Partner abuse

– recognition and management in general practice

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What's the problem?

The suffering and fear engendered by partner violence, which includes threats and controlling behaviours, is usually hidden. The health ramifications are often unrecognised. They include gastric upsets, unintended pregnancy, pelvic/abdominal pain, sexually transmitted infections, poor compliance with medications, poor antenatal attendance, low birth-weight, suicidal behaviour, insomnia, anxiety and depression, eczema and asthma exacerbations, palpitations, hyperventilation, fatigue, headaches and chronic pain, eating disorders, and drug, alcohol and nicotine abuse. Physical manifestations include fractures, burns, soft tissue injuries, consequences of sexual assault/abuse, damaged hearing, impaired vision, epilepsy, and loss of dentition.[1,2] It occurs with little regard for race, age, income or education level.[3,4]

Few incidents of partner abuse reach the headlines, but in New Zealand around 12 women are killed annually by their partner.[5] Often this is during the time they are trying to leave a relationship, or in the 12 months following separation. The question *'why doesn't she just leave?'* has a salutary answer. It may be safer to stay until a careful plan is made and support is in place.

General practitioners are in an ideal position to recognise partner violence and respond early before crises occur

About eight New Zealand children die each year as a result of family violence. For the survivors the adverse effects of ongoing domestic violence on developing minds are well documented and have ramifications not only for health and education, but eventually in the criminal justice system. Where partner abuse is occurring, child abuse is also going on in 40–50% of cases.[5,6,7,8,9]

Facts

One-third of women, over a lifetime, report incidents in relationships that are easily recognised as unhealthy. The key is fear, and loss of autonomy that develops from a pattern of coercive behaviours by a partner.[1,4,10,11,12] By deduction, 66% of women are in healthy and mutually acceptable relationships, and have not experienced intimate partner abuse in any form. With the help of family, friends and community resources most patients 'spiral out' of their unhealthy situations. About 8–15% of women will have experienced abuse in the previous 12 months.[1]

A small proportion of that number will be in dangerous situations with a partner or ex-partner and may present in a crisis that needs intervention and/or referral on the same day.[12,13]

Costs

In 1994 the cost of visits to general practice as a result of domestic violence was conservatively estimated at $26.5 million. Vote Health costs were $140 million. The cost to the country as a whole probably exceeded the total wool clip income for that year – the lowest estimate being $1.2 billion with a more likely cost being $3.4 billion. Nine years later one can only guess the price we pay for an illegal, entirely unacceptable drain on our national economy.[14]

Typically 87–95% of partner abuse is perpetrated by males,[3,15,16] but a small number of females also intimidate, threaten and injure males.

Men and women in same-gender relationships may also suffer abuse – always consider the possibility if you have a concern that a patient has an unsolved set of symptoms, complaints or injuries.

Legal support

The Domestic Violence Act (1995) enables victims of family violence to obtain protection orders against perpetrators older than 17 years and force them to face the facts of the damage they are doing to those with whom they have close relationships. Orders can be obtained on the day and many patients will qualify for legal aid.

What has this to do with general practice?

General practitioners are in an ideal position to recognise partner violence and respond early before crises occur. The aim is to prevent adverse health consequences, be they intentional injury or ongoing mental or physical symptoms or an associated illness.

An Auckland study identified doctors as the person most abused women hoped would understand and provide information, support and help when abuse occurs at home.[17] Many women in studies here and overseas have reported unconditional support and kindness, which has 'saved my life' or 'kept me sane'. Careful documentation was also useful later in legal procedures.[18,19] Others record poor responses that had made situations worse. These include disbelief ('not Jim – he's such a good chap'), calling perpetrators in to 'sort this out', suggesting she appease, forgive or behave differently, referrals for 'relationship counselling', and prescription of tranquillisers and antidepressant medication without consideration for safety when sedated. This kind of response leaves women in danger, and with the impression that partner violence is their fault.[19]

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Few GPs have had the opportunity to learn about partner abuse and how to respond to it. Not many of us have had a chance to clear the myths we all grew up with, and reconsider the reality that a significant number of families experience daily. Sadly, some of us will have had personal experience of abuse in our own close or extended families.

Our position of trust allows us to ask questions on a sensitive issue that women often find too difficult to raise without encouragement

Institutional support

In 2001 the NZMA produced a position statement[20] on family violence that is in line with the Australian, British, Canadian and American Medical Associations. It addresses the extent and nature of the problem and outlines the adverse health effects on individuals and society. It states that medical practitioners have a key role in early detection and appropriate intervention for victims. It encourages the use of research-based, best practice guidelines for recognition and management, suggesting that the medical response needs to be consistent with the ethics of beneficence, non-maleficence and justice. The NZMA supports research and education at all levels, with routine enquiry and intervention after practitioners have had opportunities for training.

In 2002 the Ministry of Health published a Child and Partner Abuse Family Violence Intervention Guideline[21] that drew on international as well as local research and best practice, as part of the effort to reduce interpersonal violence, a key goal in the New Zealand Health Strategy 2000.

The RNZCGP, in collaboration with The College of Practice Nurses, DSAC, MOH, ACC and Women's Refuge has recently published *Recognising and responding to partner abuse* – A resource for general practice.

So – what to do?

- Seek training – available to all GPs with their practice nurses via DSAC trainers, presented either in one four-hour, or two two-hour sessions. It will familiarise you with the resources, offer the opportunity to meet referral agencies in your area and understand what they can provide. You will have a chance to practise routine enquiry with case scenarios that are commonly met and you will be provided with information and resources to give to patients.
- Set up simple systems in practice so that privacy, safety and support are available to both patients and the team.
- Consider using your new skills right away – it's easier than you think!
- Use the tool provided in the training kit to audit and monitor what is happening – and gain MOPS points.

Principles of safe intervention

- You don't have to 'fix' the problem.[22] Recognising and offering appropriate information and support while the patient decides what to do and when, is the aim. The British concept word is 'empowerment'.
- State that violence, forced sex, threats, harassment and intimidation are always wrong, against NZ law, and that no one 'deserves' to be treated in that way.

- Document carefully and objectively, detailing your findings and your assessment of the consistency of this with history given to you. Observations of psychological state and behaviour are useful. Outline the treatment required and the information given. This will provide assistance if a patient wishes to pursue a Protection Order or other legal remedies at a later date.
- Provide emergency contact numbers and written information on partner abuse. Assure her or him that your door is open no matter what her or his future situation or choices might be.
- Don't hold discussions on this issue in front of children older than two years or other family members, and never in the presence of a partner. Make no assumptions about relationship safety or relative or whanau support.
- Enjoy developing relationships with competent community resources – you will experience knowledge and readiness to support you and the patients you have concerns for in a confidential manner. Refer early to Domestic Violence Agencies for support.
- Remember to address child safety.[8,21,23] A victim's prime concern is often the effects on the children, although some may be unaware of the effect or hopeful that they have concealed the situation from the children.
- Where available and while respecting patient preference, offer culturally matched referrals.
- This is a team effort. Once concerns are identified, the nurse may be the best person in your practice to offer management, safety planning and follow-up, but your support and interest is crucial. Debrief on a regular basis. Use colleagues' experiences as well.

And the questions are...

1. *'Is there anyone at home who makes you feel no good or worthless?'*
2. *'Have you been hurt by anyone in your home this past year – by that I mean hit, kicked punched, shoved or otherwise physically hurt by your partner or ex-partner?'*
3. *'Have you been made to have sex in the past year or to do something sexually that you didn't want to do by a partner or ex-partner?'*
4. *'Do you ever feel afraid of your partner or ex-partner? Does he/she ever stop you seeing family or friends?'*

These internationally validated questions are not a prescriptive list.[21] It has been suggested strongly by researchers that the context of asking and a genuine supportive response by a doctor or nurse is of greater importance to disclosure and the confidence of the patient than the words used, or than the order of asking.[24] But lifetime experience, 12-month incidence, current and former partners need to be covered. It is essential to check on verbal, psychological, sexual and physical abuse.

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Practical responses

Research shows that a 'case finding' approach will discover only 2% of abuse but routine asking will identify closer to 25% of women who have experienced intimate partner abuse.[25,26]

Use a general introductory 'framing' statement, for example:

'Because relationship safety can affect health and patients are often not confident to bring it up themselves, we are asking people once a year how things are with partners or ex-partners' or *'Like smoking and alcohol and gambling, intimate relationships can have a big effect on your health – so I am asking my patients routinely about relationship safety'.*

1. When questioning results in a clear indication that there are no past or current concerns:

Provide basic education that resources exist, a handout detailing what constitutes partner abuse, consequent health effects, emergency numbers, along with the assurance that you'll be checking again in 12 months, is all that is necessary. Conclude with the message that this is a safe place to gain support, should anything change in the future.

You may find that her comments include 'thanks for asking' or 'that's really helpful – I've been worried about this woman at work /my friend. I'll pass it on'.

Document in the notes: P/A Nil current or past.

2. If enquiry leaves the impression that something is not right but is being denied:

There are many valid reasons why a person may not want to disclose at a particular time. The comment that you are glad all is well, but if in the future she/he has concerns the door is open, you or your nurse are available to help, along with the same education, handout and assurance that you will ask again, is appropriate.

Document in the notes: ?P/A: Denies current or past – will remind you in future of your impression and concerns.

3. Where there are serious acute injuries and an unlikely explanation:

You are justified in being very specific in your history taking. *'When I see someone with injuries like this* (black eyes, fractured tympanum,

bruising, grip marks, spiral wrist fractures or petechial haemorrhages round the neck and a hoarse voice, for example), *I am pretty sure some one has done this to a person intentionally – Has that happened to you?'*

'No doctor, a cupboard fell on me.'

If the explanation is not consistent with a serious injury pattern, suspect intentional interpersonal violence.

Document and if necessary admit to hospital. Give a clear direction to the admitting medical officer that you have serious concerns. If possible, a social worker with appropriate skills, or a domestic violence advocate should attend while she is in hospital (for injury investigation/treatment) and provide a safety/lethality risk assessment, advocacy, and safety plan.

The Australasian College of Emergency Medicine has endorsed the Ministry guidelines and some major hospitals, for example in Auckland and Hawkes Bay, have protocols and policies in place for dealing with domestic violence. Several now have an advocate on site to provide expert consultation and advice.

Some women will refuse further investigation or admission because of threats by partners or ex-partners on the consequences of disclosure. Your documentation may be crucial during legal action at a later date.

In the serious scenario outlined above, any children in the house at the time would be regarded as abused by virtue of witnessing violence. A discussion with CYPS may need to occur, clearly stating your concerns about the victim's safety in addition to that of the children, along with notification to a Domestic Violence agency so that independent support is available to her.[21]

4. From time to time women will present with injures, or will answer yes to routine enquiry.

Both need documentation and follow-up arranged for education, support and safety planning. ACC will fund this if there are physical injuries. Referral for counselling to reduce mental trauma from the effects of assault is helpful. Diagnosis of Adjustment Disorder may be appropriate. IPA mental health funding can help at times, and if there are longer-term effects that are included in the diagnosis of Post Traumatic Stress Disorder, or depression, these may be assigned as appropriate. Referral to a domestic violence agency/refuge for support, advocacy, safety planning and education is advised at the original or subsequent consultation depending on your assessment of the situation. Make an opportunity for the patient to make contact by phone, from the nurse's office for example, before she/he leaves the surgery.

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5. If the indication is that abuse has occurred in the past but patient is safe now:

Information/education and the offer to refer for counselling support to deal with the aftermath of the historic events is useful for some.

'He died six years ago. Best six years of my life. Yes he did everything, all that stuff you asked about – and that's what happened to my teeth and my knee. Thirty-four years of it. I didn't realise how bad it was while it was going on and on, just had to survive. Started slowly, you know, I was only 17 when I got pregnant. I thought he really loved me; he was jealous and all that– but now it's like being let out of a cage. I can't believe it. I still wake up and I think – I can do anything. That's why I'm at tech. At my age! (laughs). *It's never too late.'* Verbatim – 57-year-old female.

Documentation: P/A past, long-term. Safe now.

Key Points

- The health ramifications of partner violence are multiple and often unrecognised.
- About 12 women per year die from intimate partner assault.
- The key is the fear and loss of autonomy that develops from an ongoing pattern of behaviour by a partner.
- General practitioners are in an ideal position to recognise and respond early before crises occur.
- You don't have to 'fix' the problem.
- Use a 'framing' question. Cover current and past partners. Enquire about verbal, psychological, physical and sexual abuse.
- State that violence, forced sex, threats, harassment and intimidation are always wrong, against NZ law, and no-one 'deserves' to be treated like that.
- Document carefully and objectively. This will provide assistance if a patient wishes to pursue a Protection Order later.
- Ask about children – there is a high rate of co-occurrence of partner and child abuse.
- Refer early to a domestic violence agency for support, safety planning and education.

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