personnel regarding the issue of school bullying. Available at www.bullyingnoway.com.au/
- Child, adolescent psychological and educational resources – this website provides resources and up-to-date research findings regarding the issue of school bullying for students, caregivers, teachers and researchers. Available at www.caper.com.au
- Prevnet – this Canadian website provides significant information for those concerned about the issue of school bullying. Available at http://prevnet.ca/
- Mental Health Association of NSW – this fact sheet on bullying provides a good and practical advice summary for parents. Available at www.mentalhealth.asn.au/resources/schoolyard_bullying.htm.

Organisation	Telephone	Website
National		
Lifeline	13 11 14	www.lifeline.org.au
Kids Helpline	1800 551 800	www.kidshelpline.com.au

Adult survivors of child abuse 07

Key messages

- Patients abused as children may experience a range of ongoing health problems, including psychological and biological problems.[1]
- Patients abused as children have a greater health care utilisation rate than those who have not been abused.[79]
- Many patients have told no-one about the abuse, nor understand the link between their health issues and the abuse.

Introduction

A landmark national survey conducted in 1992 challenged previously held beliefs that acts of violence were single, discreet events. The survey revealed that those who have suffered violence (either sexual, physical or other) tend to be more susceptible to further acts of violence.[10,80] Furthermore, of the women surveyed, 37% reported that they had never told anyone about their experience.

This chapter explores the presentation of adults in general practice who were abused as children, including physical, emotional and sexual abuse, and neglect. Research suggests that victims abused as children are at increased risk of further abuse as adults.[81] Research has also indicated that adult survivors of childhood abuse (specifically sexual) have fewer available services and interventions available to them.[82]

Any abuse of a child can have long term sequelae and health implications. This can persist into adulthood and affect the presentations of these patients to general practice. General practitioners need appropriate training and education to help them hear and respond appropriately when patients disclose a history of abuse. This will only occur in a relationship of trust. However, this may take some time to develop as an adult abuse survivor's previous experience within relationships is tainted.

To assist with this education, The Royal Australian College of General Practitioners (RACGP) produced 'The hidden factor'. In this DVD, three women tell their stories of abuse in order that doctors and other health professionals can have a better understanding of the factors that helped with the healing process. The DVD is provided with this guideline and is also available from the RACGP (see *Resources*).

Prevalence

In a Victorian survey of women sitting in GPs' waiting rooms, 39% reported an unwanted sexual experience before the age of 16 years.[9] A community survey by Fleming showed 20% of women reported unwanted sexual experience before the age of 16 years.[8] The Women's Health Statewide Service (South Australia) also reviewed literature that revealed 30–40% of women accessing general practice have a history of childhood sexual abuse.[83]

Rates of neglect of both genders, along with physical and emotional abuse in general practice populations, are less researched. However, the Australian Institute of Health and Welfare cites that in 2006–2007 there were 58 563 substantiated notifications of child abuse in Australia.

This figure includes physical, emotional and sexual abuse, and neglect.[84] Given that there is a level of under-reporting that occurs in relation to abuse, this portrays a significant mistreatment of children and young people. It also reveals a significant number of adults who may still be suffering the after effects of the abuse.

The way in which an adult may view their childhood abuse experiences will vary greatly. As such, the needs of each patient will also differ. Anecdotally, it has been suggested that reactions of adult survivors to their abuse may fit anywhere in the spectrum from having no effect or little effect, through to a great or profound effect on the survivor's life. Many elements will factor into how much a survivor is able to cope, including the type of abuse experienced, family life, and adult experiences of abuse and violence.

Types of presentations in general practice

Surviving violence as a child can have a direct bearing on how someone relates to other people as an adult, especially in intimate relationships. It has also been correlated with ongoing health problems.[79] Patients who are survivors of child abuse have been found to have a much higher incidence of:[1]

- chronic depression
- obesity
- chronic gastrointestinal distress
- eating disorders
- psychiatric symptoms
- personality disorders
- chronic psychosomatic symptoms
- drug and alcohol abuse
- suicide attempts
- chronic pain[85]
- self harm.

Major illnesses, including cancer, chronic lung disease, fibromyalgia, irritable bowel syndrome, ischaemic heart disease and liver disease have also been linked to childhood abuse. The increased incidence of smoking is a confounding factor for these diseases.[1,86] Women with a history of child sexual abuse are also more likely to utilise medical care at a greater frequency than women who have not been abused.[79]

Victims may have suffered physical or emotional abuse, or neglect. This can result in low self esteem and difficulties with trust, and impinge on their ability to form close relationships. They may fear for their safety and have difficulties caring for themselves. Asking about family relationships when they were children and the abuse of alcohol by their parents may provide clues.

TIP

Patients who have been abused have a very negative sense of self. This makes it more difficult for them to care for themselves and to follow advice. As GPs we may be able to help by treating these patients with dignity and respect and by helping them to achieve a healthy and safe lifestyle.

Research on survivors of child abuse shows that survivors may experience flashbacks of traumatic events at any time during their adult life. Trigger factors may be:

- marriage
- the birth of a child
- themselves or their child reaching a certain age
- the death of the perpetrator (eg. family member)
- watching a television program relating to incest
- a particular place or smell.

Flashbacks may present as:

- sleep disturbances
- depression
- nightmares
- perceptual disturbances, and
- anxiety at times of sexual activity.

Some victims who have been abused as a child may develop strategies to protect themselves and compartmentalise their lives. Strategies could include psychological mechanisms such as dissociation, or behavioural disturbances such as self harm. In the long term, these strategies might become habituated as part of their personality. Unfortunately, these strategies risk being regarded by clinicians as manipulative or attention seeking. Long term use of ineffective strategies could also contribute to a person's mental and/or psychosomatic ill health.[87]

Management

Adult survivors of child abuse have a number of needs, including:

- to be believed
- to be listened to
- a nonjudgmental attitude from a doctor
- to be supported
- being permitted to accept or decline treatment options (appropriate treatment options need to be agreed on by the patient and may include individual counselling, referral to another service or self help group. It helps to have a list of resources in your area)
- validation of their experience
- safety
- privacy
- to have control (eg. to make their own decisions about when to undergo an examination)
- confidentiality and personal respect
- continued GP involvement (be clear about your role and that of the counsellor/psychologist/psychiatrist who may be seeing the patient on an ongoing basis).

TIP

Abused patients have had their boundaries invaded by violence. As GPs we need to model clear boundaries and be very careful of the patient's physical and emotional space. We need to be cognisant that we can be seen as abusive if we do not take care.

It may be appropriate to use the concept of 'continual consent' if you think a patient may feel uncomfortable. Using this technique, the doctor talks through a procedure, letting the patient know what they are about to do. Throughout the dialogue, the doctor asks the patient if they are comfortable and happy to proceed. This allows the patient the freedom to, at any time, stop the procedure if they are not willing to continue.

Case study – Lucy

Lucy and her two sons had recently moved into the area and begun renting one of the many old houses available. She presented to a GP closest to her new home, and after some obvious prevarication, disclosed that she had been a victim of incest from the age of 7 to 10 years and that 'memories' were beginning to bother her again. Lucy felt that this was because the ceiling in her new home reminded her of the ceiling in the house she lived in as a girl. 'Could I see someone who would help me forget about the ceiling, doctor?'

Further discussion revealed that Lucy had some brief counselling many years ago that she had found disturbing rather than useful. She did not want to see another counsellor about the incest or go to a group therapy session. She just wanted to be able to look at the ceiling with equanimity. The GP referred Lucy to a psychologist who was experienced in behavioural modification and treatment of phobias. The psychologist designed a program for Lucy, which she found useful.

Discussion

You may not agree that this is the answer to the situation, and it may not be the answer for another patient. The most important issue is to hear what patients are telling us, and work with them to find their solutions, not ours!

Case study – Susan

Susan, 21 years of age, presents to your surgery requesting a Pap test. While taking a history, Susan reveals that she is dissatisfied with her sexual relationship; she doesn't enjoy sex, feels uncomfortable and finds it very hard to relax. She asks you if this is normal. Her reason for wanting a Pap test is that she has been talking with her friends about STIs and they seemed to think that regular tests were a good idea. Although she is not sexually active at the moment she says she would feel happier to have a full check up.

On examination, Susan is extremely tense and performing the test is difficult. You stop the examination, coming to the conclusion that to proceed would be detrimental to Susan. Susan is upset and once she is dressed you reflect back to her that the examination was anxiety provoking. She calms down and says that she will come back in a couple of weeks now she knows what is involved. Before she leaves you inquire about any past unpleasant sexual experiences. She repeats that she doesn't enjoy sex but that she can't remember anything of a frightening or threatening nature.

One week later Susan reappears at your surgery saying she has been disturbed since the attempted Pap test. She is having strange dreams and has a feeling something happened when she was younger. After some discussion she says she thinks something happened with her older brother and some of his friends but that the memories are unclear. She is obviously distressed.

Diagnosis

- Sexual dysfunction
- Child sexual abuse

Management

Together you explore the options, ie. counselling (individual or group) and whether she wants to see a counsellor at the local centre or to see you on a weekly basis. You discuss strategies for getting a good night's sleep and you assess her supports by way of friends and relatives. If she were particularly depressed or suicidal, then the option of a local crisis team or psychiatric help could be applicable.

Outcome

Susan opts to go and see a counsellor at the local sexual assault service. As the waiting period is 3 months you offer to see Susan on a weekly basis for support. She agrees to this arrangement. Nine months later she comes to see you for a Pap test. Although Susan is slightly tense, she is able to relax and the examination is performed successfully. Susan is extremely pleased as this indicates she has made progress in her counselling sessions. She thanks you for your involvement.

As a GP you may not always know the outcome. Sometimes you will see patients while they are in counselling. They may be at a difficult time in this process and they may require your encouragement. They may present physical symptoms which need to be explored but may be related to abuse such as a sore throat or gagging related to former oral sex, or pelvic pain related to previous abuse.

Keep in mind that resources will vary from one area to another and it is often difficult to find enough or appropriate resources. Referrals could be to:

- another GP with a special interest in this field
- a psychologist with an interest and training in this field
- a social worker or counsellor
- a sexual assault service (if they are resourced to see patients who have not had a recent sexual assault)
- a psychiatrist with an interest in this field.

TIP

It is important to check with the patient the gender of the therapist they would like to see. Have a plan if the referral does not work out the way you had hoped, giving them clear permission to return to you. It is also important to offer to continue to be their GP while they are undergoing counselling.

Resources

- After abuse – this book, written by Victorian psychiatrist Dr Gita Mammen, outlines types of treatment, is jargon free and may be helpful to GPs trying to find an appropriate referral or seeing patients in a counselling role
- Better Access Initiative – the MBS item relating to the GP Mental Health Care Plans may be useful for patients wanting to initiate ongoing mental health care. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba or the RACGP information relating to the scheme available at www.racgp.org.au/mentalhealth/betteraccess
- The hidden factor DVD is available to order at www.racgp.org.au/publications/orders.

Organisation	Telephone	Website
National		
Advocates for Survivors of Child Abuse	1300 657 380 02 8920 3611	www.asca.org.au
Australian Capital Territory		
Service Assisting Male Survivors of Sexual Assault	02 6262 7377	www.apex.net.au/~samssa/
New South Wales		
NSW Rape Crisis Centre	1800 424 017 02 98196 565 TTY 02 9181 4349	www.nswrapecrisis.com.au
Dympna House	1800 654 119 02 9797 6733 TTY 02 9716 5100	www.dympnahouse.asn.au
Queensland		
Brisbane Rape and Incest Survivors Support Service	1800 242 526 07 3391 0004	www.brissc.com.au/
Tasmania		
Sexual Assault Support Service	03 6231 1811	www.sass.org.au/
Laurel House	03 6334 2740	www.laurelhouse.org.au/
Victoria		
Victorian Centres Against Sexual Assault	1800 806 292	www.casa.org.au/
Western Australia		
Incest Survivor's Association	08 9227 8745	www.isa.asn.au/

Sexual assault 08

Key messages

- Sexual assault is very common, with one in five women having experienced such an assault.[88]
- Many victims do not report sexual assault; therefore the effects, both physical and psychological, may go untreated.
- Particular groups are at greater risk of sexual assault, including young people, those with a disability, and those who have previously experienced abuse.

Introduction

Consent in instances of sexual assault may be negated by many factors, including age, intellectual ability, the use of force or threats, and the use of drugs and/or alcohol. People who have been sexually assaulted report higher rates of adverse health outcomes.[89,90] An act of sexual assault is an act of violence – not a legitimate expression of a person's sexuality.

Sexual assault is a distressing and difficult issue, therefore counselling and a nonjudgmental approach is essential. High quality forensic and medical care is also critical to successful patient outcomes. General practitioners not familiar with forensic care should consult an appropriate sexual assault centre (see *Resources*). In general practice, GPs may not see many acute sexual assault presentations and may more often be involved in follow up or other health issues, such as patients asking for emergency contraception or sexually transmitted infection (STI) checks.

Prevalence

A 2001 Australian survey identified that the prevalence of self reported sexual coercion was 21.1% in women and 4.8% in men;[88] which is similar to rates in many developed countries.[91] Using broad definitions of sexual coercion, the Australian survey found that 2.8% of men and 10.3% of women reported sexual coercion under the age of 16 years.[88,92–94] Only 31.5% of men and 37.9% of women had ever talked to someone about the assault, with the majority talking solely to a friend. A low 2.6% of men and 8.4% of women reported the incident to police. This data provides a small insight into how common sexual coercion is in our society, and how infrequently disclosure is made or legal action instigated.

People at an increased risk of sexual assault

Certain groups of people appear to experience sexual assault more frequently, including:

- young people aged 15–24 years[92–94]
- alcohol users (either consumed by choice or via spiked drink/s)[95]
- illicit drug users (taken by choice or consumed via spiked drinks), including those injecting[96]
- people who have experienced a previous sexual assault[97]

- the homeless[98,99]
- people with a disability (including learning difficulties)[101]
- people in custody[101]
- people living in poverty[96]
- sex industry workers[102]
- people who travel
- people living in an area of war and civil crisis[103]
- people with a history of childhood sexual assault[10,104] (up to one in 3 women who were sexually assaulted as a child report sexual assault as an adult)
- indigenous people.[105,106]

The majority of victims who have been sexually assaulted do not report the incident to the police. They may fear that they will not be believed, or are reluctant to enter a system that will treat them as being responsible for the assault. Reporting of sexual assault is also dependent on the person's previous experience with authority figures. This may also be influenced by cultural issues (see *Chapter 10*).

Types of presentations in general practice

A patient may disclose a sexual assault immediately, or years after the event. Medical consequences of sexual assault can include:

Immediate effects

- Physical
- Unintended pregnancy and STIs
- Psychological.

Sexual assault is extremely damaging to the victim's sense of safety and self esteem. It can result in a range of physical, mental and emotional disturbances.

Rape trauma syndrome (RTS)[107] describes the experience following rape or severe sexual assault and has two phases:

- the acute phase when the person's life is disrupted completely, and
- the long term phase when the person recovers from the rape and reorganises their life.

Long term effects

Recovering from sexual assault can take many years. There are many ways of dealing with the experience. The more common presentations are listed in *Table 8*.

Table 8. Common presentations of sexual assult

• Fear	• Disrupted menstrual cycle
• Self blame/self harm	• Exhaustion
• Guilt	• Gastrointestinal problems
• Anger	• Severe sleep disturbances
• Concern about relationships	• Urinary, genital and pelvic pain
• Shame	• Joint stiffness
• Flashbacks	• Other chronic pain states
• Substance abuse	• Eating disorders, anxiety or depression
• Sexual dysfunction	• Ambivalence regarding legal prosecution
• Suicide or suicidal ideation	• A sense of being damaged or contaminated
• Lack of energy	

Any postassault reactions, such as those outlined, are important to note as nearly one-third of victims will develop rape related post-traumatic stress disorder (PTSD).[108] (See *Appendix 1* for the DSM-IV criteria for PTSD.) Victims are also three times more likely to experience a major depressive disorder compared to those who have not been sexually assaulted.[109]

TIP

For patients who present for emergency contraception or STI check, consider gently enquiring as to whether consensual sex took place.

Disclosure of sexual assault

Disclosure of sexual assault can take the GP by surprise. However, there are a number of strategies that can be used in dealing with a disclosure. Taking victim concerns into account helps to set the scene for the consultation. Previously, it has been noted that these concerns can revolve around issues of confidentiality (especially relatives and friends finding out), issues of blame and medical issues (eg. pregnancy and STIs).

TIP

Sexual assault or other forms of abuse may be a causative factor in patients being treated for depression.

The issue of confidentiality can present ethical issues. It involves balancing the patient's confidentiality and disclosure of a potential risk for the wider community, as the perpetrator may re-offend. General practitioners may be mandated to report the assault of patients under a certain age. Discussion with a colleague, sexual assault service and/or medical defence organisation may help clarify any dilemmas the GP may have in making such a report.

Management

Management will vary depending on when the assault occurred. It is important to listen to the patient, believe their story, and be nonjudgmental and supportive. Management includes:

- being aware of treatment options
- allowing the patient to accept or decline treatment options
- being aware of local resources (eg. sexual assault counsellors, group support)
- contraception, STIs and what needs to be offered now
- forensic examination if a recent assault (needs to be performed by a doctor trained in this field with the correct equipment for later legal assessment)
- follow up – patients may return for follow up at 2, 6, and 12 weeks
- continuing your involvement as the patient's GP.

Any investigations performed depend on the nature of the assault. Screening recommendations, suggested prophylaxis and a review program are outlined in *Tables 9–11*.

Table 9. Baseline screening recommendations for STIs

Infection	Test	Site (take according to history)
HIV	HIV antibody	Blood
Hepatitis B	Hepatitis B surface antigen (HbsAg), core antibody (anti-HBc) and surface antibody (anti-HBs)	Blood
Syphilis	Rapid plasma regain (RPR) + treponema pallidum haemagglutination assay (TPHA)	Blood
Chlamydia	Polymerase chain reaction	Endocervical swab, first void urine or high vaginal swab
Gonorrhoea	Polymerase chain reaction or microscopy, culture and sensitivity (MC&S)	Endocervical swab, first void urine, rectal swab* or throat swab*
Trichomonas	Microscopy, culture and sensitivity (MC&S)	High vaginal swab

* MC&S only as PCR is not validated for these sites

Source: Mein JK, Palmer CM, Shand MC, et al. Management of acute adult sexual assault. Med J Aust 2003;178:226–30

Table 10. Suggested prophylaxis for STIs

STI	Treatment
Chlamydia	Azithromycin (1g orally)
Hepatitis B	Hepatitis B vaccine (1 mL intramuscularly [IM]) For high risk add: Hepatitis B immune globulin (400 IU IM*)
Gonorrhoea (only if high risk)	Ceftriaxone (250 mg IM) **OR** Where local gonococcal sensitivities permit: Ciprofloxacin (500 mg orally) **OR** Amoxycillin (3 g orally) and probenecid (1 g orally)
Syphilis (if high risk)	Benzathine penicillin (1.8 g IM)
HIV (if high risk)	Telephone local infectious diseases or sexual health physician urgently
Other STIs	Consult local infectious diseases or sexual health physician

* Available from Commonwealth Serum Laboratories

Source: Mein JK, Palmer CM, Shand MC, et al. Management of acute adult sexual assault. Med J Aust 2003;178:226–30

Table 11. Review program

2–3 days
Assess injury healing if relevant

2 weeks
Test results, pregnancy testing, healing, coping
Follow up testing: chlamydia, gonorrhoea, trichomonas (depending on local practice and whether previous treatment was given)

3 months
Follow up serological tests for HIV, hepatitis B virus, syphilis

6 months
Follow up serological test for hepatitis C virus if a test was performed initially
Examine and swab, as appropriate, all sites that as a result of the assault are at risk of infection

Source: Mein JK, Palmer CM, Shand MC, et al. Management of acute adult sexual assault. Med J Aust 2003;178:226–30

Male sexual assault

A common issue for men who have been sexually assaulted is concern about their sexuality. Sexual acts that they may have been forced to perform (or have performed on them) may challenge their perception of their sexuality. For example, getting an erection or ejaculating during the assault are physiological processes, but may be interpreted by the victim as an emotional response. It is good to take the time with your patient to ensure that they understand the difference.

Male sexual assault may involve more force and violence, and physical injuries may be more severe. Societal and other values may prevent men from disclosing sexual assault; again the strategies discussed earlier can be applied.

Police involvement, sexual assault teams

The decision whether to report an assault to the police is ultimately the victim's. They may want to access help in making their decision through rape crisis and sexual assault centres. A nationwide list can be found at Forensic and Medical Sexual Assault Clinicians Australia Inc (see *Resources*). The most important exception to this rule is mandatory reporting for children, in which case medical practitioners are mandated to report child abuse (see *Chapters 5* and *11*).

There may be other circumstances where the medical practitioner may consider reporting. This relates to cases where the person has an intellectual disability, dementia or where an ongoing risk is present for the victim. In these circumstances discussion with a medical defence union and colleagues may be of use before deciding whether to disclose to the police.

Case study – Polly

Polly, 26 years of age, presents to the GP with worries about 'the possibility of vaginal infection'. On careful history taking the story began to take shape. Polly worked part time in a club while studying. She reveals that she had gone home with one of the local patrons for a cup of coffee and he had sexually assaulted her. She has been unable to tell anyone since it happened 2 weeks ago.

Diagnosis

Polly has been sexually assaulted and now has concerns about pregnancy and STIs. She appears to have continued to function without being able to address her feelings or seek help until now.

Management

The GP needs to acknowledge that Polly has been sexually assaulted and then help her deal with the consequences. Is she pregnant? Does she have chlamydia, gonorrhoea, HIV, hepatitis B or syphilis? All these issues need to be addressed in this and subsequent consultations. Emotionally, Polly needs to talk about what has happened to her so that she can perhaps understand and be aware of some of the symptoms of PTSD. The doctor should explore the options with Polly of reporting the incident to the police, being referred to a sexual assault service for counselling, and considering if she could share this with a member of her family or with a friend. Polly is also given the option of seeing the GP once a week for 4–5 sessions to begin to work through these issues. The GP could consider using a mental health plan and using a mental health referral to someone with appropriate training in this area.

Outcome

Polly is not pregnant nor has she contracted any STIs. She opted to see the GP for four sessions and was able to discuss this with her family who were very supportive. She may need further help. Other victims may feel more comfortable talking with a counsellor or attending a sexual assault centre.

Resources

- Adult sexual assault – this article discusses forensic care for those who have suffered adult sexual abuse. Available at www.australiandoctor.com.au/htt/pdf/AD_HTT_033_040___MAY25_07.pdf
- Better Access Initiative – the MBS item relating to GP Mental Health Care Plans may be useful for victims wanting to initiate ongoing mental health care. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba
- RACGP information relating to GP Mental Health Care Plans. Available at www.racgp.org.au/mentalhealth/betteraccess.

Organisation	Telephone	Website
National		
Forensic and Medical Sexual Assault Clinicians Australia Inc	02 6244 2184	www.famsacaustralia.org.au/
Lifeline	13 11 14	www.lifeline.org.au
Australian Capital Territory		
Canberra Rape Crisis Centre	02 6247 2525	
New South Wales		
Rape Crisis Centre	1800 424 017 02 9819 6565 02 9819 7842 TTY 02 9181 4349	www.nswrapecrisis.com.au
Northern Territory		
Crisis Line	1800 019 116	
Sexual Assault Referral Centre	08 8922 7156	www.nt.gov.au/health/comm_svs/facs/sarc/sarc.shtml
Women's Information Centre	Alice Springs 08 8951 5880	
Dawn House	08 8945 1388	
Ruby Gaea House	08 8945 0155	
Queensland		
Statewide Sexual Assault Helpline	1800 010 120 07 5591 2397	www.health.qld.gov.au
Zig Zag Young Women's Resource	07 3843 1823	www.zigzag.org.au
South Australia		
Crisis Care	131 611	
Women's Information Service of South Australia	1800 188 158 08 8303 0590	www.wis.sa.gov.au
Yarrow Place Rape and Sexual Assault Service	1800 817 421 08 8226 8787	www.yarrowplace.sa.gov.au/
Tasmania		
Sexual Assault Support Service	03 6231 1817	www.sass.org.au/
Laurel House	03 6334 2740	www.laurelhouse.org.au/
Victoria		
Centre Against Sexual Assault	1800 806292	www.casa.org.au/
Women's Information and Referral Exchange	1300 134 130	www.wire.org.au
Domestic Violence and Incest Resource Centre	03 9486 9866	www.dvirc.org.au
Western Australia		
Crisis Care Unit	08 9325 1111 1800 199 008	
Sexual Assault Resource Centre	1800 199 888 08 9340 1828	www.kemh.health.wa.gov.au/services/sarc/index.htm

Elder abuse 09

Key messages

- Elder abuse is an important issue for general practitioners providing aged care.
- Elder abuse is not acceptable or excusable.
- Elder abuse may occur in aged care facilities or in the community.
- If confronted with elder abuse, establish the patient's capacity to make decisions in his/her best interests. If the patient does not have capacity, then help needs to be sought from the person legally responsible for giving consent for their health care (this must not be the abuser). If this person is the abuser, seek help from the appropriate advocacy source in your state or territory.

Introduction

Elder abuse is a term referring to any intentional or negligent act by a caregiver, or any other person, that causes harm (physical, emotional, economic, social or neglect), or a serious risk of harm, to an older adult. This occurs where the older person and the person carrying out the action or behaviour are in a relationship which involves trust, dependency or proximity. It is also defined in terms of abuse of human or civil rights.[110–114]

Elder abuse occurs in all cultural and socioeconomic strata whenever there is an imbalance of power. Abuse may occur to elderly people being cared for by family or other community carers, or in aged care facilities when the frailty of elderly residents renders them unable to defend themselves. An abuser may be a family member or carer, and in the case of older persons in residential care, the abuser may be another resident (sometimes with dementia), a staff member (including volunteers), visitors or family members.

Elder abuse may occur for many reasons. For example, caring for a family member means there may be a change in role where the carer becomes the 'parent' and the 'parent' becomes the 'child'. This can be frustrating and act as a catalyst for abusive behaviour.

TIP

If the GP is aware of parent/child 'reversal' frustration, they may be able to help the carer acknowledge this change and how they might manage it.

Prevalence

There are no reliable national statistics in relation to elder abuse either in the home or in residential aged care facilities (RACFs).[111] However, some reports suggest that approximately 3–5% of older Australians are abused.[110,115] There may be five unreported instances of abuse to every one reported.[112] The real incidence of elder abuse is obscured due to a number of factors, including fear of retribution (real or perceived) when reporting a complaint. The aging of Australia's population and the increasing numbers of adults with dementia contribute to the anticipated growth in elder abuse.[110]

The GP is often the first independent professional to see an elderly victim of abuse. There are a number of reasons cited as to why medical practitioners have not been more involved in managing cases of abuse. These include lack of awareness, discomfort, lack of time, and anxiety regarding legal action.[110,113,116]

Types of presentations in general practice

A predisposing factor to elder abuse is dependency caused by physical impairment, dementia, mental illness, stroke, sensory impairment, or intellectual impairment.[111,113,114] This risk factor is true, regardless of whether the older person is being cared for in the home or in an RACF. However, as the majority of RACF residents have some form of dependency such as cognitive impairment, the GP and RACF staff should be alert to the possible occurrence of elder abuse.[113]

If the possibility of abuse is suspected or concern is raised, you could use your consultation time to observe the emotional reactions and body language of the older person and the suspected abuser. Also, observe face-to-face interactions between the two. If the patient is in an RACF, remember that an abuser may be another resident (sometimes with dementia), a staff member (including volunteers), visitors or family members.

TIP

A useful tool to assess elder abuse is the 'Elder Abuse Suspicion Index' (see *Appendix 3*). This tool should be used with the patient when they are alone.

Signs and symptoms

General behaviours that a person experiencing abuse may exhibit include:

- Being afraid of one or many person/s
- Irritable or easily upset
- Worried or anxious for no obvious reason
- Depressed, apathetic or withdrawn
- Change in sleep patterns and/or eating habits
- Rigid posture and avoiding contact
- Contradictory statements not from mental confusion
- Reluctance to talk openly.

Physical abuse includes:

- A history of physical abuse, accidents or injuries
- Injuries such as skin trauma, including bruising, skin tears, burns, welts or fractures, bed sores, ulcers
- Signs of restraint (eg. at the wrists or waist).

Sexual abuse includes:

- Bruising around the breasts or genital area
- Unexplained genital infections
- Damaged or bloody underclothing
- Bruising on the inner thighs
- Difficulty in walking or sitting.

Emotional abuse includes:

- A history of psychological abuse
- Reluctance to talk, fear, anxiety, nervousness, apathy, resignation, withdrawal, avoidance of eye contact
- Rocking or huddling up
- Loss of interest in self or environment
- Insomnia/sleep deprivation
- Unusual behaviour or confusion not associated with illness.

Economic abuse includes:

- History of fraudulent behaviour or stealing perpetrated on the patient
- Lack of money to purchase medication or food
- Lack of money to purchase personal items
- Defaulting on payment of rent or RACF fees
- Stripping of assets from the family home or use of assets for free.

Neglect includes:

- A history of neglect
- Poor hygiene, bad odour, urine rash
- Malnourishment, weight loss, dehydration (dark urine, dry tongue, lax skin)
- Bed sores (sacrum, hips, heels, elbows)
- Being oversedated or undersedated
- Inappropriate or soiled clothing, overgrown nails, decaying teeth
- Broken or missing aids such as spectacles, dentures, hearing aids or walking frame.

Management

If the patient has the capacity to give you a history, it should be taken by the doctor, in private, without any others present. Your suspicions should be raised if the history or findings are inconsistent with the outline provided by others.[111] Ask the patient direct questions, and if suspicion of abuse is confirmed, request permission from the patient to report the information to the appropriate parties (*Table 12*). However, although there is no legal compulsion requiring GPs and other health professionals to report elder abuse, any abuse affects the health and wellbeing of the patient. (See *Chapter 11* for information on reporting elder abuse.)

Understanding the mitigating factors for people who abuse vulnerable elders can provide information for intervention and preventive strategies.[110] Abuse by family members may be about:

- money
- inability to cope with the changes experienced by the patient
- inability to cope with changes in the relationship
- a history of abuse within the family (eg. the patient has been the perpetrator of abuse in the past)
- other family issues (eg. discord among family members).

Reasons for abuse being perpetrated by others:

- mental illness or limited stress coping skills experienced by carers (both in RACFs and in the community)
- carers being provided with inadequate training or suffering fatigue
- other residents in RACFs where their behaviour is not being supervised.

Management of sexual or physical assault

If you are given permission by the patient, or you are satisfied that there are grounds to believe that the patient has been abused (eg. the patient's guardian has told you of the abuse), you may want to notify the police. Once it is established by the police that abuse has occurred, they will conduct any further notification or questioning.

In criminal cases you should document all injuries and consider photographing injuries before initiating treatment. You will need to gain consent from the patient to photograph injuries. In the case of sexual assault, evidence may need to be collected by forensic examination. There are forensic specialists to consult or refer to if you do not have these skills (see *Chapter 8*).

The ongoing safety of the patient is paramount. Safety may only be achieved by transferring the patient from home or the RACF to another facility. Fear of retribution is a real fear.[117] Notify the coroner if a death has occurred following an incident of elder abuse.

Table 12. Management of sexual or physical abuse

- Counselling – support and counselling may be needed by the victim, the resident's family, RACF staff and the abuser
- Documentation – any report or suspicion of abuse should be clearly documented, including quotes from the patient (and others) and photographs of injuries. Documentation in RACF progress notes may be inappropriate if the doctor knows of, or suspects, the abuse is being perpetrated by an RACF employee. In this instance, progress notes should be kept off premises in the GP's patient files
- Reporting elder abuse – there are a range of reporting mechanisms that may be appropriate, depending upon the specific circumstances, particularly the type of abuse, location and suspected abuser:
  - cases of a criminal nature – if there is suspicion that a crime has occurred or if protection is required for the victim or other, the police should be notified[114]
  - cases relating to professional malpractice – the Health Services Commissioner in each state has the power to investigate complaints relating to providers of health services, such as GPs, nurses and allied health professionals[114] and should be contacted in cases relating to professional malpractice. RACF staff misconduct also comes under state jurisdiction and may be reported to the appropriate professional body (eg. medical board, nurses board in each state)
  - cases relating to the RACF – the Federal Department of Health Office of Aged Care Quality and Compliance deals with policies and procedures concerning standards of care in the RACF and can be contacted regarding cases of known or suspected abuse occurring within a RACF
  - cases requiring guardianship intervention – if the case relates to an older adult who is incapable of making reasonable decisions (eg. due to dementia) the matter should be referred to the Public Guardian (or your state equivalent) for investigation or advocacy (see *Resources*)

Resources

- Elder Abuse Suspicion Index – this tool was developed from research conducted on cognitively intact seniors in an ambulatory setting.[113] A positive response to any of questions 2–6 on the index should be viewed as adequate to generate suspicion of elder abuse. It is a practical tool that can be used within the GP consultation. The Elder Abuse Suspicion Index can be viewed in *Appendix 3*
- General practice in residential aged care – the North West Melbourne Division of General Practice have released the second edition of their general practice in residential aged care resource. This is a comprehensive tool kit for use by RACF staff, GPs, other health service providers and divisions of general practice. It covers information pertaining to abuse, along with other care issues surrounding RACFs and is available at www.nwmdgp.org.au.

Organisation	Telephone	Website
National		
Aged Care Complaints Resolution	1800 550 552	www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-complaints-index.htm
Elder Abuse Prevention Association	1300 884 665	www.eapa.asn.au/
Office of Aged Care Quality and Compliance	1800 550 552	www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-quality-about.htm-copy2
Residential Care Rights	1800 700 600	www.agedrights.asn.au/rights/home.html
Australian Capital Territory		
Community Advocate (ACT)	02 6207 0707	www.oca.act.gov.au/index.html
New South Wales		
Office of the Public Guardian	1800 451 510	www.lawlink.nsw.gov.au/opg
Northern Territory		
The Office of Adult Guardianship	08 8922 7116	www.nt.gov.au/health/org_supp/performance_audit/adult_guard/guardianship.shtml
Queensland		
Office of the Adult Guardian	1300 653 187	www.justice.qld.gov.au/guardian/ag.htm
South Australia		
Office of the Public Advocate	1800 066 969	www.opa.sa.gov.au/
Tasmania		
The Public Trustee of Tasmania	03 6233 7608	www.publicguardian.tas.gov.au/
Victoria		
Office of the Public Advocate	1800 136 829	www.publicadvocate.vic.gov.au
Western Australia		
Office of the Public Advocate	1800 807 437	www.justice.wa.gov.au/P/publicadvocate.aspx?uid=4000–7544–4009–6912

Case study – Winnie

Winnie, aged 69 years, is fiercely independent. She has been a patient of yours for a number of years. She has severe arthritis and requires more and more help with activities of daily living. Even with regular visits from community services, she finds it difficult to cope, but she is adamant that she doesn't want to go to hospital.

Eventually she moves in with her daughter and husband and their young sons. The neighbours begin to complain about the noise. Since Winnie has moved in there is not much space in the house and the children are fighting more often, shouting and generally playing up. Winnie's daughter receives no help from her other sisters and is expected to cope with the increased washing, cooking and other duties without complaint.

When you make house calls to Winnie you notice that she has marks and bruises on her arms and upper torso. These are explained away by her daughter, who says that she is becoming clumsier and keeps knocking into things. Winnie just shakes her head and says nothing, even when you speak to her in private.

Diagnosis

The GP needs to acknowledge that abuse may be happening in this situation. The GP uses the Elder Abuse Suspicion Index (see *Appendix 3*) to help with the assessment.

Management

The GP may involve the home nursing service, home help, day centre, carer support groups or other local services to relieve the pressure on this family. Another alternative is to seek the help of the aged care assessment team. Respite care or admission to an RACF are other options, depending on what is available.

Outcome

Winnie remains in her daughter's house with some extra aids (eg. a toilet raise, home help for bathing, respite care), which allows her daughter time out of the house; and Winnie attends the day centre once a week. The GP is not sure if this will alleviate the situation and maintains a close watch on Winnie.

Cultural and community diversity 10

Key messages

- People from different cultural/community groups will present issues of abuse and violence in varying ways and the health system's response needs to be culturally appropriate.
- In Australia, approximately one in 4 people is a first generation migrant, and 60% of Australian immigrants come from non-English speaking backgrounds.[119]
- 68% of surveyed New South Wales Aboriginal women said they had been abused as a child, 75% of these women noted that abuse involved sexual assault; 68% noted that they felt they still required counselling and support to deal with this childhood abuse.[120]
- 63% of lesbian/bisexual women report lifetime abuse compared to 37% of heterosexual women.[121]
- People with an intellectual disability are at a greater risk of abuse and violence.[122]

Introduction

In order to address the cultural/community diversity of patients who present, general practitioners need to:

- respect and appreciate the values and beliefs of all patients
- be informed of cultural/community issues relevant to their patients
- acquire the ability to examine personal beliefs and assumptions.

Not only do patients bring culturally influenced values, beliefs and behaviours to clinical practice, so do health professionals. Framing abuse and violence as a health issue has made it necessary for GPs to examine their own feelings about abuse and violence. They must confront their own belief systems and values to see how this impacts on clinical decision making. Just as doctors develop clinical skills, there is also a degree of cultural competence that needs to be developed. 'Cultural competence' is a set of congruent behaviours, attitudes and policies that come together enabling professionals to work in a cross cultural situation. 'Competence' implies having the capacity to function effectively as a doctor (and a practice) within the context of the cultural beliefs, behaviours and needs of patients and their communities.[123]

Not all members of a gender, family or culture ascribe to the same values. The best expert on their culture is the person who has come to see the GP. The patient will be able to identify how their cultural beliefs influence their gender roles; expectations in family roles; what constitutes abuse and violence; and how willing they are to disclose, and why.

Culturally and linguistically diverse people

Australia is a culturally diverse nation built on the migration of people from many countries. Some people will not identify cultural issues as being important to their health care. However, for others, it may be important for the effectiveness of the doctor-patient interaction.

In 2006, within the Australian population:[124]

- 22.2% were first generation immigrants
- 15.8% spoke a language other than English at home
- religious affiliations were: 25.8% Catholic, 18.7% Anglican, 19.3% other Christian, 1.7% Islamic, 4.5% other religion, and 29.9% no religion.

Despite these statistics, the measure of cultural identity may not be a spoken language, religion and/or place of birth. Ascribing cultural identity takes in a range of intangible components, and as such, it is impossible to represent in figures. This indefinable nature of culture exemplifies the importance of being aware of the potential for cultural misunderstanding in every day practice.

It has been identified that assistance and support offered to culturally and linguistically diverse (CaLD) women which is culturally appropriate and in their own language is extremely important in empowering women to feel that they can make changes in their lives.[125]

Another CaLD issue relates to the ethnicity of the GP and its congruence with the practice population. It is suggested that this may affect clinical care, with doctors of a similar culture and/or race being more aware of health disparities experienced (eg. access to services). General practitioners belonging to the same CaLD group may also be an important mitigating factor in addressing abuse and violence; if GPs understand how to operate within a culture, they may be able to offer more helpful and relevant advice. Conversely, where the GP is of a similar background to the patient, the possibility of the existence of abuse and violence, as defined in mainstream society, might be more difficult for the doctor to consider.

Aboriginal people and Torres Strait Islanders

Life for Aboriginal people and Torres Strait Islanders today is strongly influenced by the effects of dispossession, genocide and attempts to strip away cultural identity. Exemplifying this are historical accounts of Queensland Aboriginal 'reserves' legislating treatment such as head shaving, flogging, chained work gangs and confinement. 'Feelings of frustration, fear, anxiety, anger, rage, hatred, and depression, as well as the essential need to suppress these feelings, became part of the day-to-day lived experience'.[126] It is within this lived experience that many indigenous children were raised and their behaviour formed.

As perpetrators of violence, some indigenous men have suggested that feelings of powerlessness and lack of self worth are associated with their violence. Use of violence seems to provide the abuser with a positive response which, as a result, is repeated. This results in yet another dimension in an exceptionally complex biopsychosocial problem.

Many indigenous people identify alcohol as a contributing factor to abuse and violence and have introduced alcohol free programs and other preventive health programs into communities.

The topical issue of abuse and violence in Aboriginal and Torres Strait Islander communities is not easily tackled. However, cultural sensitivities must be applied. A Western Australia State Government enquiry revealed that while Aboriginal women account for 3% of the population, 50% of intimate partner abuse incidents reported to the police involve Aboriginal women.[127] This statistic indicates greater police involvement with indigenous family violence than in mainstream society. New South Wales research notes that Aboriginal men are 6.2 times more likely than non-Aboriginal men to be an offender of intimate partner abuse.[120]

Support services include the recent report 'Ampe akelyernemane meke mekarle – Little children are sacred' produced by the Northern Territory Government, which provides an insight into the elements affecting child sexual abuse in Aboriginal and Torres Strait Islander communities (see *Resources*).

The apology by the Australian Federal Parliament in 2008 to the Aboriginal people and Torres Strait Islanders of Australia, and specifically to the 'Stolen Generation', is an important step in the healing of relationships. The words spoken now need to be operationalised into practical and realistic solutions. There is an opportunity for GPs to participate in this process.

Gay, lesbian, bisexual and transgendered people

Diverse sexual orientations and gender identities can be seen as another area of cultural diversity, requiring specific knowledge and skills of the GP.[128] It is particularly important for the GP to understand the impact of societal homophobia (prejudice against homosexuals) and transphobia (prejudice against transgendered people) on this group of people. Homophobia and transphobia commonly manifest in abuse and violent outbursts toward gay, lesbian, bisexual and transgendered people. This ranges from victimisation of same sex attracted young people at school, to harassment in the workplace and violence in public places. Experiences of such violence, and the perpetual fear of homophobic and transphobic assault, has a negative impact on the mental and physical health of these people. It can lead to the need to conceal their sexual orientation or gender identity to reduce the risk of violence. It can also lead to nondisclosure within consultations, as the patient cannot predict the attitude of the health care provider.

There is a predominant assumption in society that violence within same sex relationships does not exist, or that it is not as confronting as violence within heterosexual relationships. Yet, 63% of lesbian/bisexual women report lifetime abuse as compared with 37% of heterosexual women.[121] However, this is rarely assessed for in the health care system, despite its known impact on the health of patients.

Lack of abuse identification occurs not only due to the underreporting of incidents, but also the assumption of 'mutual combat'. This implies that violence is reciprocated or, at the very least, the victims are able to defend themselves if necessary, because they are of the same gender. These statements are sometimes true. However, this provides an additional level of emotional complexity to a situation. Victims may question whether they have the right to call themselves a victim if they responded with violence, and may feel guilty for having participated in a violent way. Conversely, they may berate themselves for not defending themselves.

Barriers to disclosure of intimate partner abuse in gay and lesbian relationships have been cited as:[129]

- internalised homophobia – the internalisation of negative attitudes and assumptions about homosexuality
- declaration – the fear of being 'outed' to friends, family and/or work colleagues
- emasculation – men declaring abuse at the hands of another man may be disempowering
- police heterosexism – a number of studies display homophobic behaviours and violence both permitted and committed by the police
- societal homophobia – society tends to not promote disclosure, whether this be due to homophobia or a tendency to view the world in terms of heterosexuality.

Cultural sensitivity can encourage disclosure of sexual orientation and gender identity, and therefore related experiences of violence. This can be displayed to gay, lesbian, bisexual and transgendered people within the general practice setting in the following ways:[121]

- waiting areas – displaying materials specific to nonheterosexual people including a rainbow flag sticker and specific information pamphlets on local services and support groups
- staff training – ensuring that all staff are trained not to make assumptions about the gender of patients, and to be aware of other forms of heterosexism
- practice policy – including antidiscrimination statements specific to sexual orientation and gender identity
- communication within the consultation – the use of gender neutral language when discussing partners, being openly nonjudgmental about different lifestyles.

People with disability

Research surrounding people with a disability is scant. However, it is suggested that those intellectually disabled are three times more likely to suffer abuse and violence than those intellectually abled.[130] There are currently no figures surrounding the incidence of abuse for those physically disabled within Australia, although American research indicates that 33% of those with a physical disability will experience sexual abuse at some point in their lives.[131]

The Australian Bureau of Statistics states the overall prevalence of disability as 20% (reporting having a disability of some type); with 5.9% reporting a profound or severe core activity limitation whereby they require one or more of self care, mobility or communication services. This leaves this group of patients reliant on carers for some of their needs.[132] Intellectual disability is estimated at 1.86% of the population.[133] People with intellectual disability are over-represented as those who have crime perpetrated against them, with 50–99% having been sexually exploited by the time they reach adulthood.[122]

Types of abuse and violence for those with physical and intellectual disability may also differ. While sexual and physical assault are reported, research suggests that abuse can extend to rough handling, inattention, carers using drugs or alcohol, verbal abuse and withholding care information.[134]

There are a number of things that can aid in more effective communication with disabled patients:[135]

- attending to the person's comfort, needs and routines
- using appropriate communication tools
- using open and specific questions
- where verbal content is reduced, increasing the use of image vocabulary
- considering attention span
- using appropriate support people.

Types of presentations in general practice

Patients from any of the diverse groups of people mentioned will present to GPs. Due to many constraints, such as the unacceptability of homosexuality in society or the stigma of disability, these patients may be unwilling to report their experience of violence.

Other chapters in this guideline provide further information as to types of presentation, dependent on the type of abuse experienced. It is essential to note that GPs need to be particularly aware that this group of people may have specific needs.

Management

It is important to improve cross cultural communication and empathy, thus enabling patients to become actively involved in their health care. One way to achieve this is by keeping in mind a number of methods in your consultation:

- the patient's perspective on their situation and the issues they are facing is the basis for their experience. Listen to this perspective and try to understand it
- acknowledge the patient's perspective in ongoing consultations and revisit this from time to time
- negotiate a mutually agreed on treatment plan.

Abuse intervention is a complex area. What works for one patient may not work for another – even with patients from the same culture/community. A set of guidelines, or finite skills, will not necessarily enable provision of care in situations that involve abuse and violence. Instead, working within a malleable framework and fostering cultural competence as a core value of your profession will enable you to explore options with patients.

Members of many minority groups find that language barriers pose a significant problem in their efforts to access health care. When the GP and patient do not speak the same language it can lead to loss of important cultural information, misunderstanding of instruction, poorly shared decision making, or possibly, ethical compromises. Abuse and violence identification and intervention is difficult without the proper linguistic tools. The use of certified translators is recommended (see *Resources*). It is inappropriate to place children, family members or friends in the role of interpreter, particularly when abuse and violence is an issue. *Table 13* outlines recommended guidelines for working with interpreters.

Table 13. Guidelines for interpreters[123]

- Use professionally trained interpreters
- Meet with the interpreter before the visit, to share the agenda
- Talk directly to the patient, not the interpreter
- Use words, not gestures, and avoid technical terms
- Speak slowly, one question at a time
- Check frequently with the patient to ensure the patient is understanding
- Maintain eye contact with the patient by sitting or standing next to the interpreter and across from the patient
- Allow the interpreter to interrupt if needed
- Repeat the phrases using different words if the message is not understood
- Be alert to any discomfort the patient or interpreter may have with each other
- Meet with the interpreter afterward to get their impressions of the visit and to debrief

There may be times when it is appropriate for patients who are CaLD, disabled, gay, lesbian, transgender or Aboriginal or Torres Strait Islander to be referred to specialist services. Work with the patient to identify appropriate services if required.

Resources

- What's needed to improve child abuse/family violence in a social and emotional well being framework in Aboriginal communities – this National Aboriginal Community Controlled Health Organisation's (NACCHO) position paper outlines the risk and protective factors to family violence from a policy perspective. Available at www.racgp.org.au/aboriginalhealthunit/policy/9504
- 'Ampe akelyernemane meke mekarle: Little children are sacred' – this report, produced by the Northern Territory Government, outlines the elements affecting child sexual abuse in Aboriginal and Torres Strait Islander communities. Available at www.nt.gov.au/dcm/inquirysaac/pdf/bipacsa_final_report.pdf.

Organisation	Telephone	Website
Aboriginal and Torres Strait Islander		
Indigenous Disability Network		www.abhealth.net/
Aboriginal Family Violence Prevention & Legal Service	1800 105 303	www.fvpls.org/
SA Aboriginal Family Support Services	08 8212 1112	www.afss.com.au/
People with a disability		
Australian National Disability Abuse and Neglect Hotline	1800 301 130	www.disabilityhotline.org
NSW Intellectual Disability Rights Service	1800 666 611	www.idrs.org.au
NSW Criminal Justice Support Network – 24 support service for the intellectually disabled	1300 665 908	www.idrs.org.au/cjsn/index.html
Gay, lesbian, bisexual and transgendered		
Another Closet: Domestic Violence in Gay and Lesbian Relationships		http://ssdv.acon.org.au/
Victorian Gay and Lesbian Switchboard	1800 184 527	www.switchboard.org.au/
NSW Lesbian and Gay Anti-Violence Project	1800 063 060	http://avp.acon.org.au/
Gay and Lesbian Health Victoria Clearinghouse	03 9285 5382	www.glhv.org.au/?q=clearinghouse
Transgender Victoria	03 9517 6613	http://home.vicnet.net.au/~victrans/
Culturally and linguistically diverse		
Translating and Interpreting Service	131 450	www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/index.htm
NSW Multicultural Health Communication Service	02 9816 0347	www.mhcs.health.nsw.gov.au/mhcs/index.html
Queensland Multicultural Health Services Directory	07 38953119	www.health.qld.gov.au/multicultural/health_workers/services.asp
Queensland Immigrant Women's Support Service	07 3846 5400	
Victorian Immigrant Women's Domestic Violence Service	03 9898 3145	www.iwdvs.org.au/
Multicultural Council of NT	08 8981 1784	www.mcnt.org.au/
The Forum of Australian Services for Survivors of Torture and Trauma (member list provides refugee centres around the country)		www.fasstt.org.au/contact/members.html

Violence and the law 11

This chapter is for the purpose of providing a general outline of issues to consider when a patient presents as the victim of criminal assault. The information in this section is not legal advice. This information may be useful as a resource to guide the patient to consider realistic options of legal protection for their own safety. If the patient expresses an interest, the contact references may be passed on to the patient who must take responsibility for his or her own legal issues.

Key messages

- General practitioners are responsible for medical care – encourage patients to seek help and referral for legal matters.
- Documenting injuries and the information reported by patients is essential.
- Assault occurring between family members is a criminal offence.

Introduction

When a patient discloses an assault, it is important that the GP understands the basic legal framework in which the patient will operate. Clarity and accuracy is important when considering reports that will be provided to the legal system.

This chapter outlines responses to abuse and violence involving legal intervention. However, Australian states and territories have differing legislation that may apply to one or all of these types of abuse. Legal responses to violence are not the domain of general practice. It is important to consult your medical defence organisation for advice in matters that have legal relevance.

Intimate partner abuse

Generally the law can address intimate partner abuse (domestic violence) in two ways: criminal charges and 'restraining orders' which are legislated under civil law. Each state and territory in Australia has its own legislation dealing with protection for victims of violence – the name 'restraining order' is used in this chapter as a generic term. Some states call them 'apprehended violence orders' while another may call them 'intervention orders'.

If your patient is a victim of intimate partner abuse, you may direct them, if appropriate, to get legal advice, to court services assisting in restraining orders, or to go to the police. Within the police force there are specially trained officers who can assist victims to access appropriate services and orders to provide safety. You may obtain advice from the police on behalf of your patient without mentioning the patient's name. However, be aware when acting as an intermediary and encourage the patient to talk to the police themselves, even if they don't identify themselves. The patient may be helped by meeting with a trained police officer directly. (See *Referrals and resources* for links regarding restraining orders.)

There are also court support services that can be very helpful for women who have suffered intimate partner abuse. Availability of these services can vary, and are offered by local community agencies. They may also be accessed at the court.

Sexual assault

No matter how long ago the sexual assault happened, a victim can, and may wish to, contact the police. In the event that they do, they can contact any police station, which will, in turn, arrange for a trained officer to contact the victim. Most Australian states have specialised crime units that deal with abuse issues.

If the event occurred recently, forensic evidence is best collected in the first 72 hours after the assault. Forensic evidence will be important if the patient decides to go to court about this matter. If the GP is not trained in the collection of forensic evidence, it is best done in a sexual assault service (see *Resources*). The implications of, and consent to, collect this evidence will need to be discussed with the patient by a professional qualified to do so. Sensitivity in both the discussion and collection of evidence is required so as to not revictimise the patient. Forensic and medical sexual assault clinicians are qualified to deal with these issues.

In many Australian states there are specific sexual assault services, often sited at a hospital. Patients can be referred for forensic examination and for counselling services whether they choose to report, or not report, the assault.

Child abuse

Mandatory reporting is only necessary when the assault is perpetrated against people under the age of 18 years (16 years in New South Wales). Each Australian state and territory has different legislation as to what must be reported by whom. (See *Table 7*, *Chapter 5* for more information.)

Depending on your state or territory, mandatory reporting may apply to your patient. Your patient may also wish to think about obtaining restraining orders or referral to sexual assault services, if appropriate. (See *Chapters 4* and *5* for further information.)

The complex nature of abuse, and the multifarious effects it has on children, their families and friends make mandatory reporting a confronting issue for doctors. The significant point to remember is that mandatory reporting requires the GP to report a suspected offence to the relevant authorities in the conditions set out in the legislation. This means that the doctor has no role to play in the wider issues affecting the patient which extend beyond proper patient care and treatment. The wider issues, such as the family environment and living conditions, fall within the responsibility of the various state and territory child protection authorities.

Elder abuse

There is no mandatory framework requiring GPs and other health professionals to report elder abuse. However, it may be the case that a patient is exposed to abuse or violence threatening his or her safety. If the patient has lost capacity, and is unable to make decisions in his or her own best interests, the assistance of a substitute decision maker may be required.

In the case of suspected abuse where a patient has lost capacity, the first step is to check the patient's record to identify if a substitute decision maker has already been appointed. If there is no clear indication of a substitute decision maker, or that person is the suspected abuser, you will need to contact the public guardian, public advocate or appropriate body in your state if it is considered necessary or desirable to safeguard the patient's wellbeing.

If the patient has capacity, patient consent may be sought to enlist the support of the public guardian, public advocate or similar person to protect the patient or to remove the person from threatened risk.

In circumstances where the doctor reasonably believes there is an imminent threat of harm to the patient, the police can be called by the GP without contravening any privacy principles.

Table 14 lists government websites that are useful reference points for the GP, or family members of the patient who is incapacitated, and qualifies for assistance of the public guardian, public advocate or similar person. For more information about guardians and advance care directives visit www.racgp.org.au/guidelines/advancecareplans.

Table 14. Advocacy groups in each state	
Victoria	www.publicadvocate.vic.gov.au
New South Wales	www.lawlink.nsw.gov.au/lawlink/opg.nsf
Western Australia	www.justice.wa.gov.au/p/publicadvocate.aspx
South Australia	www.opa.sa.gov/
Queensland	www.justice.qld.gov.au/
Australian Capital Territory	www.publicadvocate.act.au
Northen Territory	www.nt.gov.au/justice
Tasmania	www.publicguardian.tas.gov.au
National	www.health.gov.au/internet/main/publishing.insf/content/aging

For any GP wishing to take steps to assist a patient through the appointment of a public advocate or public guardian, it may be desirable to first seek professional advice without identifying the patient in order to ensure that their situation falls within the jurisdiction of the relevant public advocate or public guardian.
If it is deemed appropriate, a GP can report elder abuse to a number of different agencies, including the police, residential aged care facility, and the Public Guardian NSW, or state equivalent (see *Resources*, *Chapter 9*). Restraining orders and sexual assault services may be considered, if appropriate.

Reporting to the police

Patients should be encouraged to approach the police directly and report the assault.

This is important information for the patient, as the thought of being able to activate and/or cease criminal action at a time they choose may encourage them to seek police assistance now. This can help to re-empower the patient by giving them back some sense of control.

The second option is important as the patient can reinstate the complaint in the future when they feel more confident and able to cope with the situation. However, it can also remain simply as a 'statement'. Further to this, a number of counselling services can be made available to a victim of assault via victim of crime support agencies. These differ in each state and contact can be made via the police.

The police can also arrange services to aid in medical treatment, such as interpreters (usually the same gender as the patient) for those who do not speak, or are not proficient in, English. Advocates and other services can also be arranged for those who are cognitively impaired.

There may be a range of reasons that the patient may not wish to involve the police, such as fear of retribution, the event having occurred some time in the past, or embarrassment. The GP should consider reporting an assault to the police, even when the patient does not, if a gun, knife or other weapon has been used. Where the GP reasonably believes that the patient is in imminent threat of danger, the consent of the patient should be sought to report the matter to the police. If the patient is not capable of giving the consent for any reason, which may include intimidation, the medical practitioner is relieved of any obligation to adhere to privacy principles to the extent that disclosure is necessary to safeguard the patient's immediate wellbeing. You may want to seek legal advice if you are in doubt, but common sense should be applied if the patient is manifestly in danger or threat of physical harm, and the police contacted.

Restraining orders

If your patient is afraid that they will be assaulted again, stalked or otherwise harassed, it may be worthwhile for them to obtain a restraining order. A restraining order made by a court attempts to restrict or prohibit certain behaviours by the perpetrator. Orders may include: prohibiting a person from harassing or threatening the victim, and/or approaching the victim's home or place of employment. In some jurisdictions, the court has the power to order that the perpetrator be excluded from the family home.

Details of these orders are different for each state and territory (*Table 15*). However, restraining orders may relate to:

- recent assaults, threats and/or harassment by a partner, family member, friend or stranger and the person is fearful of it happening in the future
- actual or threatened damage to property.

In most Australian states and territories, an approved proxy can take out a restraining order on behalf of the victim. It is preferable that a person obtaining a restraining order asks for advice about the legislation in their state/territory, what orders are available, and what will afford them the most adequate protection (see *Referrals and resources* for links to appropriate sources regarding restraining orders.)

It is beyond the scope of this guideline to advise in relation to the law in each state and territory. At the same time a complaint about criminal conduct is made to the police, their assistance should be sought and, if necessary, further legal advice obtained.

Privacy and imminent threat

Sometimes the patient does not fall under mandatory reporting laws and does not want to go to the police, but the GP may perceive an imminent threat. This might be a situation such as a patient who is cognitively impaired, or there has been a life threatening risk, such as when a gun or knife is involved. In these instances, you may wish to contact the police, but reporting is not mandatory. It is wise to get advice from appropriate authorities in these instances, including your medical defence organisation.

Within your practice there are a number of steps you can take to make dealing with abuse issues easier. It is important to discuss issues surrounding abuse with all staff and decide upon a practice policy relating to police reporting. This will give you a clearer framework within which to operate. State police forces now have trained domestic violence officers who may be a helpful resource for managing these issues in general practice.

If you suspect that an adult patient is being repeatedly assaulted and that patient is not willing to approach the police, you should still provide the patient with information on appropriate services (eg. domestic violence services) (see *Chapter 13*). Also consider approaching the police yourself. Remember if there is a serious and imminent threat to the life and health of an individual, it may be appropriate to provide a report to the police on the basis that there is an overriding duty in the 'public interest' to disclose information. These are often difficult and complex cases and you are encouraged to seek advice from colleagues and/or your medical indemnity insurer if faced with this situation.

What else should I do?

The service most frequently identified as the first point of contact for victims of assault is a doctor or hospital. This initial contact is important in a patient's decision to address the violence. It is important for health professionals to understand the legal consequences of abuse. However, remember that you do not need to, and should not, provide advice to your patients in these matters. Providing your patient with information and links to appropriate services is important as this provides the patient with the avenues they require to make an informed choice.

Therefore, it is helpful to be able to provide your patient with appropriate medical care, accurate information and referrals. But most importantly to provide the message that their safety is paramount and that what is happening to them is:

- not their fault
- not okay
- is a crime.

Patients may make very different choices to yours. It is very important to respect their choices, stay involved and consider the stages of change (see *Chapter 14*).

Table 15. Intervention type and process in each Australian state and territory

State	Type of intervention
Australian Capital Territory	In the ACT, it is necessary to apply for a personal protection order under the *Protection Orders Act*, 2001 as amended by the *Domestic Violence and Protection Orders Amendment Act*, 2005. The assistance of the police should be enlisted for the purpose of seeking an order Further information is available at www.victimsupport.act.gov.au and www.legalaid.canberra.net.au
New South Wales	A GP or member of their practice staff needs to obtain an apprehended personal violence order (APVO), as opposed to a domestic violence order If a threat is imminent (eg. a patient is in the practice or consulting room) contact the police in the first instance. The police can remove the offending party and then, if there are grounds, the GP can apply for an APVO Further information is available at www.legalaid.nsw.gov.au/asp/index.asp?pgid=484
Northern Territory	Nondomestic violence in the NT may be addressed by calling the police and having them attend. If the GP or staff request that the person leaves the premises and they refuse, the police can physically apprehend or remove the person from the premises under the *Trespass Act* Further information is available at www.nt.gov.au/dcm/legislation/current.html (Go to view legislation alphabetically, then look up the *Trespass Act*)
Queensland	For domestic relationships (eg. spouse, intimate partner, family and informal care) a person may exercise rights under the *Domestic and Family Violence Protection Act,* 1989. For further information visit www.communities.qld.gov.au/violenceprevention or phone the Violence Prevention Team on 07 3224 4477. All other relationships (eg. unknown parties, work colleagues) fall under the *Peace and Good Behaviour Act*, 1982. A person may make a complaint to a justice of the peace that a person has threatened assault or property damage and that the complainant is in continuing fear of the person complained of Further information is available at www.legalaid.qld.gov.au/Legal+information/ and www.justice.qld.gov.au/ourlaws/factsheets/l15pgb.htm
South Australia	It is possible for the police to obtain a restraining order by telephone in urgent situations A complaint should be made to the police, who will apply to the court on behalf of the complainant. In urgent situations applications can be made by telephone Further information is available at www.lawhandbook.sa.gov.au/ch18s10s01s06.php
Tasmania	People who want to apply for a restraining order in Tasmania may obtain further information at www.magistratescourt.tas.gov.au/about_us
Western Australia	An intervention/restraining order form can be obtained either through the police who may apply to a Magistrate for an order by telephone in exceptional circumstances. There is no need to get a lawyer if the police are involved Further information is available at www.police.wa.gov.au/YOURSAFETY/FamilyViolence/tabid/895/Default.aspx#rorder and www.justice.wa.gov.au/
Victoria	Further information about the process involved in seeking an intervention order in Victoria may be obtained from the Magistrates' Court of Victoria at www.magistratescourt.vic.gov.au Victoria Legal Aid and the Victoria Law Foundation have produced a detailed booklet on intervention orders. This gives a practical overview of the issues, and contact details The Magistrates' Court of Victoria also has useful information about taking out an intervention order at www.magistratescourt.vic.gov.au

Referrals and resources

- Surviving the legal system – further information relating to the Australian legal system surrounding sexual assault can be found in 'Surviving the legal system: a handbook for adult and child sexual assault survivors and their supporters' by Dr S Caroline Taylor and published by Coulomb Communications. Dr Taylor is a Victorian Post-Doctoral Research Fellow with particular expertise in this field. The book outlines the legal process, trial strategies and tactics, along with other useful information such as court systems and support groups.

Organisation	Telephone	Website/email
National		
Forensic and Medical Sexual Assault Clinicians Australia Inc	02 6244 2184	www.famsacaustralia.org.au/
Australian Capital Territory		
Legal Aid Commission ACT	1300 654 314	www.legalaid.canberra.net.au/
Legal Aid Commission ACT (domestic violence restraining orders line)	02 6217 4299	
Magistrates' Court	02 6217 4273	www.courts.act.gov.au
New South Wales		
Legal Aid NSW	1300 888 529	www.legalaid.nsw.gov.au
Legal Aid NSW (this website provides multilingual information)		www.legalaid.nsw.gov.au/asp/index.asp?pgid=715
Law Access NSW	1300 888 529	www.lawaccess.nsw.gov.au/
Local courts (listing of courts in NSW)		www.lawlink.nsw.gov.au/lawlink/local_courts/ll_localcourts.nsf/pages/lc_courtlists
Coalition of Aboriginal Legal Services NSW		www.coalsnsw.com.au
Northern Territory		
Legal Aid NT	1800 019 343	www.ntlac.nt.gov.au/
Magistrates' Court (listing of courts in NT)		www.nt.gov.au/justice/ntmc/contact.shtml
North Australian Aboriginal Family Violence Legal Service	1800 041 998	
Queensland		
Legal Aid QLD	1300 651 188	www.legalaid.qld.gov.au/
Legal Aid QLD (this website provides multilingual information)		www.legalaid.qld.gov.au/Publications/Translated+material/Translated+material+-+view+by+publication.htm#dvcas
DV Connect (QLD government)	1800 811 811	www.justice.qld.gov.au/courts/dv.htm
DV Connect (this website provides multilingual information)	1800 811 811	www.justice.qld.gov.au/courts/dv/orders.htm
Department of Communities	07 3224 4477	www.communities.qld.gov.au/violenceprevention/forms/index.html
Magistrates' Court (listing of courts in QLD)		www.justice.qld.gov.au/courts/contacting/add_mag.htm
Aboriginal & Torres Strait Islanders Corporation (QEA) for Legal Services	1800 012 255	Email: info@atsils.com.au
South Australia		
Legal Services Commission SA	1300 366 424	www.lsc.sa.gov.au/
Interpreting and Translating Centre	131 450	www.translate.sa.gov.au/
Magistrates Court (listing of courts in SA)	08 8204 2444	www.courts.sa.gov.au/pdf/civil_localities_directory.pdf
Aboriginal Legal Rights Movement Inc	08 8211 8824	www.geocities.com/Athens/Acropolis/7001/alrm.htm
Tasmania		
Legal Aid TAS	1300 366 611	www.legalaid.tas.gov.au
Magistrates Court (listing of courts in TAS)		www.magistratescourt.tas.gov.au/lists
Magistrates Court (forms for applying to receive a family violence order can be found here)		www.magistratescourt.tas.gov.au/divisions/family_violence/forms
Tasmanian Aboriginal Centre	03 6234 8311	Email: hobart@tacinc.com.au
Victoria		
Legal Aid VIC	1800 677 402	www.legalaid.vic.gov.au
Legal Aid VIC (this website/info line provides multilingual information)	1800 677 402	www.legalaid.vic.gov.au/multilingual.cfm
Magistrates' Court of Victoria	03 9628 7991	www.magistratescourt.vic.gov.au
Victorian Aboriginal Legal Service Co-operative Ltd	1800 064 865	www.vals.org.au
Western Australia		
Legal Aid WA	1300 650 579	www.legalaid.wa.gov.au
Magistrates' Court (listing of courts in WA)		www.justice.wa.gov.au/M/magistrates_locations.aspx?uid=0987-0974-4964-6070
Department of the Attorney General (forms for applying to receive a family violence order can be found here)		www.justice.wa.gov.au/M/magistratescourt_restraining.aspx?uid=9145-0955-8240-7018
Aboriginal Legal Service of Western Australia (Inc)	1800 019 900	www.als.org.au

12 The doctor and the importance of self care

Key messages

- Self care is essential for general practitioners managing patients who are victims of abuse and violence.
- Stress can be reduced by working as a practice team and engaging other agencies.

Introduction

Managing the effects of abuse and violence on our patients is stressful, but at the same time it can be a rewarding aspect of general practice. If the general practitioner feels empowered, then that empowerment can positively enhance the doctor-patient interaction. Factors that contribute to this enhancement are ongoing training, clearly delineated practice policies, case management supervision, clear doctor-patient boundaries and a developed network of resources and referrals.

As well as the usual stresses associated with difficult and time consuming patients, there are factors that are important to address for GPs working with patients who have suffered abuse or are currently being abused. The trauma that these patients have been through constantly challenges individual limits and drains personal resources.[136] General practitioners often face professional isolation, ambiguous success, unreciprocated giving, and failure to live up to their own expectations for ensuring positive change.[137] Dealing with these issues is important, not just for the health of the GP, but also so that s/he can maintain as objective a stance as possible in order to facilitate a successful outcome for the patient.

Vicarious traumatisation is the inner transformation of the care givers experience as 'a result of empathetic engagement with victims, clients and their trauma material'.[138] This is a particular danger when dealing with those who are, or have, experienced abuse and violence.

It is important to maintain an environment where there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence. Those who work in this field need to be vigilant about ways to overcome compassion fatigue, renew the joy in practice, create life balance,[139] and adequately care for their own physical, mental, emotional and spiritual health.

TIP

'You cannot give to others out of emptiness in yourself'. (A GP)

Saakvitne and Pearlman[138] developed a model whereby health professionals can explore their situation and think about solutions. This occurs by identifying issues of **a**wareness, **b**alance and **c**onnection (ABC) in each of the GP's 'realms':

- personal
- professional, and
- organisational.

Using this model (*Table 16*) may help set the stage for good self care.[136,138]

The following explores the model in relation to the management of patients who are suffering or have suffered abuse or violence.

Table 16. Example ABC strategies

	Personal	Organisational
Awareness	• Proactively instigate self care strategies • Understand and improve your awareness of when you are stressed, tired, overwhelmed	• Ensure your practice has a mentor or supervisor to support your professional development • Consider using debriefing strategies (formal or informal) in your practice • Cultivate open and supportive dialogue with your practice team • Ensure organisational boundaries are known and understood by patients (eg. home visits, consultation length)
Balance	• Review your lifestyle and consider healthy options • Seek balance in all spheres of your life: physical, psychological and social	• Review workload regularly to ensure that all members of the practice team are adequately supported • Take care in scheduling complex care needs patients
Connection	• Consider joining a social action group where you have a passion for change • Talk to others about work, debrief safely • Nurture positive relationships with family and friends	• Join a peer support or Balint group or informal network • Undertake regular continuing professional development with your colleagues

Awareness

Personal

- Where the GP is of a similar background to the patient, the possibility of family violence might be more difficult for the doctor to consider[140]
- The GP can get drawn into the deceit; the unwillingness to disclose[140]
- The GP may feel powerless and fearful for the patient's safety when that patient chooses a path that the GP considers dangerous[140]
- The patient could remain at risk and the GP has to learn to live with that concern[140]
- It is a difficult and stressful path supporting and empowering the patient while resisting the temptation to direct[140]
- Hearing about abuse and violence confronts the GP's own beliefs about the family and the world. It can make the him/her feel uncomfortable and challenges their sense of security
- Dealing with complex and seemingly hopeless situations over and over again can erode the GP's ability and self confidence, and diminish their sense of purpose and enjoyment of their career[141]
- There is a need to recognise reactions by developing awareness of the personal signals of distress before they get to dangerous levels, and try to find words to articulate inner experiences[6]
- The lack of safety and security in the lives of patients involved in abuse and violence repeatedly confirms the physical and emotional perception of alarm, danger and its impact; in the GP as well. The GP may also be left with the same feelings of a personal sense of vulnerability and intolerance of violence.

Professional

- Dealing with the perpetrator is even more difficult than dealing with the victim, especially in rural practices where the entire family is likely to be well known to the GP[140]
- The GP is likely to also feel at risk, especially if they are drawn into the power dynamics of the violence or if they are dealing with the perpetrator.[140]

Organisational

- GPs are trained to deal with individuals and to take personal responsibility rather than delegate[142]
- Dealing with abuse and violence as part of a team will mean developing new skills.

Balance

Personal

- Lifestyle choices that promote 'wellness' include relationships, religion or spirituality, focusing on success, maintaining a balance in life and a positive outlook[139]
- There is a need for purposeful physical, intellectual, spiritual, and relationship sustenance[139]
- Without a positive countervailing exposure to human good and world order, a GP may experience the same loss of a sense of personal control, of freedom and of trust.

Professional

- Appropriate support for the doctor in both training and clinical practice needs to be readily available, especially considering that 14% of male doctors and 31% of female doctors have a personal history of child abuse or physical violence with an intimate partner[140]
- GPs with less perceived control, greater stress from uncertainty, higher job demands and fewer social supports are at greater risk of burnout[143]
- One of the difficult balances in abuse and violence is the stress of maintaining confidentiality and still getting added support from other health professionals
- As with other complex and time consuming occupations, it is important to have clear boundaries between work and home, to attend peer support groups, and to maintain professional development and training activities[141]
- As a defence against the sometimes intense feelings of helplessness a GP may take on the role of a rescuer or saviour. There is a fine line between caring for someone and disempowering them from finding their own solutions.

Organisational

- Organisational balance involves a sense of control over the practice environment, social support from colleagues and satisfaction with work demands and resources[143]
- Many organisations seem to be caught in a struggle between promoting the wellbeing of their patients and trying to cope with the policies and structures in a system that tends to stifle the empowerment and wellbeing of their staff[144]
- GPs need physical security and a safe, confidential workplace, support for continuing education, and adequate vacation and sick leave
- Staff will be supported by a shared aim and purpose, adequate staffing and a sense of team management. This will decrease the risk to individuals within the practice, as well as to the organisation.

Connection

Personal

- Working in teams is associated with being better able to cope with stress[142]
- If a GP is becoming burnt out there may be increased substance use, pessimism and suspiciousness of both patients and colleagues[141]
- If a GP is aware of suffering from compassion fatigue or burnout they need to ask for help and find activities that connect with mind, body and support networks[141]
- Social support systems can provide understanding and renew emotional reserves.[141]

Professional

- Confidentially debriefing with colleagues can reduce stress levels by sharing the experience, 'normalise' emotional reactions, develop more understanding of reactions, and learn stress management strategies
- Peer support groups, professional development and training activities can also be replenishing and reinforce the value and meaning of work.

Organisational

- Working and communicating well as a team with the GPs, practice nurses and receptionists within the practice, and with public health nurses, teachers, police and other agencies, is very important in the identification and management of abuse and violence.[140]

Resources

- Keeping the doctor alive – this guidebook provides medical practitioners with information and resources on strategies for self care as an essential element of their professional life. It aims to encourage medical practitioners to recognise and discuss the challenges facing them, promote self care as an integral and accepted part of the professional life of medical practitioners, and assists medical practitioners to develop useful strategies for self care. It is available to purchase from the RACGP website at www.racgp.org.au/publications/tools#9.

Organisation	Telephone	Website
Australian Capital Territory		
Doctor's Health Advisory Service	02 6270 5410 0407 265 414	
New South Wales		
Doctor's Health Advisory Service	02 9437 6552	www.dhas.org.au
Northern Territory		
Doctor's Health Advisory Service	08 8927 7004	
Queensland		
Doctor's Health Advisory Service	07 3833 4352	
South Australia		
Doctor's Health Advisory Service	08 8273 4111	
Doctor Doc – Rural Doctors Workforce Agency	08 8234 8277	www.ruraldoc.com.au/content_sub.php?id=26
Tasmania		
Doctor's Health Advisory Service	03 6223 2047 (BH) 03 6235 4165 (AH)	
Victoria		
Victorian Doctor's Health Program	03 9495 6011	www.vdhp.org.au
Western Australia		
Colleague of First Contact	08 9321 3098	

13 Broaching and managing the subject of violence

Key messages

- Dealing with situations of abuse and violence can be traumatic, time consuming and draining for both general practitioners and the practice team.
- Dealing with these situations also holds the potential for effective patient outcomes.
- It could be beneficial to set up a network of support both within the practice and the broader community in order to share ideas, build referral contacts and exchange information.

Introduction

The subject of violence is complex and requires an approach that addresses the issue at multiple levels. Using the concepts of practice prevention,[145] general practitioners might wish to employ some of the methods discussed below to encourage disclosure. Using the stages of change as outlined in *Chapter 14* can be helpful with the management of the individual patient.

It is important that the practice has an agreed aim to provide a safe and nonjudgmental environment for patients who have experienced abuse and violence. This could be promoted by having a practice meeting of all staff where strategies are agreed on and by identifying any issues that practice members may have with abuse and violence. This will enable the building of a team within the practice that can provide optimal support to patients and staff.

The issues that may need to be discussed are:

- patient confidentiality
- possible scenarios that may override confidentiality (eg. child abuse, suicidiality, use of weapons in abuse) (see *Chapter 11*)
- how the practice will use its resources in the care of the patient who has suffered abuse
- practice policy on the management of the victim, perpetrator and children who may all be attending the same practice
- recognition that it is not possible for one doctor to attend to the needs of these three groups
- practice policy that enables all three groups to receive care
- safety of the patient, staff and doctor.

At a consultation level

- Think about the words to use when speaking about abuse and violence. Consider ways of asking patients if they are adult survivors of child abuse (see *Appendix 2*). Debate continues about the benefit of screening all patients for intimate partner abuse (see *Chapter 3*). However, examining screening tools can help GPs familiarise with the types of questions that could be asked should a patient be suspected of experiencing intimate partner abuse. For example:
  - is there a lot of tension in your relationship?
  - do you ever feel frightened by what your partner does or says?
  - do arguments ever result in you feeling down or bad about yourself?

- Regardless of whether a patient discloses, validating statements are important. For patients who do disclose, this will confirm that they are not responsible; for those who are not yet ready, this will ensure they know the consultation is an open forum for disclosure. Examples of these types of statements are:
  - this is not your fault. You did not cause this
  - everybody deserves to feel safe at home
  - I am concerned about your safety and wellbeing
- An important safety issue is to ask if the victim has been threatened with a weapon or whether the perpetrator has access to weapons
- Develop a list of local services and keep this list in each GP's office (see *Appendix 4*)
- Consider displaying and/or offering pamphlets and leaflets in the consultation room as well as in the waiting room as patients may not wish to take information away with them in full view of other patients and/or staff.

At a practice level

- Have standard appointment cards printed with relevant telephone numbers for emergency and other services; including those dealing with abuse and violence on the back of the card. Pamphlets relating specifically to abuse services may alert the perpetrator. If this information is discovered by the perpetrator, it could be the catalyst for further abuse
- Have articles pertaining to health in a folder in the waiting room. Include articles on abuse and violence along with, for example, smoking, diet, menopause
- Display posters in the waiting room
- Have a way of identifying patients who are either victims or perpetrators of violence in patient records. This will enable other treating doctors to care for the special needs of the patient
- Address any staff misconceptions and beliefs about abuse and violence.

At a community level

- Develop a list of local services and keep this list in each GP's office
- Consider having someone from the practice place preliminary calls to various organisations to identify what services they provide; develop networks
- Consider forming a working group in the local area or division of general practice to network GPs with local refuges, sexual assault centres, intimate partner abuse centres and other agencies
- Some GPs become involved in the community. For example, organising a public forum to help raise community awareness about abuse and violence and the options available for change. Speakers could include survivors of abuse, police, leaders in the local community, GPs and other services.

Resources

- For more information on implementing change at a practice level, refer to the RACGP Putting prevention into practice: Guidelines for the implementation of prevention in the general practice setting (the 'green book'). Available at www.racgp.org.au/guidelines/greenbook.

Stages of change 14

Key messages

- The long term morbidity associated with intimate partner violence is significant and often disabling.
- Using a decision balance will provide considerable insight into a person's reasons for staying versus leaving an abusive relationship.
- Doing something is always worthwhile, especially:
  – a strong statement that violence is never okay
  – that you believe the patient.

Introduction

One of the difficulties general practitioners face in intervening in situations of violence, particularly in the case of intimate partner abuse, is that victims may choose to remain in the relationship. This can be the case even when it seems to those outside the relationship that the most sensible course of action would be to leave. As a result, GPs may become frustrated and exasperated in their attempts to intervene.

The model

The Transtheoretical Model of Behaviour Change[146–148] is commonly referred to as the 'stages of change' model (*Figure 6*) and is used in many clinical settings to determine patient readiness for change, including intimate partner abuse and other types of abuse and violence.[149–151]

The stages of change model recognises that:

- behaviour change does not occur in a linear fashion
- patients progress through predictable stages of change before reaching an action stage
- every stage of change is necessary because people learn from each stage
- one intervention cannot be applied to all patients as some will be at different stages of 'readiness' than others.

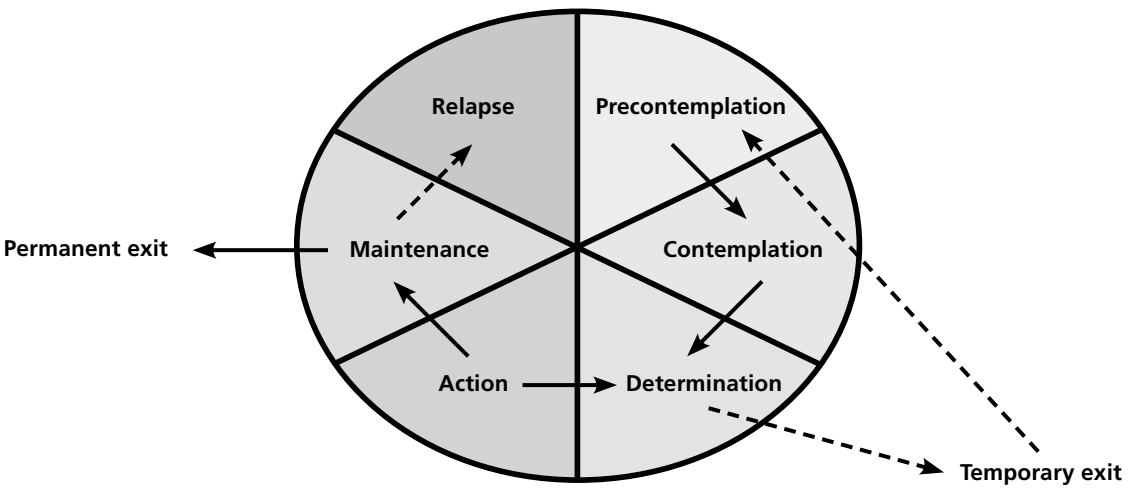


Figure 6. Stages of change

The model describes change as a process, often referred to as a 'cycle of change'. Depending on where someone is within the change process, different strategies to achieve change will be effective.

'Stage matched interventions may help physicians manage… intimate partner violence more effectively and avoid overloading the victim with information for which she is not ready'.[151]

The stages of change can be categorised into five components:

- Precontemplation – the patient is not intending to change their behaviour for at least 6 months
- Contemplation – the patient has not begun to change their behaviour but intends to do so within 6 months. This stage is categorised by ambivalence (if the perpetrator is also a patient of the GP, this may generate ambivalence in the GP)
- Determination – the patient has not begun to change their behaviour but intends to do so in the next 30 days
- Action – the patient has changed their behaviour in the past 30 days
- Maintenance – the patient has practised the new behaviour for at least 30 days.

Relapse occurs from time to time and patients may switch from maintenance to relapse to action in a continuing cycle.

Remember that for any behaviour to change, three ingredients are necessary:[152]

- current situation/behaviour is a problem or concern
- the person will be better off if they change
- a belief that change is possible.

Stages of change – violence

Precontemplation

In the precontemplation stage, the person is not aware or does not accept that they have a problem or that there is a possibility they could change. A person at this stage may be a patient you have seen for years for depression, persistent headaches or vague somatic complaints. You begin to explore the possibility that they are experiencing violence or have experienced violence in the past with questions such as:

- 'How are things at home?'
- 'Have you ever felt unsafe in the past?'

It may be important that you simply suggest the possibility of a connection between what may be happening at home or in the past and their presenting symptoms.

- 'Often people who have these types of health problems are experiencing difficulties at home. Is this happening to you?'
- 'Sometimes these symptoms can be associated with having been hurt in the past. Did that ever happen to you?'

It is ineffective at this point to suggest breaking the pattern (eg. leaving home), but any message of support and identifying that alternatives exist, may be a trigger for change.[151–153]

It is useful at all stages of change to signal your support and acknowledgment that any violence is not acceptable. Also, be aware that there are many barriers to patients raising the issue of abuse and violence.[154–157] These include:

- Patient barriers:
  - fear of perpetrator and pressure from them to not disclose
  - failure to recognise events as abuse
  - self doubt and low self esteem
  - powerlessness and fear of loss

  - reluctance to seek help, as they often see it as their own problem
  - shame/embarrassment about the situation is often a huge deterrent to telling a GP, particularly if there is not an established stable relationship with one GP
  - denial – the patient knows there is a problem but is hiding it from her/himself
  - love and loyalty (albeit misguided). Not wanting the GP to think badly of the perpetrator, particularly if there is a family doctor who also sees other family members (a problem in small or rural communities)
  - inability to recognise the cycle. The patient continues to see each episode as a discrete event 'caused' by some specific event
  - the patient clings to hope that it will stop and everything will be okay; so best to just keep it private
  - co-dependency – there may be a high level of emotional co-dependency for some women. They feel that they must maintain the marriage at all costs. In these cases, the GP needs to assess the patient's level of dependency on her partner (emotional and financial)
  - abuse happened in the past and the patient perceives that it is no longer relevant
- GP barriers:
  - knowledge
  - awareness and interest
  - interpersonal skills and behaviour
  - attitudes/beliefs – the GP may communicate attitudes (directly or indirectly) that discourages disclosure (eg. must have a father for children, religious beliefs)
  - abuse happened in the past and the GP perceives that it is no longer relevant
  - GP perceives a carer would never abuse their parent, child or other person.

Contemplation

In the contemplation stage, the patient has identified a concern (or perhaps even a problem) but remains ambivalent about whether or not they want – or are able to – make any changes.

> 'Yes, I know my husband beats me occasionally, but in between he's okay. He's not nasty to the children and he treats me well'.
>
> 'Yes, my father was very hard on us… but we were really a happy family'.
>
> 'Yes, my daughter gets very tired and angry… but she really does look after me well'.
>
> 'Yes, but' is the classic phrase associated with the contemplation phase. Part of the person wants to change and another part does not.

In this stage it is useful to encourage patients to look at possibilities for change should they decide to do something. Just pointing out that there are options, that violence in any form is wrong and that they do not have to put up with it, will help build self esteem and identify you as a supportive agent.

> 'Whatever you decide to do about the situation, if you think I can help, please let me know. I am happy to discuss this with you and we can explore the options together'.

To determine how abuse is perceived by patients ask them to rate how important the problem is on a scale from 1 to 10. If they rate only 1 or 2, ask them what they would need to happen to change this to an 8 or 9. Similarly, if they rate a 7 or more out of 10, try to get a more complete picture of their situation by asking them why their rating was a 7 and not a 2 or 3.

Mary's experience

Mary is a professionally employed woman in her late 40s who experienced significant intimate partner abuse during her (now ended) 23 year marriage. Before leaving her abusive partner, the violence escalated and she reached a crisis where her physical safety was seriously threatened. She identified a turning point when she recognised her domestic situation was abusive. This is when she moved from a precontemplation to a contemplation stage.

"A turning point for me in my journey out of my abusive marriage was gaining access to domestic violence literature. I remember sitting with a small publication in my hands and reading through a list of different types of abuse: emotional, psychological, social, financial, physical, and a list of common behaviours in these categories. I was in a state of shock because I could tick most of the categories and behaviours on the list as 'my life'. The book also discussed the 'cycle of violence' and I could identify closely with the patterns it described. I had always considered myself an intelligent, well educated person but the 'cycle of violence' occurring in my life had created so much confusion that I was unable to put it all together and understand that this was systematic cyclic abuse being used to control me and that living with the stress was making me increasingly physically sick. I could not deny it to myself any longer."

A decision-balance matrix is also a constructive tool to explore a patient's ambivalence about their partner.[149] Ask the patient to consider/complete *Table 17*. Emphasise that the reasons entered in the boxes must be their own reasons, not what someone else has told them. (See *Appendix 5* for an example of Mary's completed decision balance.)

Table 17. Decision-balance matrix

	Like/benefits/capacity	Dislikes/costs/barriers
Stay the same		
Change (eg. leave partner, take out an intervention order)		

Mary's experience

Mary recently completed her own decision balance retrospectively (*Appendix 5*). She commented:

"I think completing the decision-balance would have been a very useful exercise for me to do during the last couple of years before leaving my marriage. It gave me the opportunity to list the multitude of issues I was struggling with in the years before I left. There is a visual reminder of the pros and cons of making change, something tangible rather than just the violently fluctuating emotions and sense of fear. I think it is important to recognise there will be many losses as well as gains in making changes and this is what we all have to weigh up. You realise that grieving for some things is an inevitable part of the process regardless of how bad the relationship is."

The GP needs to consider both dimensions of exploring a 'decision balance', the emotional as well as the cognitive. On an intellectual level the victim may have a clear understanding of their circumstances and acknowledge that they should leave. However, the fear associated with leaving the relationship and coping alone may be incredibly strong, as the victim may feel emotionally ill equipped for the enormous physical and emotional effort involved in making the changes.

Fear and the sense of powerlessness engendered by intimate partner abuse can be a prevailing deterrent to victims trying to move forward and away from abusive partners. Often regaining confidence and emotional strength can be a gradual process, so that even small advances are initially viewed as real hurdles. General practitioners need to be aware that moving out of an abusive relationship may take quite some time; sometimes years. The GP can be an important source of ongoing support and strength to the victim if they are nonjudgmental of the rate of change and supportive of the decisions and choices the victim makes along the way.

Contemplation stage interventions

- Affirm the abuse is occurring
- Assess the risk to safety of the patient and any children
- Assess level and quality of social support available
- Document the abuse
- Educate the patient about abuse and how it affects health
- Explore options
- Discuss a safety plan
- Know resources for domestic violence support agencies
- Make appropriate referrals.

Mary's experience

Mary's confiding in her GP and friends was pivotal in changing her internal dialogue and provided the reality check she needed to confront this pattern of violence and become more confident and decisive about changing her circumstances.

"It took a long, long time for me to give up the hope, the dream that things were going to change. I had adopted a strategy of forgetting abusive events as quickly as possible as a means of coping and surviving. It often came as an enormous shock when my GP or friends reminded me of an event or how I had felt at the time because I was editing my consciousness, trying desperately to dwell on the good things and kindnesses that always followed the abusive episodes that left me incredibly emotionally vulnerable and usually quite unwell physically."

Determination

At the determination stage something has happened to tip the scales in favour of change. This is often triggered by an external event.[8] It may be that the perpetrator has started to hit the victim's children. Many women in abusive home situations tolerate the violence 'for the sake of the children', but when they too become the victims, this can be the catalyst for change.

It may be that the abuse has escalated to a 'new' level. It may be that the first incidence of physical abuse has occurred or a more serious episode of physical abuse has occurred causing injury, or a serious threat has been made which leads to a change in the woman's sense of her and her family's personal safety if she does nothing. It may also be that the woman's perception of the risk of the abuse being repeated has changed. The abuse may have entered a 'crisis' stage and there is a perception that it is 'out of control'

'I've had enough', 'Something has got to change', are statements frequently heard in this stage of change.

Now it is important that the GP is aware of local resources and any resources the patient may have within their own social network and family. It is good to clarify:

- What is it that the patient wants to change? Is this realistic and possible – the patient may need to explore alternative options and change thinking
- How does s/he intend to go about it? Assess current level of risk and discuss a safety plan
- What role does s/he want you to play? Legal issues (eg. documenting injury/impact and/or referrals to domestic violence counselling/services).

Mary's experience

"During a particularly bad period in my marriage, my GP suggested that I see a psychiatrist. This was helpful because he affirmed that it was my domestic situation that was making me ill and that it was my husband who needed therapy. This was very empowering for me to hear this. The medication [given to me by the psychiatrist] helped to stabilise my mood, and my personal strength and ability to think more clearly began to grow. My husband had repeatedly refused to seek any counselling or therapy during the 23 years we were together. Later on, I confided in one of my university lecturers that my home situation was affecting me very badly and I was having problems coping with my course. She suggested I speak to a professional and referred me to a therapist she knew."

"The therapist worked intensively with me with a focus on the future. She helped me to explore ways that I could make changes and gain some control over my life. She helped me to set goals and identify tasks that needed to me done. She recommended a change in medication and encouraged me to open my own bank account and make extra keys and arrange somewhere I could go in an emergency. I suppose this is when I finally decided I would leave because I now believed I had the strength and support to do it."

Action

The action stage is when the plan – devised in the decision phase – is carried out. A well thought out and supported plan has more chance of succeeding than something acted out on impulse. The action may be:

- talking to family and friends
- changing the locks on the house
- going to see a counsellor
- talking to someone at a refuge or shelter
- leaving the relationship
- taking out an intervention order
- reporting the abuse to the police.

In the situation of a patient leaving their partner, it may be at this point that the GP loses contact with the patient. The patient may move to safety at a friend or relative's home, a refuge or out of the area, and there may be extremely good reasons why a victim needs to sever links with the GP. They may be receiving threats and may need to start completely afresh to avoid being found by the perpetrator.

When helping patients with a comprehensive action plan, ensure that you provide them with a referral to a new GP, if you can. This GP will be able to continue supporting the changes being made.

If this situation arises, remember that confidentiality is extremely important. Make sure that the practice is aware that information relating to that patient is not to be disclosed to anyone.

Mary's experience

"Following the first incident of serious physical violence I saw my GP who documented my injuries and counselled me at length. She, better than anyone, knew my history and she was as frightened for me as I was for myself and told me that I must leave him now – she had never articulated her fears for me so strongly before. We discussed my options and explored my available supports and I left the appointment feeling completely numb and paralysed. However, I was now determined to leave and my thoughts were preoccupied with putting as much in place as possible in the 2 months leading up to the night the death threats occurred."

"I can't even remember what the trigger was on that Saturday night but he was very drunk and he had just lost the job he had recently started. I sat frozen with fear on my bed for hours while he screamed at me that he wanted to kill us both. I could not get out of the house but I managed to lock myself in a bedroom and waited till he left the house the next day before leaving the room. That day I went to see my mother to see if I could stay with her for a while but she was frightened. I went home and locked myself in my room again overnight. On Monday I went to work and spoke to a friend who is a GP and academic and he listened and counselled me at length. He advised me to contact the police to seek assistance, however, I was told there was nothing they could do while I was living in my home with my husband. I never went home again. I had nothing with me except my handbag and the clothes I was wearing."

Maintenance

Maintaining change is often extremely difficult. Most of the time it does not become apparent what change actually means until we have done it. For example, if a woman leaves and finds it emotionally more difficult to be on her own than to deal with violence, she is likely to return. If through leaving she has been denied access to her children, she may also feel compelled to return.

There are many reasons why people return to violent situations, but enjoyment of the violence is not one of them. It may be that several attempts to leave are made before long term success is achieved.

While it may seem that the patient is making an unwise choice, it is more productive to get a better understanding of why the patient chooses to stay. There may be very compelling reasons why the victim believes they cannot leave at this stage. For example, fear for safety and/or lack of external support (personal, financial). Making judgments about the merit of the decision is rarely useful and may alienate the victim.

Mary's experience

"In the first few weeks after leaving I was very ill, both physically and emotionally. The sense of loss and grief for the life I had known for the past 23 years was immense; my home, my garden, my pets and everything I had created was in that house. I could barely function, bursting into tears constantly night and day – I just couldn't control it. I was extremely anxious. I couldn't eat… I couldn't sleep without drinking alcohol. I felt like there was an electric current vibrating through by whole body and I just wanted it all to stop. I found myself thinking that if I could get home again, this violent emotional upheaval and the painful physical symptoms would go away. This is not what I wanted, or how I wanted my life to go. It was the most awful, distressing time of my life. I felt like I would have accepted comfort from almost anywhere. I was incredibly vulnerable and frightened that my husband would follow through with his threats to suicide. I was terrified for my own personal safety and was very concerned that I was putting my mother's safety at risk by staying with her."

"This time I did not go back even though I considered it many times… I knew I would not survive if I did and the many small steps I had made towards independence with the help of a number of people, including my GP, meant that I now had the strength, health and support to leave."

Relapse

In one case, relapse could be when a woman returns to the violent relationship, in another it could be that she has kicked the perpetrator out of the house, but after a period of some months agrees that he can return. Relapse is not failure. It may take more than one attempt or trying an alternative strategy before a long term solution is achieved.

Notes on stages of change

While the stages of change model can be useful, transition through the model is not usually linear. It is preferable to maintain a degree of flexibility rather than adopting a rigid approach when choosing intervention strategies. Motivation can fluctuate considerably, even over short periods of time.[158]

Counselling for intimate personal abuse should address the following, regardless of the stage of change:[153]

- emphasise that abuse and violence is wrong and that no one deserves to be mistreated or harmed
- provide information regarding abuse and violence, options for dealing with it, and community resources and services
- ask what help the patient needs and/or wants and communicate continuing support
- discuss and develop a safety plan.

Providing support at all stages may be the external trigger that many patients identify as leading to making changes.

References

1. World Health Organization. World report on violence and health. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. Geneva: WHO, 2004.
2. Taft A, Hegarty KL, Flood M. Are men and women equally violent to intimate partners? Aust N Z J Public Health 2001;25:498–500.
3. Australian Medical Association. Position statement on domestic violence. Canberra: Australian Medical Association, 1998.
4. Australian Bureau of Statistics. Women's safety survey. Canberra: AGPS, 1996.
5. Walker L. The battered woman. New York: Harper and Row, 1979.
6. Taylor N, Mouzos J. Community attitudes to violence against women survey 2006: a full technical report. Canberra: Australian Institute of Criminology, 2006.
7. Office of the Status of Women. Community attitudes to violence against women. Detailed report. Canberra: AGPS, 1995.
8. Fleming JM. Prevalence of childhood sexual abuse in a community sample of Australian women. Med J Aust 1997;166:65–8.
9. Mazza D, Dennerstein L, Ryan V. Physical, sexual and emotional violence against women: a general practice-based prevalence study. Med J Aust 1996;164:14–7.
10. Mouzos J, Makkai T. Women's experience of male violence: Findings from the Australian component of the International Violence Against Women survey. Canberra: Australian Institute of Criminology, 2004.
11. Hegarty KL. Barriers to disclosure of domestic violence in general practice. Final report. Canberra: Department of Health and Aged Care, 1997.
12. People J. Trends and patterns in domestic violence assaults. Sydney: NSW Bureau of Crime Statistics and Research, 2005.
13. Mouzos J. Femicide: the killing of women in Australia 1989–1998. Canberra: Australian Institute of Criminology, 1999.
14. Bates L, Redman S, Brown W, Hancock L. Domestic violence experienced by women attending an accident and emergency department. Aust J Public Health 1995;19:293–9.
15. O'Donnell C, Smith A, Madison J. Using demographic risk factors to explain variations in the incidence of violence against women. J Interpers Violence 2002;17:1239–62.
16. deLahunta EA, Tulsky AA. Personal exposure of faculty and medical students to family violence. JAMA 1996;275:1903–6.
17. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders – DSM IV. 4th edn. Washington DC: American Psychiatric Association, 1994.
18. Wallace A. Homicide: The social reality. Sydney: New South Wales Bureau of Crime Statistics and Research, 1986.
19. Taft A, Shakespeare J. Managing the whole family when women are abused by intimate partners: challenges for health professionals. In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 145–62.
20. Brewster AL, Milner JS, Mollerstrom WW, Saha BT, Harris N. Evaluation of spouse abuse treatment: description and evaluation of the Air Force Family Advocacy Programs for spouse physical abuse. Mil Med 2002;167:464–9.
21. Hegarty KL. What is intimate partner abuse and how common is it? In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 19–40.
22. Hegarty KL, Feder G, Ramsay J. Identification of partner abuse in health care settings: Should health professionals be screening? In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 70–92.
23. Putt J, Higgins K. Violence against women in Australia: Key research and data issues. Canberra; Australian Institute of Criminology, 1997.
24. Intimate partner abuse and health professionals: New approaches to domestic violence. Roberts G, Hegarty KL, Feder G, editors. London: Churchill Livingstone Elsevier, 2006.

25. Echevarria A, Johar A. Beyond bitter moments: Non-English speaking women's access to support services for survivors of domestic violence. Fairfield West: Ettinger House, 1987.
26. Australian Bureau of Statistics. Personal safety survey. Cat no. 4906.0. Canberra: AGPS, 2005.
27. Roberts GL, O'Toole BI, Lawrence JM, Raphael B. Domestic violence victims in a hospital emergency department. Med J Aust 1993;159:307–10.
28. March L, de Vries Robbe M, Vinen J, Horner D, Roberts G. Prevalence of domestic violence among patients attending a hospital emergency department. Aust and N Z J Public Health 1995;20:364–8.
29. Webster J, Sweett S, Stolz TA. Domestic violence in pregnancy. A prevalence study. Med J Aust 1994;161:466–70.
30. Taft A. Violence against women in pregnancy and after childbirth: Current knowledge and issues in health care responses. Sydney: Australian Domestic & Family Violence Clearinghouse, 2002. Available at www.adfvc.unsw.edu.au/PDF%20files/Issuespaper6.pdf [Accessed 3 April 2008].
31. Campbell J, Laughon K, Woods A. Impact of intimate partner abuse on physical and mental health: how does it present in clinical practice? In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006.
32. McCauley J, Kern DE, Kolodner K, et al. The 'battering syndrome': prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. Ann Intern Med 1995;123:737–46.
33. Hegarty KL, Gunn J, Chondros P, Small R. Association between depression and abuse by partners of women attending general practice: descriptive, cross sectional survey. BMJ 2004;328:621–4.
34. Friedman LS, Samet JH, Roberts MS, Hudlin M, Hans P. Inquiry about victimization experiences. A survey of patient preferences and physician practices. Arch Intern Med 1992;152:1186–90.
35. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med 2006;166:22–37.
36. Gerbert B, Moe J, Caspers N, et al. Physicians' response to victims of domestic violence: Toward a model of care. Women & Health 2002;35:1–22.
36. Gerlock AA. Health impact of domestic violence. Issues Ment Health Nurs 1999;20:373–85.
37. Heise LL. Violence against women: an integrated, ecological framework. Violence Against Women 1998;4:262–90.
38. Danielson KK, Moffitt TE, Caspi A, Silva PA. Comorbidity between abuse of an adult and DSM-III-R mental disorders: evidence from an epidemiological study. Am J Psychiatry 1998;155:131–3.
39. Humphreys C, Regan L, River D, Thiara RK. Domestic violence and substance use: tackling complexity. Br J Soc Work 2005;35:1303–20.
40. Sharps PW, Campbell J, Campbell D, Gary F, Webster D. The role of alcohol use in intimate partner femicide. Am J Addict 2001;10:122–35.
41. Thompson MP, Kingree JB. The roles of victim and perpetrator alcohol use in intimate partner violence outcomes. J Interpers Violence 2006;21:163–77.
42. Brown TG, Werk A, Caplan T, Seraganian P. Violent substance abusers in domestic violence treatment. Violence Vict 1999;14:179–90.
43. Mintz HA, Cornett FW. When your patient is a batterer: what you need to know before treating perpetrators of domestic violence. Postgrad Med 1997;101:219–28.
44. Helfritz LE, Stanford MS, Conklin SM, Greve KW, Villemarette-Pittman NR, Houston RJ. Usefulness of self-report instruments in assessing men accused of domestic violence. Psychol Rec 2006;56:171–80.
45. Adams D. Guidelines for doctors on identifying and helping their patients who batter. J Am Med Womens Assoc 1996;51:123–6.
46. Taft A, Broom DH, Legge D. General practitioner management of intimate partner abuse and the whole family: qualitative study. BMJ 2004;328:618.
47. Miller D, Jaye C. GP's perception of their role in the identification and management of family violence. Fam Pract 2007;24:95–101.
48. Victorian Community Council on Crime and Violence. Management of the whole family when intimate partner violence is present: Guidelines for primary care physicians. Melbourne: Victorian Government Department of Justice, 2006.
49. Stiles MM. Witnessing domestic violence: the effect on children. Am Fam Physician 2002;66:2052, 5–6, 8 passim.
50. Street AE, King LA, King DW, Riggs DS. The associations among male – perpetrated partner violence, wives' psychological distress and children's behaviour problems: A structural equation modeling analysis. J Comp Fam Stud 2003;34:23–40.
51. Levendosky AA, Lynch SM, Graham-Bermann SA. Mothers' perceptions of the impact of woman abuse on their parenting. Violence Against Women 2000;6:247–71.

52. National Child Protection Clearinghouse. Child abuse statistics. National Child Protection Clearinghouse resource sheet. Canberra: Australian Institute of Family Studies, No. 1, 2008. Available at www.aifs.gov.au/nch/pubs/sheets/rs1/rs1.pdf [Accessed 7 July 2008].
53. Australian Bureau of Statistics. Australian social trends. Cat no. 4102.0. Canberra: AGPS, 2003.
54. Child Protection and Family Services. What is child abuse? Melbourne: State Government of Victoria, Department of Human Services, 2008. Available at www.cyf.vic.gov.au/child_protection/library/publications/protection/what [Accessed 23 July 2008].
55. Available at www.cyh.com/healthtopics.
56. Zwi KJ, Woolfenden SR, Wheeler DM, O'Brien TA, Tait P, Williams KW. School-based education programmes for the prevention of child sexual abuse. Cochrane Database Syst Rev. Available at www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004380/frame.html.
57. Geeraert L, van den Noortgate W, Grietens H, Onghena P. The effects of early prevention programs for families with young children at risk for physical child abuse and neglect: a meta-analysis. Child Maltreatment 2004;9:277–91.
58. Child Protection Senior Officers Group. New South Wales interagency guidelines for child protection intervention. Sydney: NSW Department of Community Services, 2006. Available at www.community.nsw.gov.au/docswr/_assets/main/documents/interagency_guidelines.pdf [Accessed 30 April 2008].
59. Department of Human Services. Protecting Victoria's children. Child protection practice manual. Melbourne: State Government of Victoria, 2007.
60. Slee P. The PEACE pack: A program for reducing bullying in our schools. In: Jimerson SR, Swearer SM, Espelage DL, editors. The International Handbook of School Bullying. New York: Routledge, 2008.
61. Smorti A, Menesini E, Smith P. Parents' definitions of children's bullying in a five-country comparison. J Cross Cult Psychol 2003;34:417–32.
62. Bond L, Carlin JB, Thomas L, Rubin K, Patton G. Does bullying cause emotional problems? A prospective study of young teenagers. BMJ 2001;323:480–4.
63. Fekkes M, Pijpers FI, Fredriks AM, Vogels T, Verloove-Vanhorick SP. Do bullied children get ill, or do ill children get bullied? A prospective cohort study on the relationship between bullying and health-related symptoms. Pediatrics 2006;117:1568–74.
64. Rigby K. Consequences of bullying in schools. Can J Psychiatry 2003;4:583–90.
65. Sourander A, Ronning JA, Niemela S, et al. What is the early adulthood outcome of boys who bully or are bullied in childhood? The Finnish 'From a Boy to a Man' study. Pediatrics 2007;120:397–404.
66. Rigby K, Slee PT. Bullying in Australia. In: Morita J, Smith P, Junger-tas J, et al, editors. School bullying around the world challenges and interventions. Tokyo: Kaneko Shobo Co, 1999.
67. Bond L, Wolfe S, Tollit M, Butler H, Patton G. A comparison of the Gatehouse Bullying Scale and the peer relations questionnaire for students in secondary school. J Sch Health 2007;77:75–9.
68. Bottroff V. The development of friendships and the puzzle of autism. In: Slee P, Rigby K, editors. Children's peer relations. London: Routledge, 1998.
69. Slee P. Bullying: Health concerns of Australian secondary school students. Int J Adolesc Youth 1995;1:29–39.
70. Williams K, Chambers M, Logan S, Robinson D. Association of common health symptoms with bullying in primary school children. BMJ 1996;313:17–9.
71. Fekkes M, Pijpers FI, Verloove-Vanhorick SP. Bullying behavior and associations with psychosomatic complaints and depression in victims. J Pediatr 2004;144:17–22.
72. Kaiser Family Foundation. Highlights and charts pack. Washington: Kaiser Family Foundation, 2002.
73. Nansel TR, Overpeck M, Pilla RS, Ruan WJ, Simons-Morton B, Scheidt P. Bullying behaviors among US youth: prevalence and association with psychosocial adjustment. J Am Med Assoc 2001;285:2094–3100.
74. Rigby K, Slee PT. Manual for The Peer Relations Questionnaire. Adelaide: University of South Australia, 1995.
75. Lyznicki JM, McCaffree MA, Robinowitz CB. Childhood bullying: implications for physicians. Am Fam Physician 2004;70:1723–8.
76. Dawkins J. Bullying in schools: doctors' responsibilities. BMJ 1995;310:274–5.
77. Wolke D, Samara MM. Bullied by siblings: association with peer victimisation and behaviour problems in Israeli lower secondary school children. J Child Psychol Psychiatry 2004;45:1015–29.
78. Hahn R, Fuqua-Whitley D, Wethington H, et al. Effectiveness of universal school-based programs to prevent violent and aggressive behavior: a systematic review. Am J Prev Med 2007;33(2 Suppl):S114–29.
79. Chartier MJ, Walker JR, Naimark B. Childhood abuse, adult health, and health care utilization: results from a representative community sample. Am J Epidemiol 2007;165:1031–8.
80. Easteal P, editor. Survivors of sexual assault: A national survey. Canberra: Australian Institute of Criminology, 1992.

81. Coid J, Petruckevitch A, Feder G, Chung W, Richardson J, Moorey S. Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. Lancet 2001;358:450–4.
82. Stojadinovic T, editor. Listen and believe community campaign against child sexual abuse. Child Sexual Abuse: Justice Response or Alternative Resolution Conference; 2003 1–2 May; Adelaide. Australian Institute of Criminology.
83. Women's Health Statewide. The Care of Adult Survivors in General Practice Project, 2007.
84. Australian Institute of Health and Welfare. Child protection Australia 2006–2007. Cat no CWS 31. Canberra: Australian Institute of Health and Welfare, 2008.
85. Walling MK, Reiter RC, O'Hara MW, Milburn AK, Lilly G, Vincent SD. Abuse history and chronic pain in women: I. Prevalences of sexual abuse and physical abuse. Obstet Gynecol 1994;84:193–9.
86. Anda RF, Croft JB, Felitti VJ, et al. Adverse childhood experiences and smoking during adolescence and adulthood. J Am Med Assoc 1999;282:1652.
87. Mammen G. After abuse. Camberwell: ACER Press, 2006.
88. de Visser RO, Smith AM, Rissel CE, Richters J, Grulich AE. Sex in Australia: experiences of sexual coercion among a representative sample of adults. Aust N Z J Public Health 2003;27:198–203.
89. Miller TR, Cohen MA, Wiersema B. Victim costs and consequences: A new look – National Institute of Justice Research Report. Maryland: US Department of Justice, Office of Justice Programs, 1996.
90. Tjaden P, Thoennes N. Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey. Denver: US Department of Justice, Office of Justice Programs, 1998.
91. Coomaraswamy R. Report of the Special Rapporteur on violence against women, its causes and consequences. Geneva: World Health Organization, 1997.
92. Australian Bureau of Statistics. Population by age and sex, Australian States and Territories. Canberra: AGPS, 2006.
93. Australian Bureau of Statistics. Recorded crime – victims. Canberra: AGPS, 2005.
94. Peipert JF, Domagalski LR. Epidemiology of adolescent sexual assault. Obstet Gynecol 1994;84:867–71.
95. Hurley M, Parker H, Wells DL. The epidemiology of drug facilitated sexual assault. J Clin Forensic Med 2006;13:181–5.
96. Tucker JS, Wenzel SL, Straus JB, Ryan GW, Golinelli D. Experiencing interpersonal violence: perspectives of sexually active, substance-using women living in shelters and low-income housing. Violence Against Women 2005;11:1319–40.
97. VanZile-Tamsen C, Testa M, Livingston JA. The impact of sexual assault history and relationship context on appraisal of and responses to acquaintance sexual assault risk. J Interpers Violence 2005;20:813–32.
98. Alder C. Homeless youth as victims of violence – Report to the Criminology Research Council. Melbourne: University of Melbourne, 1989.
99. Bassuk EL, Weinreb LF, Buckner JC, Browne A, Salomon A, Bassuk SS. The characteristics and needs of sheltered homeless and low-income housed mothers. JAMA 1996;276:640–6.
100. Martin SL, Ray N, Sotres-Alvarez D, et al. Physical and sexual assault of women with disabilities. Violence Against Women 2006;12:823–37.
101. Robertson JE. Rape among incarcerated men: sex, coercion and STDs. AIDS Patient Care STDS 2003;17:423–30.
102. Church S, Henderson M, Barnard M, Hart G. Violence by clients towards female prostitutes in different work settings: questionnaire survey. BMJ 2001;322:524–5.
103. Amowitz LL, Reis C, Lyons KH, et al. Prevalence of war-related sexual violence and other human rights abuses among internally displaced persons in Sierra Leone. JAMA 2002;287:513–21.
104. Loh C, Gidycz CA. A prospective analysis of the relationship between childhood sexual victimization and perpetration of dating violence and sexual assault in adulthood. J Interpers Violence 2006;21:732–49.
105. Al-Yaman F, Van Doeland M, Wallis M. Family violence among Aboriginal and Torres Strait Islander peoples. Canberra: Australian Institute of Health and Welfare, 2006.
106. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander social survey. Canberra: AGPS, 2002.
107. Burgess AW, Holmstrom LL. Rape trauma syndrome. Am J Psychiatry 1974;131:981–6.
108. National Centre for Victims of Crime, Crime Victims Research and Treatment Centre. Rape in American: A report to the nation. Arlington, VA: National Centre for Victims of Crime, 1992.
109. Green AH. Child sexual abuse: immediate and long-term effects and intervention. J Am Acad Child Adolesc Psychiatry 1993;32:890–902.
110. Elder Abuse Prevention Project. Strengthening Victoria's Response to Elder Abuse. Melbourne: State Government of Victoria, Department for Victorian Communities, 2005.

111. Elder Abuse Prevention Unit. EAPU – Promoting the right of older people to live free from abuse. Queensland Government, Department of Communities, 2007. Available at www.eapu.com.au/ [Accessed 26 February 2007].
112. National Centre on Elder Abuse. Frequently asked questions. National Centre on Elder Abuse, 2006. Available at www.elderabusecenter.org/default.cfm?p=faqs.cfm [Accessed 26 February 2007].
113. Victorian Community Council Against Violence. Preventing elder abuse through the health sector. Melbourne: State Government of Victoria, Department of Justice, 2005.
114. Victorian Health and Community Services. With respect to age: A guide to health service and community agencies dealing with elder abuse. Melbourne: Aged Care Services Victoria, 1995.
115. Australian Society of Geriatric Medicine. Position statement no. 1: Elder abuse. Sydney: Australian Society of Geriatric Medicine, 2003. Available at www.asgm.org.au/posstate.htm [Accessed 26 February 2007].
116. McCreadie C, Bennett G, Gilthorpe MS, Houghton G, Tinker A. Elder abuse: do general practitioners know or care? J R Soc Med 2000;93:67–71.
117. The Senate Committee of Inquiry. Quality and equity in aged care report. Canberra: Commonwealth Government of Australia, 2005.
118. Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI)©. J Elder Abuse Negl 2008;20:276.
119. Australian Bureau of Statistics. Migration. Canberra: AGPS, 2006.
120. Lawrie R. Speak out speak strong. Researching the needs of Aboriginal women in custody. New South Wales: Aboriginal Justice Advisory Council, 2002.
121. McNair R, Kavanagh A, Agius P, Tong B. The mental health status of young adult and mid-life non-heterosexual Australian women. Aust N Z J Public Health 2005;29:265–71.
122. Keilty J, Connelly G. An exploratory study of the barriers facing women with an intellectual disability when they make a statement to the police about sexual assault. Sydney: Intellectual Disability Rights Service, 2000. Available at www.idrs.org.au/pubs/statement.html [Accessed 21 May 2007].
123. Rodriguez MA, Saba G. Cultural competence and intimate partner abuse: health care interventions. In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 179–96.
124. Australian Bureau of Statistics. Census 2006. Basic community profile. Canberra: Australian Bureau of Statistics, 2006. Available at www.abs.gov.au/websitedbs/d3310114.nsf/Home/census [Accessed 4 May 2008].
125. Echevarria A, Johar A. Beyond bitter moments: Non-English speaking women's access to support services for survivors of domestic violence. Fairfield West: Ettinger House, 1987.
126. Atkinson J. Intimate partner abuse and Indigenous peoples. In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 197–212.
127. Gordon S, Hallahan K, Henry D. Putting the picture together. Inquiry into response by government agencies to complaints of family violence and child abuse in Aboriginal communities. Perth: Department of Premier and Cabinet, 2002.
128. McNair R. Lesbian health inequalities: a cultural minority issue for health professionals. Med J Aust 2003;178:643–5.
129. Relf MV, Glass N. Gay and lesbian relationships and intimate partner abuse. In: Roberts G, Hegarty KL, Feder G, editors. Intimate partner abuse and health professionals New approaches to domestic violence. London: Churchill Livingstone Elsevier, 2006; p. 213–28.
130. Wilson C, Nettlebeck T, Potter R, Perry C. Intellectual disability and criminal victimisation. Canberra: Australian Institute of Criminology, 1996.
131. Nosek M. Sexual abuse of women with physical disabilities. In: Krotoski D, Nosek M, Turk M, editors. Women with physical disabilities – achieving and maintaining health and well being. Baltimore, USA: Paul Brookes Publishing Co, 1996.
132. Australian Bureau of Statistics. Disability. Canberra: AGPS, 2003.
133. Wen X. The definition and prevalence of intellectual disability in Australia. Canberra: Australian Institute of Health and Welfare, 1997.
134. Saxton M, McNeff E, Powers L, Curry M, Limont M, Benson J. We're all little John Waynes: A study of disabled men's experience of abuse. J Rehabil 2006;72:3–13.
135. Blyth J, editor. Sexual abuse of people with a disability practice and prevention: Contemporary Issues in Adult Sexual Assault in NSW Conference; 2003 12–14 February University of Technology, Sydney.
136. Hudnall-Stamm B. Secondary traumatic stress: self-care issues for clinicians, researchers and educators. Lutherville, MD: Sidran Press, 1995.

137. National Centre for Posttraumatic Stress Disorder. Working with trauma survivors: what workers need to know. National Centre for Posttraumatic Stress Disorder Fact Sheet. Washington, DC: Department for Veteran's Affairs, 2007.
138. Saakvitne K, Pearlman L. Transforming the pain: a workbook on vicarious traumatisation. London: Norton, 1996.
139. Weiner EL, Swain GR, Wolf B, Gottlieb M. A qualitative study of physicians' own wellness-promotion practices. West J Med 2001;174:19–23.
140. Miller D, Jaye C. GPs' perception of their role in the identification and management of family violence. Fam Pract 2007;24:95–101.
141. Snowdon T, Benson J, Proudfoot J. Capacity and the quality framework. Aust Fam Physician 2007;36:12–4.
142. Edwards N, Kornacki MJ, Silversin J. Unhappy doctors: what are the causes and what can be done? BMJ 2002;324:835–8.
143. Freeborn DK. Satisfaction, commitment, and psychological well-being among HMO physicians. West J Med 2001;174:13–8.
144. Figley CR. Coping with traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel, 1995.
145. The Royal Australian College of General Practitioners. Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting. Melbourne: The RACGP, 2006.
146. Prochaska JO, Di Clemente CC. Transtheoretical therapy: toward a more integrative model of change. Psychotherapy: theory, research and practice. 1982;19:276–88.
147. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Applications to addictive behaviors. Am Psychol 1992;47:1102–14.
148. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. Am J Health Promot 1997;12:38–48.
149. Burke JG, Denison JA, Gielen AC, McDonnell KA, O'Campo P. Ending intimate partner violence: an application of the transtheoretical model. Am J Health Behav 2004;28:122–33.
150. Frasier PY, Slatt L, Kowlowitz V, Glowa PT. Using the stages of change model to counsel victims of intimate partner violence. Patient Educ Couns 2001;43:211–7.
151. Zink T, Elder N, Jacobson J, Klostermann B. Medical management of intimate partner violence considering the stages of change: precontemplation and contemplation. Ann Fam Med 2004;2:231–9.
152. Rollnick S, Mason P, Butler C. Health behavior change. Edinburgh: Churchill Livingstone, 1999.
153. Chang JC, Dado D, Ashton S, et al. Understanding behavior change for women experiencing intimate partner violence: mapping the ups and downs using the stages of change. Patient Educ Couns 2006;62:330–9.
154. Beaulaurier RL, Seff LR, Newman FL, Dunlop BD. Internal barriers to help seeking for middle-aged and older women who experience intimate partner violence. J Elder Abuse Negl 2005;17:53–74.
155. Gutmanis I, Beynon C, Tutty L, Wathen CN, MacMillan HL. Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. BMC Public Health 2007;7:12.
156. Hlavka HR, Kruttschnitt C, Carbone-Lopez KC. Revictimizing the victims: interviewing women about interpersonal violence. J Interpers Violence 2007;22:894–920.
157. Petersen R, Moracco KE, Goldstein KM, Clark KA. Moving beyond disclosure: women's perspectives on barriers and motivators to seeking assistance for intimate partner violence. Women Health 2004;40:63–76.
158. Litt J, Girvin H. Stages of change: a critique. Behavior Modification 2002;26:223–73.

Appendix 1. DSM-IV Post-traumatic stress disorder criteria

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognisable content

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma specific re-enactment may occur

(4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

(5) psychological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (eg. unable to have loving feelings)

(7) sense of a foreshortened future (eg. does not expect to have a career, marriage, or children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: American Psychiatric Association. Diagnostic and statistical manual of mental disorders – DSM-IV, 4th edn. Washington DC: APA, 1994; p. 247

Appendix 2. Abuse assessment screen

1) Have you ever been emotionally or physically abused by your partner or someone important to you?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

2) Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

3) Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

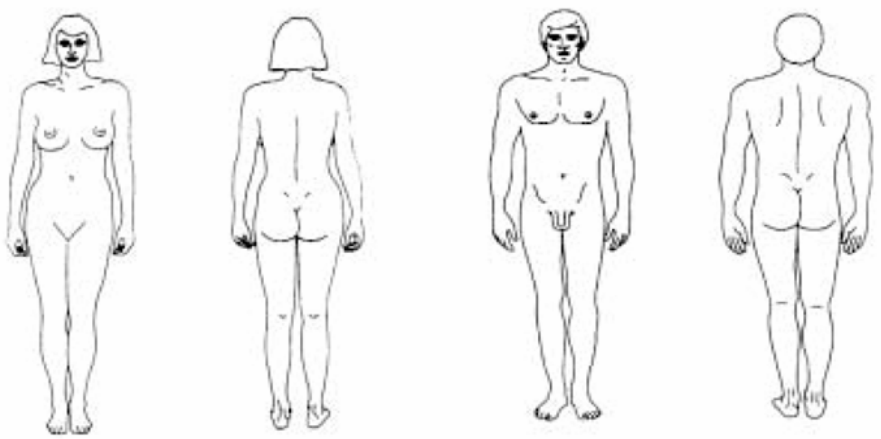
4. Within the last year, has anyone forced you to have sexual activities?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

5. Are you afraid of your partner or anyone you listed above?
   Yes ☐ No ☐

MARK THE AREA OF INJURY ON A BODY MAP AND SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

If any of the descriptions for the higher number apply, use the higher number.

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon



Source: Family Violence Prevention Fund

Appendix 3. Elder Abuse Suspicion Index

ELDER ABUSE SUSPICION INDEX © (EASI)			
EASI Questions **Q.1-Q.5 asked of patient; Q.6 answered by doctor** **Within the last 12 months:**			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
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?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com

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Appendix 4. Local resource directory

Name of service – personnel contact	Telephone number
Child abuse services	
Counsellors	
Sexual assault services	
Counsellors	
Intimate partner abuse services	
Counsellors	
Services for children living in abusive families	
Abuse of the elderly services	
Respite care	
Women's refuges	
Local police	
Legal aid services	
Local Magistrates' Court	
Services for men	

Appendix 5. Mary's decision balance

	Like/benefits	Dislikes/costs
Stay the same	I will maintain my current identity – I have been married for 23 years and being Paul's wife is who I feel I am, my patterns of being, how I relate to others is as a married person I have a relationship with someone who understands my grief at not being able to have children There are good times and I know he loves me and is faithful to me I feel I have a safety net if I am married Sometimes I feel he cares more about my welfare than anyone else and he is there for me when I am sick He does a lot around the house and in the garden He always knows where I am and if I am safe I love my home and garden, my neighbourhood and I want to stay here I will continue to have a partner and not be alone and come home to an empty house Our shared history and memories is extensive I will be better off financially He has always controlled all our financial affairs and kept them a secret so I know very little about our affairs as he pays all the bills Mutual friendships and social life will stay the same Relationships with husband's children and family will be maintained	I will remain desperately unhappy most of the time I will continue to be 'trapped' in the house while he drinks until he is very drunk most nights and weekends I will continue to be abused and will not be able to prevent it I will continue to have little or no control over many aspects of my life including financial affairs I will continue to be forced to sacrifice many things that are important to me in order to keep the peace I will continue to sleep alone and spend a lot of time hiding in my bedroom I will continue to suffer from extreme stress and anxiety and will continue to feel unwell and exhausted My domestic situation will continue to prevent me from achieving my professional goals and complete my studies as the abuse escalates when I appear preoccupied and 'selfish' My friends will continue to feel that they cannot visit me at home because of Paul's hostility toward them and constant nagging of me My family will continue to stay away from my home He will continue to put me down and embarrass me in front of others, and my good friends and family will continue to not invite/include us because of this, knowing if they say something to him it will 'back fire' on me afterward I will continue to feel my life is not my own and is 'on-hold'
Change, eg. leave partner, take out a restraining order	I will be taking control of my life and protecting myself from the violence and abuse It will take time but I will learn to cope by myself I will have control of the information I need to make decisions about my life and future I have some good friends who I know will support and help me I will stop feeling like I'm dying a slow death, trapped in a house with a man who is usually very drunk and angry I can begin to build a new life, new friends and hopefully in time feel happy again The abuse and fear and humiliation will stop	I will have to leave my home and find somewhere to live I am extremely fearful of leaving because of the consequences for my personal safety if I try to leave I will face a great deal of hostility from Paul and I feel like I don't have the strength and the knowledge required for all the changes I will need to make I will be alone, no home, no children and no husband I will have to 'fight' to get anything out of the marriage because he has repeatedly threatened that if I leave I will get nothing because I contributed nothing to the marriage I know it will be extremely difficult for me to start over and regain a sense of who I am again and my confidence is low