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Intimate partner violence

Identification and response in general practice

Background

Intimate partner violence is a common problem among women attending general practice, with around one in 10 women currently experiencing physical, sexual or emotional abuse by a partner. Abused women frequently present with physical and psychosocial issues. Yet intimate partner violence often remains concealed and addressing it poses challenges for the clinician and patient alike.

Objective

Although some of the general recommendations in this review may also apply to same-sex relationships and to women who abuse men, this article discusses identifying intimate partner violence in women who present to general practice.

Discussion

Identifying intimate partner violence is important in clinical practice as it underlies many common physical and mental health presentations. Facilitating disclosure and responding effectively requires good communication skills. Safety assessment of women and their families, pinpointing level of readiness to contemplate action, and providing appropriate referral options and ongoing nonjudgmental support are elements of an effective response. General practitioners have the potential to identify women and support them safely on a pathway to recovery, thereby avoiding the long term impacts of intimate partner violence.

Keywords: domestic violence; general practice; spouse abuse

CPD

Case study

Marilyn is an accountant, 30 years of age, married for 8 years to a construction worker. She presents with low energy and headaches that have affected her for over a year. They have worsened in the past month (since her husband was laid off), affecting her mostly at the end of the day. She has trouble sleeping and reports aches and pains all over. She has been to several other clinics in the past year but has found nothing to be helpful. She has had blood tests, been prescribed painkillers, been advised to get more exercise and change her diet. She desperately needs something to be done for her today as her husband is getting impatient with the lack of results. She is concerned he will become very angry with her when she returns home today. Marilyn's doctor asks, 'what happens when your partner becomes angry?' She has not previously been asked this question and she hesitates. Her doctor says, 'I would really like to hear what is going on at home'. She bursts into tears and slowly the story of her experience of partner violence unfolds. The doctor assesses her safety and Marilyn indicates she feels she can manage what is happening for now. They make a follow up appointment for ongoing support.

Intimate partner violence (IPV) is defined by the World Health Organization as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.[1] Abuse includes physical and sexual violence, emotional abuse (eg. prohibiting the partner from seeing family and friends, ongoing humiliation or intimidation), economic restrictions (eg. preventing the partner from working, confiscating earnings), and other controlling behaviours (eg. monitoring movements, restricting access to information or assistance). Survivors of IPV report that the psychological abuse is often worse than the physical violence.[2] Repeated, coercive, sexual or severe physical violence is largely perpetrated against women by men, although lifetime prevalence of isolated

violent acts within relationships is comparable between men and women.[3] Multiple lifetime victimisation is common. A personal history of child abuse is a risk factor for being a victim or perpetrator, and perpetrators are likely to come from violent families.[4] Some of the general recommendations in this review may also apply to same-sex relationships and to women who abuse men, however, there is limited evidence from these groups.[5]

Intimate partner violence is the leading contributor to morbidity and mortality for women of child bearing age.[6] Intimate partner violence is highly prevalent in general practice patients, with presentations of psychological and physical symptoms commonly a consequence of IPV. A GP in full time practice is likely to see up to five women per week who have experienced abuse in the past year.[7] Where a GP suspects IPV in the family, the safety and health of the children also needs to be considered, given the close association with child abuse.[8]

When to suspect IPV

The *Guidelines for preventive activities in general practice*[9] draw on recent consensus guidelines[10] recommending that clinicians ask all pregnant women about IPV. A case finding approach can be taken in situations where patients show clinical indicators of IPV[11] (*Table 1*). Common presentations by women include both somatic and psychological complaints, the most prevalent mental health sequelae being depression, anxiety, substance use and post-traumatic stress disorder.[11,12] Men who use violence at home may present asking for help with anger issues, relationship problems or drug/alcohol use.[13] Children who witness violence may present with behavioural, learning or psychological issues.[14]

How to sensitively ask about IPV

Systematic reviews demonstrate insufficient evidence to recommend for or against the screening of all women.[5] The majority of women are open to being asked about IPV if undertaken in a sensitive and nonjudgmental way,[15] and good communication skills facilitate disclosure independent of clinician gender.[15] It is recommended that GPs move from generic questions about relationship problems to direct enquiry about abuse and violence (*Table 2*).[16,17]

Priorities and principles of management

Guidance in this area comes from systematic reviews,[5] women's voices[15] (*Table 3*) and international expert consensus guidelines.[10] In their initial response, GPs need to validate the experience, clearly state that any violence in relationships is unacceptable (*Table 4*) and support the woman to consider her various options.[17] General practitioners also need to assess safety[17] (*Table 5*) and respond to the woman's safety needs by tailoring their approach to her position in terms of naming the abuse and readiness for action.[18] Women who fear for their lives or are in crisis need to be connected with specialist IPV services. While the referral process is similar to that used with acute suicide risk in general practice, it differs in that services can only be sought with the woman's consent. Respecting women's wishes and assessment of safety are essential in empowering women to seek their own solutions.[19]

Responses need to be different for women at various points in a cycle of change (*Table 6*). The majority of women seen in general

Table 1. Clinical indicators of partner abuse[11]

General	Physical
• Delay in seeking treatment/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	• Obvious injuries, especially to head/neck or multiple areas • Bruises in various stages of healing • Sexual assault • Sexually transmissible infections • Chronic pelvic pain • Chronic abdominal pain • Chronic headaches • Chronic back pain • Numbness and tingling from injuries • Lethargy
Psychological	**Pregnancy indicators**
• Insomnia • Depression • Suicidal ideation • Anxiety symptoms and panic disorder • Somatoform disorder • Post-traumatic stress disorder • Eating disorders • Drug and alcohol abuse	• Miscarriages • Unwanted pregnancy • Antepartum haemorrhage • Lack of prenatal care • Low birth weight of infant

practice are not in crisis, rather, they require ongoing support to explore their options, which may include referral to specialist services about legal, financial and housing needs, or to psychological therapy. Advocacy, particularly for women from refuge populations, has been shown to reduce abuse and increase safety behaviours and use of community resources.[20] Psychological treatments based on cognitive behaviour therapy delivered by clinicians trained in IPV management have been shown to be effective in reducing depression in abused women.[5] There is limited evidence and services for male survivors of abuse.[17]

Table 2. Possible questions to ask if you suspect intimate partner violence[17]

Are you now or have you recently been afraid of your partner/expartner?
What happens when your partner gets angry?
Have you felt humiliated or emotionally abused by your partner/expartner?
Sometimes partners use physical force. Is this happening to you?
Has your partner ever physically threatened or hurt you?
Have you been kicked, hit, slapped or otherwise physically hurt by your partner/expartner?
Within the past year, have you been forced to have any kind of sexual activity by your partner/expartner?

General practitioners frequently see all members of the family. The central principles of whole family care are safety and confidentiality (within legal limits) for victims, children and perpetrators. Clinicians should never attempt to raise IPV with the offending partner without first seeking the woman's permission.[17] Joint counselling is not recommended and specific counselling needs to be by professionals trained in abuse and violence. Perpetrator management in general practice is based on consensus guidelines which suggest similar principles to the management of women survivors.[10] General practitioners should funnel questions to potential perpetrators from the general, 'how are things at home?' to the specific, 'how do your partner/children respond when you shout/hit/threaten?'[17] If disclosure of use of violence occurs, it is appropriate to acknowledge the unacceptability of violent behaviour and offer ongoing support (if he is willing to change), which may involve referral to an accredited behaviour change program. Of vital importance is assessing the patient's suicide risk and the family's safety. Explanation of the limits of confidentiality is also appropriate.

Legal obligations of the GP

General practitioners can assist patients by having basic understanding of the legal implications of IPV. The Northern Territory is the only jurisdiction that has mandatory reporting requirements whereby any adult must report IPV to the police if they reasonably believe that a person has experienced, or is likely to suffer, serious physical harm.[21]

Table 3. What women say they want from clinicians[15]

Before disclosure or questioning	Immediate response to disclosure
Understand the issue, including knowing community services/appropriate referrals	Respond in a nonjudgmental way, with support and belief of experiences
Ensure that the clinical environment is supportive, welcoming and nonthreatening	Acknowledge complexity of the issue, respect the woman's unique concerns and decisions
Place brochures/posters in the clinical setting	Put patient identified needs first and ensure social/psychological needs are addressed
Try to ensure continuity of care	Take time to listen, provide information and offer referral to specialist help
Be alert to the signs of abuse and raise the issue	Validate her experiences, challenge assumptions and provide encouragement
Use verbal and nonverbal communication skills to develop trust	Address safety concerns
Assure abused women about privacy, safety and confidentiality issues	
When the issue of intimate partner violence is raised	**Response in later interactions**
Be nonjudgmental, compassionate and caring when questioning about abuse	Be patient and supportive, allow the woman to progress at her own therapeutic pace
Be confident and comfortable asking about intimate partner violence	Understand the chronicity of the problem and provide follow up and continued support
Do not pressure to disclose, as simply raising the issue can help	Respect the woman's wishes and do not pressure her into making any decisions
Ask about abuse several times as disclosure may occur at a later date	Be nonjudgmental if women do not follow up on referrals immediately
Ensure that the environment is private and confidential	

Child abuse often co-exists with IPV and if the nonoffending parent has been unable to improve her own or children's safety or there are any concerns for the children's safety, GPs are mandated to report to child protection services. (See the article 'Child abuse: mandatory reporting requirements' by Sara Bird in this issue.)

Child abuse increasingly includes exposure to IPV in the home, given the detrimental impact witnessing abuse has on outcomes for children and young people.[14] Yet mandatory reporting in relation to childhood exposure to IPV remains controversial with many arguing that it discourages mothers to disclose abuse. At present, mandatory reporting for child exposure to IPV applies in the Northern Territory only.[22] Where a GP suspects that there is imminent and serious risk to a patient or her child's wellbeing, it is appropriate to disclose to the police on the basis of an overriding duty in the public interest. The difficulty for individual practitioners is deciding when this should be done. It is advisable that GPs seek legal advice from their indemnity insurer and/or medical defence organisation.[18]

Table 4. Possible validation statements if a woman discloses[17]

Everybody deserves to feel safe at home
No-one deserves to be hit or hurt in relationships
I am concerned about your safety and wellbeing. Let's work together on this
Abuse is common and happens in all kinds of relationships. It tends to continue. You are not to blame
Abuse can affect your health and that of your children

Table 5. Assessing the safety of abused women[17]

How safe does she feel?
What does she need in order to feel safe?
Has the frequency and severity of violence increased recently?
Is he obsessive about her?
Has she been threatened with a weapon?
Does he have a weapon in the house?
Does he have a drug issue or a history of criminal activity?
Does he have a psychiatric history?

Legal options for women

It is appropriate to clearly communicate that IPV is a crime, and encourage patients to obtain their own legal advice to protect themselves and their children. General practitioners can refer patients to local community legal centres, women's legal services, legal aid and court support services. General practitioners should document injuries and other health effects and the frequency and severity of abuse. In all jurisdictions, victims of domestic assault/injury (including sexual assault), intentional damage to property, and threats of such behaviour can apply under civil law for a protection order (variously known as intervention, apprehended or restraining orders).[23] The legislation in several jurisdictions expressly includes 'economic' and 'psychological' abuse as forms of IPV. Violating an order constitutes a criminal offence. Orders may be sought directly through the court by victims themselves or by an approved proxy (eg. police) on their behalf, and may be obtained even if the victim and perpetrator live together. An interim order can be implemented immediately in situations where the victim is at high risk.

Table 6. Stages of change for a woman experiencing intimate partner violence[18]

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

Table 7. Resources for patients and GPs (Australia wide)

	Telephone	Website
National Sexual Assault, Family & Domestic Violence Counselling Line	1800 200 526	fahcsia.gov.au
Relationships Australia	1300 364 277	relationships.org.au
Domestic Violence Resource Centre	State based	dvrc.org.au
Kids Helpline	1800 55 1800	kidshelp.com.au
Aboriginal Family Violence Prevention & Legal Service	1800 105 303	fvpls.org
Lifeline	13 11 14	lifeline.org.au
MensLine Australia	1300 78 99 78	mensline.org.au
National Association of Community Legal Centres	02 9264 9595	naclc.org.au
Translating and Interpreting Service	131 450	immi.gov.au/tis

Resources and supports

Individuals exposed to IPV have a range of requirements encompassing health, legal, housing, welfare, counselling, social connectedness, training and employment. The most appropriate resource and support options are usually those available at a local level. Local generalist women's information services or domestic violence resource centres can provide a range of options for responding to diverse and complex needs (*Table 7*).[18]

Summary

Intimate partner violence is a serious, common and persistent public health problem that compromises the social and moral fabric of our society. Intimate partner violence is not limited to physical violence; there are many different types of violent and controlling behaviour. As patients experiencing IPV may present with a wide range of physical and psychosocial health issues, GPs need to consciously consider IPV in their patients. If approached in a sensitive and nonjudgemental way, the majority of women are open to being asked about IPV and awareness of this can help break down the conspiracy of silence surrounding this issue. The tools and resources identified here can help GPs identify and respond to IPV in their patients. Acknowledging women's autonomy is central in the process of supporting them and their children to achieve safer, healthier lives.

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Conflict of interest: none declared.

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