The doctor and the woman
“who fell down the stairs”

Family doctor’s role in recognising and responding to intimate partner abuse

Sylvie Lo Fo Wong
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Citations from Roddy Doyle’s novel: ‘The woman who walked into doors’
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Voor mijn ouders Jeane en Aloysius
The doctor and the woman “who fell down the stairs”
Family doctor’s role in recognising and responding to intimate partner abuse

Een wetenschappelijke proeve op het gebied van de
Medische Wetenschappen

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Chapter 1

“I fell down the stairs again,…No questions asked. What about the burn on my hand? The missing hair? The teeth? I waited to be asked. Ask me. Ask me. Ask me. I’d tell her. I’d tell them everything. Look at the burn. Ask me about it. Ask. No.”

“The woman who walked into doors”. By Roddy Doyle
General introduction

The doctor and the woman who “fell down the stairs”.

Family doctor’s role in recognising and responding to intimate partner abuse.

General introduction
Prologue

One morning my patient Mrs.K. came in. She had a bad wound in the palm of her right hand and asked my assistant to have a look at it. I knew Mrs.K., (45 years and mother of three grown-up children) for quite some years now and she visited me several times a year with chronic pain complaints in various parts of her body. Her neck and back as well as her joints were often sore. I was never able to diagnose a specific disorder and no therapy had ever been successful. In a moment my assistant called me to have a look and I was astonished to encounter a deep, nasty infected wound at the basis of her thumb going right through the palm of her hand. This had happened four days ago she said, “a little accident in the kitchen, you know, just cut my hand...”. This lady, who had sought my care on numerous occasions when I was not able to find out what was wrong with her, now came when it was too late to stitch her wound. After one probing question (and looks, probably too) on how this had really happened, she reluctantly admitted that she had been wounded when her ex-husband, from whom she recently divorced, attacked her in her kitchen and broke a bottle on her head. In an attempt to avoid more cuts by the broken bottle, she lifted up both arms and protected her face. This resulted in the wound of her right hand and also of both her underarms. The wounds to her underarms as well as those on her head were healing, but her hand had got infected. Her husband did not allow her to seek medical care for her wounds and warned her that she would end up even worse, should she talk to anyone about what had happened. Only because her grown-up sons opposed to their father for abusing their mother, and stimulated her to seek medical care, she found the strength to withstand his threats. It came out that this was not an incident but ‘business as usual’. Most of the time she managed, but often she was afraid of permanent damage and sought physical examination, withholding her true story. After so many years of physical, emotional as well as sexual abuse, she lost the sense of standing up for her self. Her sons finally convinced her to get the divorce, supported and took care of her.

At last, after so many years I was able to see what had been wrong with Mrs.K.

I never asked Mrs.K. about her relationship or whether she had been abused when she presented earlier with her medically unexplained symptoms. Now I learned that they were often directly related to the violence she endured and the distress it brought about in her life. Only now, when it became quite obvious, I saw what was wrong with Mrs.K. There must have been many more patients like Mrs.K., who sought my assistance as a family doctor, whose real condition I had overlooked. Although I assessed myself as willing to assist abused women, obviously I knew too little to recognise partner abuse adequately. Neither was I aware of the extent of women’s reluctance to disclose their situation.
During my training in medical school, in family medicine and in the regular curriculum of the continuous medical education (CME), there had been no education on domestic violence or intimate partner abuse. I expected many more colleagues to have the same reluctance in addressing partner abuse because of insufficient knowledge about this subject. This conclusion became the starting point of my study.

**Background of intimate partner abuse**

Abuse by an intimate partner happens to be worldwide a common problem which results in an increase of health problems. For a long time, both governments and the healthcare sector saw partner abuse as a minor social problem restricted to the private domain. Only since the past two decades this has changed conspicuously. An increasing number of studies in developed and developing countries, show that it is a much wider spread phenomenon and with many more health problems for victimised women than previously was suspected. A review of population-based surveys on intimate partner abuse around the world, reports that between 10-52% of women, have ever experienced violence by an intimate partner.\(^1\,\,2\) While the term intimate partner abuse is gender-neutral, women, 18-45 years of age, are the main group to experience this type of violence, which is mostly inflicted by a male (ex-)partner.\(^3\,\,5\)

The landmark study on domestic violence/partner abuse of women, the World Health Organisation’s Multicountry Study 2005, reveals that “intimate partner violence is the most common form of violence in women’s lives, much more so than assault or rape by strangers or acquaintances”.\(^1\) This study, performed among 24,000 women in 10 countries, stands out for labelling intimate partner violence/abuse as a major public health issue.

Partner abuse takes place in the privacy of a relationship, and often continues for years. Although partner abuse is a crime, ‘blaming the victim’ is still a common social reaction to this form of violence.\(^3\,\,6\) To date women are often accused of having provoked or deserved the abuse for being disobedient or unfaithful. It is tragic to observe that in many cultures, husbands are still permitted to discipline their wives by battering and controlling behaviour.\(^7\,\,8\)

**Definition**

Domestic violence mostly affects women and children but the term covers a broad range of family violence. Referring to domestic violence against women, the terms intimate partner abuse, intimate partner violence and partner abuse are used interchangeably. In research, partner abuse is generally defined as: all acts that inflict physical, sexual, emotional or psychological abuse by a (ex-)partner and assumes power inequality between partners.\(^3\,\,9\) Social isolation, deprivation of liberty and financial resources as well as sexual coercion and controlling behaviour by the perpetrator, are also included in the definition of partner abuse.\(^10\,\,11\) The exertion of
power and control is the core of intimate partner abuse. It leads to a pattern of behaviour where one of the partners is frequently afraid of the other as a result of the combination of physical, sexual and emotional abuse.

In the earliest studies on domestic violence, performed in the seventies by feminist researchers, the terms: ‘woman abuse’ and ‘wife battering’ were common. Nowadays they do not comply with partner abuse taking place in homosexual and lesbian relationships nor do they give room to the possibility of men being abused by female partners. Yet, cases of women who chronically and systematically abuse their male partner rarely come forward. Studies which report equal violence of men and women in relationships are contested, because of research methods, biased samples and restricted definitions.

Context of the study
Despite international acknowledgement that partner abuse is a highly prevalent and serious problem in medical practice, the medical journals in the Netherlands showed a remarkable lack of attention for the subject. In the Dutch primary care, no specific research has been performed on intimate partner abuse, until this present study. Greatly in contrast to international medical journals, a search in the leading Dutch medical journals over twenty years (1983-2003), revealed only five short articles on violence against women. No major research reports were found among these papers. In the same period, four short papers focused on sexual abuse and rape (not specifically by a partner) and one on (violent) traumatic events, which included intimate partner abuse. In 2001 a short document, providing a general guideline for approaching all types of traumatic events (from war experiences, robbery to family violence) was published by the Dutch College of General Practitioners.

At that time there were already two studies on the prevalence of domestic violence in the Netherlands. On the authority of the Ministry of Social Affairs a large-scale nationwide survey took place in 1989 which specifically focused on women (general population) in heterosexual relationships. This study performed by Römkens, used a semi-structured questionnaire in face-to-face interviews (n=1,016). The results revealed a prevalence of 21% of the women in the Netherlands to have ever experienced violence by a male intimate partner and one in nine women to have experienced severe systematic physical abuse. Another study in 1997, authorised by the Ministry of Justice, used a telephone survey of both male and female respondents (general population) and included all types of domestic violence (n=1058). They found 53% of the Dutch population to have ever experienced at least one event of violence by a family member. Male respondents reported more abuse in childhood and adolescence whereas female respondents encountered more abuse by a partner.
In 1998, the Public Health Authority (GGD) of Rotterdam (the Netherlands) surveyed family doctors in their area (n=281; response 54%) and asked how often they identified abused women. The majority of the respondents (66%) saw less than 5 patients per year, in whom they identified partner abuse; 16% identified 5-20 cases while 18% never encountered an abused female patient.

According to studies among family doctors internationally, lack of education on partner abuse is a common reason for under-identification of abused women. Whether this is also the case in the Netherlands, is hypothetic, since only limited research has been done on family doctors’ knowledge and state of education regarding intimate partner abuse.

International research on health consequences and the ‘burden of disease’ due to partner abuse, show a higher incidence of health problems and healthcare utilisation in abused women compared to non-abused women. A growing number of studies report that abused women consult their family doctor more frequently than female patients who are not abused. Nonetheless, these patients are rarely recognised as such in medical/family practice.

So far the observed lack of publications on partner abuse and the limited research on this topic in the Dutch medical field, reveal an underdeveloped area, specifically in family medicine. Considering this, the need to perform a comprehensive study emerged, in order to gain more understanding of the family doctor’s role regarding intimate partner abuse and to develop tools to improve awareness/recognition of and response to abused female patients in daily practice.

Brief overview of earlier studies in family practice

One of the earliest publications on intimate partner abuse of women, to be found in Medline was published in 1975 in the British Medical Journal: ‘Wife battering, a preliminary survey of 100 cases’ by J.J.Gayford. Since then, many studies on domestic violence and more specifically on intimate partner abuse have followed. Research has been performed in primary care and family practices, emergency and hospital departments and in prenatal care. The diversity in domestic violence or partner abuse studies, ranges from large population based surveys to smaller qualitative studies. Research in the family practice setting has a distinct scope and covers the following topics: 1) epidemiological aspects: prevalence and health consequences, 2) family doctors’ perspectives, 3) abused women’s perspectives, 4) systematic reviews and guidelines.

Epidemiological aspects

Prevalence

Until the nineties researchers in this domain discussed the lack of a precise definition of intimate partner abuse that existed. As a result, a variety of definitions of partner
abuse was used, which often impaired a comparison of studies. Partner abuse could be defined as one single minor incident to exclusively repeated physical violence or criminal acts. Surveys, performed in the past three decades among women in the general population across a multitude of countries worldwide, showed that partner abuse is a serious and wide spread problem. However, due to diverse definitions and different survey methods, these studies report a sample of 10 to 52% of the women experienced partner abuse at some point in their lives. In the absence of a valid and comprehensive research instrument, the Composite-Abuse-Scale (CAS), was developed and validated to measure type and severity of partner abuse among female patients in the medical setting. The cumulative incidence of partner abuse among female patients visiting their family doctor turned out to be higher than among women in the general population. Cross-sectional surveys in waiting rooms in family practice in Australia, Ireland and the United Kingdom, report that 37-41% of female patients, were ever abused by a male partner. US studies of lifetime prevalence show a range from 33-39% for women seeking medical care. A Turkish cross-sectional survey in primary care, performed in an urban area, found 49.5% of the female patients (>16 yrs) to have been ever abused by their husband.

Hegarty states “that it is more than likely that a full-time family doctor is seeing one to two female patients a week who are survivors of partner abuse and who they, the family doctor, do not detect.” Bradley reports that only 5% of the victimised women have been asked about abuse by their family doctor. Richardson found only 7% of the abuse documented in victimised patient’s medical record. Partner abuse is seldom recognised by physicians and female patients seldom disclose partner abuse spontaneously. Both doctors and women report a number of barriers to discuss abuse in the medical visit.

Health consequences
Not surprisingly, surveys on health consequences, show that abused women are frequent users of medical services. Partner violence induces short-term as well as long-term sequels. Women present a variety of complaints, sometimes quite obvious, like wounds, bruises and fractures, which are all visible signs of battering. However, the non-obvious problems like chronic somatic or mental complaints and disorders seem to be more frequent symptoms of violence. Chronic undefined pain of neck and back, headaches, stomach complaints and abdominal pain, vaginal discharge and sexually transmitted diseases, dizziness and hyperventilation, anxiety, depression and sleeping disorders, substance abuse and drug addiction constitute a ‘short list’ of frequently presented problems which often hide a history of partner abuse. Studies and reviews in the past decade have
reported an association between pregnancy and increased risk of partner abuse, both in industrialised and non-industrialised countries.\textsuperscript{43,58,59}

Abused women’s increased health problems are sufficiently reported in surveys. However, only rarely research has been done on abused women’s medical records, in order to search for whether there exists a pattern of symptoms of partner abuse.

**Screening**

Because of the high prevalence of intimate partner abuse and the serious health consequences for abused women, health authorities in 1992 in the US and in 1997 in Canada, started to recommend screening/routinely questioning of all female patients on partner abuse, in primary care practice.\textsuperscript{10,60} This call to screen all women has influenced the research field. A stream of studies followed, focusing on the development of feasible and valid screening instruments. The most frequently used instrument in population-based surveys in the mid-1970s to the mid-1980s and early 1990s, was the Conflict Tactics Scale (CTS).\textsuperscript{61} This 19-item questionnaire was developed to measure the use of reasoning, verbal aggression and physical violence in resolving family conflicts. As an exclusive measure of partner abuse, however the CTS is limited, as it does not provide information on the context and consequences of abuse. Yet, in the absence of valid instruments at that time, it was used for screening. In the nineties a number of new screening instruments were developed in the hope that availability of a simple and reliable instrument would help health-care providers identify abuse victims. Amongst others there are: the Partner-Abuse-Interview (PAI), the Hurts-Insults-Threatens and-Screams (HITS), the Woman-Abuse-Screening-Tool (WAST), the Abuse-Risk-Inventory (ARI), the Abuse-Assessment-Screen (AAS), the Index of-Spouse-Abuse (ISA), the Index of-Spouse-Abuse-Physical Scale (ISAP-P), the Partner-Violence-Screen (PVS), the Women’s-Experience with-Battering (WEB).\textsuperscript{62-65,66-68} These sets of questions were tested among female patients in primary care and emergency departments. However, none have been validated against measurable outcomes. The sensitivity of most screening instruments turned out to be moderate and no trials on the effectiveness of screening in healthcare settings for reducing harm to victims of abuse have been published.\textsuperscript{69,70}

Studies evaluating the implementation of screening protocols by measuring how often doctors routinely questioned women about abuse, mostly reported low screening rates with a decrease over time.\textsuperscript{71}

**Screening versus case finding**

In the light of the severity of partner abuse there is an ongoing debate between proponents for screening and those for case finding.\textsuperscript{72} Guidelines in the US, launched in 1992, recommended asking routinely all women, who visit family practice about partner abuse.\textsuperscript{10} The U.S. Preventive Task Force (USPTF) like the Canadian
Task Force on Preventive Health updated these recommendations as from 2003 and stated they found insufficient evidence to recommend for or against routine screening of women for intimate partner violence. Task Force on Preventive Health updated these recommendations as from 2003 and stated they found insufficient evidence to recommend for or against routine screening of women for intimate partner violence.\textsuperscript{73}

Furthermore screening instruments are not found to be sensitive enough to detect all abuse victims.\textsuperscript{74} Nevertheless, proponents of routinely asking all women in the medical setting are found both in the US and the UK.\textsuperscript{68,75,76}

On the other side of the spectrum are the researchers on partner abuse and family violence, who dispute the grounds for routinely asking all women and who recommend selective questioning of ‘symptomatic’ women: case finding. Proponents of the latter are found in Canada, Australia and in the UK.\textsuperscript{12,77,78}

Advocates of routinely questioning and screening, emphasise that partner abuse is a widely prevalent and serious problem, with consequences not only for women, as it also involves their children who witness the abuse.\textsuperscript{79-81} Moreover, lack of valid and sensitive indicators, hinders the recognition of abused women together with the fact that an unknown proportion of abused women will possibly seek medical care only for preventive care. This group states that screening is feasible and would increase the identification of partner abuse and will provide many more abused women with referrals to support services.

Proponents of selective questioning and case finding emphasise that feasible and safe solutions for this complex problem are lacking, moreover screening all women is not proven to be harmless. Furthermore, the sensitivity of screening instruments is too moderate, and questioning about abuse, is not as simple as a diagnostic test. One of the potential harms are the expected false negatives and the reprisal of violence by men against women who seek medical care, but were not ready to disclose.\textsuperscript{82}

Studies show that 43 to 85\% of the respondents, including non-victimised women, find it acceptable of being routinely questioned about partner abuse.\textsuperscript{42,43,70} The broad distribution of the approval by women of routinely screening for intimate partner violence, reflects the differences in study design and questioning on this matter. Recent studies on physician’s preferences report that doctors in general (77\%) do not favour screening women on partner abuse.\textsuperscript{70,40}

According to Ramsay’s systematic review, there is little evidence that training doctors increases the recognition of abused women, nor does it improve screening activities.\textsuperscript{70} Another possible harm may lie in the lack of knowledge and skills of providers in addressing the issue, resulting in unrealistic advices and prejudiced responses.\textsuperscript{60,83} Experts on partner abuse substantiate that responding to women who disclose, requires a skilful approach and a non-judgemental attitude. Without specific training, doctors who routinely question all women lack the adequate equipment to respond in a professional way.\textsuperscript{84}
Summarising, with regard to the high prevalence of intimate partner abuse among female patients in family practice, there still appears to be a lack of clear evidence on what should be advised: routine screening of all female patients or selective questioning of ‘symptomatic’ women.

Family doctors’ perspectives: afraid of ‘Pandora’s box’?

**Barriers to discuss partner abuse**

Since the early nineties, doctor’s attitude and practices towards partner abuse are commonly investigated in surveys. The results of these studies stand out for consistency, although they were performed in different countries. Some outcomes are similar to qualitative studies addressing family doctors’ attitude regarding partner abuse. It is often reported in studies that doctors should play an active role in asking patients about partner violence, due to the fact that abused women are inclined to seek more medical care than those who are not. At the same time it is emphasised that family doctors, due to a number of barriers, fail to identify abuse in female patients. In qualitative studies, doctors’ barriers to discuss partner abuse are explored more in depth. Fear to offend the patient, fear of opening “Pandora’s box”, the assumption that they have nothing to offer are prominent findings. However, reluctance to see it as a medical problem, patient’s unresponsiveness and denial, and lack of knowledge on how to respond are also mentioned. Some studies report that female doctors recognise more abused women and consider it more a healthcare issue than male doctors do, whereas others found no differences.

**The effects of training**

Despite a number of publications in leading medical journals, partner abuse seems an unfamiliar subject in most medical education curricula and the effects of training are disputed. There are conflicting findings on the effects of education to improve identification of abused female patients. Studies report a variety of education programs, from brief courses (2 hours) focusing on the instruction of a screening protocol, while others present a more comprehensive training (2 days) including consultation skills training. None of the studies reported a program in which they dealt extensively with family doctors’ prejudicial views and attitudes. In measuring the effects of education, studies which focus on screening practices, observed a temporary increase of screening practices and identified patients while others found no change in number of screened or identified patients.

**Managing partner abuse**

Few studies address response of family doctors to abused women and methods to deal with the situation. Responding to patient cues is important and will encourage a patient to disclose. Supporting patients who disclose with validating messages as
well as breaking through denial, non-judgemental listening, planning for safety and careful documenting of the event, are advised.\textsuperscript{87,99,100} In other studies, family doctors committed to caring for abused patients, mentioned that “burnout” may occur as a result of dealing with mandatory reporting and patient’s reluctance to disclose. Furthermore, doctors will be more helpful when a woman acknowledges the abuse and discloses spontaneously.\textsuperscript{101} A recent study that followed family doctors in their management of abused patients, found practices that are contraindicated, such as breaking confidentiality and undertaking or referring for couple counselling.\textsuperscript{83} A lack of knowledge and training can have a negative impact on patients as well on doctors themselves.\textsuperscript{54}

Summarising, with regard to what is already known about doctors’ barriers in attitude and the conflicting findings on the effects of educating doctors, the need emerges for a more profound search for an education program on partner abuse that works and how a doctor’s gender affects his/her attitude towards abused female patients.

Abused women’s perspectives: what’s in ‘Pandora’s box’?

Barriers to disclosure

Worldwide, studies on women’s barriers to disclosure, report that female patients are reluctant to disclose because of fear to be judged by their doctor, fear that confidentiality would be breached, shame and feelings of guilt.\textsuperscript{46,47,96,102-105} At the same time all studies point in the same direction: women want to be asked and helped to overcome their barriers. Usually women have been warned by their partner not to talk about the violent relationship, and are afraid of their partner’s retaliation. They also fear to loose the custody of their children once their problematic situation becomes known. However, according to abused women, direct inquiry about partner abuse will increase disclosure significantly, especially in women who are ready and willing to disclose.\textsuperscript{46,106,107}

Preferred responses

Qualitative research underlines that women value compassion, acknowledgement of the abuse and support in doctor’s responses. Also confidentiality, the reassurance of a woman’s worth, not treating her as a victim, knowing that it takes time to make final decisions and asking her about the children, was mentioned. Abused women pass through a number of stages of change and the acknowledgement of this process is important.\textsuperscript{97-99,106-109} Women do not prefer enforced disclosures or mandatory reporting to police agencies nor do they prefer shelter homes. Studies following women in the medical setting after disclosure, are few. Only recently women were studied more in depth on their process of disclosure to their doctor and how changes took place.\textsuperscript{107,110}
Most studies on women’s preferences of doctor’s responses, barriers to disclosure and process of change, enrolled women from shelter homes or support programmes; most studies are retrospective. Women, who are currently abused, rarely participate in research and studies that followed abused women over time, are not found. Little is know of what women who currently live with their abuser value from their doctor in disclosure and what this actually brings about in their life situation.

**Systematic reviews and guidelines**

A number of systematic reviews provide evidence for recommendations for family practice to manage intimate partner abuse in female patients and for the whole family in case abuse is present. To date the recommendation to screen all women for partner abuse, has not been supported by evidence and is unable to meet the current screening criteria.

The development of a critical pathway for intimate partner violence assessment and intervention is the latest development in this field. This instrument is intended for practical interdisciplinary use across healthcare settings, aims to improve quality, includes all care processes and focuses on improvement of desired patient outcomes.

In 2005, international guidelines for “Family practitioner’s management of the whole family when violence is present”, were developed in a research team lead by Taft et al. in cooperation with an international group of researchers. Publication is expected in the course of 2006. This document will provide evidence based recommendations on how to approach, respond and aid victims, perpetrators and children when partner abuse is present in the family.

**Implications for research**

Based on the results of these earlier studies we identified a number of themes for further research in family practice:

**Family doctors’ attitudes towards partner abuse**

Looking at family doctors’ attitudes in identifying and responding to partner abuse, it is remarkable that the role gender plays reveals conflicting findings. Some studies reported no differences between male and female doctors while others found female doctors to recognise more abused women and to view partner abuse more as a healthcare issue. None of the studies were specifically designed to gain more profound insight in the role of a doctor’s gender, resulting in a lack of knowledge on this matter. Considering the recent shift that is taking place in family medicine, where the number of female family doctors is rapidly increasing, more in depth knowledge of gender-related differences will be needed to address the issue more effectively in training.
In surveys, various questionnaires have been used to classify doctors’ attitudes. No specific attitude-scale has been developed to measure common views and attitudes. Such an instrument might be useful in itself and to assess the effects of training on partner abuse.

**The effects of training family doctors on partner abuse**

To date most studies point out that there is no evidence that training in partner abuse will substantially improve awareness of and identification of abused female patients in family practice. Most studies measuring the effects of training assess levels of screening women for partner abuse after a brief educational program and seldom after a thorough training. In view of the complexity of partner abuse and the doctor’s role in assisting the whole family, it would be of interest to explore more in depth the effects of training family doctors to gain more insight in what doctors really gain from education and how it affects daily practice.

Abused women more often seek care for health problems in primary care than women who are not abused, and in this respect family doctors are in an advantageous position to identify these patients’ conditions and backgrounds.³⁴

**Abused women’s perspectives on the role of the family doctor**

Since abused women have predominantly been studied retrospectively in selected populations of women in support programs or in shelter homes, little is known about women who are currently abused by their partner or who were abused in the past but never disclosed this to anyone before. It would be therefore of interest to study abused women who shortly before revealed their abuse situation and explore their experiences and views on the disclosure to their family doctor. This may contribute to more profound knowledge on appropriate responses towards abused female patients in family practice. It would also be of interest to learn how a disclosure affects a woman’s way of handling the abuse situation.

While abused women who disclosed their real condition have never been followed over time, it would be of interest to gain insight in women’s situation and ways of handling the abuse (experiences) on the long run. Knowledge on women’s developments and how they handled their situation after disclosure, will provide insight in the role a family doctor should hold in following these patients.

**Abused women’s healthcare utilisation: ‘symptoms’ of partner abuse**

All studies on sequels of partner abuse focus predominantly on mental health complaints like depression, anxiety and sleeping problems. Chronic pain and gynaecological symptoms are also found to be prevalent among abused women. This knowledge is mostly acquired from surveys among abused women. Few studies have addressed the utilisation of health-care as recorded in patient’s medical record. For
doctors, who encounter patients in a short visit of mostly 10-15 minutes, it is difficult to identify patients at risk when no predictive indicators are at hand.

Due to the fact that most abused women predominantly seek medical treatment, withholding the abuse, a pattern of symptoms would be useful to recognise these patients. Although there is substantial knowledge of the health consequences of partner abuse in female patients, to date a set of symptoms or key-features of abused women for use in daily practice, is lacking.

**Study aims, research questions, general design and methods**

**Study aims**

Against the background as described above, the following study aims were formulated:

- To improve our understanding of family doctors’ barriers to identify partner abuse
- To develop effective tools to overcome these barriers
- To investigate whether these tools improve doctors’ awareness and identification of partner abuse (**primary study aim**)  
- To improve our understanding of the significance of disclosure to identified abused women

To achieve these aims, we formulated seven research questions and investigated these with distinctive designs and methods. We focused both on family doctors’ and abused female patients’ perspectives.

**Research questions**

1. Will a training program on partner abuse, be effective in raising family doctors’ awareness and improve active questioning when partner abuse is suspected? (**primary study aim**)  
2. What are family doctors’ views, attitudes, experiences and practices, regarding abused female patients and does doctor’s gender really matter?  
3. Is it possible to develop a short instrument to measure (prejudicial) views and attitudes towards partner abuse of family doctors?  
4. In which ways does a training on partner abuse affect family doctors’ attitudes, abilities and confidence when dealing with abused female patients in daily practice?  
5. What do women value most in disclosing partner abuse to their family doctor, and does it influence ways in handling the abuse situation?  
6. What are the most important changes in abused women’s situation in the year after the disclosure?  
7. Is it possible to discern characteristics or a pattern of healthcare utilisation of abused women in family practice?
General design

General features of the design

The principal research question is addressed in an intervention study with a randomised controlled design, measuring the effects of training family doctors on partner abuse. Six other research questions are addressed in studies which are grouped around this principal study.

We situated the study in one confined urban area (Rotterdam and surrounding areas, 2nd largest city of the Netherlands) with a multi-ethnical population and a broad range in city districts (wealthy to very poor), suburban communities and nearby villages. In October 2002 one mailing was sent to all 412 family doctors in the address file of the District Association of Family Physicians (DHV), inviting them to participate in the study: “Women abuse and the role of the family physician”. The letter included a description of the study, of what was offered to and expected from participants. Fifty-four family doctors (26 male and 28 female), agreed to join the study and were included.

For the design of the intervention study: see Figure 1.

At the same time the primary researcher made an agreement with local organisations that no other education on partner abuse for family doctors would take place among doctors in this area, during the intervention period.

Rotterdam is also the residence of the family practice of the primary researcher (SLFW).

General perspective

In spite of the general consensus in the literature, that the effects of educating family doctors on partner abuse are limited, we pursued our intention to improve doctors’ awareness and active questioning with a training course. We assumed that if we were able to provide a training, specifically designed to induce meaningful learning experiences on partner abuse, active questioning and eventually identification of partner abuse would increase.

Considerations

Beforehand we determined that we had no aspirations to recommend or to implement screening of all women for partner abuse in family practice. In the lively debate that is going on between proponents of routinely asking all women about partner abuse and those who recommend case-finding through asking ‘symptomatic’ women, we chose the latter. This position determined the primary outcome measure of our intervention study. With the reporting of cases in which a doctor asked about/discussed partner abuse with female patients (incident reporting) we entered a new path. No earlier studies in this field were found to use this effect-measure.
Another characteristic of our design is the investigation of the role of doctor's gender regarding partner abuse. This choice implied that the inclusion of equal numbers of male and female doctors was crucial. Bearing in mind that at present, the older male doctors are being replaced by younger female ones, this shift in family medicine calls for investigation to assess gender-related effects on patient care. Partner abuse is certainly not a gender neutral problem and deserves to be addressed at this point. Although some studies on partner abuse have assessed gender differences in views on abused female patients, this was done in broad samples of healthcare providers. No studies focused on family doctors in a randomised study. We conclude that this aspect of our design added a new feature in the analysis of our data.

Methods
The following section goes into the research method used to answer each question. The four studies on the family doctors and three studies on the identified patients are presented in the chronological order in which they were executed.

1. Exploring views, attitudes, experiences and practices toward abused women: a qualitative study.
To understand family doctors’ barriers in recognising and responding to abused female patients, a qualitative method was used to enable in-depth exploration of family doctor’s views, experiences, practices. We aimed to address these findings in the training. The study was specifically designed to investigate gender-related differences.
Six focus groups took place with 1.5 hour discussions each. The groups were guided by a qualified social scientist, familiar with leading groups and no special interest in domestic violence. A topic guide with eight key questions was used to generate discussion between the participants. For design of the focus group study see Figure 2. After stratification, thirty-seven participants (20 female and 17 male doctors) of the intervention study were randomly assigned to the focus group study. Eight participants outside the intervention study (4 female and 4 male doctors) were purposely approached to join the focus groups to gain additional information from participants outside the intervention study. The focus groups as well as the moderator were of the same gender. (See fig.2) This method was chosen to enable participants to express themselves freely and unhindered by self-censorship regarding ‘politically incorrect’ opinions on this sensitive issue. The focus group discussions took place prior to the training in February 2003. The discussions were audio-taped and transcribed for analysis.
A qualitative analysis inspired by the grounded theory method (Strauss & Corbin; 1998) was conducted to search for similarities and differences in views, experiences and practices between male and female family doctors. The transcripts were
analysed by two independent researchers and findings were discussed in the research group for final conclusions. Themes that emerged from these focus groups were applied in the intervention training.

The results are presented in chapter 2: Discussing partner abuse: does doctor’s gender really matter? A focus group study.


A randomised controlled trial (RCT) was designed to measure family doctors’ awareness, and active questioning of female patients on partner abuse after a 1.5 day training in May 2003. For contents of the training see Appendix 1. For design of the RCT see Figure 1.

Three groups participated in the study: a ‘full-training’, a ‘focus group alone’ and a control group. The dependant variable was the doctor’s performance in asking/discussing partner abuse with female patients. Data collection took place via reporting of every female patient (>18 yrs) suspected of, or identified with partner abuse (incident reporting) during six months in an intervention period from March to September 2003 for ‘focus group alone’ and control group and from May to November 2003 for the ‘full-intervention’ group. Patients were registered and reported anonymously to the researcher, with a specified registration form. Doctors were asked to collect information about: patient characteristics; whether the disclosure was ‘patient-initiated’ or ‘doctor-initiated’; doctors’ reasons for asking about abuse; whether abuse was confirmed: currently, formerly, both or denied; length of the visit.

The primary outcome measure was the number of reported cases (n-cases); secondary outcome measure was the number of non-obvious signs/reasons to suspect/discuss abuse in each of the cases. At the end of the registration period seven categories for asking about abuse were formed to cover all signs/reasons. We distinguished: ‘obvious’ and ‘non-obvious’ signs/reasons. ‘Obvious’ were: 1) the patient broached the abuse, 2) the doctor knew of a patient’s abuse situation and suspected a new episode or 3) injury. ‘Non-obvious’ were: 4) undefined (chronic) somatic complaints, pain, 5) mental complaints/disorders, 6) a combination of both or 7) other reasons not classified as ‘obvious’. In the category ‘other’, behavioural problems of children were frequent.

With statistical analysis the 3 study groups of doctors were compared for the primary and secondary outcome measures to identify whether significant differences occurred that could be attributed to the intervention/training.

The results are presented in chapter 3: Increased awareness of intimate partner abuse after training. A randomised controlled trial.
3. **Pre- and post-training survey to test a short and feasible instrument to measure family doctors’ attitudes towards partner abuse: a quantitative study.**

At the start and the end of the intervention period, all participating family doctors completed a questionnaire to gather information on: demographics; number of identified patients per year; having knowledge of victims among family/friends/colleagues; experiencing barriers in responding to abused women and prior education/training on intimate partner abuse. The questionnaire also included a 14-item scale with 5-point Likert scoring, to measure attitudes towards partner abuse. For the questionnaire and scale: see Appendix 2. The aim was to test the feasibility, reliability and validity of the scale as an instrument to measure family doctors’ attitudes on partner abuse. The scale was developed in the expert group of the study and piloted among a group of non-participating family doctors outside the study region. Analysis was carried out to test reliability and validity of the instrument. Next, analyses of the data were carried out to compare pre- and post-training scores between study groups.

The results are presented in **chapter 4: Asking about partner abuse: an offence for the patient? Testing a short and feasible instrument to measure family doctors’ attitudes towards partner abuse.**

4. **Exploring the ways in which a training affected family doctors in recognising and responding to abused female patients in daily practice: a qualitative study.**

During the intervention period of six months, several participating family doctors from the full-training group mentioned, that the training had been very effective in identifying abused women and they broached the possibility that this may not be manifest in the effect-measures of the RCT. To investigate the many ways in which the training had affected family doctor’s recognition and management of intimate partner abuse in daily practice we interviewed 20 respondents, 5 to 10 months after the training. We used a topic guide and audio-taped the interviews. For the interview guide see Appendix 3. The transcripts of the interviews were qualitatively analysed according to the grounded theory method (Strauss & Corbin) by three independent researchers.

The results are presented in **chapter 5: “I am not frustrated anymore.” Family doctors’ evaluation of a comprehensive training on partner abuse.**

5. **Exploring the views of identified abused women on the disclosure to their family doctor: a qualitative study.**

In a qualitative study, face-to-face in-depth interviews were conducted with thirty-six abused women who had shortly before (< 4 weeks) been identified as abused by their family doctor. Women who agreed to participate and signed an informed consent form were interviewed by one of the two female experienced interviewers.
We used an interview guide and explored women’s reason(s) to visit the family doctor, views on the disclosure, experiences in the visit, their ways of handling the abuse situation and whether they were offered assistance by their doctor or referred to support agencies. For the interview guide 1, see Appendix 4a. To guarantee a maximum of confidentiality the conversations were not taped. A woman’s answer was summarised for confirmation before a next topic was broached. All interviewed women completed the Composite Abuse Scale (CAS), which measures type and severity of the experienced abuse. For the Dutch version of the CAS, see Appendix 5.

The interviews were qualitatively analysed by two independent researchers to discover important themes.

The results are presented in chapter 6: Talking matters. Women’s views on disclosure of partner abuse and its influence on handling the abuse situation.

6. Following abused women to explore the changes in their situation one year after disclosure: a qualitative study

Follow-up interviews were conducted approximately one year after the first interview. We conducted twenty-five face-to-face in depth interviews and explored women’s developments in a semi-structured interview to gain insight in women’s actual abuse situation at that time, changes in handling the abuse or its sequels and the role of their family doctor and support services in this period. For the interview guide 2 see Appendix 4b.

Two independent researchers qualitatively analysed the transcripts of the interviews and in mutual consultation they reached consensus on the most important themes.

The results are presented in chapter 7: Changes in women’s situation after disclosure of partner abuse. A follow-up of abused women.

7. Abused female patients’ utilisation of healthcare in family practice: a comparative descriptive study of medical records

A retrospective study design was used to describe abused women’s healthcare utilisation in comparison with the average female patient from the Second Dutch National Survey in General Practice 2001 (DNSGP-2). Eight months after the intervention study, all family doctors who reported cases of abused female patients were asked to deliver anonymised data from electronic medical records, in print. The number of consultations, prescriptions for pain-medication, tranquillisers, antidepressants, gastro-intestinal medication, type of presented health problems and referrals were collected. Data were compared to the general female population in family practice as provided by the DNSGP-2. Among the identified abused female patients we identified two disclosure groups: a ‘patient-initiated’ and a ‘doctor-initiated’ disclosure group and they were compared to assess possible bias of the
study design. With statistical analysis the abused women’s frequency of visits, prescription rates for pain-medication, tranquillisers, anti-depressants were compared with the DNSGP-2 female patient. We described the presented health problems and referrals of the studied population.

The results are presented in **chapter 8: Abused women’s utilisation of healthcare. A descriptive study on medical records in family practice.**

**Outline of the thesis**
The main body of the thesis is a series of seven articles (chapter 2 to 8). Each article stands on its own and comprises an introduction and a methods paragraph, as a result of which a certain degree of repetition is inevitable.

Chapter 9 provides a general discussion of the most important findings of the present study for final conclusions. Recommendations for further research, education/training are made.

Chapter 10 presents a summary of each chapter in English and Dutch.

Figure 1. Design of the intervention study: a randomised controlled trial

- Study population n = 412 (family doctors in Rotterdam & surrounding areas, 2002)
- Mailed

- Research sample n = 54 (13%) female 28 / male 26 (family doctors who consented to participate)

- Stratification: gender / city district / practice setting

- Randomisation into 3 study groups: ‘full-training’ - ‘focus group alone’ - control group

- Focus groups n = 37 (17m / 20f)

- ‘full-training’ group n=23 (10m / 13f)

- ‘focus group alone’ group n=14 (7m / 7f)

- Control group n=17 (9m / 8f)

- Training

- 6 months: incident reporting
  1. Cases: suspect / discuss abuse
  2. Reasons to suspect

- Number of reported cases
- Reasons to suspect / discuss abuse

- 6 months: incident reporting
  1. Cases: suspect / discuss abuse
  2. Reasons to suspect

- Number of reported cases
- Reasons to suspect / discuss abuse

- Number of reported cases
- Reasons to suspect / discuss abuse
Figure 2. Design of the focus group study

Participants from the intervention study (37)
20 female, 17 male doctors

Participants outside the intervention study (8)
4 female, 4 male doctors

FOCUS GROUP STUDY  N=6
Participants: 24 female & 21 male doctors

8 female

8 female

8 female

7 male

7 male

7 male
References


Chapter 1

96. Hamberg K, Johansson EE, Lindgren G. "I was always on guard"--an exploration of women abuse in a group of women with musculoskeletal pain. *Fam Pract* 1999;16(3):238-44.


“They were all the same; they didn’t want to know. They’d never ask. Here’s a prescription; now fuck off. The young ones were the worst. The young ones in Casualty. So busy, so important.”

“The woman who walked into doors”. By Roddy Doyle
Family doctors discussing Intimate Partner Abuse: does physician’s gender really matter?
A focus group study

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Abstract

Purpose: The aim was to explore gender differences in family doctors’ views, attitudes, experiences and practices regarding intimate partner abuse against women.

Methods: We used the focus group method with a stratified, randomized sample. Six focus groups, three male and three female groups took part. Two independent researchers analyzed the transcripts of the conversations.

Results: The most remarkable results in discussing partner abuse were the differences between the male and the female groups, although similarities were also noted. Major contrasts in opinions were seen in: 1) the role of sexuality: part of the male family doctors stated that denial of sexual relationships by a spouse was a contributing and eliciting factor to male aggression whereas female doctors emphasized unanimously the humiliation of sexual coercion and the danger of opposing. 2) Children as witnesses: an important issue in the female groups was not discussed in the male groups. 3) female doctors talked about emotional involvement with patients and male doctors about keeping distance 4) female doctors viewed leaving an abusive partner as a process whilst male doctors saw no progress, 5) experiences with abused patients: female doctors remembered more actual cases and 6) practices in managing partner abuse differed.

Conclusion: These remarkable gender-related differences between doctors could affect care for abused women. Doctors should be aware of gender related views, attitudes and practices that can be harmful to their patients.

Keywords: intimate partner abuse; women; gender; family physician; focus group
Introduction
There is broad agreement to recognize intimate partner abuse as a serious health concern for women. Worldwide population surveys among women indicate that between 10-50% were at some stage abused by an intimate partner. Cross sectional studies in waiting rooms of family doctors in the UK, Ireland and Australia found that 37-41% of the female patients ever experienced partner abuse. In general it is a hidden problem in medical practice, as under-reporting is almost universal. On the other hand doctors often refrain from asking because of feelings of powerlessness, inability to offer a useful intervention, skepticism and aversion to the problem. Partner abuse is the sort of problem wherein a doctor’s attitude is of great importance to help patients disclose and start necessary care. Some more profound knowledge on doctor’s attitude comes from focus group studies that describe how physicians with special interest in domestic violence identify and treat victims of partner abuse. They emphasize the necessity of an atmosphere that promotes self-disclosure together with the need to break through denial and the skill of nonjudgmental listening.

In spite of the recognition of partner abuse as a major problem, as it does not only affect women but also their children, a gap still remains between the required attention for abused female patients and professional training. Guidelines on management of partner abuse have been released but little is known about their reach, acceptance and implementation in family practice.

The ongoing under-identification and lack of attention for abused women calls for a closer look at family doctors’ attitude regarding this problem. In this respect, the recent increase of female family doctors must be taken into account. Research shows female doctors to be more interested in psychosocial problems and female patients to give more psychosocial information to female doctors. Some studies on partner abuse find female doctors to be more involved with victims, showing more commitment and adequate responses compared to male doctors, where others find no effect of gender.

Considering these conflicting findings on gender influence and the recent increase of female family doctors, a qualitative study may provide more insight in the role of gender. We therefore conducted a focus group study to explore the views, attitudes, experiences and practices towards intimate partner abuse and to explore whether gender really matters in discussing these topics.

Methods
Study design: see Figure 1.
This focus group study was part of a larger project to evaluate the effects of training on identifying female patients with intimate partner abuse in a randomized controlled trial. In the first part of the study we aimed to explore the views, attitudes, experiences and practices of family doctors towards partner abuse. Topics that emerged from the focus groups were also used in the (intervention) training in the second part of the study.

Because partner abuse has not been studied before in the Netherlands, a qualitative research method, focus group discussion, was chosen to enable in-depth exploration.\(^{33}\)
In October 2002 all family doctors in Rotterdam and non-urban surroundings (n=412) were mailed and invited by letter to participate in the study. Fifty-four family doctors (13%) agreed to participate. Twenty-six male and twenty-eight female doctors from all types of practice settings, districts and age groups were included in the intervention study. The focus on the influence of gender required a comparable number of male and female doctors. The research sample was divided into strata with similar characteristics: gender, districts and practice setting. From this sample 37 participants were assigned to the focus groups (N=6). Eight family doctors in the same region (mainly non-responders) were purposely approached and added to the focus groups, to diminish selection bias and gain information from participants outside of the intervention study. Finally we formed six focus groups (3 male and 3 female) in which 45 doctors participated. On account of the sensitivity of the issue along with our aim to explore gender differences, we conducted exclusively single gender groups to enhance an unhindered exchange of opinions and minimize bias from social acceptability in the discussions. Self-censorship is known as one of the pitfalls of focus groups. In this type of research information is gathered from group interaction until theoretical saturation takes place. In studies with homogeneous groups, in general two to four groups are assessed enough to reach that point. Groups contained a mix of all ages, practice types and districts in order to diminish inter group differences but for gender. Participants in a group were not from the same practice. For the demographics of the participants: see Table 1.

| Table 1: Demographics of focus group participants and total/study population |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                               | Male n=21                   | Female n=24                 | Total n=45                  | Study population n=415 m 74% / f 26% |
| Age groups                   | 47%                         | 53%                         | n (%)                       |
| < 40 yrs                     | 4                           | 6                           | 10 (22)                     | 13                          |
| 40-50 yrs                    | 4                           | 12                          | 16 (36)                     | 43                          |
| >50 yrs                      | 13                          | 6                           | 19 (42)                     | 44                          |
| Practice type #              |                             |                             |                             |                             |
| Solo                         | 6                           | 3                           | 9 (21)                      | 43                          |
| Group*                       | 11                          | 13                          | 24 (53)                     | 42                          |
| Health centre†               | 3                           | 8                           | 11 (25)                     | 14                          |
| District type #              |                             |                             |                             |                             |
| Wealthy                      | 6                           | 5                           | 11 (25)                     | 77                          |
| Mixed                        | 7                           | 6                           | 13 (30)                     |                             |
| Deprived                     | 7                           | 13                          | 20 (45)                     |                             |
| FT≥ 4 days                   | 11                          | 3                           | 14 (31)                     | 77                          |
| PT< 4 days                   | 10                          | 21                          | 31 (69)                     | 23                          |

* 2 or more doctors in one family practice  
† cooperation of family doctors with other primary health care professionals  
# Practice type, district type: total number for male doctors does not add up to 21 because 1 participant (a trainee) was not settled  
∞ Survey of the District Association of Family Physicians Rotterdam & surroundings 2003
Data collection and analysis

A short questionnaire provided demographic data and the participant's estimate of the number of abused female patients encountered in one year and information on previous education on domestic violence.

A moderator with the same gender as the group conducted the focus groups in February 2003. The two moderators were qualified senior social scientists, familiar with leading groups and with no special interest in domestic violence. The topic guide with eight key questions was developed in discussion with the moderators and tested in a pilot. All questions were used to generate discussion among participants. (See Table 2)

Table 2: Interview guide

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>What images do you have when you think of the abuse of women by an intimate partner?</td>
</tr>
<tr>
<td>2.</td>
<td>Which feelings and inclinations do you recognize thinking of women abused by an intimate partner?</td>
</tr>
<tr>
<td>3.</td>
<td>In your opinion, which kind of behavior would you label as abuse and which behavior is not abuse in intimate partner relationships?</td>
</tr>
<tr>
<td>4.</td>
<td>What causes abuse of women by an intimate partner?</td>
</tr>
<tr>
<td>5.</td>
<td>What do you find difficult when you encounter this problem in your surgery?</td>
</tr>
<tr>
<td>6.</td>
<td>Which experiences did you have with patients on this subject? (Positive and negative)</td>
</tr>
<tr>
<td>7.</td>
<td>Which internal barriers do you recognize when you suspect intimate partner abuse in daily practice?</td>
</tr>
<tr>
<td>8.</td>
<td>Do you as a family physician have a task in the field of intimate partner abuse?</td>
</tr>
</tbody>
</table>

Participants received a small incentive (€ 40) for their effort.

Group discussions lasted one hour and a half each and were recorded on audiotape and transcribed by the research assistant. Both the researcher (SL) and the assistant (MS) observed the group discussions and took field notes and described non-verbal interactions.

The first researcher (SL) checked the transcripts with the field notes and she and a second researcher (AJ) analyzed each transcript. All comments were sorted per gender, per key question. This procedure resulted in 16 documents. The two researchers independently searched for patterns that emerged with each question and subsequently they defined the most important themes together. In case of disagreement both researchers tried to reach consensus on the influence of gender. In case of a remaining discrepancy a third researcher (ALJ) read the transcripts with a focused question and the three analysts discussed until agreement was reached. To examine the findings on themes more closely, all qualitative data were entered in the ATLAS.ti software program (Visual Qualitative
Data Analysis-Management-Model Building-Version WIN 4.2) to compare groups and genders. The transcripts were coded and the specific themes within the groups’ narratives were identified in accordance with the grounded theory method.\textsuperscript{34} The study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: CMO, region Arnhem – Nijmegen, nr.2002/275.

**Results**

In the course of purposive sampling of non-responders by telephone, we found that time-investment and not viewing partner abuse as a medical issue as reasons for non-response. Our sample differed from the general population of family physicians in the region because of our equal number of males and females whereas this 75-25%. Female physicians are younger, work more often in part-time hours and in health centers.

In all six groups participants discussed their views, attitudes, experiences and practices for the first time with colleagues. Regarding gender, the group discussions differed merely on the accent on issues and we did not get new themes after two groups both male and female. The third groups provided mainly confirmation. In the discussion of views, attitudes and professional role regarding partner abuse, we found several similarities and differences between male and female groups.

**Similarities**

*Cultural background* was a prominent theme in all groups. Participants explicitly named Turkish, Moroccan and Surinam-Hindustani ethnic groups with repressive attitudes towards women, together with their supposed legitimized violence as expression of masculinity, as important causes of partner abuse. The doctors mentioned that a lack of social support from the family limited the opportunities to leave a violent relationship, especially in women with arranged marriages. All participants underlined their vulnerable position. Repression and abuse of women in fundamentalist Christian religions were also mentioned in this respect.

*Inequality of power*, the dominant position of men in general, was also viewed as an important reason for women to become a victim or to stay in an abusive relationship. *The powerless attitude in women*, manifested as resignation and passivity was viewed as an important aspect of ongoing violence in relationships. Women’s supposed unwillingness to leave her abuser was generally incomprehensible and evoked frustration.

*Perpetrators’ motivations and backgrounds* were extensively discussed. In all groups the cause of violent behavior was seen as the outcome of upbringing, child neglect and abuse, but also as a result of alcohol-, drug-abuse and accompanying psychiatric diagnoses.
Powerlessness of the doctor was considered to be a barrier when partner abuse was suspected. Across groups, inability to solve the problem caused irritation. Most doctors acknowledged that abused women frequently consulted for undefined somatic complaints.

Doctors’ fear of perpetrators’ aggression as a barrier in addressing partner abuse was mentioned explicitly and comprehensively in all groups. Especially if the doctor knew about the criminal history of the perpetrator or had experienced violence by some patient before they would refrain from asking.

The double role of a family doctor giving medical care to both victim and perpetrator was seen as a major barrier in responding to partner abuse. All participants stressed that knowing the background of a perpetrator made it difficult. Understanding perpetrators’ motives as well as disbelief, anger and shock were expressed. Fear of making false accusations, causing offence and the risk of losing a patient, were serious concerns.

The task of the family doctor was primarily seen as identifying the abuse. The majority of participants expressed this opinion in all groups. Supporting women in abusive relationships was the next objective. Most participants agreed that they were under-identifying abused women. Patients’ reluctance to disclose, time constraints and unawareness of the possibility of abuse, were often mentioned in this respect. Two doctors, one male and one female, would not see it as their task to identify abuse but considered that rather as a waste of time.

Differences

Views on the role of sexuality: in discussing the causes of partner abuse, in one of the male groups the role of sexuality became a central issue. In this male group the denial of sex by a spouse was viewed as a contributing and eliciting factor to male aggression. Some doctors expressed the opinion that women could exercise power by refusing sex and therefore provoke violence.

* “Sex plays an important role, I have never seen a good sexual relationship go together with abuse” “Let’s put it simply, a woman has one means of exercising power and that is simply keeping her legs together and he will have his way…”

“It contributes, I think, it plays an important role.”

“I sometimes explain to the lady: he hits, that’s unpleasant, but if you constantly keep your legs together, that’s also terribly unpleasant, that’s not hitting but just as aggressive sometimes…”

“Sometimes explaining that keeping your legs together is also an aggressive act, if she acknowledges this, then at least she knows why the hitting occurs, because it is also a smack…”

* Quotations were translated from Dutch to English.
There was one strong contrasting opinion in this group:

“I think it is just the other way around, the sexual relationship is bad because of a bad personal relationship, and not the other way around”

But opinions in the group did not move to his side.

The two other male groups were less explicit in their views on sexuality. However in one group the acknowledgement of women’s rights to set limits in sexual relationships nowadays was accompanied by laughs and jokes. In the other group one doctor made the assumption that sometimes the woman’s ‘teasing’ behavior provoked male aggression. In response to this remark another participant opposed and considered it a socially unacceptable opinion.

In contrast, the female groups pointed out a different view on the role of sexuality. They emphasized unanimously the humiliation of sexual coercion, the danger of opposing to a partner’s sexual demands and a woman’s right to set limits in a sexual relationship. In none of the female groups, laughs or jokes accompanied the discussion of this theme.

“I can say something about what I think is normal… about the law… you don’t have to put up with everything as a woman…”

“I think coercion, to me violence is… when there is something with coercion…..coercion to do sexual acts… and when women resist then the hitting starts, that’s the process…”

Views on leaving an abusive relationship: male doctors saw abused women step into abusive relationships time and again. Leaving did not lead to any progress for women and this view was mainly expressed in all male groups.

“…there are women that repeatedly come into the same situation, they divorce and choose another partner and then it often is the same…”

“…she leaves and chooses another partner and the next month it’s all over the same, the new partner picks up the thread where the other one left it”

In female groups, leaving an abuser was predominantly viewed as a process. Women could learn from their experiences although it would sometimes take time and more than one abusive relationship. The observation that repetition does not only stand for failure was solely heard in the female groups.

“…it is my experience with several women that it is a process, yes and that more things are needed, patience for instance.” “I sometimes see a woman get into the same situation, time after time, but I think, well those things happen and maybe it will take three attempts before she succeeds … it is important that I don’t despair.”

Emotional involvement with victims: in all female groups, several doctors mentioned that they could manage only a limited number of these cases a day. Female doctors tended to be more emotionally involved with abused patients and reported difficulties
in distancing themselves from these problems. As a self-defense mechanism some even decided to block communication when confronted with too many cases.

“...I can handle only three of these cases a day, a pity for the fourth one but I simply cannot take more...” “That's even too many.”

In all male groups, doctors said they experienced few or no difficulties in discussing abuse with a patient. Avoiding emotional involvement was predominant. If male doctors blocked the communication, they mentioned time constraints as a limiting factor. Involvement was viewed as tricky business with low success rates and therefore the primary reaction was keeping distance.

“...I don't want to have anything to do with it” “... because it is dangerous territory... every step you make you end up in a marsh with quicksand.”

Children as witnesses: as children were not explicitly mentioned in the topic guide, a great difference appeared in the way groups discussed the position of the children. In all female groups concerns about children witnessing the abuse were raised spontaneously. Doctors discussed and expressed their professional responsibility for the children.

“The children, that bothers me, you don’t have good resources for them...they risk growing up and becoming perpetrators and victims...” “...they don’t have to be abused themselves... but they see it happening...”

In the course of the discussion the female doctor that denied having a task in identifying partner abuse modified her opinion at the end of the focus group, because of the children.

In the male groups, children as witnesses were not discussed. Only twice short remarks were made about child abuse as this was seen as a more serious problem than partner abuse and with a more acute need to act.

Experience with partner abuse cases: female doctors talked in more detail about their experiences with abuse cases although no numbers were mentioned. They reported to have been confronted with severe cases of abuse, occasionally with deadly consequences.

In male groups participants mentioned that they hardly came across any cases of abuse although doctors working in deprived districts stated they saw more.

“...coming here this evening ...it was not easy to remember a number of actual cases. I came across six cases in all these (twenty) years...”

Practices in managing partner abuse: female doctors exchanged strategies on how to respond to abused women, how they actively asked, managed and assessed the safety of their patients and meanwhile reflecting on their own emotions.

“(I asked)... how safe are you, is it possible to go home, what kind of care is possible .... get someone in the home, finally we made a phone call, I said call from here and ask your friend to come over, or whatever. It didn’t work out, then
she went home, and in the afternoon the police came when she was shot dead… so this makes it more complicated for me”

In the male groups there were fewer discussions on how actual cases were handled. Theorizing on how to respond and whether questions to identify abuse should be asked or not was the main issue.

“But yes, how often does it occur?” “Maybe more often than we think.” (Assenting rumor) “But maybe we don’t see it.” “Yes exactly, ok, but is there a question for help?” “That is the second thing.” “Yes, yes, that is the point.” “But if you get a question for help, do you know what you are going to do?” “Well I don’t know, it depends on the situation, no…”

There was much agreement about the limited effects of actively questioning a patient about abuse. Male doctors reported they would rather wait until a woman decides to disclose her problem at first, emphasizing the need of a question for help. But if a patient revealed her situation and asked for help, she could count on their support.

**Discussion**
Our study confirms the assumption that gender differences would emerge in discussing partner abuse.

The first finding in this context was that the course of the discussion and the expressed views on the role of sexuality were considerably contrasting. At least part of the male family doctors showed views on sexuality that are harmful to victims. Holding women responsible for their abuse because of denying of sex, is harmful to female patients and represent a personal prejudice.26 37 A doctor’s view on sexuality will certainly hinder or facilitate an abused woman in raising the real nature of her problem. These contrasting opinions on the role of sexuality between genders have not been reported to this extent in other studies. However a recent report provided a parallel to our finding in the section on opinions regarding violence against women.16 This view demonstrates a discrepancy with the standard of a modern society underlining a woman’s right to self-determination. In addressing the issue of sexuality in training for providers, it is necessary to include a substantial part on how to deal with personal prejudices and not focus on knowledge of guidelines alone.

The second striking finding is that in the male groups children, as witnesses of abuse, were not discussed. Overlooking the children is also described in one other qualitative study but without its relationship with gender.13 Education programs on child-abuse should address more explicitly the consequences of children witnessing abuse. It is possible that educators on child abuse overlook partner abuse as a condition for child-abuse.

* The Emancipation Monitor 2004, edited by the Social Cultural Plan Bureau and the Central Bureau for Statistics, monitors cultural changes in the Netherlands, has found that 32% of the male respondents held the view that a married man(or similar situation) can set his rights on sexual relationships against 17% of the female responders.
The third finding on differences is that female doctors showed more emotional involvement, active questioning and engagement with abused patients while male doctors held more negative views and kept more distance, mainly theorizing on how to respond. One possible explanation is that women, abused by men, are more likely to disclose abuse to a female doctor rather than to trust a male doctor. This finding is consistent with other studies that report female doctors to be more interested in and more involved with psychosocial problems and female patients giving more information to female doctors. This contrast may come from the difference in number of identified abused patients between male and female doctors. The negative side-effect of too much emotional involvement is a considerable distress which leads to less availability for problem patients. The possibility remains that compared to male doctors, female doctors actually see more cases and even more severe ones in shorter time. It seems that the fact that female doctors are mostly working part-time schedules, is no obstacle for abused female patients. Another pitfall for female doctors is that too much identification with a female victim can hinder a professional attitude and performance.

This study adds another new finding. These doctors, working mainly in the multi-ethnic community of Rotterdam, the second largest city in the Netherlands, almost unanimously stated that the repression of women in Turkish, Moroccan and Surinam-Hindustani groups, contributes to partner abuse. No other studies in the field of medicine, have reported explicitly, that repressive standards towards women in certain cultures were seen as an important contributor to partner abuse. Only recently the influence of culture and ethnic background on women's abuse has been explored, with the call to identify specific aspects of culture that are relevant to partner abuse. Further similar themes that were mentioned in all groups are well known from other studies. The view that the woman's unwillingness to leave the abuser is responsible for ongoing abuse (‘blaming the victim’) and at the same time the acknowledgment of the woman's vulnerable position because of power inequality between men and women, underline doctors' ambivalence regarding abused women. Together with powerlessness and problems with caring for victim and perpetrator, the dilemmas and barriers that doctor's experiences are almost universal. The view that identification of partner abuse as a waste of time also reflects doctor's powerlessness on this matter is of importance. We may have grasped the background of non-responder's opinion that partner abuse is not a medical issue. Finally we wish to highlight the doctors' fear for perpetrators' aggression. For these doctors it appeared to be a major barrier in addressing abuse in their surgery. While the current debate focuses on routinely asking all women, doctors' barriers remain under-estimated.

* In the questionnaire the estimates of identified abused female patients in 1 year: male doctors:2.48 female doctors:3.19 (not corrected for part-/full-time)
In all six groups the separation of participants in gender groups, was initially questioned. Doctors are seldom aware of the impact of gender on their attitude and professional performance. All participants accepted the explanation given by the moderator that a sensitive matter can only be discussed openly in a single gender group.

The strength of this design is the opportunity to explore family doctors’ responses to partner abuse and the gender-related nature of some of them. We aimed to diminish bias by performing stratification and randomization and add participants from outside the intervention study. The main limitation of this study is that most doctors who volunteered and agreed to participate are assumed to be more interested in partner abuse than other doctors. Because of the explorative character of this study, findings cannot be generalized to the whole population of family doctors. These findings do not necessarily represent participants’ performance in daily practice.

However this study highlights gender specific views, attitudes and experiences that need more attention both in research and training. It is interesting to theorize on the role of gender-related views and attitudes on the one side and the influence of experience and education on the other side. Or was it primarily gender socialization that focused male doctors more on the role of sexuality whilst the female doctors were too emotionally involved? It is known from studies on male and female psychological development of identity and gender roles, that primacy of autonomy and competitiveness for men and emotional attachment and relational ties for women are basic.39 It is a challenge to search for confirmation or refutation of these findings in future studies. Development of a questionnaire to investigate opinions and attitudes regarding violence against women is one of the options. This could lead to more attention for gender related provider differences in circulating domestic violence guidelines. Training should address these specific barriers to achieve acceptance and implementation of guidelines.27,40

**Conclusion**

Few studies explicitly address the role of gender and in this respect this focus-group study adds new information. Education on partner abuse should provide training experiences that address in particular gender-related issues in order to overcome personal barriers. For instance male doctors should reflect on the effects of masculine views on sexuality and female doctors should learn in particular to balance more their emotional involvement and professional attitude. Acknowledging these barriers, the emphasis should lie on the many and various lessons to be learned, both by male and female doctors in order to improve quality of care for victims of partner abuse.
Acknowledgement
We wish to thank all the participating family doctors; the moderators: Door Hezemans and Ron Alma, for leading the discussion in the focus groups; the research assistant: Margriet Straver, for processing the conversations.

Conflict of Interest: No one of the six authors has declared a conflict of interest.

Ethical approval: The study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO-nr.2002/275

References
"The doctor never looked at me. He studied parts of me but he never looked at my eyes....He never saw me. Drink, he said to himself. I could see his nose twitching, taking in the smell, deciding. None of the doctors looked at me."

“The woman who walked into doors”. By Roddy Doyle
Increased awareness of Intimate Partner Abuse after training
A randomised controlled trial

SH Lo Fo Wong
F Wester
SSL Mol
ALM Lagro-Janssen

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Abstract

Background: Intimate Partner abuse is very common among female patients in family practice. In general doctors overlook the possibility of partner abuse.

Aim: To investigate whether awareness of intimate partner abuse as well as active questioning, increase after attending focus group and training or focus group alone

Design: Randomised controlled trial in a stratified sample.

Setting: Family practices in Rotterdam and surrounding areas.

Methods: A ‘full-training’ group (n=23) a group attending focus group discussions alone (n=14) and a control group (n=17) were formed; data collection with incident reporting of every female patient (>18 yrs) that was suspected of, or presented partner abuse during a period of six months. Primary outcome measure was the number of reported patients; secondary outcome measure was the number of cases with non-obvious reasons to suspect/discuss abuse.

Results: Comparison of the ‘full-training’ group (n=87 cases) vs. the control group (n=14 cases) resulted in a rate ratio of 4.54 (95% confidence interval 2.55 to 8.09, p<0.001); the ‘focus group alone’ (n=30 cases) vs. control group: rate ratio of 2.2 (95% confidence interval 1.14 to 4.26, p=0.019); ‘full-training’ vs. the ‘focus group alone’ group: rate ratio of 2.19 (95% confidence interval 1.36 to 3.52, p=0.001).

Comparison of the ‘full-training’ group to the un-trained groups for awareness of partner abuse in case of non-obvious signs resulted in: odds ratio 5.92 (95% confidence interval 2.25 to 15.62, p<0.01) All corrected for gender, district, practice setting, working part-/full-time, experience and age of the doctor.

Conclusion: training was the most significant determinant to improve awareness and identification of intimate partner abuse. Active questioning increased especially in case of non-obvious signs. The focus group on its own doubled the awareness of partner abuse.

Keywords: intimate partner abuse, abused women, family medicine, general practitioners, , training, randomised controlled trial.

How this fits in:
- Intimate partner abuse is highly prevalent among women visiting family practice.
- Health consequences of partner abuse are underestimated.
- Doctors in general are not aware of the possibility of partner abuse.
- Training should focus on recognising patients with non-obvious signs of partner abuse.
Increased awareness of intimate partner abuse after training

Introduction

Increasingly, research shows the high prevalence of Intimate Partner Abuse, worldwide. Cross sectional studies among female patients in waiting rooms of family practices, consistently report that 37-41% of women have experienced physical, sexual and/or emotional abuse by an intimate partner at some stage in their lives. These studies found that most women who experienced violence in their relationship are not identified and only 5% had been asked by their family doctor, together with a poor recording of abuse in medical records. Family doctors, although in a unique position to identify abuse, are in general not aware of the possibility of partner abuse. Also barriers such as fear of opening ‘Pandora’s box’, time constraints, aversion of the problem and discomfort with the double role of caring for both victim and perpetrator, are universal in this respect. On the other hand a majority of female patients approve of being asked about abuse during consultation. This suggests that doctors should take a more active role in addressing abuse. However, training in identifying and responding to partner abuse is mostly lacking. Disappointing results from educational programs, screening protocols, guidelines and mandatory continuing medical education (CME) to increase identification, indicate that there is still a lack of knowledge on how to reach health care professionals on this subject.

The debate between experts, arguing that all women in healthcare settings should be routinely questioned about partner abuse versus those that underline more targeted case-finding, continues. Intimate partner abuse is not a disease that can simply meet the accepted screening criteria and moreover physicians, in majority, do not favour screening. Consultation time in medical practice is limited and medical visits should be effective and meaningful. Many consultations with abused women result in diagnostic tests, referrals to medical specialists, physiotherapists and medication in search for explanations for chronic somatic complaints. However, the real nature of their problem remains concealed. Being aware and recognising non-obvious signs related to partner abuse followed by active questioning, could be a more appropriate way to identify abused women and lower the threshold to talk about their problem. This method reflects the common situation in family practice where a doctor is familiar with a patient’s medical history, personal background and ideally provides confidentiality and continuity of care.

Considering these facts, the following questions are raised:

- Will training be effective in stimulating family doctors to question women more actively about partner abuse when they suspect it and will identification increase?
- Can doctors’ awareness of the possibility of partner abuse in patients, presenting non-obvious signs, increase through training?
Methods

Definitions

According to the literature we defined intimate partner abuse as physical, sexual, emotional or psychological abuse. We focused on female victims (≥18yrs) abused by a male partner.

Participants

To calculate the sample size we combined findings from a systematic review and cross-sectional studies. We judged that prevalence figures of partner abuse among female patients in waiting rooms of family practice in Australia, Ireland and the UK, with a comparable system of family practice, would match the situation in the Netherlands. We used the estimate that a full-time practitioner sees one to two female patients a week, who are undetected victims of partner abuse, to calculate the proportion of cases that would occur during our intervention period. Together with the baseline identification of 0-3% by Ramsay we estimated the proportion of case-finding in six months in the control group to be 0.5 case: 0.01 of the total and the proportion in the experimental group on 2.5 cases: 0.05. A sample of 50 participants was needed for a significance level of 0.05 and a power of 80%.

All registered family doctors (n=412) in Rotterdam and surrounding areas were mailed in October 2002 and invited to participate in the study. Fifty-four family doctors agreed to join the study (26 male / 28 female doctors) and were included. Most participants were keen to join in and only eighteen doctors had to be approached actively to maximize the diversity of the sample in order to cover all types of districts, (wealthy, mixed, deprived), practice settings, (solo-group practices-health centres) age groups, (<40, 40-50, >50) and gender.

Design: See Figure 1

Randomisation

Participants were numbered at first and then grouped into strata, according to gender, district type (wealthy-mixed-deprived) and finally to practice type (solo-working in group practice or health centre). Members of a team, (group practice or health centre), were linked to each other and marked. The research assistant, blinded against the participants’ name and that of the group practice or health centre, executed the randomisation by sequential assignment of a number to a group.

The study groups

Three groups were formed: ‘full-training’: n=24, ‘focus-group alone’: n=14 and control: n=16. After one male participant in the ‘full-training’ group fell ill, he had to be moved to the control group.
The study groups were intentionally different due to the training, which required twelve participants per training group to maximise comfort in dealing with a sensitive matter; this resulted in a ‘full-training’ group of two subgroups. In the course of preparing the training, the insight arose that the focus group discussion in itself was
an experiment and had to be compared as such. Furthermore we choose to enlarge the control group instead of the others to cope with eventual fall-out. Participants working in the same practice were allocated to the same group to avoid contamination of the intervention. After randomisation we distinguished, both in the ‘full-training’ and the control group four clusters of two participants and in the ‘focus-group alone’ group, one cluster of three participants. This resulted finally in a cluster-size of 1.2. Nevertheless, we assumed that asking women about partner abuse took place during a one-to-one conversation as part of the consultation. Moreover, most cluster-members worked part-time hours, not on the same day. We therefore did not take clustering into account in recruiting our sample.

**Effect-measures**

The dependant variable of the study was the doctor’s performance. Our primary effect measure was: the number of reported cases wherein partner abuse was discussed or suspected. Our secondary effect measure was: the number of cases with non-obvious signs to suspect/discuss partner abuse. We aimed to improve doctor’s awareness of non-obvious complaints/disorders presented by women, as signs of a hidden background of partner abuse. These signs were dealt with and listed as key-features of partner abuse, in the handout notes of the training. Key-features were derived from studies on health consequences of violence against women, and consisted amongst others of increased health-care utilisation, unexplained chronic pain, depression, sleeping problems and somatisation disorder in particular.\(^{19,21-27}\) Seven categories were formed to cover all signs to suspect and discuss abuse. Categories 1-2-3 were defined as *obvious signs*. Categories 4-5-6-7 were defined as *non-obvious signs*: See Box 1

**Box 1 Categories: signs to suspect/discuss intimate partner abuse**

<table>
<thead>
<tr>
<th>Obvious signs</th>
<th>Non-obvious signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient initiated disclosure of abuse</td>
<td>4 Undefined somatic complaints/chronic pain</td>
</tr>
<tr>
<td>2 Recently abused or abuse known to the doctor</td>
<td>5 Mental complaints/disorder: e.g. depression, sleeping problems, anxiety, substance abuse</td>
</tr>
<tr>
<td>3 Injury</td>
<td>6 Combination of somatic and mental complaints/disorders</td>
</tr>
<tr>
<td></td>
<td>7 Others</td>
</tr>
</tbody>
</table>
Data collection
In line with our study aim to measure awareness of partner abuse and active questioning, we used incident reporting to collect data. The participants registered and reported cases during six months when:
1. The doctor suspected and asked about abuse, whether the abuse was confirmed or not, taking into account that denial is common in abused women who are asked for the first time.\(^\text{7,19,28}\)
2. The doctor suspected but did not ask, mostly for safety reasons.
3. The patient initiated disclosure of abuse.
Cases were registered on numbered forms, anonymously with a patient’s study number and electronic medical file number alone. Each case could only be reported once. Doctors were asked to specify their reasons for suspecting and/or discussing abuse briefly, in their own words.
Case registration and reporting:
- The control group (n=17) started with the registration and reporting of cases after personal instruction by the research assistant. (Week 12 - 38 in 2003)
- The ‘focus group alone’ group (n=14) took part in a focus group discussion in February 2003 and then started to register and report cases after personal instruction by the research assistant. (Week 12 - 38 in 2003)
- The ‘full-training’ group (n=23) took part in the focus group discussion and followed a 1.5 day training on partner abuse in May 2003 after which they started to register and report cases. Instruction took place at the end of the training. (Week 20 - 46 in 2003)
All registered cases were reported to the researcher. At the end of the 6-month period, all signs filled out on the forms were categorised by the researcher.

Focus groups and training
The focus group discussion that preceded the training was considered a low-grade intervention. We conducted 6 group discussions, lead by a qualified social scientist, and explored in a focused way: views, experiences, barriers and practices regarding partner abuse. In these structured group-discussions, which took 1.5 hour each, participants were encouraged to question one another and discuss the subject. The topics that emerged from the focus groups were applied in the training. The training was developed to deal with all the negative associations towards abused patients and provide tools to overcome these barriers. The aim was to enhance awareness for non-obvious signs, to increase active questioning and to improve professional attitude in responding to abused women. (The training provided 9 CME credits)

For the content of the training: see Box 2.
Box 2 Contents of 1.5 day training

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attitude: aversions, prejudices and barriers; small group discussion and plenary clarification</td>
</tr>
<tr>
<td>2</td>
<td>Theory: background and coping strategies in intimate partner abuse; profiles of perpetrators; effects on children</td>
</tr>
<tr>
<td>3</td>
<td>Epidemiology: prevalence; clinical presentation &amp; key features; patient’s views</td>
</tr>
<tr>
<td>4</td>
<td>Consultation skills: role play with diagnostic tool &amp; clinic with simulation patient</td>
</tr>
<tr>
<td>5</td>
<td>Information: Police Domestic Violence Program; Resources Abused Women</td>
</tr>
<tr>
<td>6</td>
<td>Legal aspects: lawyer specialised in abuse</td>
</tr>
<tr>
<td>7</td>
<td>Vignettes: pre- and post-testing of written cases</td>
</tr>
</tbody>
</table>

If partner abuse was discussed during consultation, the patient was informed about the study. Patients were unaware of the intervention the doctor received.

**Analysis**

Data of the participating doctors and the reported cases on the registration-forms were entered into an SPSS statistical data file (12.0.1). We did not take clustering into account in the analysis due to the rather small cluster-size (1.2).

The main effect measure: ‘number of reported cases’ followed a Poisson distribution in all three arms. First we compared the ‘full-training’ group with the control group at first, next we compared the ‘focus group alone’ with the control group and finally the ‘full-training’ with ‘focus group alone’. We compared all groups by using a multivariate Poisson-regression analysis with the SAS statistical package (8.2 Genmode procedure). Comparison between ‘focus group alone’ versus ‘full-training’ and control group was done to assess part of our experiment: the effect of just talking in a focused way about the subject.

Regarding the secondary effect-measure: ‘number of cases with non-obvious signs’: the trained group (‘full-training’) and the un-trained groups (‘focus group alone’ and control group) were compared by a multivariate Logistic regression analysis with the SAS statistical package (8.2 Logistic procedure). All computations were corrected for gender, age, experience, working hours, type of practice setting and residential district to overcome possible imbalances.

**Results**

For demographics of the study groups in the research sample compared with the study population are detailed in Table 1.

Of all the family doctors in Rotterdam and its surrounding areas, 13% took part in the study. The research sample was more often female, younger, working part-time hours, shorter in residence and practising in cooperation with others. None of the participants received previous training on any form of domestic violence. (This has not been on the programme of continuous medical education for more than 20 years
and the number of papers on the subject that have been published in national medical journals is, until recently, been negligible.

Table 1 Demographics of study groups, research sample, population of family physicians of Rotterdam & surroundings

<table>
<thead>
<tr>
<th></th>
<th>Full-training</th>
<th>Focus group alone</th>
<th>Control</th>
<th>Research sample</th>
<th>Rotterdam FP-population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=23</td>
<td>n=14</td>
<td>n=17</td>
<td>n= 54 (%)</td>
<td></td>
<td>% (n=415)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>7</td>
<td>9</td>
<td>26 (48.1)</td>
<td>74</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>7</td>
<td>8</td>
<td>28 (51.9)</td>
<td>26</td>
</tr>
<tr>
<td><strong>Working hours</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time ≥ 4 days</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>17 (31.5)</td>
<td>77</td>
</tr>
<tr>
<td>Part-time &lt; 4 days</td>
<td>15</td>
<td>9</td>
<td>13</td>
<td>37 (68.5)</td>
<td>23</td>
</tr>
<tr>
<td><strong>Age category</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>15 (27.8)</td>
<td>13</td>
</tr>
<tr>
<td>40-50</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>20 (37.0)</td>
<td>43</td>
</tr>
<tr>
<td>&gt;50</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>19 (35.2)</td>
<td>44</td>
</tr>
<tr>
<td><strong>In residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 15 yrs</td>
<td>11</td>
<td>9</td>
<td>9</td>
<td>29 (53.7)</td>
<td>32</td>
</tr>
<tr>
<td>≥ 15 yrs</td>
<td>12</td>
<td>5</td>
<td>8</td>
<td>25 (46.3)</td>
<td>68</td>
</tr>
<tr>
<td><strong>District</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wealthy</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>13 (24.1)</td>
<td>Not asked</td>
</tr>
<tr>
<td>Mixed</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>14 (25.9)</td>
<td></td>
</tr>
<tr>
<td>Deprived</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>14 (25.9)</td>
<td></td>
</tr>
<tr>
<td><strong>Practice type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo practice</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>11 (20.4)</td>
<td>43</td>
</tr>
<tr>
<td>Duo/Group practice</td>
<td>14</td>
<td>4</td>
<td>7</td>
<td>25 (46.3)</td>
<td>42</td>
</tr>
<tr>
<td>∞</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>18 (33.3)</td>
<td>14</td>
</tr>
<tr>
<td><strong>Health centre #</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Source: Survey of the District Association of Family Physicians Rotterdam & surroundings 2003;
∞ 2 or more doctors in one family practice # cooperation of family doctors with other primary health care professionals

Number of reported cases

A total of 131 cases were reported in six months. Table 2 outlines the types of reported cases.

The ‘full-training’ group with 23 doctors (trained in two subgroups) reported 87 cases (mean 3.78; subgroups: 3.67, 3.91). In eleven of these cases (12.6%) partner abuse was not confirmed after questioning and in two cases (2.3%) the doctor did not ask because of an accompanying partner or child. The ‘focus group alone’ group with 14 doctors reported 30 cases (mean 2.14). The control group with 17 doctors reported 14 cases (mean 0.82).
Table 2 Number (percentages) and type of reported cases (n=131)

<table>
<thead>
<tr>
<th></th>
<th>Full-training N cases (%)</th>
<th>Focus group alone N cases (%)</th>
<th>Control N cases (%)</th>
<th>Total N cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asked/ abuse confirmed</td>
<td>53 (60.9)</td>
<td>17 (56.7)</td>
<td>7 (50)</td>
<td>77 (58.8)</td>
</tr>
<tr>
<td>Asked/abuse not confirmed</td>
<td>11 (12.6)</td>
<td>0</td>
<td>0</td>
<td>11 (8.4)</td>
</tr>
<tr>
<td>Suspected/not asked</td>
<td>2 (2.3)</td>
<td>0</td>
<td>0</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td>Patient initiated disclosure</td>
<td>21 (24.1)</td>
<td>13 (43.3)</td>
<td>7 (50)</td>
<td>41 (31.3)</td>
</tr>
<tr>
<td>Total cases</td>
<td>87</td>
<td>30</td>
<td>14</td>
<td>131 (100)</td>
</tr>
</tbody>
</table>

Regarding the reported cases, the patient initiated disclosures decreased in the ‘focus group alone’ and ‘full-training’ group, in favour of more active questioning.

**Analysis:**
As there was no difference between the two ‘full-training’ subgroups, we performed all computations on the aggregate. All computations were corrected for gender, district, practice setting, working part-/full-time, experience and age of the doctor.

Comparison of the ‘full-training’ and control group resulted in a rate ratio of 4.54 (95% confidence interval [CI]: 2.5 to 8.09, p<0.001), a significant effect of the training.

Comparison of the ‘focus group alone’ and control group resulted in a rate ratio of 2.20 (95% CI: 1.4 to 4.26, p=0.019). Comparison of the ‘full-training’ group and the ‘focus group alone’ group resulted in a rate ratio of 2.19 (95% CI: 1.36 to 3.52, p<0.001), reflecting the single effect of education. To assess the influence of gender on our outcomes, we compared the ‘full-training’ and the control group, after correction for gender. We obtained the following outcomes: ‘full-training’ versus control group: rate ratio of 0.90 (95% CI: 0.59 to1.37, p=0.612), a non-significant outcome.

In total 11 women did not confirm abuse. Comparing the study-groups without these cases led to the following outcomes: ‘full-training’ and control group resulted in a rate ratio: 4.26 (95% CI: 2.35 to 7.74, p<0.001); ‘focus group alone’ and control group resulted in a rate ratio: 2.35 (95% CI: 1.19 to 4.66, p=0.014); ‘full-training’ and ‘focus group alone’ resulted in a rate ratio: 1.81 (95% CI: 1.13 to 2.90, p=0.014).

**Non-obvious reasons to suspect / discuss partner abuse**
For an overview of reported categories of reasons, see Figure 2.
This overview shows the variety of reasons across the study groups with in the control group the highest percentages of ‘obvious’ signs (box1) versus the ‘full-training’ group that shifted to the ‘non-obvious’ signs.
In the category ‘others’, a mixture of non-obvious signs were presented. The most remarkable one was ‘behavioural problems of a child’ sometimes referred by a school nurse or brought up by the mother.

Summarised suspect of partner abuse for non-obvious signs increased in the ‘full-training’ group compared to the ‘focus group alone’ and control groups: See figure 3.

Analysis:
We compared the ‘full-training’ group with the other two groups that received no training (‘focus group alone’ and control). The odds ratio to suspect/discuss partner abuse for non-obvious reasons/signs was 5.92 (95% confidence interval 2.25 to 15.62, p < 0.01) in the full-training group, a significant effect. The analysis was corrected for gender, district, practice setting, working part-/full-time, experience and age of the doctor.
Finally several participants, along the intervention period, informed us that the training also provided them with tools, to deal with other types of family violence. They also raised the issue of a gap during the intervention period, due to the summer
holidays (3-4 weeks per participant), which possibly reduced the number of reported cases. A future paper will explore extensively the hidden effects of the training.

**Figure 3: Percentages obvious vs. non-obvious signs to suspect/discuss intimate partner abuse, per study group**

![Diagram showing percentages for full-training, focus group alone, and control groups.]

**Discussion**

**Summary of main findings**

This study demonstrates that a one and a half day training for family doctors increases awareness and identification of partner abuse in female patients up to 4.5 times, whilst active questioning about abuse increases almost six times in case of “non-obvious” signs. In this respect the training is successful in overcoming existing barriers in attitude (such as feelings of powerlessness, fear to offend) and lack of knowledge.

The finding that focus group discussion alone, in itself doubled the rate of active questioning should be viewed as remarkable. Discussing one’s prejudices and experiences on this subject with colleagues, proved to make family doctors more alert. Although it lacks the effectiveness of knowledge, information and practising of skills, its value lies in increased awareness.
**Comparison with existing literature**

An increase of identification directly after a training course is a well-known effect. Most intervention studies assess numbers of screened patients according to a protocol with a short follow-up period and often show a decrease to baseline on the long term.\(^{31,32}\) Some experts stress that the effects of training without structural changes in the regular curriculum of continuous medical education (CME) are unlikely to change clinical practice.\(^{30}\) One of the differences with other studies is that in measuring the effects of brief training, these studies retrieve data from medical records with the number of screened patients as primary outcome.\(^{14,33}\) Our design focused more on the doctor-patient encounter and we measured doctor’s performance which is mostly evaluated in self-administered surveys or medical record reviews and rarely with incident reporting as we did. We also did not find any other study that evaluated training with the effect-measure: recognising abuse in patients with ‘non-obvious signs’. However our method proved to be reliable and can be duplicated.

Research on predictive indicators of partner abuse is ongoing and shows that injury is not a major indicator.\(^{34}\) There is enough evidence to suspect partner abuse in women with chronic undefined somatic complaints and mental complaints/disorders like sleeping problems, anxiety and depression.\(^{3,4,19,21-27,35}\) We used this evidence to provide a set of key-features of the clinical presentation of partner abuse, which the intervention group applied successfully. Questioning women with these indicators (in fact the use of a ‘risk profile’) proved to lead to an increase of identification.

**Strengths and limitations of the study**

Several limitations of this study should be discussed. First, it is likely that family doctors with more interest in partner abuse than the norm signed up. Despite their supposed interest, there was obviously much room to improve their awareness of partner abuse. Secondly half of the participants were female which may have influenced the outcomes, as some studies claim that female doctors detect more abuse in women.\(^{36}\) However, statistical analysis did not support a significant difference between male and female doctors. Another limitation is that we did not take clustering into account in recruiting our final sample, mainly because of the cluster-size (1.2), resulting in a somewhat underpowered study. However the relative under-power of our study did not influence the effects and considering the significant outcomes, small p-values and acceptable confidence intervals, our final sample size was justified.

Another limitation lies in the follow-up period of six months. Generally the effect of training tends to diminish in time.\(^{14}\)
Altogether the research sample represents 13% of the family doctors in Rotterdam and surrounding areas. Comparison with the general population of family doctors could lead to even more striking results. Thoughts on why we succeeded so well in this study must be viewed in the context of the prevalence of partner abuse among female patients in family practice. Hegarty et al. estimated that every full-time family doctor sees one or two undetected cases every week. In this respect our results reveal just a bit more of the tip of the iceberg. Looking from another perspective, a thorough training, in recognising, responding and managing partner abuse in a population with a high prevalence and low baseline recognition, is bound to yield high results. Our trained participants, by overcoming their barriers, were able to lower the threshold to disclosure of abuse. This change in attitude regarding woman abuse is as much a benefit of the training sessions as knowledge on the subject. Finally, when doctors ask female patients more frequently about abuse, they should keep in mind that denial inevitably will occur more often than before. Doctors may wrongly suspect abuse, as women may not feel to disclose.

**Implications for clinical practice and future research**

In the absence of solid evidence that training improves awareness and case finding, the debate continues between proponents of routinely questioning all women in the surgery on partner abuse (screening) and those who favour questioning of women who present symptoms and a medical history that could hide abuse (selective questioning and case-finding).

It is known that doctors do not favour screening, mostly because of lack of education, lack of effective interventions and fear of offending and endangering patients. This study provides substantial evidence that training improves awareness as well as identification of partner abuse.

Patients ideally should disclose abuse in a safe environment where their motives of remaining with their abuser and assessment of their situation are professionally met. Disclosure is only the start of an intensive process for an abused woman and her children. It takes much effort and is often not without risk to their safety. Formerly abused patients can experience long term health effects and disclosing their background can open up possibilities to start to come to terms with their past. Finally, primary care researchers need to go beyond a superficial view on chronic complaints and disorders in female patients. Surveys on mental health problems, chronic undefined pain and somatisation should consider partner abuse as an important variable in patient’s background and include abuse related questions. Producers of guidelines on these topics can no longer ignore the growing knowledge of health problems that are highly related to history of abuse.
Conclusion
In the debate between proponents of routinely questioning every woman about partner abuse (screening) and those who favour selective questioning and case finding, our findings sustain the latter. Our study shows, that training improves awareness of abuse, which leads to active questioning of women with ‘non-obvious signs’, and results in increased identification of abused women. Disclosure may lead to more effective and meaningful consultations both for abused women and doctors. Our training programme on intimate partner abuse provided a feasible and evidence-based method for daily practice. Educating doctors can make a difference.

Acknowledgements
We wish to thank the family doctors for participating in the study; the research assistant Margriet Straver for her field work, introducing the registration forms and data entry; Ellen Nijenhuis, senior trainer - psychologist for training the participants; Roos Bernsen, Erasmus Medical Centre for statistical advice; Hans Bor, Radboud University Medical Centre for statistical advice and for executing the analysis; Jan-Marc van Dam (Chelmsford, UK) for English language corrections.

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Ethical approval: The study was undertaken with the consent of the ethical committee of the Radboud University Medical Centre: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO- nr.2002/275

References
“Doctor’ll be here in a minute. I knew her; she’d seen me before. She looked at me. She nodded at me. In wars again. Yes, I said. She looked at her watch. Fell down the stairs again, I told her. She was nice. I didn’t want to disturb her.”

“The woman who walked into doors”. By Roddy Doyle
Asking about partner abuse: an offence for the patient?
Testing a short instrument to measure family doctors’ attitudes towards partner abuse.

SH Lo Fo Wong
P. Verdonk
R Römkens
F Wester
ALM Lagro-Janssen

Submitted
Abstract

Objectives: To investigate family doctors’ attitudes towards partner abuse with a 14-item scale and to test feasibility, reliability and validity of the scale.

Methods: The study took place in 2003 within the framework of an intervention study to measure awareness and identification of partner abuse in family practice, after training. Family doctors (n=54) were randomly assigned to one of the three study groups (one trained and two untrained groups) and completed a 14-item scale (5-point Likert) at baseline and 6 months later at the end of the study. The items were tested for reliability to construct a one-dimensional ‘attitudes towards partner abuse’ scale. Higher scores on the items were allocated to a more facilitating professional attitude. We compared the differences between study groups.

Results: The ‘attitudes towards partner abuse’ scale shows an internal reliability of Cronbach’s α: .74 at baseline and .69 at follow-up. The mean score on the scale at baseline was equally high in all three groups and in the direction of a facilitating attitude. Statistical comparison of mean scores at follow-up showed that the untrained groups had shifted somewhat, however the trained group had shifted most (but not significant) to a more facilitating attitude. Comparing the individual items, the trained group showed a significant change into a more facilitating direction on two items. The training was the most important factor for a shift on the scale.

Conclusion: The training was the only influential factor in achieving a more facilitating attitude. Further research in a larger sample is needed, to validate the ‘attitudes towards partner abuse’ scale.

Keywords: intimate partner abuse, family practice, general practice, attitude, scale, education, training.

Box message:
What is already known: As a consequence of restricted views, prejudicial attitudes towards partner abuse and lack of knowledge, family doctors, in general, fail to detect partner abuse in daily practice. A short and feasible scale to measure doctors’ attitude is lacking.

What this study adds: A 14-item scale to measure family doctors’ ‘attitudes towards partner abuse’. The scale shows that viewing partner abuse an ‘exclusively’ a relationship problem and fear of offending when asking the patient about abuse, significantly changed after training.

Suggestions for further research: Further research in a larger sample is needed, to validate the scale.
Introduction

Intimate partner abuse is highly prevalent among female patients in family practice and has both short-term and long-term health consequences for abused women and survivors of former abuse.\textsuperscript{1-6} As a consequence of restricted views, prejudicial attitudes towards partner abuse and lack of knowledge, family doctors, in general, fail to detect abused women in daily practice.\textsuperscript{7,8} A range of cross-sectional studies reported that 37 to 49.5\% of women in waiting rooms of family practice ever experienced abuse by a partner.\textsuperscript{3-5,9,10} Ramsay et al. reported a baseline recognition of partner abuse by physicians of 0-3\% in their systematic review of published quantitative studies.\textsuperscript{11}

Surveys among female patients in waiting rooms of family practice in Australia, Ireland and UK report that only 5-7\% of abused women had ever been asked about partner violence by their doctors.\textsuperscript{4,5,12} To date most family doctors underestimate the prevalence and do not regard it as a healthcare issue.\textsuperscript{8,11,13,14} In general, domestic violence researchers recommend more and systematic education to improve doctors’ attitudes and knowledge on partner abuse.\textsuperscript{3-5,11,15,16}

Several in depth studies on family doctors’ attitudes and practices regarding partner abuse reported barriers such as: fear of offending the patient, time constraints, confusion with the double role as a family physician and attributing blame for the abuse to the women.\textsuperscript{7,8,17-20} Moreover, it is well-known that physicians will not ask questions if they do not know how to deal with the answers. Studies that searched for factors that influenced doctors’ attitude towards abused women, reported that female gender and having received training were of importance.\textsuperscript{8,14,18,19} However, others found no association between female gender and a more supportive attitude toward abused women.\textsuperscript{7,21} Saunders et al. developed in 1986 the ‘Inventory of Beliefs about Wife-Beating’, a 31-item questionnaire, and tested it among a broad population in diverse healthcare settings. They found a relationship between training and sympathetic attitudes about battered women. However, it was unclear whether the training changed the attitude or whether providers with a positive attitude sought training.\textsuperscript{18} More recently in 1997 Gadomsky et al. assessed a multifaceted intervention training.\textsuperscript{14} Due to disappointing response rates, the authors stated that the observed changes, although significant, were difficult to attribute to any one of the components of the intervention.

Restricted views, considering partner abuse only as a private matter, ‘blaming victim’ and prejudices like ‘women will always return to their abuser’ are ever present among family doctors and may have an even greater impact, compared to other medical settings.\textsuperscript{7,8,17,22,23}

To facilitate a change in family doctors’ attitudes and prejudicial opinions on partner abuse, we developed a comprehensive training program and tested it in a randomised controlled trial (RCT).\textsuperscript{24} During the six months intervention period the
trained group reported 4.5 times more abused patients than the control group. As part of this study all participants of the RCT completed a questionnaire which included a 14-item scale on attitudes towards partner abuse. The aim of the present study was to test the feasibility, reliability and validity of the scale as an instrument to measure family doctors’ attitudes on partner abuse. We aimed to explore whether the training had affected doctors’ opinions and attitudes on the scale and the role of doctors’ gender.

Method

Sample and design
As part of a randomised controlled trial (RCT) to improve family doctors’ professional role towards abused female patients, all family doctors enrolled in the study \( n=54 \) completed a questionnaire, including the scale, at baseline and at the end of the study. The study took place in Rotterdam (the Netherlands) from March 2003 until November 2003.24

In the RCT we provided a training (intervention) and measured doctors’ performance during a six-month period with incident reporting of abused female patients \( (n\text{-reported patients}) \). After stratification we randomised the included participants in a ‘full-training’ group \( (n=23) \), a ‘focus group alone’ group \( (n=14) \) and a control group \( (n=17) \). The ‘full-training’ and the ‘focus group-alone’ groups participated in a one-and-a-half hour focused group discussion to explore views, attitudes, practices and experiences with abused female patients.25 The aim of the subsequent training was to deal with all the negative associations towards abused female patients, to provide tools to overcome these barriers. Preliminary to the 6-months intervention period, the ‘full-training’ group received a one-and-a-half day training. The ‘full-training’ group reported 4.5 times more cases than the control group and 2.2 times more than the ‘focus group-alone’ group.24

For an outline of the training program see: Box 1.

**Box 1. Outline of the 1,5 day training program**

| Attitude: aversions, prejudices and barriers; small group discussion and plenary clarification | 60 min |
| Theory: background and coping strategies in intimate partner abuse; profiles of perpetrators; effects on children | 20 min |
| Epidemiology: prevalence; clinical presentation & key features | 20 min |
| Diagnostic tool & abused patients’ views | 20 min |
| Consultation skills: role play with diagnostic tool & clinic with simulation patient | 180 min |
| Information: Police Domestic Violence Program; Abused Women’s Support Agency | 75 min |
| Legal aspects: lawyer on legalities, documenting, patients’ rights, confidentiality & jurisprudence | 45 min |
| Vignettes: pre- and post-testing of written cases | 20 min |
Development of the scale
The scale was developed in the involved expert group, based on the literature, a pilot and discussions. A draft of the scale with 30 statements on attitudes regarding partner abuse of women, was sent out to 60 family doctors outside the study for comments and amendments. The statements were sampled from existing scales and translated into Dutch. Forty-eight doctors (80%) responded, and provided comments on the phrasing of the items. The statements were rephrased according to the collected comments from the pilot. This resulted in a final questionnaire with 14 items requiring answers on a five-point Likert-scale: strongly agree to strongly disagree. The scale constituted of frequently reported beliefs, attitudes and common prejudices of healthcare providers, associated with lack of education on partner abuse in earlier qualitative and quantitative studies. Item scores were allocated to a professional facilitating direction when a doctor acknowledged to have a role in recognising of and discussing partner abuse with female patients and held non-judgemental opinions on and supportive attitudes towards abused female patients. The scale was part of a questionnaire to gain information on: respondents’ demographics, experiences with partner abuse, previous training on domestic violence and assessment of what was seen as important in a training program on partner abuse.

Data collection
The questionnaire, including the scale, was distributed to all participants (n=54) at baseline in February 2003, and the second one six months later at the end of the study. Six additional questions were asked to list: how often the physician encountered abused women in their practice in one year (never; 1 to 3; 4 to 6; 7 to 9; ≥10 times); knowing abused women among relatives, friends or colleagues (yes/no); estimate of frequency of suspect on partner abuse per year (open question); practice in discussing suspect on abuse with patients (5-point scale: never to always); experiencing barriers in discussing partner abuse (5-point scale: never to always); prior training on domestic violence/partner abuse (open question). Two questions were asked to explore the importance attributed to attitude and skills training as part of the training. (5-point scale: not important to highly important)

Analysis
First 5 items were recoded in order to have all items pointing in the same direction. Exploratory factor analyses was carried out with SPSS (version 12.0) in order to construct a meaningful and reliable scale to measure family doctors’ attitudes towards partner abuse. Our exploration provided a one-dimensional attitude scale which measures doctors’ attitudes regarding partner abuse. Cronbach’s α coefficient of internal reliability was .74 at baseline and .69 at follow-up.
We explored the mean scores at baseline and in follow-up, per study-group and the differences between groups.

With Estimated Marginal Means we compared the three study groups for the dependent variable: difference between follow-up and baseline scores, correcting for mean attitude score at baseline.

Univariate Analysis of Variance test was used to compare the dependent variable (difference between follow-up and baseline scores) for training and gender, corrected for baseline score. Kruskal Wallis Non-parametric test was used to compare groups for progression on the separate items at follow-up, in search for items that changed significantly after training.

Preliminary exploration of the attitudes scale with Principal Component Analysis displayed the possibility of two components of the attitude scale. Due to the size of the sample \((n=50)\) further investigation of this concept was limited.

**Results**

All 54 respondents completed the survey at baseline and at follow-up there was one non-respondent. Due to missing values, 50 questionnaires could be analysed at baseline and 51 at follow-up.

For an overview of respondents characteristics compared to the study population of family doctors in area: see Table 1.

We aimed to include equal numbers of male and female doctors in the sample, which differs from the population of family doctors in this area, where 1 out of 4 is female. This resulted in a sample with more doctors working in health centres (mostly female) and less solo working doctors. Moreover our respondents were younger and worked more often part-time.

**The questionnaire**

None of the respondents had ever attended an educational program on intimate partner abuse, under- as well as post-graduate. Education on child abuse was mentioned once and on domestic violence twice. The latter dated from more than 15 years before, and did not provide specific attention to partner abuse.

Participants were asked, at baseline, to estimate the mean number of identified abused female patients per year. The male respondents estimated they identified: 2.48 patients and the female respondents: 3.19. The means were not corrected for working hours of the physician. This results in a higher case-load in a shorter time for female doctors, as they worked predominantly part-time. (see Table 1)

Respondents were questioned, at baseline, about barriers in discussing partner abuse with the patient. Almost two-thirds of the respondents \((70\%)\) experienced
‘variable’ to ‘always’ barriers. Slightly half of the respondents (47%) discussed their suspect with the patient only ‘sometimes’ to ‘rarely’.

We asked to assess a number of specified training components from ‘not important’ to ‘highly important’ on a 5-point scale. ‘Discussing attitudes’ was found ‘important’ to ‘highly important’ by 100% of the respondents; ‘theories’ scored 92.6%; ‘information on referral services’: 83.3%; ‘skills training’: 80%; ‘epidemiology’:76% and legal aspects:70.3%.

Table 1. Overview of respondents characteristics compared to the population family doctors in Rotterdam and surrounding areas. *

<table>
<thead>
<tr>
<th>Gender</th>
<th>Full-training n=23</th>
<th>Focus group alone n=14</th>
<th>Control n=17</th>
<th>Research sample n= 54 (%)</th>
<th>Rotterdam * (n=415) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>7</td>
<td>9</td>
<td>26 (48.1)</td>
<td>74</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>7</td>
<td>8</td>
<td>28 (51.9)</td>
<td>26</td>
</tr>
<tr>
<td>Working hours</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Full-time ≥ 4 days</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>17 (31.5)</td>
<td>77</td>
</tr>
<tr>
<td>Part-time &lt; 4 days</td>
<td>15</td>
<td>9</td>
<td>13</td>
<td>37 (68.5)</td>
<td>23</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;40</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>15 (27.8)</td>
<td>13</td>
</tr>
<tr>
<td>40-50</td>
<td>8</td>
<td>4</td>
<td>8</td>
<td>20 (37.0)</td>
<td>43</td>
</tr>
<tr>
<td>&gt;50</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>19 (35.2)</td>
<td>44</td>
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<td>In residence</td>
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<tr>
<td>&lt; 15 yrs</td>
<td>11</td>
<td>9</td>
<td>9</td>
<td>29 (53.7)</td>
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<tr>
<td>≥ 15 yrs</td>
<td>12</td>
<td>5</td>
<td>8</td>
<td>25 (46.3)</td>
<td>68</td>
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<td>District</td>
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<td></td>
<td></td>
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<tr>
<td>Wealthy</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>13 (24.1)</td>
<td>Not asked</td>
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<tr>
<td>Mixed</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>14 (25.9)</td>
<td></td>
</tr>
<tr>
<td>Deprived</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>27 (50.0)</td>
<td></td>
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<tr>
<td>Practice type</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Solo practice</td>
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<td>5</td>
<td>2</td>
<td>11 (20.4)</td>
<td>43</td>
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<td>Duo/Group practice ∞</td>
<td>14</td>
<td>4</td>
<td>7</td>
<td>25 (46.3)</td>
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<td>Health centre #</td>
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<td>5</td>
<td>8</td>
<td>18 (33.3)</td>
<td>14</td>
</tr>
</tbody>
</table>

* Source: Survey of the District Association of Family Physicians Rotterdam & surroundings 2003, only percentages;
∞ 2 or more doctors in one family practice  # cooperation of family doctors with other primary healthcare professionals

‘Attitudes towards partner abuse’ scale

Mean scores within and between groups were compared. Higher scores on the scale represent a more facilitating attitude.

At first we computed the mean scores for baseline and follow-up. Next, we analysed the differences between groups. In all study groups we found high mean scores at baseline, signifying that the participants held a facilitating attitude. The mean scores at baseline resulted in: ‘full-training’ group M=3.85; ‘focus group-alone’ group
M=3.93; control group M=3.84. The mean scores at follow-up resulted in: ‘full-training’ group M=4.12; ‘focus group-alone’ group M=4.00; control group: M=3.92. The differences in mean score between follow-up and baseline: ‘full-intervention’ Md=.27; ‘focus group-alone’ group Md=.07; control group Md=.08.

With Estimated Marginal Means of the dependent variable: difference between follow-up score and baseline score, we compared the outcomes per study group (corrected for Mean baseline score=3.87). The results showed that the ‘full-training’ group shifted further in the direction of a facilitating attitude on the scale with: 0.255 (CI 95%=-.140 to .371); the ‘focus group-alone’ group with: 0.103 (CI 95%=-.45 to .251); the control group with: 0.065 (CI 95%=-.073 to .203).

Though not significant, by testing the mean difference on the attitudes scale with Univariate Analysis of Variance test we found the training to be a more influential factor (2-tailed p=.082) than gender (2-tailed p=.487). By testing one-tailed, the outcome of training is significant: (p=.041).

Comparison of the items at follow-up
For mean item scores of the trained and untrained groups, at baseline (1) and follow-up (2) see Table 2.

Comparing the differences of scores on the individual scale items, between groups, at follow-up, with Kruskal Wallis Non-parametric test, (corrected for baseline score) we found 2 items to have advanced significantly in the ‘full-training’ group and none in the other study groups. Item 6: ‘Partner abuse is exclusively a relationship problem’ shifted to a higher score (p=.011) as well as item 11: ‘Asking about partner abuse is an offence for the patient’ (p=.002).

Discussion

Main findings
The training was the most influential factor to explain respondents’ shift in attitudes towards partner abuse on the scale. Exploring the data with Principal Component Analysis (PCA) exposed that a one factor model provided the best fit to our data. The ‘attitudes towards partner abuse’ scale shows sufficient reliability. To establish construct validity, an adequate number of items was tested and the intelligibility and feasibility was pilot tested. Item analysis, testing for reliability and validity analysis by means of PCA and tests demonstrating differences between groups were conducted. To our knowledge, this short instrument is the first one to be tested in a randomised controlled trial.

At least two items that targeted doctors’ lack of knowledge and prejudicial views, changed statistically significant with our training. Viewing partner abuse exclusively as a relationship problem, means that the criminal aspect of violence against a
partner is excluded. Besides, it overlooks the mental and physical health consequences for the women involved, neglects the consequences for children who witness the abuse and reduces the doctor’s opportunity to intervene. The view that female patients will be offended when asked about violence by a partner, represents a common barrier of family doctors, resulting in the reluctance to address the subject. Fear to offend a patient may also hide the fear of a positive answer and not knowing what to do next.²⁰,²⁵,²⁷ During the training both items were discussed at large as many participants agreed with these statements or were uncertain beforehand. Asking a patient about partner abuse was practised as part of the consultation skills training in which all respondents of the ‘full-training’ group took part. Restricted views that partner abuse is ‘exclusively’ a relationship problem and fear of offending the patient when asking about abuse, have been left behind, which opens up the opportunity for family doctors to discuss more extensively their suspect on partner abuse with female patients and intervene when needed. The significant shift on these two items certainly correlates with the increase of active questioning about partner abuse among the ‘full-training’ group, resulting in the success of the intervention training.²⁴ Although both other study groups also shifted into a facilitating direction on many items, they did not change significantly on the scale.

In search for accessible goals of training we can now state that family doctors’ attitudes on partner abuse are amenable to change and measurable with a short instrument. Our study provides a scale that needs testing among a larger sample of family doctors in the future.

In earlier research, gender, length of service and training appeared to have some effects on doctors’ attitudes with respect to a more sympathetic attitude towards abused female patients and less restraints.⁸ In our data, there was no association with gender and a shift to a more facilitating direction, possibly because we enrolled a sample (male and female) with pre-existing positive attitudes.

**Strengths and limitations**

As a limitation we can note that selection bias may have played a role with mostly motivated family doctors in our project. Taking this into account as well as the rather small number of the sample, we found nonetheless the training to succeed in inducing a shift in doctors’ attitudes to a more facilitating direction on the 14-item scale. Although not at the level of .05 but at .08 (2-tailed), with regard to the small sample size, the rigorous stratification and randomisation procedure, the shift on the scale was remarkable.

Although the development of the scale was limited by the small number of respondents, it was tested in a randomised study and all items contributed sufficiently to internal reliability to measure doctors’ attitudes. Validity of the scale was provided by the significant differences, between groups, on at least two items, (table 2) and
Table 2. ‘Attitudes on partner abuse’ scale (14-items); 5-point Likert scores: totally agree > totally disagree; means (sd) trained group & untrained group at baseline (1) and follow-up (2)

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean Scores Likert Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trained 1 (sd)</td>
</tr>
<tr>
<td>1# It is not a family doctor’s task to identify abused women during consultation</td>
<td>4.22 (.67)</td>
</tr>
<tr>
<td>2# Asking about partner abuse is not needed, women will disclose spontaneously</td>
<td>4.09 (.60)</td>
</tr>
<tr>
<td>3 Discussing partner abuse takes too much time during consultation</td>
<td>3.04 (1.12)</td>
</tr>
<tr>
<td>4 Asking about partner abuse is useless, you are unable to solve the problem</td>
<td>4.13 (.82)</td>
</tr>
<tr>
<td>5# With accidents in the home, I never consider partner abuse as a cause</td>
<td>3.52 (.73)</td>
</tr>
<tr>
<td>6 Partner abuse is exclusively a relationship problem</td>
<td>4.26 (.77)</td>
</tr>
<tr>
<td>7# Partner abuse has no negative consequences for children in the home</td>
<td>4.65 (.49)</td>
</tr>
<tr>
<td>8 Women provoke partner abuse with their behaviour</td>
<td>3.78 (.85)</td>
</tr>
<tr>
<td>9 Partner abuse is a private matter in which I do not interfere</td>
<td>4.26 (.69)</td>
</tr>
<tr>
<td>10 Women, abused by a partner, will always return to their abuser</td>
<td>3.22 (.67)</td>
</tr>
<tr>
<td>11 Asking about partner abuse is an offence for the patient</td>
<td>3.91 (.73)</td>
</tr>
<tr>
<td>12 The partner is also my patient, I am unable to act in abusive relationships</td>
<td>4.09 (.52)</td>
</tr>
<tr>
<td>13 The responsibility for violence in a relationship lies with both partners</td>
<td>3.04 (.83)</td>
</tr>
<tr>
<td>14 Asking about partner abuse does not support women</td>
<td>4.04 (.48)</td>
</tr>
</tbody>
</table>

# These items are recoded; * p=.011; ** p=.002 : Non-parametric test Kruskal Wallis

underpinned by the results of the primary study.\textsuperscript{24} Content validity of the scale, was ensured by using items that were tested in previous scales combined with items
reported in qualitative research on family doctors’ attitudes regarding partner abuse.14,26 There is a broad agreement in the literature that family doctors in general lack knowledge on partner abuse and that prejudices, represented in our items, are common.7,8,18 In this study one criterion for assessing the validity of the scale was available from the self-report questionnaire. The majority of the participating family doctors (70%) reported to experience barriers in discussing partner abuse. Theoretically, barriers which derive from prejudicial opinions and attitudes, are reflected in all items of the scale. The issue of construct validity needs further investigation.

Our findings can not be generalised due to the selection bias of our study with family doctors in a restricted area (Rotterdam and surrounding) who sought training on the subject and were already on the positive side of the attitude scale.

Finally, looking at the progression on the individual items within groups, the possibility remains that the scale had some learning effect also on non-trained respondents.

A final limitation of this study is the possibility of social desirable answers on the questionnaire and the scale. In a future study, a ‘social desirability’ assessment is recommended.

Implications for education, research and practice
Given the high prevalence in family practice of abused female patients, seeking help with medically unexplained symptoms or mental problems, family doctors can no longer refrain from seeking training on the subject. However, courses that focus merely on knowledge but refrain from addressing extensively prejudicial attitudes, are limited in facilitating change.14,28,29 We agree with Cohen et al. and Warshaw that widespread changes in professional attitudes are necessary to improve the response to family violence. Breaking down myths and assumptions that underlie prejudices among both male and female family doctors, is highly needed in training programs on partner abuse/family violence.7,30 Especially viewing partner abuse as an exclusively relationship problem and fear of offending the patient, should be dealt with.

Surveying doctors’ attitudes with a short and valid instrument, before and directly after training, is a useful method to evaluate the effects of education. This study provides a 14-item scale, which proved to be a feasible and reliable instrument to discriminate between trained and non-trained family doctors and measure progression on items that reflect common barriers to discuss partner abuse with a female patient in family practice. Change to a more facilitating attitude will result in more active questioning and subsequently to more disclosures by abused female patients.24

More rigorous research is needed in a next study to test the possibility of two or more components in a doctor’s ‘attitude towards partner abuse’. The attitudes scale should
be investigated with factor analysis and validated in a larger population of family doctors.

**Conclusion**

A promising short and reliable instrument to measure family doctors’ attitudes is at hand. Further development of the scale should add knowledge to the existing gap on how to reach doctors on partner abuse and what changes can be achieved regarding attitudes of family doctors, after training.

**Acknowledgements**

We wish to thank the family doctors for participating in the study; the research assistant Margriet Straver for processing the data; Ellen Nijenhuis and Door Hezemans, both senior trainers and social scientists, for their contribution in training the participants; Hans Bor, Radboud University Medical Centre for statistical advice and for executing the analysis;

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**Conflict of interest:** none of the five authors has declared a conflict of interest.

**Ethical approval:** The study was undertaken with the consent of the ethical committee of the Radboud University Medical Centre: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO- nr.2002/275

**References**

“What made you do that? Fuckin’ doctors. What made you do that?....Looking at my eye...He didn’t want an answer; he muttered, thought he was being nice... None of them wanted answers.”

“The woman who walked into doors”. By Roddy Doyle
“I am not frustrated anymore”
Family doctors’ evaluation of a comprehensive training on partner abuse

Sylvie Lo Fo Wong
Fred Wester
Saskia Mol
Toine Lagro-Janssen

Submitted
Abstract

Purpose: The aim of this study was to discover in which way a training program, specifically tailored to change family doctors’ awareness, identification and management of partner abuse, affected their daily practice. The training dealt extensively with attitudes, prejudicial views and consultation skills, meanwhile addressing knowledge items.

Method: Twenty of the 50 family doctors who participated in a one and a half day training program on partner abuse were interviewed. A topic guide with open-ended questions was used, in order to collect in-depth data.

Results: The family doctors evaluated the training program to be useful in raising their awareness of partner abuse in female patients; it greatly increased their criteria to suspect partner abuse in female patients. The training generally resolved any questions and frustrations they had concerning the subject and made them feel more confident and equipped to discuss and aid abused patients. The favourite method of education, especially for male doctors, was through the use of role-playing. Participants recommended a revision course every few years to retain awareness on the subject. Female doctors expressed more benefit from the training than the male doctors.

Conclusion: A training on partner abuse, tailored to change attitudes, prejudicial views and improve consultation skills, did affect family doctors’ awareness, recognition and response to abused female patients, in a positive way. Future research should focus on innovative teaching systems about partner abuse.

Key words: domestic violence, intimate partner abuse, education, training, family practice, general practice, qualitative research.
Introduction

There is a lack of a more profound understanding of the effects of educating family doctors on intimate partner abuse. Evaluative studies on this matter focus primarily on improvement of screening on partner abuse and on referral rates after brief training.\textsuperscript{1-4} Outcomes are mostly assessed by surveys, medical record review and occasionally qualitatively.\textsuperscript{1,3,5-7} Although partner abuse in female patients is related with a higher use of medical services in family practice, family doctors consistently fail to suspect partner abuse in female patients or often refrain from asking.\textsuperscript{8-10} This reluctance, to date, results from the prejudicial view that asking a patient about partner abuse is offensive, will open up ‘Pandora’s box’ and that doctors have nothing to offer.\textsuperscript{11}

In general, family doctors need training to recognise and appropriately respond to abused female patients.\textsuperscript{10,12,13} At the same time, there is a general consensus about the limited effects of mandatory continuing medical education (CME) on domestic violence.\textsuperscript{1,7} In the literature we found training programmes in general to be brief or to focus mainly on knowledge, skills and screening protocols and rarely to be comprehensive and address personal attitudes and prejudices regarding partner abuse.\textsuperscript{5} The disappointing results of education inevitably raised the question: what does work, in terms of changes in daily practice, when training family doctors on this subject.

Some studies evaluated training programs which provided consultation skills in role plays or a survivor’s narrative and assessed the effects of training more extensively.\textsuperscript{14-16} Yet the addressing of doctors’ attitudes, resistances and personal prejudices towards abused women within the frame of a training program on partner abuse, is rarely found.\textsuperscript{11} Up to now one study has evaluated in depth, family doctor’s management of intimate partner abuse after training.\textsuperscript{4} In Taft’s study, the family doctors generally felt under-skilled in counselling and without the support of professional supervision and debriefing, many were stressed by the additional demands necessary to manage partner abuse. The doctors also illustrated their difficulties with the complexity of disclosure and with referral processes required in partner abuse cases.

To address the identified gap on how to effectively meet with family doctors limited awareness, attitudes and practices we carried out a randomised controlled trial in 2003 and evaluated the effects of a 1.5 day comprehensive training on partner abuse.\textsuperscript{16} All participants of the training took part in 1.5 hour focus group discussions that preceded the training. These group discussions aimed to explore family doctors’ views, attitudes, experiences, practices and gender-related differences, in order to address these issues in the training program. Furthermore, the training provided extensively room for consultation skills and addressed knowledge and information of referral services on partner abuse as well. (See Appendix A) The training resulted in
an increased awareness of partner abuse up to 4.5 times in the trained group, compared to the control group.
The aim of the present study is to discover in which ways this training program affected the family doctors’ awareness and management of abused female patients. We will explore these issues among a group of family doctors who followed the training program. We aim to understand how and which training components contributed most to change family doctors’ awareness, attitude and management of partner abuse, in daily practice.

Methods

Design and setting
The study consisted of semi-structured interviews with 20 of the 50 family doctors in Rotterdam and surrounding areas (the Netherlands). Participants followed a training within the framework of an intervention study (randomised controlled trial; n=54) which started in 2003 and aimed to improve active questioning of female patients about abuse. Participants who were part of the untrained group in the RCT were given the opportunity to follow the training after the intervention period.

Sampling participants
Twenty family doctors were chosen at random from the total sample that followed the training (n=49) to participate in the interview study, ensuring equal numbers of male and female doctors. None of the approached doctors refused to cooperate. The primary researcher invited these family doctors to participate in a telephone-call, then sent an information sheet to each contact with the procedure of the in-depth interview. We presumed that 20 interviews (almost half of the total sample) would suffice to reach saturation.

Data collection
All interviews were conducted in March 2004, three months after the intervention study ended. The interviewees had followed the training between 5 to 10 months earlier. A semi-structured interview format with an interview guide was used. The interview guide was developed in the involved research group and included questions on the doctor’s knowledge of partner abuse, changes in practices regarding identification and management of partner abuse, usefulness of the program and their recommendations about future training. The family doctors were also encouraged to recount their most recent encounter with an abused woman in order to illustrate their ways of asking a patient about partner abuse, and how they managed such cases. After piloting, the interviews were conducted in English by a
medical student-researcher (PC), recorded and then transcribed by the interviewer. The interviews lasted between 20 and 45 minutes. Due to technical problems only 18 interviews were recorded. The transcripts were sent to the participants for approval and to check that there was no confusion due to the use of a foreign language (English).

**Analysis**
The 18 transcripts were read through three times by the interviewer to identify the prominent themes. The transcripts were then analyzed using qualitative coding. Categories for coding were introduced and the transcripts were coded manually. In order to minimize researcher bias, two other readers (TL, SLFW) also studied the transcripts, and the themes that had emerged were discussed. The common themes were coded and grouped together. In order to show how frequently an opinion was raised, basic counting methods were used. In relevant themes, comparisons were made between male and female family doctors. The final concept was reviewed and commented upon by the research group.

**Results**
The mean age of the interviewed doctors was 47.6 (range 35 to 61 years); mean age of the male doctors was: 51.5; female doctors': 43.6 years. The mean time in residence was 16 years (range 2 to 30 years). The interviewed sample is comparable to the research sample of the RCT, with only a slight overrepresentation of older, more experienced doctors and those working in deprived areas. For characteristics of the interviewed sample in comparison to the research sample: see table 1.

**Main findings**
Analysing the 18 interviews, the following central issues emerged: a) suspicion criteria and awareness; b) confidence in addressing partner abuse; c) usefulness of the training in daily practice; d) most useful part of the training; e) effects on opinions and views; f) effects on management; g) future training; h) gender differences in views on respondents’ ability to manage partner abuse.

a) **Suspicion criteria and awareness**
Two thirds of the doctors said that the training had increased their suspicion criteria. Before the training, signs and symptoms that made them suspect abuse were bruises and pains due to unexplained accidents or if the patient actually broached the subject.
Table 1 Characteristics of the interviewed doctors # (n=20); the research sample of the RCT (n=54)

<table>
<thead>
<tr>
<th></th>
<th>Interviewed doctors n=20 (%)</th>
<th>Research sample RCT n=54 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10 (50)</td>
<td>26 (48.1)</td>
</tr>
<tr>
<td>Female</td>
<td>10 (50)</td>
<td>28 (51.9)</td>
</tr>
<tr>
<td><strong>Working hours</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time ≥ 4 days</td>
<td>5 (25)</td>
<td>17 (31.5)</td>
</tr>
<tr>
<td>Part-time &lt; 4 days</td>
<td>15 (75)</td>
<td>37 (68.5)</td>
</tr>
<tr>
<td><strong>Age category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40</td>
<td>4 (20)</td>
<td>15 (27.8)</td>
</tr>
<tr>
<td>40-50</td>
<td>8 (40)</td>
<td>20 (37.0)</td>
</tr>
<tr>
<td>&gt;50</td>
<td>8 (40)</td>
<td>19 (35.2)</td>
</tr>
<tr>
<td><strong>In residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 15 yrs</td>
<td>9 (45)</td>
<td>29 (53.7)</td>
</tr>
<tr>
<td>≥ 15 yrs</td>
<td>11 (55)</td>
<td>25 (46.3)</td>
</tr>
<tr>
<td><strong>District</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wealthy</td>
<td>4 (20)</td>
<td>13 (24.1)</td>
</tr>
<tr>
<td>Mixed</td>
<td>4 (20)</td>
<td>14 (25.9)</td>
</tr>
<tr>
<td>Deprived</td>
<td>12 (60)</td>
<td>27 (50.0)</td>
</tr>
<tr>
<td><strong>Practice type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo practice</td>
<td>3 (15)</td>
<td>11 (20.4)</td>
</tr>
<tr>
<td>Duo/Group practice</td>
<td>9 (45)</td>
<td>25 (46.3)</td>
</tr>
<tr>
<td>Health centre</td>
<td>6 (30)</td>
<td>18 (33.3)</td>
</tr>
</tbody>
</table>

#  Two interviews were not recorded

After the training, the suspicion criteria for the majority of the participants had progressed into a multitude of symptoms including unexplained or vague complaints such as headaches and chronic pains or depression, sleeping problems, gynaecological or sexual problems, recent divorce, and also frequent visits to the doctor:

I-8 – “Now a lot of things make me suspect. Vague complaints, especially when frequently different complaints come forward, gynaecological consultations, recent divorce, being a single parent with children, ....so now a lot more, including the similar things like before.”

Most doctors said that at the very least, the training had made them more aware of the possibility of partner abuse in a patient during consultation:

I-9 “Now (following the training) I feel much better. Also because now I am more aware, I am very much surprised to discover cases I would never have thought about before. I remember one case where without the course I would not have thought about it.”
b) Confidence in addressing partner abuse

Two thirds of the doctors felt that prior to the training, they were not well enough equipped to address the subject. After the training, fifteen of the interviewees felt much more confident and better equipped to ask about and discuss partner abuse:

I-3 “Now I feel more free to ask,…before the training I didn’t feel sufficiently equipped to ask directly. After the training, I felt, whenever I suspected it, I just have to ask.”

Other doctors gained tools they could use:

I-10 “I had a generally empathetic feeling. I thought I was well equipped enough. I think the strategy of questions provides a very useful tool (diagnostic instrument). I didn’t have this tool before this course, so now I feel even better equipped. And I am also less afraid of asking. It’s a very intimate question. I ask about sex, so why shouldn’t I ask about violence?”

Many participants expressed they had difficulties in asking patients about partner abuse, before the training. These included: defining it too time consuming; not knowing how to help; not wanting to hear about abuse; concern of asking the wrong questions and being too confronting; feeling embarrassed because of the suspect; fear of offending:

The four doctors who said they had no difficulties in asking were all male (see gender differences later).

Most of the doctors said the training had helped them to overcome these difficulties:

I-19 “You just don’t feel comfortable in asking about it. Then you just have to learn that it is something that is going on, so just ask. You’re the one that has to know about it, so you just need to have more self-esteem to ask about it. That really has changed me.”

One of the doctors who said he had no difficulties in asking patients about abuse, said that the training nevertheless had helped:

I-20 “I don’t find it difficult to ask a patient anything. I have enough experience, but you need to know when and where and what to ask… Now I have more knowledge to suspect it and I know now what and how to ask.”

c) Usefulness of the training in daily practice

All of the family doctors except one said they had found the training useful in daily practice and most of them saying “very much so”. Specific ways in which the course had been useful to them were: becoming more at ease with partner abuse (n=10), the legal and police aspects (n=8), asking directly (n=7), asking more often (n=6), knowing more signs (n=6), having more tools to help deal with victims (n=6), knowledge about the magnitude of the problem (n=5), experiencing less barriers (n=4), learning that they are not responsible for solving the problem (n=3) and knowing the reasons why some women continue in abusive relationships (n=2).
One of the family doctors expressed his frustrations and how the education helped him deal with them:

I-6 “It explained situations in the past when I was very frustrated. I remember a woman who told me she was being abused. I had given her the number of a shelter home, and she had to go to X and had no money. I gave her money and took her in my car to the railway station and after 2 or 3 weeks, she came telling me that she had looked for another doctor, and was back with her husband again. I was very frustrated then and angry, and now, because of the course, I understood what happened.”

One doctor mentioned that the education had helped her deal not only with partner abuse, but also with child abuse.

d) Most useful part of the training
The doctors reflected on which part of the training program they had found most useful. The content of the course can be seen in Appendix A.
The consultation skills using role-plays was the most preferred method of learning, with half of the doctors remarking that it was one of their favourites:

I-19 “The role-playing, when we practiced ourselves (small groups) made the most impression on me... I was the one sitting in front (patient role) ..”
The next most valued part of the course was the presentation of the diagnostic tool, with seven references to it. Other valued training parts were the discussion about attitudes (n=4), the lecture on epidemiology (n=4), the scoring of the written cases (n=3), the information on referral services (n=2), police domestic violence program (n=2), legal aspects (n=2), the combination of everything (n=2) and the theories (n=1).
One of the doctors who had assessed the scoring of the written cases the most useful part, was amazed that he had changed so much during the course:

I-6 “The most useful part, was at the start of the training, we got questions (written cases) about patient histories to answer. We had to mark them. And after the training, you got similar things, and I was surprised how I changed my mind in those 2 days.”

e) Effect on opinions and views:
Over half of the doctors felt that during the course, their opinions and views on partner abuse had changed. Here are some of their thoughts:

I-4 “In the sense that abuse is much more prevalent than I ever thought....and we just don’t discover it...while patients carry on with it.”
I-18 “There is much that we are not aware of, and even if you cannot solve the problem, there is a lot we can do to address the problem.”
Many doctors thought the prevalence figures of partner abuse amazing and hard to believe. It was discovered that at this point, that resistance arose in accepting the outcomes of studies among the general population and in family practice. Disbelief and discomfort was brought forward by more sceptical doctors as they underlined that it made them feel insufficient:

**I-11** “Well, it makes you feel quite insufficient, these epidemiological data … so we should detect more abused women and children than we do by now. I’m not sure of these figures, because it is always an estimate, and how can you ever know the exact figures, so I am trying not to feel too insufficient. I just don’t really believe that the numbers are that high, and you can’t prove it either.”

**f) Effect on management:**
The majority said that since following the training, they have suspected more cases of partner abuse (n=14), asked more patients about abuse (n=14), and had detected more cases (n=10). Over half felt that after the training they knew more about agencies and services for abused women. Two thirds of the doctors now used these services more often and have started to refer patients on a more regular basis. Finally, concerning the effects of the training, the doctors were asked if the advice they now gave to their patients and their management was different following the course. Eleven of them felt that this had changed. These doctors expressed that their response to abused women and management had changed from usually ‘telling women to leave’, to practising the issues they had learned during the training, e.g.: telling patients that partner abuse is not normal; referring more adequately; explaining the legalities; being more direct with the patients; trying to follow up and see the patient more often after disclosure; doing less problem solving on their own; less often advising to leave a partner.

However, the ways of dealing with patients differ within this sample. Some of the doctors emphasised that you should refrain from advising your patient directly in such a circumstance to prevent unnecessary pressure; while others in contrast, took a more active stand and would stimulate women to seek possibilities to cope with the problem. This illustrates that apparently the training resulted in more than one way to manage the problem and that participants took home messages that matched their management style and practices.

Finally, this doctor’s whole outlook on managing partner abuse had changed:

**I-10** “I am not frustrated anymore … Before the course I found it much harder.”

**g) Future training**
The doctors were asked if they would like some more training on this at some point in the future, and all said yes to this, except two men of which one said: possibly, in a few years.
The family doctors are worried that their awareness of the problem was already diminished. Some mentioned that though they were enthusiastic and determined to identify more patients, this just happened. Nearly all the participants said they would like a refresher course in a couple of years:

I-3 “I think your knowledge and awareness will diminish in time, so some repetition would be good.”

For this booster course, some of the doctors felt that a shorter course would be more appropriate for them, with more emphasis on how to manage abuse cases. All of the family doctors said they would recommend this course to their colleagues with some having done so already. One participant thought that hospital doctors should also follow training and others suggested that the course should be more widely marketed to reach more family doctors. All of the interviewees except one said that medical school does not adequately address domestic violence and intimate partner abuse. One doctor emphasised that there should be just as much on domestic violence as there is on alcohol, but there isn’t.

h) Gender differences

Whilst conducting these interviews, a new theme emerged. It was discovered that generally speaking, the female doctors differed from the male doctors regarding the ways they learned from the training and how it affected their daily practice. The male doctors expressed a greater level of confidence in their own abilities before training, compared to the female. All of the female doctors except one said they find dealing with intimate partner abuse to be very challenging, whereas only half of the men did.

I-3 “I was too embarrassed to ask… I thought, I can’t ask- she has to tell me herself, otherwise she will be too embarrassed when I ask.”

When asked what difficulties doctors had prior to the training in asking patients about partner abuse, only four doctors said they had none. All of these were male doctors:

I-12 “No, the difficulties were not within me. I discovered that they (abused women) had difficulties in telling me… Maybe I didn’t use the right words, but I didn’t find it difficult.”

Many of the male doctors interviewed, who worked with a female colleague, said they thought female abuse victims would probably be more comfortable discussing the issue with a female colleague. Also, going through each part of the interviews, in every aspect the female doctors had changed more than the men following the training. When asked if the training had made it easier for the male doctors to talk to abused women, only half of them said yes, whereas all of the female doctors answered positively. Following the training, the majority of female doctors thought they had detected more abuse cases, whereas only three of the men did.
Another interesting issue is that when asked which part of the education helped them the most, the male doctors were much more keen on the role-plays than the women, who preferred more the lecture of theories on partner violence and the diagnostic instrument. The occurrence of gender differences regarding this subject was also noted by female participants. In answer to the question how the training could be brought to more family doctors one female doctor said:

I-11 “Well, then you would have to make it compulsory, because there are a lot of my male colleagues who just don’t think that it is an issue.”

Interestingly, some of the male doctors interviewed, put forward that men could also be victims of partner abuse and they would like to see more attention for men abused by women:

I-13 “… you could get the idea that only women are being abused, but that is not true.”

Looking at the figures and quotes in this study, female doctors considered partner abuse of female patients to be much more of a healthcare issue than the male doctors did. As a whole they reported to have changed more than the male doctors did, as a result of the training and gained most out of it.

**Conclusion**

**Summary of main findings**

Integrating attention for consultation skills-training, doctors’ attitudes and prejudicial views at an extensive level in a training on partner abuse, will lead to more awareness, identification, changes in opinions and practices and possibly in more appropriate care for abused female patients.

This study adds to the current literature on educating family doctors about intimate partner abuse, and is the first of its kind to look into this issue in the Netherlands. The interviewees gave a vivid insight in what was actually learnt, how it was used and how it improved their day-to-day practice and the actual care for abused patients. The training greatly increased their suspicion criteria, made them feel more equipped and generally resolved any question and frustration they had concerning the subject. The diversity of learning points and the validation of the consultation skills training expressed among this group reflect the key theories on learning and learning styles as described by Kolb. Learning by doing is highly relevant in medicine and healthcare. Not only does it improve technical skills in performance, but also receiving feedback on ones approach, provides relevant experiences regarding professional attitudes. In this respect, all education programs on partner abuse/domestic violence should integrate practising of consultation skills in their courses. Lectures on epidemiology, guidelines and theories on partner abuse will have less impact without practical experience.
With regard to the discomfort that had arisen during the lecture on prevalence of partner abuse, it has to be acknowledged that in reaction to astonishing facts, resistance is a natural way of coping and should not be confused with profound denial.

A key new theme to emerge from this study was the need for continuing medical education (CME) on partner abuse or domestic violence and the whole family. In spite of the general consensus on the limited effects of CME on this subject, it was interesting to find these participants acknowledge that a revision every few years was needed. The insight that the problem is much more prevalent than many other problems for which education is accessible, is growing. Medical faculties, professional training on family medicine and CME associations however seem not to prioritise the integration of partner abuse/family violence in their curricula.

The discovery that the female doctors thought partner abuse to be a more serious healthcare issue than their male counterparts did, is a confirmation of earlier studies. In a questionnaire that was filled in at the start of the main study, male doctors estimated they identified on average 2.5 abused female patients in one year whilst female doctors estimated 3.2. These estimates were not corrected for working hours and female doctors worked predominantly part-time. (see Appendix B) This difference illustrates that female doctors in fact already had been seeing more cases in shorter time.

As to date the majority of the family doctors are male, education on partner abuse should specifically address this difference of view which inevitably will influence ones attitude and practices. The aim is to ensure equal quality of care for abused female patients, whether they visit a male or a female doctor.

The finding that male doctors thought female patients to be more comfortable discussing partner abuse with their female colleagues, suggests this is to be considered more of a task for female doctors. Female doctors, although identifying more abused patients, felt less confident and well-equipped (at first) to perform this task. Thus remains both the possibility that abused female patients indeed choose to disclose their situation more often to a female doctor or that female doctors, in spite of their low confidence, more often ask patients about abuse. However, leaving identification and assistance for abused female patients in health centres and group practices solely to female practitioners should not be recommended.

The finding that female doctors gained more from the training raises the complex question whether this is because women generally gain more from such training programs, or because they are not as confident as their male counterparts in their abilities as a doctor. It is also possible that female doctors who were actually seeing more abused women, wanted more extension of their knowledge on the subject. The case could also be that they had been more open about their uncertainties or were basically more interested in the subject. The latter could have accounted for the
finding that female doctors valued mostly the theory and diagnostic instrument. They obviously wanted to gain more insight and knowledge to fill in their gaps on how to approach abused women.

The finding that male doctors in general felt more confident about the subject and expressed less difficulties in asking female patients about abuse is contradictory to what they valued as the most useful part of the training: the consultation skills training. Possible explanations are that male doctors were less sensitive or open about their gaps and discovered they had much to learn and therefore gained the most from this part. It also may be less appealing for male doctors to listen to how men are perpetrators, and feel substitute shame, or more simply that the pragmatic method of role-playing reflects a preference for an action-oriented approach.

**Comparison with existing literature**

There is only limited literature and research to link this study to, especially when looking at studies from family practice. Some studies found that only 16% of the doctors had received some form of education on partner abuse/domestic violence and that one of the main barriers to inquiring about abuse was a lack of knowledge and skills on this subject. In another study looking at doctors’ responses to abused women this figure was even less; only 8% of the doctors expressed they had had some form of training into the area of partner abuse. In the study at hand, none of the participants had had any prior education and two thirds of them felt they were not equipped with sufficient knowledge and skills to deal with abused patients prior to the training.

The increase in suspicion criteria was also found by Taft in the pre and post training evaluation. Prior to the education, Taft reports that the most commonly mentioned identifiers of partner abuse were bruising or injuries (80%) closely followed by depression (67%) and anxiety (40%). After the training, these symptoms progressed to a multitude of more somatic complaints, such as abdominal pain, sexual problems and visiting the doctor on a regular basis, similar to the findings in our study. Virtually all of the participants in this study mentioned the need for more training in the future, as they felt their awareness of partner abuse had decreased in time. Fanslow et al’s study, which was performed directly after implementation of a protocol, reported an increase of identification of partner abuse at an emergency department. Upon follow-up evaluation at the same site after one year, they found that rates of identification had dropped back to the baseline.

**Strengths and limitations of the study**

Although the sample size was small, with just 18 transcripts to be analysed, the point was reached where no new themes emerged. Selection bias is inevitable in this type of study. Participation was voluntary, doctors with the attitude that partner abuse is
not an issue will not be likely to participate. The doctors involved would not have agreed to participate in the study unless they were proactive in their desire to improve their skills when dealing with abused patients. There is also the possibility of reporting bias to consider. This phenomenon is due to the desire to give “socially acceptable” answers concerning attitudes, perceptions and beliefs. Altogether, the opinions expressed in this study are probably more positive than those in the population of family doctors as a whole.

Finally, the fact that the interviews were conducted in English throughout must be taken into account. Although of the doctors’ level of English was very high, however, on several occasions doctors found it difficult to express their thoughts as accurately as desired by themselves. The transcripts were sent to the participants for a check, and no comments were received in return. Moreover, the results do show consistency.

Implications for clinical practice and research

In order for family doctors to improve their awareness of and response to abused female patients, they must first realise the scale and reality of the problem, then become more comfortable in their own attitudes, and finally become more confident in their ability to aid these patients. Training family doctors to identify partner abuse is vital as it facilitates a suitable approach of many otherwise unexplained medical conditions.

Our training addressed participants’ actual learning needs and provided a balanced mix of learning methods which resulted in the above mentioned change in daily practice. We recommend that medical faculties and CME organisations incorporate courses that are specifically tailored to change awareness and attitudes regarding partner abuse as well as improvement of consultation skills, in their standard curricula. A dedicated and sustained approach by medical associations will be needed to place training on family violence/intimate partner abuse, highly and structurally on the agenda.

The possibility that different training programs be offered to male and female doctors in the future requires further investigation: i.e. more action, role-play based training for the men, and more theoretical discussion for the women. Research on this topic should be a priority.

Acknowledgements

We are greatly indebted to Philippa Callegari, BSc, medical student at Imperial College, London (UK), who within the framework of the Socrates Program in 2004, in cooperation with the research group, developed the interview guide, conducted the interviews and worked out the transcripts.
Funding: none.
Conflict of interest: none declared by the authors.
Ethical approval: the intervention study was undertaken with the consent of the ethical committee of the Radboud University Medical Centre: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO- nr.2002/275

References


APPENDIX A
Details of the Training Program Content
Title: “Women abuse and the role of the family doctor”
Duration: course of 3 consecutive daily periods of 3 hours (1.5 day)
Group size: 12-14 participants
Trainers: Ellen Nijenhuis, senior trainer/psychologist and staff member of the Training Institute for Family Medicine, Erasmus Medical Centre Rotterdam; Sylvie Lo Fo Wong, family physician and researcher at the Radboud University Medical Centre, Dept. Family Medicine/ Women’s Studies Medical Sciences
Location: the Rotterdam Continuing-Medical-Education Centre for Family Medicine; Capelle a/d IJssel
Costs: none, the course was granted.
CME Credits: 9 points

Contents of the course:

1. **Attitude**: focus on personal learning aims: 30 min; awareness of aversions, impediments and prejudices: small group discussion: 15 min followed by plenary discussion: 30 min; total: 1.15h
2. **Theories**: interactive lecture on violence in relationships, cycle of violence, victim’s coping strategies, profiles of perpetrators, risk factors for abuse: 20 min
3. **Epidemiology**: interactive lecture on prevalence in general population and in family practice; clinical presentation and medical consequences: 20 min.
4. ‘Women Abuse Screening Tool’ as a diagnostic instrument; abused patient’s recommendations: interactive lecture + introduction of role-play and role distribution: 20 min.
5. **Consultation skills**: identifying victims, coping with the problem without solving it immediately. Role-play and feedback in small groups followed by plenary discussion of learning points: 1.5 hours.
6. **Introduction of referral services**: Rotterdam Police Domestic Violence program (1 police-officer) and Abused Women’s Support Agency (2 social workers); 1h15min;
7. **Clinic with a simulation patient in a difficult role**: practising consultation skills with direct feedback from both the trainer and the simulation patient; 1.5 hours.
8. **Legal aspects**: documenting; medical chart; patient rights; law and confidentiality; jurisdiction by a lawyer specialized in domestic violence/partner abuse: 45 min.
9. **Scoring of written cases**: measuring awareness of partner abuse in female patients at the start and the end of the course by written cases: 2x 10min. Every case consisted of a short description of a patient 1)complaint/question, 2) medical history and 3)background. Method: power point presentation with scoring forms; one first set of 10 cases was presented at the start of the training and a second set of 10 similar cases, at the end. Scoring of each case was done on two levels; at the first level suspect was scored: yes-doubt-no; at the second level reason to suspect was scored: patient’s complaint/question - medical history - background. Scoring-time of each case was limited to 40 seconds per level.
### APPENDIX B

**Participant’s characteristics**

<table>
<thead>
<tr>
<th>Coded number</th>
<th>Gender</th>
<th>Age</th>
<th>Part-/full-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>M</td>
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</tr>
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<td>Part-time</td>
</tr>
<tr>
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</tr>
<tr>
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<td>F</td>
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<td>Part-time</td>
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<td>6</td>
<td>M</td>
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</tr>
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<td>7</td>
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</tr>
<tr>
<td>8</td>
<td>M</td>
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<td>10</td>
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</tr>
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<td>M</td>
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<td>Part-time</td>
</tr>
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<td>12</td>
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<td>13</td>
<td>M</td>
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<td>Part-time</td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>55</td>
<td>Full-time</td>
</tr>
</tbody>
</table>

Note: Participants 1 and 17 were the initial two interviews that did not record. Therefore, they have not been used in the analysis.
“Trapped in a house that would never be mine. With a husband who fed on my pain. Watching my children going nowhere with me; the cruellest thing of the lot. No hope to give them. They saw him throw me across the kitchen. They saw him put a knife to my throat. Their father; my husband.”

“The woman who walked into doors”. By Roddy Doyle
Talking matters

Abused women’s views on disclosure of partner abuse to the family doctor and its role in handling the abuse situation

Sylvie Lo Fo Wong
Fred Wester
Saskia Mol
Renée Ròmkens
Door Hezemans
Toine Lagro-Janssen

Submitted
Abstract

Objectives: We aimed to explore what women, who disclosed partner abuse to their family doctor, valued most in the visit, and whether disclosure played a role in handling their abuse situation.

Methods: In depth interviews were held with abused women, within 4 weeks after disclosure to their family doctor. The interviews were coded and analysed by two independent researchers to discover important themes, after which they elaborated these into concepts.

Results: Thirty-six women were interviewed. Most women went to see the doctor for some medical complaint, and only three women planned to disclose the abuse. Twenty-five women valued most their doctor's empathetic or empowering approach and nine women valued most the instrumental approach. Eight women of the latter group wanted this approach combined with an empathetic or empowering approach. After disclosure to the family doctor, a group of women \( n=20 \) perceived a real change in their possibilities. They appeared to be in a position we named: ‘in transition’, a state in which they started or continued a process of change. Another group of women \( n=13 \) appeared to be in a ‘locked-up’ position, a state without any prospect on change, feeling out of control and fearing the abuser. Three women reacted with reserves towards change.

Conclusion: Empathy and empowerment from the family doctor are important to women who disclose partner abuse. Doctors should acknowledge the advantage of their position as a professional confidant and should encourage women to talk, bearing in mind the role of disclosure in handling the abuse situation.

Key words
Intimate partner abuse; women; family medicine; general practice; communication; qualitative research
Introduction
Family doctors often refrain from asking female patients about partner abuse, mostly out of fear of offending women. After disclosure many doctors do not feel comfortable counselling an abused woman, and wonder if their efforts are worthwhile.\textsuperscript{1,2} These are important reasons why partner abuse often remains unidentified.\textsuperscript{3-8} In contrast to doctors, the majority of female patients approve of doctors asking, whether they are in an abusive relation or not.\textsuperscript{3,5,9,10} Women who have disclosed, want their doctor to take a complete history and ask about current and past violence.\textsuperscript{9-12} They emphasize that doctors should show compassion, confirm a patient’s self-worth, acknowledge both the abuse and the fact that time is needed to make final decisions.\textsuperscript{12,13} Two recent studies indicate that abused women who disclosed and subsequently participated in a support program, went through a changing process. According to the 5-stages of change model, it is of importance that a woman sees the abusive relationship as a problem and is open to the advantages of change (stage of contemplation) in order to be able to disclose.\textsuperscript{14,15} Studies on communication in family medicine in general, show that empathetic communication heightens both the level of comfort and disclosure on the part of patients.\textsuperscript{16,17} To date, too little is known what abused women, who do not participate in any support program, value in the interaction with the doctor and what the disclosure brought about in their situation. Moreover, research among women who still live with their abuser is lacking as it is difficult to enrol these women in a study.\textsuperscript{15} Abused women’s views on what they want and need from providers of primary care, have been studied solely in samples of women participating in support programs.\textsuperscript{11,14,15} A study on women who have disclosed to their family doctor, only recently before, could provide more insight on the effects of doctor’s performance and practices. Family doctors could benefit from this information in order to revise their assumptions regarding the assistance of abused women, and become more engaged.\textsuperscript{1,18,19} Our objective was to interview women shortly after disclosure to understand what abused women valued most in the doctor’s performance and what it meant for their feelings after the visit and their position in handling the abuse situation. We aimed to capture initial impressions and opinions, unbiased by time and exposure to assistance programs.

Methods

\textit{Study design and setting}

We conducted in depth interviews with female patients who had disclosed abuse shortly before to their family doctor. This qualitative study was part of an intervention study to improve detection of partner abuse that was carried out in 2003 in Rotterdam (the Netherlands). We aimed to enrol as many identified women as possible for the interviews.\textsuperscript{20}
Enrolment of participants

The intervention study resulted in 118 female patients identified with partner abuse: currently \( n=76; 64.4\% \), formerly \( n=33; 28\% \) or both \( n=9; 7.6\% \). To enrol our sample we requested that at the end of the visit, the family doctor asked all identified patients to participate. Women, who consented to participate, received written information about the study, signed an informed consent form and were reported to the research assistant directly after the visit. Doctors were asked to note a woman’s reason(s) if participation was refused, as well as their own reasons for not asking a woman.

Data collection

The study took place from March – November 2003. Within one week after a woman disclosed, the interviewer called her for an appointment. The interview took place, if possible, at the woman’s home or at the doctor’s office, according to her wish and safety. Women were interviewed mainly in Dutch by one of two experienced female communication experts. We offered women from ethnic minorities with language problems, a translator. None chose for this option. On several occasions a daughter, who helped by translating when necessary, accompanied them.

The interview guide provided open ended questions and covered issues like: reason(s) to visit the family doctor, expectations and preferences, what was valued most, feelings directly after, perceived changes in possibilities to handle the abuse situation or abuse related complaints and whether the doctor offered his/her assistance or referred. The topic list was developed and discussed in the research group. We also collected background information: age, marital status, ethnicity and residential area.

Prior to the study, we consulted the local Victim Support Service on how to address these women. This resulted in the advice not to record the conversations on tape to maximize confidentiality. So, the answers to questions were summarized and presented to the respondent for confirmation and noted before a new topic was broached.

Finally the respondents completed the Composite Abuse Scale\(^*\) (CAS) in order to assess type and severity of the experienced abuse. The CAS distinguishes four major types of abuse experienced by women: severe combined abuse, emotional abuse, physical abuse and harassment. This scale has been developed and validated in family practice in Australia.\(^{21}\)

At the end of the interview, the women received a gift voucher of €15.

Immediately after the interview, the notes were transcribed and processed in ATLAS.ti (a software program for qualitative research), by the research assistant

\(^*\) The scale was developed in Australia, translated into Dutch by the researcher and checked by a bilingual native Australian translator, to capture any discrepancies.
(MS). As the interviews were not taped, the transcripts provided summaries of women’s answers to the questions, highlighted with quotes. As a high proportion of women were currently living with an abusive partner, there were concerns for their safety. Therefore the transcripts were not offered for member check. The interviews were processed and saved with only a woman’s study number.

Data analysis
The narratives were analysed with qualitative coding. For a start, the two researchers (SL, DH) read and reread the transcripts to gain insight in the most important themes that emerged. Next the answers were grouped, per question, in ATLAS.ti. The two, independently coded the answers and established the final codes in dialogue. Finally they independently categorised each woman’s position in handling the abuse situation, and in mutual discussion they reached consensus. A woman’s position was seen as a result of her perceived possibilities, her considerations and actions regarding change. The research group commented upon the concepts and discussed them intensively for final conclusions.

This study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: CMO, region Arnhem – Nijmegen, nr.2002/275.

Results

The women
Of the identified abused women (n=118), 86 (73%) were actually asked to participate in an interview. Thirty-two women (27%) were not asked because of: language problems, accompanying children, a patient’s psychiatric history or an unsafe situation. Women who were asked, but refused, mostly reported fear of detection by a partner or a relative, and on several occasions they were afraid to get killed. One doctor noted a patient’s answer: “If I participate in this (interview) I will end up in the graveyard.”

Thirty-six women (30.5%) gave their consent. For participant’s characteristics see Table 1.

The interviewed women are a fair reflection of the total group, and women of all age-categories, residential districts and most ethnic subgroups are represented. However, our respondents, on average are slightly older than the total sample and women from non-western ethnic minorities (mostly living in deprived districts) were far less willing to be interviewed, in contrast to women, living in wealthy districts.

We categorised a woman’s abusive situation at the moment of the interview: twenty-one women were currently living with an abusive partner (currently abused; 58.3%); eight women had left their abuser less than 1 year before (recently left; 22.2%);
seven women had been abused more than 1 year ago by a former partner but experienced no abuse from their present partner (formerly abused; 19.4%).

Table 1  Demographics of interviewed women (n=36) / total sample (n=118)

<table>
<thead>
<tr>
<th></th>
<th>Interviewed sample</th>
<th>Total sample n=118 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-25yrs</td>
<td>4 (11.1)</td>
<td>20 (16.9)</td>
</tr>
<tr>
<td>26-35 yrs</td>
<td>9 (25.0)</td>
<td>39 (33.1)</td>
</tr>
<tr>
<td>36-45 yrs</td>
<td>13 (36.1)</td>
<td>33 (28.0)</td>
</tr>
<tr>
<td>46-55 yrs</td>
<td>8 (22.2)</td>
<td>17 (14.4)</td>
</tr>
<tr>
<td>&gt;56 yrs</td>
<td>2 (5.6)</td>
<td>9 (7.6)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dutch</td>
<td>16 (44.4)</td>
<td>47 (39.8)</td>
</tr>
<tr>
<td>Hindustani Surinamese *</td>
<td>7 (19.4)</td>
<td>16 (13.6)</td>
</tr>
<tr>
<td>Creole Surinamese</td>
<td>3 (8.3)</td>
<td>5 (4.2)</td>
</tr>
<tr>
<td>Turkish</td>
<td>5 (13.9)</td>
<td>21 (17.8)</td>
</tr>
<tr>
<td>Other non-western</td>
<td>3 (8.3)</td>
<td>26 (22.0)</td>
</tr>
<tr>
<td>Other western</td>
<td>2 (5.6)</td>
<td>3 (2.5)</td>
</tr>
<tr>
<td><strong>Residential district</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wealthy</td>
<td>10 (27.8)</td>
<td>23 (19.5)</td>
</tr>
<tr>
<td>Mixed</td>
<td>7 (19.4)</td>
<td>27 (22.9)</td>
</tr>
<tr>
<td>Deprived</td>
<td>19 (52.8)</td>
<td>68 (57.6)</td>
</tr>
</tbody>
</table>

* Hindustani Surinamese descent from India; Creole Surinamese are named this way in their country of origin and represent a mixture of ethnicities, often with a proportion of African descent.

On some occasions the practice assistant made the appointment to conceal a woman’s reason for the visit, because the woman feared detection by her partner. The women were very motivated to talk to the interviewers even though it was clearly for research purposes and not for counselling.

All women completed the Composite Abuse Scale (CAS) at the end of the interview. Thirty-two women had positive scores on four or three dimensions and experienced ‘severe combined abuse’. Three women had positive scores on ‘physical and emotional abuse or harassment’ and one woman was positive for ‘emotional abuse alone’.

**Women’s reason to visit family doctor**

Women were asked to mention their main reason to visit their family doctor. This usually determines both the patient’s expectations and the doctor’s approach.
Only three women had planned to discuss partner abuse with their family doctor. None of the women who went to see the doctor for treatment of their injuries that were caused directly by violence \((n=7)\), had planned to disclose the abuse. Other women \((n=24)\) went to the doctor, predominantly for musculo-skeletal pain, headache, stomach-ache and mental complaints (depression, anxiety, sleeping problems, substance abuse) or problems of children \((n=2)\). The problems presented for children were both of a behavioural type. Some women reported that their partner usually accompanied them but that this time they had made a special effort to visit the doctor on their own, while some women made an effort to see another doctor, in the same office, than their usual one because they expected the latter to take their partner’s side.

**What women valued most**

Looking at what the majority of the women valued most of the visit, we discovered two types of communicative approaches of the family doctor: the *empathetic* and the *empowering* approach. We also found some women who preferred an *instrumental* (medical) approach, however this needed to be accompanied by one of the communicative approaches.

**Communicative approaches**

Though the majority of the women went to see the doctor for physical or mental complaints and did not plan to bring up abuse, 25 women valued most that the doctor had asked more probing questions about their situation or broached possible abuse, in response to their complaints. That he/she listened kindly and attentively to her story, showed concern and compassion (affection), acknowledged the abuse and provided emotional support: the *empathetic* approach.

“... the most important was that he listened, took me serious and that I could tell everything I wanted.”

“The doctor told me that I do not deserve abuse…”

Some even stated that the doctor should not believe their explanations in order to hide the abuse but should keep asking questions.

“... the doctor should ask even if I don’t start about it myself.”

Another finding was that only two women expected a solution for their problems, whilst the need to just talk about the abuse to a professional, was frequently mentioned:

“I did not expect anything but I wanted it off my chest”

In this respect the role of the doctor as a confidant was prominently mentioned:

“You trust your family doctor even more than just anybody who can go and pass it on.”

*Quotations are translated from Dutch into English.*
Some women also wanted the doctor to emphasize that partner abuse is not acceptable:

“...although it is common in our culture, yet the doctor should say that it is not right.” (a Turkish woman 54, married for 30 years)

From the group of 25 women who valued the doctor’s empathetic approach, 15 women emphasised that in addition, they valued the doctor’s active role even more. This *empowering* approach consisted of stimulating the patient to take action, not treating her as a victim, telling her not to be afraid and offering directive support.

“The doctor opens your eyes, … the doctor indicated that I should choose for myself and for the children.”

“He kept asking questions as a result of which it became clear to me also.”

“She said that I should not be afraid, that I am not in S. and that here I have the right to keep my children.” (a 35-yr old refugee, mother of two young children)

A woman said that after the visit she took action:

“With this last assault I went to the police. Before I never dared to, I felt too afraid and humiliated. I should have talked to the doctor earlier..”

Some women appreciated it highly that the doctor invited them, even at the end of surgery hours, to discuss their condition more thoroughly to see what could be done.  

**Instrumental approach**

A group of women (*n=9*) valued most the *instrumental* approach, with a medical examination, information and treatment. They expected removing of stitches, pain-medication or referral to a physiotherapist or medical specialist. However, eight of these women wanted the doctor to ask also non-medical questions, listen to their story or stimulate them to take action, thus an *instrumental* approach combined with an *empathetic* or *empowering* approach.

“I was afraid I had cancer again. The doctor took the right decisions but she also took notice of me and asked me about my situation at home.”

Only one woman in this group preferred solely the medical treatment.

“I went to the doctor for information on migraine and its therapy.”

Nevertheless she disclosed her abusive situation once the doctor had asked.

Two women could not recall what they expected, wanted or valued in the visit because of past negative experiences with family doctors. According to the interviewers they were mentally broken (shattered) and had serious difficulties expressing themselves.

In summary, 25 women valued most their doctor’s *empathetic* or *empowering* approach and 9 women valued most the *instrumental* approach. Eight women of the latter group wanted this approach combined with an *empathetic* or *empowering* approach.
**Women’s feelings after the visit**

All women were able to recollect their feelings directly after the disclosure, and the majority felt *relieved, calm and satisfied* \((n=25)\). A number of women expressed that only because their doctor specifically asked about abuse and listened attentively, they had been able to talk, even though they had not planned to do so. In spite of the relief, some remained fearful for their children or for their partner finding out that they had talked about the abuse.

A few women expressed *neutral feelings*, they felt the same as before, remained distant and stated that they would wait and see how things would develop \((n=4)\). One of these women felt that her doctor had not taken her seriously. Considering their stories, it seemed that these women expressed neutral feelings to avoid disappointment.

Some women felt *confronted* and compelled to face the facts \((n=7)\). Two of these women considered this confrontation necessary. It made them contemplate on their current situation and acknowledge that all their complaints resulted from their (past) experiences. The other five women in this group said they were shattered, felt caught out, ashamed, humiliated, felt powerless or cried for some hours after the visit.

In spite of the emotional disturbance of some, all women, without exception, emphasised that it was important that the doctor had asked about abuse so that it no longer needed to be hidden.

**Women’s position in handling the abuse situation**

Looking at what women said about change and how they acted in their abusive situation or with former abuse, after the disclosure, we distinguished three positions. A woman could either be *‘in transition’*, a state in which a woman started or continued a process of change, or in a *‘locked-up’* position, a state without any prospect on change, feeling out of control and fearing the abuser, or in a *‘reserved’* position, displaying a detached attitude regarding changes in their situation.

*‘In transition’*

We found a large group of women *‘in transition’* \((n=20)\). In about four weeks, the time between disclosure at their doctors’ and the interview, we found these women who were all relieved and optimistic, contemplating on action or taking steps and considering the benefits to their children. Women could be thinking of leaving, arranging to leave or having left a partner; or they were setting limits to the abuser; stopped their own drinking; called on a provider for assistance or planned to do so.

In this group we found almost half \((n=9)\) *currently abused* women who were talking about change and taking action.

*Case a)*: A 35 year-old woman, a refugee and mother of two children under the age of 10, who divorced her husband six years ago: since one year she experienced severe threats by this ex-partner who repeatedly awaited her
outside her flat, harassed and physically hurt her. She went to see her family doctor for her children because one had suddenly started bedwetting and the other one had bellyache and anxiety spells. In answer to her doctor’s direct questions she told her all about the current abuse and what had happened before. After the visit this woman felt empowered by her doctor. Not only did she receive proper care for her children but she also learned that it was possible to report these incidents to the police in order to get a court injunction and she actually did so. At the interviewers question whether she felt in a position she was able to handle her situation differently she answered:

“Yes definitely, because now I know my rights, where I stand and I will fight for it now..”

Six women of the group, who had recently left, were very positive and believed the disclosure had really changed their possibilities and they talked and acted accordingly.

Of the formerly abused, five women were working towards a real change. They now saw their eating disorder, depression or problems with intimacy, which had developed after abuse by a partner, in a different perspective. These women emphasised the new ways to handle the sequels of abuse, which they experienced daily.

‘Locked-up’
We identified a considerable group of women in a locked up position (n=13). They mainly emphasized their fear and inability to act or do anything to improve their situation. Although some of these women at first admitted possibilities for a change, after reconsidering their situation, they appeared to be a captive of their abuser. Moreover they had little or no confidence in any support institution or provider to be helpful.

In this group, most of the women (n=11) were currently abused. The significance of the disclosure to these women, at this point, was the relief they experienced by just talking to someone, rather than having the problem solved.

Case b): A 48-year old married woman, who went to see her family doctor, three days after she had been battered severely by her husband. She went for a medical examination of her injuries on the head, neck and stomach but at first she did not want to reveal how they occurred. She thought that if her husband treated her so bad for so many years she deserved it. She even asked the doctor not to document the injuries or anything she had said in her electronic medical record, because she feared that some of her husband’s relatives, who were medical professionals, would be able to find out she had talked. She refused the gift voucher because she felt unable to account for it at home.
This woman felt completely out of control towards her situation and saw no options for change:

“*I feel powerless, I want to preserve my marriage yet I don’t see a future.*”

Two women in the ‘locked-up’ group had recently left their abuser. However, this had not changed their perspectives on the future. They were still afraid and unable to see any possibilities for progress.

‘Reserved’

A third small group we named: reserved \((n=3)\). In this group we found one currently abused woman and two who were formerly abused. These women reacted detached regarding change and doubted whether the disclosure would help them to manage their situation differently.

Case c): A 47-year old married woman, mother of a 10-year old daughter, visited her family doctor because of back- and head-ache. She was on medication for cardiac complaints and suffered from articular-aches. Her partner who had kicked her in the back once again, was as violent as the former ones and she was very disappointed in him. She was content with her doctor’s medical approach and that he had listened to her. She reacted detached at the interviewer’s question:

“You can always do something. I don’t know if it brings a solution. I need a rest.”

In summary, four weeks after disclosure, twenty women were on a track to progress in handling the abusive situation. However, thirteen women did not seem to benefit from the disclosure, in terms of improving their situation. And a few women expressed a detached attitude regarding change.

**Family doctor’s assistance and referrals**

In response to the disclosure, twenty-one women were explicitly invited for a follow-up visit with their family doctor. Nine women were not specifically invited but trusted they could always call upon their doctor when needed. In six cases women mentioned that they were not offered a follow-up visit, occasionally because a woman was referred for assistance elsewhere.

Most women \((n=31)\) mentioned that their doctor had referred them or brought several possibilities for assistance to their attention. At the moment of the interview, shortly after disclosure, eighteen women made use of a referral: to a psychologist \((n=11)\), to a social worker \((n=5)\), to a shelter home for abused women \((n=1)\) and to a physiotherapist \((n=1)\). A small group did not receive any information nor referral for assistance \((n=5)\).
Undisclosed matters

To complete the picture of what women expected and valued in the visit and to assess whether we covered all the important issues in the interview, we asked at the end of the interview whether there were still matters left to disclose to the doctor. Twenty-seven women said they had no secrets anymore. They underlined that because the doctor had asked about partner abuse, they revealed even more than they had ever planned. One woman said that she could not talk more in depth with her doctor, because he was a man.

Eight women said they had much more to disclose and planned to do so in time.

“I lifted only a tip of the veil, there is so much more to say.”

They really wanted to make a clean sweep and named occasions before, on which they had told lies about accidents, circumstances regarding their miscarriages, substance abuse and about their children who suffered from the situation.

Discussion and conclusion

Discussion

Doctors, in general, underestimate their role in identifying and responding to abused women.1,22-25 Our results confirm that family doctors who, to date, still suppose they have nothing to offer to abused female patients, may review their assumptions. Of the thirty-six abused patients only three had planned to discuss their abusive relationship with the doctor. Women visited for physical and mental complaints, yet almost all preferred the doctor to communicate about their private situation and provide other than exclusively biomedical attention. Not surprisingly, most women felt that the doctors’ empathetic approach, stimulated disclosure and provided emotional support and relief. The finding that part of the women valued, in addition to empathy, the empowering approach, is noteworthy and should encourage doctors to support women in an active (stimulating) way. The question whether women benefit more from an active empowering approach rather than an empathetic one, is open to discussion. Some women might need a powerful stimulating approach while others will only need a doctor’s attentive listening.

Our findings that more than half of the women benefited almost directly from disclosure in the sense that they now felt in a position leading to change, is encouraging. Doctors who wonder if their efforts to “simply” talk are worthwhile should no longer refrain from asking about abuse. Women do not expect a solution and value to talk in the confidentiality of the doctor-patient encounter. In this respect it is also remarkable to find that women who did not seem to benefit, in terms of change, said that the disclosure was meaningful and one of the rare occasions on which they could talk about their situation to a professional. These consultations might plant a seed for a next step. Taking into account that the majority of the
interviewed women were currently abused or had only recently left, it is even more essential that doctors offer follow-up visits to these women, or provide an appropriate referral.

The fact that some women might be emotionally upset after the consultation, might refrain a number of doctors from asking about abuse. However we can state that none of the women saw this as a reason for restraint. Doctors should consider that a first-time disclosure of abuse is an important step in a woman’s process in handling the abuse and that it matters substantially whether a doctor dares to ask or not.

Our study clearly sustains the recommendation to break through denial and help women disclose. In line with earlier studies, we have no indication for damage of the relation with the patient if a doctor asks about abuse. On the contrary women were very relieved and appreciated doctor’s efforts in any case.

Bearing in mind that most of these women were severely abused, it is remarkable to find half of the currently abused women in a position of (at least) emotional transition, feeling able to start or continue a process of change, shortly after an unplanned disclosure. According to the 5-stages of change model (pre-contemplation, contemplation, preparation, action and maintenance), contemplating on change is a necessary step, preceding action. Mostly this stage remains invisible to family doctors, who might think that no progress has been made since.

**Strengths and limitations**

We studied views and experiences of abused women, and the main strength is that we succeeded to enrol a sample of severely abused women shortly after disclosure. Most studies enrol participants from women’s shelters or some time after disclosure. We captured initial impressions and responses of abused women and portrayed this group at a threshold in their process of change.

Methodologically, we are able to confirm that theoretical saturation was reached when half of the respondents were interviewed.

A possible limitation of our study is that our respondents were enrolled by their family doctors. The fact that these women were in general positive about their family doctor may reflect the already existing contact with him/her. On the other hand this sampling method is also a strength, given the fact that family doctors are the major professional group to whom women will disclose.

Our results are somewhat limited due to the fact that we interviewed relatively more women from wealthy districts and less from deprived districts or from ethnic minorities. The low representation of the latter group may reflect a culturally determined custom, not to talk to a stranger about personal problems as well as poor language proficiency.
**Implications for practice and research**

Enrolling our respondents revealed the fear and danger women felt, solely by disclosing. In managing abuse, it is indispensable to discuss safety matters. A first-time disclosure is also the moment to assess the situation in a broader perspective and ask about the condition of children and assess a woman’s hidden substance abuse. In this visit, doctors must be aware of the limitations of revealing all at once, as partial disclosure is not rare. A careful follow-up, with regard for a woman’s pace and autonomy will be needed.

New studies should follow women on their path after disclosure and explore their developments more in depth. It would be interesting to follow currently abused women and those who have recently left. For a start we conducted a second interview with the majority of these women within one year after the first interview. We will report on these interviews in a future paper.

**Conclusion**

A communicative approach of the family doctor is what women preferred mostly and in this respect empathy is indispensable in response to disclosure of partner abuse. However, an empowering approach can possibly stimulate women even more by providing directive support. It is important that family doctors acknowledge the advantage of their position whenever they suspect abuse in women. Asking a woman about abuse, encouraging her to talk, will definitely matter in her process of handling the abuse situation.

**Acknowledgements**

We wish to thank all the interviewed women for their confidence in sharing their experiences with us; all participating family doctors for enrolling the respondents and for their cooperation in allowing us to use their offices on many occasions; the practice assistants for their cooperation in making appointments; Margriet Straver and Door Hezemans: the interviewers, for their skilful interview technique; Margriet Straver: research assistant, for processing the conversations; Meredith Page (Melbourne, Australia) for checking the translation of the Composite Abuse Scale; Jan-Marc van Dam (Chelmsford, UK) for English language corrections.

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**Conflict of Interest:** No one of the six authors has declared a conflict of interest.

**Ethical approval:** The study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO-nr.2002/275
References


“I couldn’t give him what he wanted, a pregnant wife who wasn’t really pregnant…. He wanted nothing to do with me the way I was now. He hated what he saw…”

“The woman who walked into doors”. By Roddy Doyle
Changes in women’s situation after disclosure of partner abuse to the family doctor
A follow-up of abused women

Sylvie Lo Fo Wong
Fred Wester
Renée Römkens
Saskia Mol
Door Hezemans
Toine Lagro-Janssen

Submitted
Abstract

Objectives: We aimed to explore the changes in women’s abuse situation and women’s position in handling the abuse or its sequels within one year after disclosure and the role of the family doctor during this period.

Methods: A 2nd in depth interview was held with 25 identified abused women, 8 -12 months after an initial interview, which was held shortly after disclosure to the family doctor. In the 1st interview a woman’s position in handling the abuse or its sequels was categorised as: ‘in transition’, ‘locked-up’ or ‘reserved’.

Results: Seventeen women started or continued a process of change in the year after disclosure and were categorised as ‘in transition’. Eight women remained or fell back into a ‘locked-up’ position, due to complexity of the problem. In both groups, women emphasised the distress of the daily struggle in handling the sequels of the abuse. None of the women remained in a ‘reserved’ position.

Less than half of the women (n=10) made use of follow-up visits to discuss the abuse situation with their family doctor and some women (n=6) only visited their doctor for medical complaints and treatment. Women who went to a support agency (n=12), sometimes also made use both of the assistance of the support agency and the family doctor.

Many children suffered from the situation and showed behavioural problems which needed treatment.

Conclusion: Due to the distress after disclosure and the complexity of the problem, family doctors should monitor these women and their children, to provide appropriate care.

Keywords: Intimate partner abuse; women; family practice; qualitative research.
Introduction

Long-term follow-up studies of women in the medical setting after disclosure of intimate partner abuse are lacking. It is widely acknowledged that abused women are heavy users of medical services, due to increased health problems. From surveys among female patients in family practice, we know that at least 37% to 49.5% report to have been ever abused by an intimate partner. To date, family doctors rarely identify abused women and often think they have nothing to offer. Studies on women who disclosed intimate partner abuse, usually report positive results for these women. The main limitations of most studies are that they represent women who participate in support services for abused women and focus on the short-term. Most studies do not include women who are currently living with, or just left their abusive partner and those seeking assistance elsewhere (family doctor, other provider, church). It is acknowledged that women who just left an abusive partner, often risk even more violence. To date prospective studies are lacking, and too little is known of how abused women continue to manage their situation over time.

To gain more insight in whether women were able to change their life situation after disclosure we followed the group of abused women from our previous study (2003) and conducted a second in depth interview within one year after the first interview. In our previous study we interviewed women shortly after disclosure to their family doctor. At that time we discovered that most women were in one of the following positions in handling the abuse situation. We found women in a position we named ‘in transition’, starting or continuing a process of change while others seemed ‘locked-up’, without any prospect of change, fearing their abuser and remaining the captive of their situation. A few women reacted with reserves towards change. It would be of interest to family doctors to learn more about how abused women continue to manage their situation after disclosure and learn more about their role in this period.

In this present study we aim to explore the developments of this group of abused women, within one year after disclosure. The objective is to gain insight in their actual abuse situation and what women saw as the most important event that changed their lives. We studied the women’s handling of the abuse (or its sequels) and explored the role of the family doctor and support agencies during this period.

Method

Design and sampling

This study is part of a larger project which started in 2003 and aimed to improve awareness and identification of partner abuse of female patients in family practice, with a one and a half day training. Fifty-four family doctors in Rotterdam and surrounding areas (the Netherlands) participated in this trial and in six months they
reported a total of 118 abused women. As part of this larger project, we explored women’s views on the disclosure of abuse in a 1st interview.12 These patients were asked by their family doctor to participate in this interview which took place between March and November 2003.

At the time of the 1st interview women were classified in three groups according to their abusive situation: 1) ‘currently abused’ women (living with the abuser); 2) women who had ‘recently left’ their abusive partner (abuse < 1 year ago) and 3) women who had been ‘formerly abused’ (no abuse >1 year).

Subsequently, the interviewed women were asked to participate in a 2nd interview within one year and 27 women agreed.

**Data collection**

The 2nd interviews took place approximately 8-12 months after disclosure, between January 2004 and July 2004. Each respondent talked to the same interviewer as during the 1st interview. Women were contacted by telephone. If this was impossible the appointment was made through the family doctors’ assistant. There were difficulties in making appointments with ‘currently abused’ women, because of fear of detection by and retaliation of the partner.

The follow-up interview lasted between 1-2 hours. An interview guide with open questions was used.

The following issues, concerning the period after the 1st interview, were broached:

1. Women’s views on changes in the past year and on their current situation
2. Women’s views on their ability to handle the abuse situation or its sequels
3. Women’s views on the role of the family doctor and support agencies

Similar to the procedure during the 1st interviews we did not record the 2nd interviews on tape to ensure maximal confidentiality. Women’s answers were summarised by the interviewer for confirmation and they were noted before a new topic was broached. At the end of the interview each woman received a gift voucher of €15.

Immediately after the interview, the notes were transcribed. The narratives of the interviews were not offered for member check to ensure the women’s safety. The interviews were processed and saved with only a woman’s study number.

**Analysis**

Two independent researchers (SL and DH) read and reread the interviews to discover important themes in women’s lives after disclosure. The analysis focused on women’s views and experiences. In mutual consultation, the two researchers established the final codes. Next they independently categorised each woman’s position in handling the abuse situation and in mutual consultation they reached consensus. A woman’s position was seen as a result of her perceived possibilities,
her considerations and actions regarding change. Women could either be in a position defined as: ‘in transition’, ‘locked-up’ or ‘reserved’.

Ethical approval: the study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO-nr.2002/275

Results

Response

After the 1st interview nine of the thirty-six women were not willing to be interviewed for a second time, mainly because of uncertainty about their future. They found it difficult to talk about their situation and feared detection by, and retaliation of their abusive partner. Twenty-seven women consented for a 2nd interview and 25 were actually interviewed. Two women from the ‘currently abused’ group ultimately could not participate. One woman (still living with her abusive partner) was admitted to hospital on the day of the interview, due to her severe depressive state. The other woman had just left her abusive partner and was too busy moving into a new home.

For an overview of women’s characteristics compared to the group of the 1st interview and the total sample: see Table 1.

<table>
<thead>
<tr>
<th>Table 1. Participants characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Age category</strong></td>
</tr>
<tr>
<td>17-25yrs</td>
</tr>
<tr>
<td>26-35 yrs</td>
</tr>
<tr>
<td>36-45 yrs</td>
</tr>
<tr>
<td>46-55 yrs</td>
</tr>
<tr>
<td>&gt;56 yrs</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>Dutch</td>
</tr>
<tr>
<td>Hindustani</td>
</tr>
<tr>
<td>Surinamese #</td>
</tr>
<tr>
<td>Creole Surinamese #</td>
</tr>
<tr>
<td>Turkish</td>
</tr>
<tr>
<td>Other non-western</td>
</tr>
<tr>
<td>Other western</td>
</tr>
<tr>
<td><strong>Residential area</strong></td>
</tr>
<tr>
<td>Wealthy</td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td>Deprived</td>
</tr>
</tbody>
</table>

# Hindustani Surinamese descent from India. Creole Surinamese are named this way in their country of origin and represent a mixture of many ethnicities, often with a proportion of African descent.

Changes in women’s situation after one year

Women named their situation as worsened or unchanged when the possibilities to determine their lives were diminished and their health problems remained or
increased. Some were waiting for a divorce or a legal decision, others were still being abused, though sometimes less often. Women, named their situation as improved, when they were able to control their lives. Cessation of the abuse or divorce were the most important life-events. Others were coping better with stressful events in their current relationship whilst their health problems diminished.

**Women’s current abuse situation**

We categorised women in one of the three groups: ‘currently abused’ (n=6); ‘no abuse < 1 year’ (n=11) and ‘no abuse >1 year’ (n=8).

For an overview of women’s abuse situation in the 1st and 2nd interview: see Table 2.

**Table 2. Abuse situation and position regarding change in 1st and 2nd interview; contact with family doctor/support agency in 2nd interview: per respondent**

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Abuse situation 1st interview</th>
<th>Abuse situation 2nd interview</th>
<th>Process 1st interview</th>
<th>Process 2nd interview</th>
<th>Family doctor contact</th>
<th>Support agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recently left</td>
<td>No abuse &lt; 1yr</td>
<td>In transition</td>
<td>In transition</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Former abuse</td>
<td>No Abuse &gt;1 yr</td>
<td>Reserved</td>
<td>Locked-up</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Recently left</td>
<td>No abuse &gt; 1yr</td>
<td>In transition</td>
<td>In transition</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Recently left</td>
<td>No abuse &gt; 1yr</td>
<td>In transition</td>
<td>In transition</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Former abuse</td>
<td>No abuse &gt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>Locked-up</td>
<td>locked-up</td>
<td>Abuse follow-up</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Current abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>Reserved</td>
<td>In transition</td>
<td>Medical reasons</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Current abuse</td>
<td>No abuse &lt; 1yr</td>
<td>In transition</td>
<td>Locked-up</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>Locked-up</td>
<td>Locked-up</td>
<td>Medical reasons</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Current abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>Locked-up</td>
<td>Locked-up</td>
<td>Medical reasons</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Former abuse</td>
<td>No abuse &gt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>Current abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>Medical reasons</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Current abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>Locked-up</td>
<td>In transition</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>Locked-up</td>
<td>In transition</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>15 *</td>
<td>Former abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>Former abuse</td>
<td>No abuse &gt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Former abuse</td>
<td>No abuse &gt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>Abuse follow-up</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>Current abuse</td>
<td>No abuse &lt; 1 yr</td>
<td>In transition</td>
<td>In transition</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>19</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>Locked-up</td>
<td>Locked-up</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>20</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>In transition</td>
<td>Locked-up</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>21</td>
<td>Recently left</td>
<td>No abuse &lt; 1 yr</td>
<td>Locked-up</td>
<td>In transition</td>
<td>Abuse</td>
<td>No</td>
</tr>
</tbody>
</table>
Changes in women’s situation after disclosure of partner abuse

<table>
<thead>
<tr>
<th></th>
<th>Recently left</th>
<th>No abuse &lt; 1 yr</th>
<th>In transition</th>
<th>In transition</th>
<th>follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>23</td>
<td>Former abuse</td>
<td>No abuse &gt; 1 yr</td>
<td>Reserved</td>
<td>In transition</td>
<td>Abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>follow-up</td>
</tr>
<tr>
<td>24</td>
<td>Current abuse</td>
<td>Current abuse</td>
<td>In transition</td>
<td>Locked-up</td>
<td>Abuse</td>
</tr>
<tr>
<td>25</td>
<td>Recently left</td>
<td>No abuse &lt; 1 yr</td>
<td>Locked-up</td>
<td>In transition</td>
<td>Abuse</td>
</tr>
</tbody>
</table>

* In the 2nd interview respondent 15 revealed that she was also currently abused at the time of the 1st interview but kept this a secret. In the 2nd interview she was classified as no abuse < 1 yr.

Currently abused (n=6)

Of the six ‘currently abused’ women, five were still living with the same abusive partner and one woman, although divorced some years ago, still suffered from violent assaults by her ex-husband.

Case 24: a woman aged 36, a refugee and a mother of two children (under 11). Last year she went to see her family doctor because of health problems of both children. After the doctor had asked her about possible abuse, she disclosed that for one year her ex-partner repeatedly threatened, harassed and hit her just outside her flat. During the visit to her doctor she felt empowered and learned that she could take action. She reported the abuse to the police, but in spite of all the legal decisions he kept threatening her and in the past year he started a lawsuit to get custody of the children.

“Over the past few months he kept threatening me, he has not been here anymore, still the situation has not changed, there will be a lawsuit now... it makes me sick and the children too.”

No abuse < 1 year (n=11)

Eleven women had not been abused during the past year: six were from the ‘currently abused’ group, four had ‘recently left’ and one was ‘formerly abused’ during the 1st interview. Two women remained with their partner but said that the abuse had stopped while the others had left or divorced.

Case 1: a woman aged 34 and a mother of two children. Her ex-husband had started to abuse her physically during her first pregnancy, 15 years ago. The year before she had left him and had moved into her mother’s home with both her children. In the 2nd interview she was divorced and looking forward to move into her own flat. Her main problem now was her son’s behavioural problem. She had taken him to a child’s psychiatrist for therapy. She had also met a new partner. The most important change was:

“Now I feel much stronger, I am not afraid anymore, also not of my ex. I followed a training to become more assertive.”
There was one woman who had disclosed to be ‘formerly abused’, in the 1st interview. Yet, in the 2nd interview she revealed that she was again battered by her new partner at that time, but had chosen not to disclose this to anyone out of shame. Shortly after the visit to the doctor and the interview she had left him:

Case 15: a woman aged 39 and mother of one adolescent son. The year before she went to see her doctor because of fatigue. She had been abused for years by her former partner, but not by the current one, she said at that time. Her biggest problem then, was that her son started to act violently against her. The most important change during the past year, was that she divorced her husband recently. She was proud that it had not taken her as long as in the past to put an end to it. She emphasised that she and her son had started anew since they moved out.

“At first you are in it, you stay, out of fear and hope for the better. You keep on fighting, especially for my son to have a better life.” Now: freedom and peace. The feeling that I can live again. My physical complaints in general, are gone; I have far fewer stomach-aches.”

No abuse > 1 year (n=8)
Eight women indicated they had not suffered from abuse for more than 1 year. Most women talked about a definite improvement of their situation except for one woman who had been abused long before.
Neither of these women returned to their (ex-)partner in between the interviews.

Case 17: a woman aged 54, single (two adult daughters). The year before she went to see her family doctor because of panic attacks and sleeping problems. She was overwrought and unable to work. When the doctor had questioned her
more thoroughly she revealed that she had been battered, threatened and insulted for years by her ex-partner. She never discussed the abuse before with a doctor, although she had similar complaints at that time. After the disclosure her doctor started to treat her with antidepressants and referred her to a psychologist. In spite of the problems she experienced at her job (announced future lay-off of all employees), she emphasised that her life had changed since she started to talk about her abusive history.

“…In the beginning it was hard, I had these panic attacks …the most important change is that I have become more like myself, I dare to do things now, get into the car, get on the bicycle and go everywhere.”

**Women’s position in handling the abuse situation or its sequels**

At the time of the 2\(^{nd}\) interview a number of women were in a position we named: ‘in transition’, same as in the 1\(^{st}\) interview. Other women started to consider changes only after the 1\(^{st}\) interview and then took actions. A woman’s position was determined as ‘in transition’, in case she started or continued a process of change, assessed her situation improved and was able to take hold of her life situation. We also encountered women who at first were planning and really wanted to change their situation. However, one year later they had relapsed to a position we named ‘locked-up’, without any prospect of change, remaining the captive of their abuser or the long-lasting sequels of former abuse. None of the women were categorised as ‘reserved’.

‘In transition’ (n=17)

Twelve women still continued to make progress, though they emphasised that carrying on with their lives was a daily struggle.

Case 17: Despite the announced layoff from her job, she was not resigning to the difficulties and reflected upon the sequels of her past and her current process of change:

“I am still building it all up. I am still struggling with myself and I expect it will take quite some time.”

Three women, who were in a ‘locked-up’ position at first, we now categorised as: ‘in transition’. They were clearly progressing compared to the year before.

Case 13: a woman aged 37, mother of an adolescent daughter. The year before she went to see the doctor to take care of her wounds after her husband had beaten her because of her self-assured attitude. After some years of separation, because of her partner’s violence, they had reunited recently. She had become more independent during that period. Because of her religious principles she now stayed with her partner but was very pessimistic and had no prospect of a future without violence. At the time of the 2\(^{nd}\) interview her situation had changed considerably. Her husband had stopped acting violently. After he
joined her for church visits, he started to accept her independency. However difficult at times, she said that she maintained her self-confidence. She was quite content with her situation:

“I am satisfied with the present situation. We do have our quarrels now and then, but not like before. Being able to talk to one another is improving; some times it is still difficult…. I am confident that I can stay strong enough to continue the situation as it is now.”

Two women who were classified as ‘reserved’, the year before, were clearer now about their needs and efforts to change their situation.

Case 7: a woman aged 47, abused consecutively by several partners since she was 18, went to see the doctor because of back- and headaches the year before and talked about the abuse to her doctor. At that time she doubted whether taking action like leaving would be of help. She was now still living with this partner but he had unexpectedly stopped his violent behaviour. Nevertheless she was busy getting a divorce. Also she started to change her behaviour.

“I have stopped to give in. It brings about more struggles between us, but I don’t want to let things take their course anymore.”

‘Locked-up’ (n=8)

Three women, who were found ‘in transition’ the year before, had now relapsed into the ‘locked-up’ position.

Case 24: in the 1st interview she was optimistic and thought that her efforts and legal actions would be effective in putting an end to her ex-partners threats. Now she admits that nothing has changed. She feels depressed, lives in despair and is afraid to lose her children. For more than six months now, she had been waiting for a decision of the Child Protection Authority.

“I am afraid that in the end he will win”

Four women who were still living with their abusive partner remained in the same ‘locked-up’ position as the year before without any prospect of change:

Case 19: a woman aged 40, (Turkish origin) abused since the beginning of her marriage, took her adult daughter with her for translation. The disclosure in the year before was important to her and she was glad that her doctor had listened to her. She said that it was common in Turkish families that wives got battered but that they were not allowed to talk about the abuse. In the 2nd interview she said that her husband (a psychiatric patient) did not hit her like in the past but now insulted her aggressively at a daily basis, kept her short of money so that even her 11-year old son was unable to participate in school-camp. She was even more desperate than before:
“The circumstances are so hard. It exhausts me. I have so many problems and I don't know what to do or where to start.”

One woman who was categorised as ‘reserved’ in the 1st interview, now was clearly ‘locked-up’.

Case 2: a single woman aged 49, a mother of one adult daughter. After having disclosed former abuse by a partner, in this 2nd interview she revealed that she had also been sexually abused by her father. When asked whether she felt able to handle her situation differently, she avoided answering the question and instead complained about her declining physical health and increasing loneliness. Unwilling or incapable to reflect on change, she remained the victim of her past experiences.

Virtually all women went through a daily struggle, whether they were positive about their changes or negative. Many women emphasised the behavioural problems of their children, who also suffered from the situation and needed treatment. Women’s attempts to end their abusive relationships were often intertwined with their children’s behavioural problems and legal procedures. One woman said:

“Going through all this, I feel strong and yet I am so very tired of all the emotions. And sometimes at night I don’t see it all so clear anymore.”

The role of the family doctor and support agencies

The role of the family doctor

Ten women were invited by their doctor for follow-up visits, to talk about their abuse situation; six other women went for medical reasons such as high blood pressure, injury, pain and other physical problems; nine women had not visited their doctor since the previous interview. Women who went to see their doctor, sometimes mentioned the use of anti-depressants, tranquillisers and stomach medication.

Follow-up visits: (n=10)

Six women, who had visited their doctor to talk about their situation were making progress compared to the year before. All of these women had left their abuser.

Case 3: after the divorce she was unable to work. As a result of her mental problems she was on antidepressants and saw her doctor regularly for conversations and medication. She would not see a psychologist anymore, due to her experiences with the couple therapy.

“I am seeing my doctor once a month because I am still on anti-depressants. He said I am having a ‘burn-out’ and I am not allowed to work, although I myself think that by now I am strong enough.”

On the other hand three women, who had visited their doctor regularly for assistance still remained in their abusive situation, felt hopeless and out of control. The problems these women experienced were very complex.
Case 24: her family doctor had seen her regularly in the past year, and also referred her to a social worker. She supported her emotionally by listening, taking time for her, and writing letters to the authorities. However her doctor was limited in what she could achieve for her.

Medical reasons: \( (n=6) \)
These women went to their doctor only for medical reasons and did not talk about the abuse anymore. Reasons mentioned were that they did not feel it necessary because they had been referred for assistance elsewhere or because the doctor did not broach the subject. One woman did not want to further discuss her situation, because her doctor was a man.

No contact: \( (n=9) \)
Nine women had not visited their doctor since the disclosure. One of them had no confidence in her doctor, others had moved or had no health problems anymore or did not think them serious enough to visit a doctor. Several of these women had been referred to a support agency:

Case 1: after her divorce she did not need to go and see her doctor anymore, as to her surprise all her physical complaints were gone. In this period she had had conversations at a mental health institution which she had been referred to. She felt no immediate need to visit her doctor because of the abuse and said that he knew her for years now and if needed she could count on his support.

In some cases a woman felt supported enough by her family doctor in the one visit of the disclosure and felt sufficiently empowered and self-confident to take care of her situation on her own:

Case 18: A woman aged 39; the year before she went to see her family doctor to have her bruises and injuries checked as advised by the police. After this visit she felt empowered to take action and to put an end to the many years of violence. She emphasised that all her physical complaints were gone once she broke with her abusive partner and did not need additional assistance from her doctor or from a support service:

“No, I worked it out all on my own….I think I will manage from now on. I want to visit the doctor to tell her how well I am doing.”

In general the role of the family doctor was diverse. Part of the doctors took an active role while others left the initiative for a follow-up to the patient. To their own surprise, all women who experienced more control over their life, said they had less physical complaints or even that they disappeared.

The role of support agencies
Twenty-one women had received a referral to a support agency and were encouraged to seek contact, while four others were not referred.
Contact with a support agency (n=12)
Twelve women who were referred to a support agency went to one of the following: a social worker, mental health institution, a psychiatrist or women’s support service. Ten of these women also went to see their family doctor during this period. Some had conversations with their doctor before or after they went to see a mental health provider, while others visited the doctor only for medical reasons. Nine women in this group said they were making progress and felt liberated, some by leaving their abusive partner and others by experiencing more control on their ways of handling former abuse and its sequels. Three women were still in a troubling situation due to the complexity of their abuse problems. Those waiting for legal decisions often felt insecure and nervous.

No contact: (n=13)
Four women in this group were not referred and had no contact with a support agency. Women who were referred, but did not seek contact, named the following reasons: ‘no time’; ‘don’t think it necessary’; ‘don’t expect much help in my case’; ‘they let me down once’; ‘I should go but I hesitate’; ‘don’t want to stir up/ hark back everything once again’. These women hardly commented on the use of support agencies.

As only less than half of the women made use of support agencies, their role of was limited.

Discussion
Summary of main findings
In this follow-up study we found that seventeen women out of twenty-five, had started or continued a process of change in the year after the disclosure of their abuse experiences. We named them: ‘in transition’ as they were clearly working hard to be in charge of their own situation, with the help of the family doctor, a support agency or independently. It was worrying to find that eight women still remained in, or fell back to a position in which they had little say over their own lives: ‘locked-up’. Due to the complexity of their problems and in spite of the assistance of providers, they did not get hold of their situation and remained the captive of their abuser, sometimes even worse than before.

From our data it becomes clear that a woman’s position in handling abuse can change rapidly over time, both in a positive or a negative direction. Due to mental health problems or external circumstances such as legal proceedings, some women lost their self-confidence. Initial good intentions relapsed and women returned to a ‘locked-up’ position. At the same time, others who at first seemed desperate, apparently found the strength to battle against their situation, clearly making progress. A woman’s path from disclosure of abuse to change of the situation, by all
means is not a linear process.\textsuperscript{14,15} Positive developments might relapse and fixed situations can develop positively and unpredictably over time. Virtually all women emphasised how they faced a daily struggle, even if their situation improved considerably in this first year. Understanding the complexity of this process is vital when doctors choose to assist women with who experienced partner abuse. As Jacobs pointed out in her study on the role of empowerment in women’s aid and social work, lack of personal autonomy and say over one’s own life is seen as a major cause of women’s health problems.\textsuperscript{14,16}

It was remarkable to find a number of women to succeed on their own, once they had discussed their situation with their family doctor. Abused women are often not expected to handle their abusive situation successfully on their own and family doctors often expect women to return to their abuser in any case.\textsuperscript{16,17}

We are unable to answer the question whether disclosure was the most important factor to a woman’s, or whether it was her internal stage at the time of disclosure. When the problem is too complicated, consultation with other providers at a multidisciplinary level will be needed. Adequate case management will require additional training.

In this study, it became apparent that a family doctor’s role was diverse. To part of the women it was important that the doctor had assisted and referred them to a support agency. At the same time, others who did well, expressed less need for a doctor’s interference. However, with regard to the complexity of the problem, monitoring female patients and their children on a regular basis would be appropriate, comparable to patients with a chronic condition, to follow-up developments that may require an intervention. The fact that many of these women were living with their children, underlines the need to also protect a child’s health. It became clear that on numerous occasions these children were suffering of health or behavioural problems and needed treatment.

The smaller half of the women opted for assistance of a support agency. This reluctance results from the fact that to a substantial number of abused women the threshold is too high. Fear of detection by their partner, shame and fear of losing custody of the children once a woman seeks help, play an important role.

\textbf{Strengths and limitations}

A major strength of this study is that we were able to enrol women who seldom participate in research. We managed to reach women from all social classes and different ethnic backgrounds. The women participated extensively and gave explicit answers and sometimes disclosed issues they had not discussed with anyone before. Therefore the interviews provided an in-depth perspective on the women’s situation. Although the interviews were neither presented nor meant as an intervention, it cannot be ignored that they may have influenced a woman’s change.
One woman, who did not want a second interview, nonetheless called the interviewer after one year, to inform her that her situation had improved considerably. She wanted to report that she was still out of the abusive relationship and had started a new life along with her two young children. Our findings, however cannot be generalised because of the exploratory design. The women who participated in our study, form a selective sample of abused women who disclosed their situation to their family doctor.

**Comparison with existing literature**

Our study, following abused women in the medical setting and not in support programs is one of the first of its kind. Chang et al. recently looked at what happened after disclosure and what women wanted doctors to do, enrolled women from support programs.11,18,19 Zink et al. focused more on important and influential factors in women’s process of change regarding the abuse, but also studied women who participated in support programs.8,20 Similar to our study, the WHO-Multicountry Study on Women’s Health and Domestic Violence (24,000 interviewees/10 countries) found that abused women appreciated the interviews and saw them as an opportunity to reflect on their experiences and become more conscious of their situation.21

**Implications for practice and research**

The abused women who went to see their family doctor for medical complaints and had talked to family doctor about the abuse, in general felt supported and many felt encouraged to handle their situation differently.12 Monitoring a woman and her children is recommended to keep up with developments that will require an intervention. Furthermore, the finding that women referred to support agencies often did not make use of this referral, suggests that doctors should provide more explicit information and seriously address a woman’s barriers. New studies should focus on the role of the family doctor in monitoring and assisting abused women and their children, after disclosure.22,23 The effects of monitoring should be studied in view of secondary prevention and early detection of post-traumatic stress disorder of the involved women and children.

**Conclusion**

Family doctors, who choose to assist abused women themselves, should be aware that sometimes the complexity of the problem will require consultation and additional training.

**Acknowledgements**
We wish to thank all the interviewed women for their confidence in sharing their experiences with us; all participating family doctors for their cooperation in allowing us to use their offices on many occasions; the practice assistants for their cooperation in making appointments; Margriet Straver and Door Hezemans: the interviewers, for their skilful interview technique; Margriet Straver: research assistant, for processing the conversations;

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**Ethical approval:** The study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO-nr.2002/275

**References**

Changes in women’s situation after disclosure of partner abuse


“The pain separated into aching limbs and muscle ....

.... Tut-tut-tut and another prescription. More pills to wash down. There was sometimes no food in the house but there was always valium.”

“The woman who walked into doors”. By Roddy Doyle
Abused women’s utilisation of health care
A descriptive study on medical records in family practice

SH Lo Fo Wong
F Wester
SSL Mol
R Römkens
ALM Lagro-Janssen

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Abstract

Background: Female patients, abused by their partner, are heavy users of medical services. To date, valid predictive characteristics of partner abuse of women are lacking.

Aims: To outline abused women’s healthcare utilisation in family practice and compare this to the general female population in family practice.

Design: As part of a primary study on the role of family doctors in recognising and managing partner abuse, we performed a retrospective study. We collected data from abused women’s electronic medical records, in anonymised form, over the period: January 1, 2001 – July 1, 2004. We compared part of these data to those from the general female population in family practice of the Second Dutch National survey in General practice 2001 (DNSGP-2).

Setting: Family Practice in Rotterdam and surrounding areas in 2004.

Methods: We compared the number of consultations and prescriptions for pain-medication, tranquillisers and antidepressants of abused women (n=92) to those of the female population of the DNSGP-2 (n=210,071). We described presented health problems and referrals of the studied group.

Results: Pain, in all its manifestations, appeared to be the most frequently presented health problem. Compared to the female population of the DNSGP-2, abused women, in all age categories, consult their family doctor almost twice as often and receive seven times more prescriptions for pain-medication.

Conclusion: A doubled consultation frequency, chronic pain and an excessively high number of prescriptions for pain-medication are characteristics of health-care utilisation of abused women in our study. These findings may contribute to the validation of a set of characteristics to suspect partner abuse in family practice.

Keywords:
Intimate partner abuse; women; health-care utilisation; family medicine; electronic medical record

How this fits in:
- Intimate partner abuse is a highly prevalent problem in family practice.
- Abused female patients are seldom recognised as such by their family doctors.
- Earlier studies report that women, abused by their partner, are heavy users of medical facilities.
- Valid characteristics of partner abuse, for application in family practice, need to be developed.
**Introduction**

Increased health problems in abused women, such as injury, chronic pain, gastrointestinal and gynaecological complaints, depression and post-traumatic stress disorder are well documented by controlled research in various settings.\(^1\text{-}^\text{10}\) In estimates on the ‘burden of disease’ it is emphasized that intimate partner violence has wide-ranging and persistent effects on women’s physical and mental health. Abused women visit health care providers more often and use more medication than comparable women.\(^11\text{,}12\)

Injury appears not to be a major predictor of partner abuse in women who visit health-care institutions. All the more, earlier studies indicated that mental health problems, undefined somatic symptoms and chronic unexplained pain in female patients, are related to partner abuse.\(^9\text{,}13\text{,}14\)

However to date, specific and sensitive characteristics to suspect partner abuse in a female patient have rarely been studied. Too little is known of how often abused women present either mental health problems or somatic complaints in family practice. Increased identification of abused women could lead to more adequate and effective care for patients. Knowledge of abused women’s actual healthcare utilisation in family practice, should contribute to the development and validation of the concept of the ‘symptomatic’ abused female patient.

Our objective was to outline abused women’s healthcare utilisation in terms of consultation frequency and prescription rates and compare these outcomes to the female population of the Second Dutch National Survey in General Practice, 2001 (DNSGP-2). Our first aim was to find out where abused women differ from the general female population in family practice. Our second aim was to describe characteristics of health-care utilisation in terms of presented health problems and referrals of abused women.

**Method**

**Definitions**

In accordance with the literature we defined intimate partner abuse as physical, sexual, emotional or psychological abuse by a partner.\(^15\) In our study we focused on women, abused by a male partner. Healthcare utilisation in this study incorporates documented consultations with the family doctor, prescriptions and referrals. Health problems are represented by all complaints and disorders, as described in the electronic medical record. (EMR)

**Study design, data collection**

We collected electronic medical records in print of female patients abused by an intimate partner. This study is part of a primary study on the effects of training on recognition of intimate partner abuse in female patients in female patients, performed...
in Rotterdam and surrounding areas (Netherlands) in 2003.\textsuperscript{16} In this study, 118 female patients either confirmed partner abuse in answer to a doctor’s question or spontaneously presented the abuse themselves. In June 2004, eight months after the intervention period had ended, we contacted all family doctors (n=41) who identified and reported abused women, and asked them to dispense as many as possible, anonymised, medical records in print regarding the abused women. We requested data over the period: January 1, 2001 – July 1, 2004. The medical records were coded with a patient’s study number and previously registered electronic file number. Thirty-two family doctors (78\%) cooperated in the present study and they delivered 92 anonymous medical files. Noted reasons for non-cooperation were: the doctor was on a holiday, the patient had moved, too much work and reserves in dispensing even anonymised information.

We collected: number of doctor-patient consultations, all prescriptions, types of complaints/disorders, referrals, demographic data, health-care insurance and length of period enrolled in practice. We had no information on income, education and employment, for these are not recorded in the EMR.

We compared our data on the number of consultations and prescriptions to those of women from the Second Dutch National Survey in General Practice, 2001 (DNSGP-2).\textsuperscript{17} This prospective study (n=415,983), delivered a broad range of data on diseases and health-care utilisation in the Netherlands and guarantees a nationwide representativeness. This survey enables us to compare the studied characteristics of abused women to those of the general female population in family practice in the Netherlands. Although the DNSGP-2 age categories differed slightly from those of our study, we judged that the differences were minimal. (Age-categories of the DNSGP-2: 15-24, 25-44 and 45-64; our study: 18-25, 26-45, 46-65)

For study design See figure 1.

**Data processing**

We focused on the most frequently prescribed medication groups, as reported by earlier studies, namely: pain-medication, tranquillisers, antidepressants and gastro-intestinal medication.\textsuperscript{3,5,13} Complaints and disorders from the EMR were converted into International Classification of Primary Care (ICPC) codes by the research assistant. In case the doctor had already coded the complaint/disorder (reason of encounter), this code was accepted. As referrals, unlike the other items, were not documented systematically, we will report on whether a woman was referred at least once for: a diagnostic test, to a specialist, a physiotherapist, a mental health care institution/social worker or abused women’s shelter or support services in the observed period. Interventions for preventive health-care (pap-smears, mammograms) were excluded. Following this procedure, the research assistant recorded all data on a registration form and next into an SPSS file.
Figure 1 Design

Abused women’s utilisation of health care

Possible bias of the sample
To assess whether our sample presented a selected population of abused women, a possible bias of our study design, we distinguished two disclosure groups:

- ‘Patient-initiated disclosure’: patient broached the abuse without a doctor’s question.
- ‘Doctor-initiated disclosure’: patient confirmed abuse in answer to a doctor’s question.

Patients were unaware whether their doctor did, or did not follow training. Information on type of disclosure was previously gathered at the time the doctor reported the patient to the researcher.¹⁶

Analysis
First we explored the data of the medical records with descriptive statistics (SPSS version 11.0) on number of consultations, prescriptions of painkillers, antidepressants, tranquillisers and stomach-abdomen medication, complaints/disorders and referrals. Next we compared the frequency of consultation and prescription rates for pain-medication and medication for the nervous system of our research sample to those of the female population of the DNSGP-2, with One-Sample T-test (SPSS).¹⁷ We were not able to compare our findings on gastrointestinal medication to those of the DNSGP-2, as prescriptions for the digestive tract, in the national survey, had been combined with those of the endocrine tract.

Regarding the reported figures on general practice contacts in this survey, 63.3% concerned exclusively doctor-patient consultations. We corrected the DNSGP-2 data.
for this percentage. To calculate the mean number of consultations per patient/year and mean number of prescriptions per patient/year of abused women, we corrected per patient for ‘period enrolled in practice’.

We explored the data on presented health problems and referrals with descriptive statistics.

Finally, we tackled the question whether our sample was biased as a result our study design. To assess the bias of this aspect of our study design, we compared both disclosure groups for demographics, consultation frequency, prescription rate and referrals with Independent Samples T-test in SPSS.

Results

Characteristics of the sample

For demographics of the research sample of abused women and all reported cases: see Table 1.

Table 1 Demographics abused women: study sample, total reported cases

<table>
<thead>
<tr>
<th>Age group</th>
<th>Study sample N=92 (%)</th>
<th>Total reported cases N=131 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25 yrs</td>
<td>14 (15.2)</td>
<td>21 (16)</td>
</tr>
<tr>
<td>26-35 yrs</td>
<td>29 (31.5)</td>
<td>42 (32.1)</td>
</tr>
<tr>
<td>36-45 yrs</td>
<td>27 (29.3)</td>
<td>38 (29.0)</td>
</tr>
<tr>
<td>46-55 yrs</td>
<td>14 (15.2)</td>
<td>19 (14.5)</td>
</tr>
<tr>
<td>&gt;56 yrs</td>
<td>8 (8.7)</td>
<td>11 (8.4)</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Study sample N=92 (%)</th>
<th>Total reported cases N=131 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch</td>
<td>38 (41.3)</td>
<td>52 (39.7)</td>
</tr>
<tr>
<td>Turkish</td>
<td>15 (16.3)</td>
<td>24 (18.3)</td>
</tr>
<tr>
<td>Moroccan</td>
<td>5 (5.4)</td>
<td>10 (7.6)</td>
</tr>
<tr>
<td>Surinam-Creole</td>
<td>5 (5.4)</td>
<td>6 (4.6)</td>
</tr>
<tr>
<td>Surinam-Hindustani (Asian)</td>
<td>12 (13.0)</td>
<td>17 (13.0)</td>
</tr>
<tr>
<td>Other Non-Western</td>
<td>7 (7.7)</td>
<td>12 (9.2)</td>
</tr>
<tr>
<td>Western</td>
<td>3 (3.3)</td>
<td>3 (2.3)</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>7 (7.7)</td>
<td>7 (5.3)</td>
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</table>

Urbanisation rate

<table>
<thead>
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<th>Urbanisation rate</th>
<th>Study sample N=92 (%)</th>
<th>Total reported cases N=131 (%)</th>
</tr>
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<tbody>
<tr>
<td>Very high</td>
<td>72 (78.3)</td>
<td>Unknown</td>
</tr>
<tr>
<td>High</td>
<td>9 (9.8)</td>
<td>Unknown</td>
</tr>
<tr>
<td>Moderate / Low</td>
<td>8 (8.7)</td>
<td>Unknown</td>
</tr>
<tr>
<td>Not urban</td>
<td>3 (3.3)</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Residential district

<table>
<thead>
<tr>
<th>Residential district</th>
<th>Study sample N=92 (%)</th>
<th>Total reported cases N=131 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wealthy</td>
<td>20 (21.7)</td>
<td>27 (20.6)</td>
</tr>
<tr>
<td>Mixed</td>
<td>21 (22.8)</td>
<td>33 (25.2)</td>
</tr>
<tr>
<td>Deprived</td>
<td>51 (55.4)</td>
<td>71 (54.2)</td>
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Enrolled in practice

<table>
<thead>
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<th>Enrolled in practice</th>
<th>Study sample N=92 (%)</th>
<th>Total reported cases N=131 (%)</th>
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<tbody>
<tr>
<td>&gt;3,5 yrs</td>
<td>68 (73.9)</td>
<td>Unknown</td>
</tr>
<tr>
<td>3 yrs</td>
<td>17 (18.5)</td>
<td>Unknown</td>
</tr>
<tr>
<td>2 yrs</td>
<td>7 (7.6)</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

The research sample is a good reflection of all reported cases (n=131).
Comparison of the sample to the general female population.

Consultation frequency

For comparison of consultation frequency of the abused women and the DNSGP-2 female patients: See Table 2.

Table 2 Comparison of mean consultation rate per patient/year between women in study group and national survey# (DNSGP-2)

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Study group</th>
<th>DNSGP-2 group</th>
<th>Sig. 2-tailed</th>
<th>Difference of the means 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages (18-65 yrs)</td>
<td>7.47 (6.5-8.4)</td>
<td>4.20</td>
<td>P&lt;0.001*</td>
<td>2.31-4.23</td>
</tr>
<tr>
<td>Youngest age group¹</td>
<td>5.03 (4.2-5.8)</td>
<td>3.35</td>
<td>p=0.001*</td>
<td>.87-2.50</td>
</tr>
<tr>
<td>Middle aged group²</td>
<td>7.79 (5.9-9.7)</td>
<td>3.99</td>
<td>P&lt;0.001 *</td>
<td>2.50-5.08</td>
</tr>
<tr>
<td>Oldest age group³</td>
<td>7.81 (4.8-10.9)</td>
<td>5.25</td>
<td>p=0.012 *</td>
<td>.74-5.26</td>
</tr>
</tbody>
</table>

Compared with One-Sample T-test (SPSS) * Significant

# Source: Second Dutch National Survey in General Practice 2001 (Utrecht, 2004; Vol. 2); all female patients: n=210.071

We compared the number of consultations per patient/year of the abused women (n=92) with the means of female patients in the DNSGP-2 (n=210.071) with a One-Sample T-test. Consultation frequency of abused women increases with age above the expected, and exceeds that of the DNSGP-2 women in all age-categories significantly (p<0.001).

Prescription rate

During the observed period, 84.8% of the women in our sample received one or more prescriptions for painkillers; 57.6% for tranquillisers; 54.3% for gastro-intestinal medication and 39.1% for antidepressants.

For comparison of the prescription rates for pain-medication and tranquillisers together with antidepressants of the abused women and the DNSGP-2 female patients: see table 3.

Pain-medication

In our sample, prescribed pain-medication was predominantly of the non-steroid anti-inflammatory group. The DNSGP-2, reported predominantly pain-medication of the non-steroid anti-inflammatory group for musculo-skeletal disorders. Women from our study sample received significantly more pain-medication than the average women in the DNSGP-2 (18-45yrs: p<0.001 and 46-65yrs: p=0.021). (See table 3)
Table 3 Comparison of mean of prescriptions per patient/year between women in study group and national survey \(⊕\) (DNSGP-2)

<table>
<thead>
<tr>
<th>Medication type / age groups</th>
<th>Study group ±</th>
<th>DNSGP-2 group</th>
<th>Sig. (2-tailed)</th>
<th>Difference of the means 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain-medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest &amp; middle aged group</td>
<td>2.010</td>
<td>0.303</td>
<td>P&lt;0.001 *</td>
<td>1.04-2.38</td>
</tr>
<tr>
<td>Oldest age group</td>
<td>2.041</td>
<td>0.601</td>
<td>p=0.021 *</td>
<td>0.24-2.64</td>
</tr>
<tr>
<td>Tranquil/ antidepressants#</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest &amp; middle aged group</td>
<td>2.111</td>
<td>0.743</td>
<td>p=0.058</td>
<td>-0.05-2.78</td>
</tr>
<tr>
<td>Oldest age group</td>
<td>3.534</td>
<td>1.788</td>
<td>p=0.109</td>
<td>-0.42-3.92</td>
</tr>
</tbody>
</table>

Comparison with One-Sample T-test (SPSS) * significant;  
\(⊕\) Source: Second Dutch National Survey on Diseases of General Practice (Utrecht, 2004; Vol. 2)  
\(∞\) We compared youngest & middle aged group from the DNSGP-2: 20-44yrs to our study group: 18-45yrs (n=70) and the oldest age group from the DNSGP-2: 45-64yrs to our study group: 46-65yrs (n=22);  
\(±\) Mean number of prescriptions per patient/year: corrected for period enrolled in practice;  # DNSGP-2: included all nervous system medication

**Tranquillisers and antidepressants**

In our sample we combined prescriptions for tranquillisers and antidepressants for comparison with the DNSGP-2. The DNSGP-2 provided only statistics of prescriptions for ‘all nervous system’, which incorporated also other than tranquillisers and antidepressants. Nevertheless we compared both groups. In the DNSGP-2, tranquillisers and antidepressants were ranked very high in the prescription top-10 for women. In our study sample, more tranquillisers and antidepressants were prescribed than in the average Dutch female population in family practice. The difference was however not significant (age 18-45yrs: p=0.058 and age 46-65yrs: p=0.109). (See table 3)

**Characteristics of healthcare utilisation of the sample**

**Presented health problems**

In this group of women, pain was far more often presented then mental health problems.

**Referrals**

Four women out of 92 did not receive any referral during the observed period of 3,5 years, whilst the large majority (85.9%) received more than one type of referral. For number of referral types: see table 4.
During the observed period 72 women (83.7%) received a referral for a diagnostic test; 55 (59.8%) to a specialist; 43 (46.7%) to a physiotherapist; 36 (39.1%) to a mental health care institution or social worker and 30 (32.6%) to an abused women’s support program or shelter.

**Table 4 Complaints/disorders: numbers of patients/percentages and referrals: number of types/percentages**

<table>
<thead>
<tr>
<th>Complaints/disorders: ICPC-codes</th>
<th>n=92 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relation-/abuse problems: Z12, Z25</td>
<td>56 (60.9)</td>
</tr>
<tr>
<td>Neck-back pain: L01,L02,L03,L83,L86</td>
<td>44 (47.8)</td>
</tr>
<tr>
<td>Abdominal pain: D01,D06</td>
<td>43 (46.7)</td>
</tr>
<tr>
<td>Stomach complaints: D02, D03, D09, D10, D87</td>
<td>43 (46.7)</td>
</tr>
<tr>
<td>Headache: N01,N02,N89</td>
<td>41 (44.6)</td>
</tr>
<tr>
<td>Depression: P03,P76</td>
<td>25 (27.2)</td>
</tr>
<tr>
<td>Hyperventilation: R98</td>
<td>16 (17.4)</td>
</tr>
<tr>
<td>Sleeping problems: P04,P06</td>
<td>16 (17.4)</td>
</tr>
<tr>
<td>Anxiety: P01 P74</td>
<td>12 (13.0)</td>
</tr>
</tbody>
</table>

**Referral types**

- No referrals 4 (4.3)
- Referrals
  - One type 9 (9.8)
  - Two types 29 (31.5)
  - Three types 31 (33.7)
  - Four types 14 (15.2)
  - Five types 5 (5.4)

**Comparison of the disclosure groups**

The abused women in our sample were partly reported by doctors who followed training on partner abuse. The trained group reported more cases of ‘doctor-initiated disclosure’ cases than other participating doctors did. The training aimed to increase recognition of abused women. In this sample, trained doctors brought in 67 patients and the untrained doctors 25. Thirty-three patients (35.9%) disclosed spontaneously (‘patient-initiated disclosure’) and 59 (64.1%) disclosed after the doctor had asked (‘doctor-initiated disclosure’). Comparison of the disclosure groups showed hardly any differences.

**Demographics**

Comparing demographics of the disclosure groups with the Independent Samples T-test, we found no significant (p > 0.05) differences for age-category, residential district or period enrolled in practice.
Health-care utilisation: consultation frequency, prescription rates and referrals

Comparing health-care utilisation of the disclosure groups with the Independent Samples T-test, resulted in only one significant difference (p=0.05). The ‘patient-initiated disclosure’ group had a higher proportion of diagnostic tests. No significant differences occurred between both groups, for the calculated means of consultation frequency and prescription rates and other referrals. See table 5

Table 5 Comparison of ‘patient-initiated disclosure’ group (n=33, 35,9%) and ‘doctor-initiated disclosure’ group, (n=59, 64,1%): age category; period enrolled; mean consultations #; mean prescriptions #; referrals.

<table>
<thead>
<tr>
<th></th>
<th>Patient-initiated</th>
<th>Doctor-initiated</th>
<th>Sig. 2-tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age category ±</td>
<td>3,0</td>
<td>2,54</td>
<td>0,07</td>
</tr>
<tr>
<td>Period enrolled ∞</td>
<td>1,27</td>
<td>1,37</td>
<td>0,46</td>
</tr>
<tr>
<td>Consultation frequency #</td>
<td>8,54</td>
<td>6,88</td>
<td>0,10</td>
</tr>
<tr>
<td>Prescriptions pain-medication</td>
<td>2,34</td>
<td>1,84</td>
<td>0,41</td>
</tr>
<tr>
<td>tranquilisers</td>
<td>2,06</td>
<td>1,43</td>
<td>0,50</td>
</tr>
<tr>
<td>antidepressants</td>
<td>0,58</td>
<td>0,09</td>
<td>0,43</td>
</tr>
<tr>
<td>gastro-intestinal</td>
<td>1,12</td>
<td>1,20</td>
<td>0,98</td>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic *</td>
<td>0,94</td>
<td>0,78</td>
<td>0,05 *</td>
</tr>
<tr>
<td>specialist</td>
<td>0,70</td>
<td>0,54</td>
<td>0,15</td>
</tr>
<tr>
<td>physiotherapist</td>
<td>0,36</td>
<td>0,53</td>
<td>0,36</td>
</tr>
<tr>
<td>mental health</td>
<td>0,45</td>
<td>0,36</td>
<td>0,14</td>
</tr>
<tr>
<td>women’s shelter</td>
<td>0,39</td>
<td>0,29</td>
<td>0,30</td>
</tr>
</tbody>
</table>

Compared with Independent Samples T-Test (SPSS); * Significant; ± age category: 1=18-25, 2=26-35, 3=36-45, 4=46-55, 5=56-65yrs; ∞ period enrolled in practice 1≥ 3,5yrs, 2=3yrs, 3 2yrs # consultation frequency: corrected for period enrolled in practice

Discussion

Summary of main findings

Compared to an average female patient in family practice, abused women’s pattern displays an almost double number of consultations together with a seven-fold use of pain-medication in all age categories. This striking picture of increased healthcare utilisation by abused women appearing from this study is alarming. A recent study in New Zealand in 2004, executed with a different design, concluded almost the same numbers for pain-medication.5

There is a high prevalence of pain in all categories: neck-back pain, headaches, abdominal- and stomach-ache. Frequent consultations for pain, seems to be a major indicator of partner abuse. Mental health problems as depression, anxiety and sleeping disorders are less frequently reported.
Pain asks for relief and abused women apparently receive prescriptions for painkillers from their family doctors far more often than average female patients. Not surprisingly almost one out of two women has been referred to a physiotherapist at least once. Although two-thirds of the abused women had social problems and one third presented mental complaints, often together with undefined physical complaints, referrals to mental health-care or social work stayed far behind those to somatic health-care, whereas shelters or support programs for abused women were the least to be referred to. One explanation for this discrepancy is that abused women who seek care predominantly for unexplained somatic complaints mostly remain unidentified and thus receive more often medical care instead of referrals to manage their abuse situation.

The pattern of an abused woman, in family practice, appears to be: one who consults her doctor twice as often than the average for unexplained chronic pain and one who is a heavy user of painkillers. Being often referred to a physiotherapist and for diagnostic tests should also ring a bell. Considering her experience with partner violence, the abused female patient seems to consume a lot of ineffective medical care.

**Comparison with existing literature**

Chronic undefined pain and an increased use of medical services are highly present in abused female patients. This is a finding of earlier studies, using self-report patient questionnaires.\(^{11,13,14,18}\) In this respect, our study confirms these findings and supplies them with evidence from the abused female patient’s medical record. Abused women are known to rather present physical or mental symptoms than disclose, and usually remain unidentified.\(^{5,14,19}\) One study that used medical records to review health-care utilisation of abused women (n=62), enrolled in a Health Maintenance Organisation, found a 1.6 higher rate of medical visits and a 1.6 higher estimated costs.\(^{20}\) In spite of the different health-care system, these outcomes approximate our findings.

**Strengths and limitations of the study**

The strength of our study lies in the fact that we were able to compare characteristics of our sample of abused women to the average female population as provided by the nationwide representative survey: the DNSGP-2. The cooperation of the family doctors, who provided a large amount of anonymous data of abused women, of whom we knew how the disclosure took place, was of great importance. The electronic medical records provided the opportunity to seek anonymously for characteristics of presented health problems and prescriptions. This would have been far more laborious and inaccurate with records in paper.
Moreover, our findings corresponds with those from other studies with different designs and provided evidence from abused women’s medical records.\textsuperscript{1,5,11,14,21} Our study was limited by the retrospective design. Therefore, we were unable to retrieve more accurate data on referrals, which is an important aspect of health-care utilisation. We also acknowledge that the health-care system in the Netherlands, which is equally available and accessible to the entire population, may possibly create utilisation that cannot be generalised to healthcare systems with a different design.

Another limitation is that we have investigated abused women’s health problems and use of medical facilities as part of an intervention study and risked bias. However, we were able to tackle this question by comparing disclosure groups and found no meaningful differences between both disclosure groups. Whether bias of improved communication skills of the participants played an important role in inducing more spontaneous disclosures, remains unanswered in this study.

**Implications for clinical practice and research**

To date there are no valid characteristics of intimate partner abuse.\textsuperscript{22} We think that our study, comparing the abused female patient to the average female patient, provided useful information, for further development of these indicators. A female patient with an increased consultation frequency and a high use of pain-medication can be viewed as ‘symptomatic’ for partner abuse and should actively be questioned by their family doctor about partner violence to prevent further inappropriate care.

To achieve a clearer view of abused women’s health problems and health-care utilisation after disclosure, a larger prospective study, following a cohort of women who disclosed partner abuse, is needed. In the meantime we suggest incorporating the evidence in educational programs on chronic pain and somatisation disorder in order to reach a broader group of physicians. We strongly advise to use these characteristics for selective questioning of female patients and subsequently case-finding of intimate partner abuse in family practice.

**Conclusion**

The high use of healthcare of abused women, as expressed in an increased consultation frequency for chronic pain and a very high prescription rate for pain-medication, no doubt should alert all family doctors. Doctors, who recognise this female patient, can no longer avoid asking about partner abuse. It is a first step to facilitate disclosure and enables more appropriate and effective care for abused female patients.
Acknowledgements
We wish to thank all 32 participating family doctors for their generous cooperation in providing so meticulously the anonymous data; Margriet Straver, research assistant, for contacting the participating doctors and for processing the data. Hans Bor, statistician (IVES, Radboud University Medical Centre) for statistical advice; Jan-Marc van Dam (Chelmsford, UK) for English language corrections.

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Conflict of Interest: No one of the five authors has declared a conflict of interest.

Ethical approval: The study was undertaken with the consent of the ethical committee of the University Medical Centre St Radboud: Commissie Mensgebonden Onderzoek, region Arnhem – Nijmegen, CMO-nr.2002/275

References
“…. She has holes in her heart that never stop killing her. She sometimes think that she has cancer;...She isn’t too fond of herself but she isn’t so certain that she is stupid any more. She manages. She is a survivor.”

“The woman who walked into doors”. By Roddy Doyle
Overview of the study
In the previous chapters we presented the results of our study on the role of family doctors regarding intimate partner abuse in female patients. The general design consisted of one principal study and six others, grouped around this one. In this last chapter we will discuss our main findings and link the separate studies to each other. We will also discuss methodological considerations, the implications for medical education and daily practice. Next we will formulate a final conclusion.

The study aims:
- to improve our understanding of family doctors’ barriers in identifying partner abuse
- to develop tools to overcome these barriers
- to investigate whether these tools improve doctors’ awareness and identification of partner abuse (primary study aim)
- to improve our understanding of the significance of disclosure to identified abused women.

To achieve these aims we investigated seven main research questions.
As we presented all studies independently (chapter 2 to 8), we will link the main findings in the following section.

Main findings

Family doctors
Training on partner abuse is effective
The general consensus that educating family doctors on partner abuse has limited effects on improved case finding of abused female patients, has been refuted.\(^1-3\) Our 1,5 day training was successful in increasing awareness and identification of partner abuse, up to 4.5 times. The trained doctors’ abilities to ask about abuse have significantly changed. Moreover, it was clear from the interviews with identified female patients that doctors should ask. It was striking to find that only three women went to see their doctor to disclose the abuse and the other 33 (92 %) had talked mainly because their doctor had asked. Women wanted to be asked. From the medical records study it became also clear that family doctors had been seeing these women almost twice as often than the average female patient.

To realise an effective training we provided an appropriate mix of education methods. The training was set up to address participants’ actual questions, frustrations and knowledge gaps, at various levels and in an optimal educational setting. Small-group teaching to enhance quality must be considered as a success factor in this respect. (Appendix 1b) Our program differed from other educational programs presented in the literature, in its extensive attention to both attitudes and consultation skills practising at the level of real experienced professional barriers. However, the duration of the training will meet resistance as family doctors prefer brief courses.\(^4\)
Doctors’ barriers often originate from persistent prejudices, resistance to deal with partner abuse and a substantial lack of knowledge.\textsuperscript{5} Lectures on theories about partner violence and epidemiological data do not change a doctor’s daily routines. Consultation skills-training does change doctors’ abilities to ask about abuse. Nevertheless, this would not have been successful, had we not addressed resistances in their views and attitudes. We are convinced, the training program needed to educate about recognition and responding to intimate partner abuse, takes at least 1.5 day.

**Characteristics of partner abuse**

Our study added new findings to the limited data on valid indicators of partner abuse. The abused women’s medical records showed a doubled consultation frequency in all age-categories and a seven-fold prescription rate for pain-medication. Pain, in all its manifestations outnumbered mental complaints and disorders. With these finding we were able to support surveys on healthcare utilisation of abused women, with evidence from medical records. This type of study, comparing the group of abused women to the average population of female patients in family practice, had not been done before and revealed remarkable differences.\textsuperscript{6-11} These results will enable us to provide a valid set of ‘key-features’ to recognise partner abuse. In addition we found that the trained doctors have been using these characteristics successfully as they suspected abuse more often in case of non-obvious signs. These characteristics support the concept of the ‘symptomatic’ woman and are of interest to family medicine, as well as to abused women.

**Family doctors’ perspectives: gender differences**

The conflicting findings from earlier studies, regarding the role of doctors’ gender in managing partner abuse, were the primary reason to study this issue more extensively.\textsuperscript{12-14,15-17} Some of the male doctors held views, like blaming women for their partner’s violence because of the denial of sexual relationships, that are in conflict with an appropriate response to the abused female patients and need to be tackled during training. From the interviews with abused patients we discovered that many women had suffered from physical as well as sexual abuse. To encounter a doctor with the above mentioned views, will certainly do harm.\textsuperscript{5,18} It is also worrying to find so many female doctors who restrict their availability for difficult cases (like partner abuse), due to the distress it brings about. The finding that many female doctors who reported a more active management (seeing more abused patients in shorter working hours), rated their own abilities to address partner abuse lower, was unexpected. This raises the question whether the assessment criteria of male and female doctors, differ at this point. One of the possible explanations may be a doctor’s socialisation, for women characterised by social involvement, oriented
towards others and the need to be appreciated.\textsuperscript{19} Whilst male socialisation aims at controlling situations, self-orientation and competition. This may explain female doctors' more active involvement and experience of uncertainties. It is also possible that the discrepancy between male and female doctors stems from a different group of abused female patients (regarding severity and complexity) in their surgery. Nevertheless, balancing emotional involvement and professional performance should be targeted in educating female doctors. For male doctors it is important to realise the effects of humiliation and abuse in order to respond appropriately and empathetically to disclosure. For that matter, it was most encouraging to find most doctors express so much benefit for daily practice from the training, beyond the obvious identification rates of the RCT.\textsuperscript{20}

In the first and second interview study it became clear that most women were living with their children at the time they were abused, some even from their first pregnancy on. Like in earlier studies, we also found that children exposed to partner abuse developed health and behavioural problems.\textsuperscript{21-23} On numerous occasions the women whom we interviewed, mentioned the suffering of their children as a result of the abusive situation. Family doctors are one of the important professionals to whom the mother will turn to in order to seek help and discuss these problems. In this respect, the finding that male doctors' seem to overlook the situation of children as witnesses of the abuse is a real problem.

That abused women would prefer to talk to a female doctor about their situation was not supported by the women's interviews. Talking with female patients about challenging subjects like partner abuse should not become a female doctor's specialty. First of all, the majority of patients do not have a choice on doctor's gender. Secondly, it did not seem to matter to interviewed women, providing that a doctor's response is helpful and not prejudiced.

\textit{'Attitudes towards partner abuse' scale}

All family doctors in our study had high scores on the scale regarding a facilitating attitude towards abused female patients. However, the significant changes which doctors showed after training were unmistakably supported by the outcomes of the RCT.\textsuperscript{24,25} The usefulness of developing this new and short instrument to measure the effects of training on partner abuse, is hereby substantiated. The instrument provides one main dimension regarding a facilitating attitude, which is important in addressing partner abuse. During a visit in which an abused female patient is willing and ready, yet reluctant to disclose and waits to be asked, a facilitating attitude will make the difference.\textsuperscript{7,26-28}
General discussion

Abused female patients
Women’s experiences
During the interviews most women grasped the chance to narrate about their abuse history as well. At times the interviews with abused women were very moving and the interviewers, both experienced and trained middle-aged women reported the need to debrief to the primary researcher. This underlines the validity of the collected information.

The recommendation from earlier studies, to break through denial was also heard in the interviews.29,30 Doctors in general report that they feel powerless in assisting abused female patients and therefore refrain from asking.5,31 The interviewed women fully trusted their doctor and therefore so many unplanned disclosures must have occurred. This underlines a family doctor’s advantageous position in discussing partner abuse. On the whole, the interviewed women assessed the visit to their doctor as very meaningful. The emotional distress some women experienced was not seen as a reason for refraining from asking. Doctors largely underestimate the influence they have just by listening empathetically, providing validating remarks and by empowering a woman in stimulating her to act.26,29 Affective communication helps patients with difficulties to express themselves. In teaching consultation skills, the value of empathetic and empowering responses should be discussed and practiced profoundly.

Changes in handling the abuse
The distinction we made in women’s position in handling the abuse situation after disclosure was not used in earlier studies. In analysing the interviews we introduced the categories: ‘in transition’ and ‘locked-up’ to illustrate a woman’s state at this point. The contrast between both positions was manifest and only few women could not be allocated to either one of them.

From the interviews we learned that facing one’s situation after having disclosed the abuse was more-or-less unavoidable and appeared to be very confronting.26 Disclosure to the family doctor opens up an important possibility for change in an abused woman’s life. Two-thirds of the interviewed women were found ‘in transition’ and heading for change one year after disclosure. However, disclosure does not always lead to change and in this respect facilitating women to talk is not enough.

Taking into account that these women visit their family doctor twice as often as the average patient, partner abuse should be viewed as a serious chronic condition. The fact that children who witness partner abuse will be harmed, should be taken into account. Abused patients and their children should be monitored to some extent, to keep up with developments that will need an intervention.

In the focus groups both male and female doctors emphasised that women mostly remained in their powerlessness, which limited a doctors’ ability to intervene.5 This
view was countered by the two thirds of the interviewed women who changed their situation within one year.

Only the eight women (one-third) who were categorised as ‘locked-up’ the year after disclosure, resemble the general image of abused women: out of control, powerless and reluctant to act.

Our study differs from Zink’s et al’s study who reported about the process of change in abused women, living in shelter homes or participating in support programs. The method of intentionally enrolling abused women in family practice, shortly after disclosure, to gain information about their expectations and experiences, was not found in earlier studies.

All identified women visited their doctor because of a medical complaint or condition. Finally, women who experienced control over their life again, felt a lot healthier and their chronic complaints seemed to have disappeared the year after. This confirms that talking to a trusted family doctor, who responds appropriately, does matter considerably.

**Screening versus case-finding**

In the debate between proponents for routine inquiry and those who recommend selective questioning of ‘symptomatic’ women, we choose for the latter. Advocates for routine inquiry argue that selective questioning and the ‘pattern of symptoms’ does not lead to improved recognition of abuse. Our study clearly proofs otherwise. The identification of and response to abused female patients should be done in a safe and appropriate manner and this requires education in this area.

**Methodological considerations of the study design and recommendations for further research**

**The effects of the training**

The fact that mostly doctors interested in the subject signed up, and yet showed a significant improvement leads to the assumption that training of a general population of family doctors, should yield even more striking results.

Review of the needs for education among the general population of family doctors, CME and training institutes in family medicine, will probably lead to the desire for shorter courses. Inevitably the goals and effects of a brief training are limited. However, we argue that an effective training program will need at least 1.5 days. Future research should investigate the optimal way to implement education on partner abuse in CME and training institutions for family medicine.

**Attitudes scale**

In search for instruments to assess the effects of education, the ‘attitudes towards partner abuse’ scale is most promising. However, as the scale was tested among a
sample of doctors, interested in the subject, it should be developed further and evaluated at a more extensive level in future research. It remains uncertain to what extent the respondents gave socially desirable answers. A follow-up study should investigate this aspect in addition to the validation of the scale. Our present study with a rather small sample yielded in one dimension: a facilitating attitude towards abused female patients. A validation study with a larger sample may lead to more dimensions.

**Focus on gender differences**
The usefulness of focusing on gender differences is often disputed. Nevertheless, the findings in our qualitative study on this issue are unambiguous. Yet no significant gender differences were found in the quantitative studies (RCT and attitudes scale). Qualitative studies and especially focus groups will reach more in-depth understanding of views, experiences and reasoning while surveys remain more superficially about these topics but enable a more accurate comparison of individual data. The different findings on gender-effects, calls for further research. Perhaps an even more profound statistical analysis of the data will provide more insight on whether gender was an effect modifier. Another more in-depth assessment, using a simulation patient, may answer more accurately the question on actual differences in doctors’ performances in the surgery.
The main gender differences that were found regarding the doctors’ perspectives should be studied further in a survey among a larger sample. As for training, we recommend investigation of the possibility that different training programs be offered to male and female doctors in the future.

**Interviewing abused female patients**
The method of interviewing women, who consented to participate after they were asked by their own family doctor, may be disputed. An already existing good relationship with the doctor must be taken into account in our findings. Practically all women positively valued the doctors’ responses. On the other hand, previous studies enrolled women from support programs, representing also a selective population, and their recommendations fit our findings.
Our choice not to record the interviews but to have the interviewer write down summaries and quotes may be questioned. This procedure inevitably led to some loss of information. However, one of the interviewers participated in the analysis of the material and through this procedure the quality was enhanced. Recording conversations with currently abused women, whilst safeguarding trust at the same time, remains a difficult issue.
Altogether, it is a challenge to perform further investigations among an broader population of abused women who have disclosed abuse to their family doctor and
follow these women over time. Enrolling a mix of abused women through media, support agencies, waiting rooms and other healthcare providers could lead to new findings.

**Abused women’s utilisation of healthcare**

As a result of the retrospective design, the findings in the medical records study were limited. We were able to study major aspects of women’s healthcare utilisation, however it was impossible to obtain a complete picture of all determinants. A prospective design, following a cohort of identified abused women, analysing their healthcare utilisation before and after disclosure, will shed more light on this matter. The significance of such a study lies in the validation of the concept of the ‘symptomatic’ abused women in order to increase recognition of and appropriate care for these patients.

**Recommendations for medical curriculum, guidelines, research and family practice**

Integration of domestic/family violence, in all its manifestations, as a topic in the medical curriculum is urgent. Curriculum units that cover chronic pain, somatising behaviour, mental complaints/disorders, child behavioural problems should include knowledge about family violence as a common background to these conditions. Professional training in family medicine should address family violence/intimate partner abuse extensively in their curriculum and integrate theories, attitudes and skills training regarding this topic. Family doctors are the most consulted healthcare providers when family violence is present, yet they often refrain from asking due to the reported barriers and lack of knowledge on the prevalence of partner abuse among their patients.

The system of Continuing Medical Education (CME) should be restructured to the point that family doctors include education on social and ethical issues in their mandatory retraining. Caring for all family members when violence is present is challenging and requires additional training for registered family doctors. Family doctors, who try to avoid addressing abuse, should no longer refrain from asking questions, considering the large extent in which they already encounter these patients in their surgeries. Referrals and monitoring in follow-up visits should be offered to women who have disclosed abuse. Following the developments may reveal negative health consequences for women and their children, requiring support and appropriate interventions.

**The Netherlands**

Medical associations, CME associations for family medicine, the scientific association for family physicians/general practitioners (NHG) and the primary care research
institution (NIVEL) have overlooked family violence/intimate partner abuse in their curriculum, guidelines and research programs. We recommend the organisations to put the issue on the agenda and inform their members on the importance of addressing family violence/intimate partner abuse in daily practice and the need to seek special training. We urge these scientific organisations in primary care and family medicine/general practice to include partner abuse and family violence in their research and guidelines program.

Other healthcare providers
Other primary care providers, midwives, physiotherapists as well as healthcare providers in preventive medicine should develop tools to recognise and respond to partner abuse. Finally also hospitals and clinical specialist have the responsibility to develop programs to raise attention among their providers to recognise and respond appropriately to an issue that affects many of their patients. In the literature we found initiatives of Primary Care institutions, Emergency Departments and Gynaecology and Obstetrics Associations in several countries, to formulate guidelines and protocols, which can be of use to others in this field. From the abused women’s interviews we learned that violence in pregnancy is common and routinely questioning of all pregnant women about possible abuse, is recommended.

Conclusions
In contrast to the literature, we conclude that educating doctors on partner abuse is effective. Our specific training to recognise and respond appropriately to abused female patients significantly changed doctors’ abilities to ask about and increased case-finding of partner abuse in daily practice.

We conclude that female patients, in whom partner abuse is suspected, should be asked. Empathy and empowerment in response to disclosure of abuse will be helpful to a considerable number of identified patients and change their situation or otherwise support them in coming to terms with their abusive history. Nevertheless, onetime asking is not enough. Abused women and their children should be offered follow-up visits in order to keep up with developments that will require an intervention. Finally, we reached more in-depth understanding of family doctors’ barriers to identify partner abuse. We found remarkable differences between male and female regarding views and practices on this subject. The role of sexuality in partner abuse, overlooking children as witnesses, emotional involvement with and availability for abused patients, views on leaving an abusive relationship and practices in responding to abused women represent main differences. The possibility that different training programs be offered to male and female doctors in the future requires further investigation.
Epilogue
What ever happened to Mrs.K.?
After having dressed her wound, I prescribed the necessary antibiotics and invited her back for a lengthy visit at the end of the day. We talked about the many years of violence she endured and about the toll for her children. She felt guilty all the time and had tried to prevent as many violent assaults as possible. She had never revealed her abuse situation when seeking relieve for her pain complaints because she was too embarrassed. Talking had helped her to reflect on her situation and face her chronic pain complaints and depressive moods as a manner of coping with the abuse.

I never got to know her ex-husband, as he was not a patient in my practice. The year after, she finally succeeded to cast off her ex-husband and moved to a new home. Her medical visits for chronic pain complaints had declined to a minimum. Her pains disappeared and she did not use any painkillers nor tranquillisers. In stead she worked full-time and enjoyed her new position in society. She was proud of her sons who were doing well in their education and supported her. It is known that men who witness the abuse of their mother have a chance of one to three to abuse their partner also.

Her youngest child was a daughter. The year after all had settled down, this girl visited me. She had to quit her education due to difficulties to concentrate, caused by sleeping problems. The years of violence in the home and the isolated position of the family had affected her. I had to refer her to a psychologist. Witnessing the abuse of her mother for years, her chance to end up with an abusive partner is one to three.

Recently, when I saw Mrs.K. to ask her consent to narrate about her story, we looked back on this period. She had clearly changed into a self-confident and cheerful woman, who now in turn, helped many others to find the strength to change their abuse situation. Her children were grown-up, living on their own and doing well. I wonder what the future holds for these young people…
References


Chapter 10

Summary / Samenvatting
Summary

Chapter 1  Domestic violence mostly affects women and children. Referring to domestic violence against women, the term ‘intimate partner abuse’, ‘intimate partner violence’ and ‘partner abuse’ are used interchangeably. This type of abuse is acknowledged worldwide as a serious issue and responsible for increased health problems. Abused women seek help from their family doctor, on a large scale, with vague complaints or injuries. At the same time it is known that women are too often reluctant to disclose the abuse to their doctor. Although partner abuse is a crime, ‘blaming the victim’ is still a common social reaction. Family doctors have an important role in recognising abused female patients but largely fail to identify abuse in female patients as a background to their complaints. To date, fear of opening ‘Pandora’s Box’ is widespread among family doctors.

Intimate partner abuse is defined as: all acts that inflict physical, sexual, emotional or psychological well-being and the exertion of power and control by a (ex-) partner. The study was executed in the Netherlands (Rotterdam) where no earlier studies had been performed on this issue in family practice. A population based survey in the Netherlands found a prevalence of 1 in 5 women to be ever abused by an intimate partner and 11% currently severely abused (Römkens, 1992). This figure is similar to surveys abroad.

This chapter provides an overview of studies performed in primary care clinics or family practice. The subject is studied from many angles, ranging from: prevalence of partner abuse among female patients in family practice, health consequences, screening instruments to identify partner abuse, family doctors’ and abused female patients’ perspectives.

Systematic reviews performed recently, together with national and international guidelines on domestic violence/intimate partner abuse, feed the lively debate between proponents for screening all women in family practice for partner abuse and those who recommend case-finding in ‘symptomatic’ abused female patients. Against the background of this debate we chose the latter.

The following study aims were formulated:

- To improve our understanding of family doctors’ barriers to identify partner abuse
- To develop effective tools to overcome these barriers
- To investigate whether these tools improve doctors’ awareness and identification of partner abuse (primary study aim)
- To improve our understanding of the significance of disclosure to identified abused women
To achieve these aims seven research questions were formulated and investigated with their own distinctive design:

1. Will a training program on partner abuse be effective in raising family doctors’ awareness and improve active questioning when partner abuse is suspected? (main study)
2. What are family doctors’ views, attitudes, experiences and practices, regarding abused female patients and does doctor’s gender really matter?
3. Is it possible to develop a short instrument to measure (prejudicial) views and attitudes towards partner abuse of family doctors?
4. In which ways does training on partner abuse affect family doctors’ attitudes, abilities and confidence, when dealing with abused female patients in daily practice?
5. What do women value most in disclosing partner abuse to their family doctor, and does it influence ways in handling the abuse situation?
6. What are the most important changes in abused women’s situation in the year after the disclosure?
7. Is it possible to discern characteristics or a pattern of healthcare utilisation of abused women in family practice?

The study design and methods are described separately for each research question.

In chapter 2 we present the results of the focus group study with the family doctors. Six groups, three male and three female, discussed views, attitudes, experiences and practices regarding partner abuse. The transcripts were analysed qualitatively by two independent researchers and in mutual discussion they formulated the central themes. The findings were discussed in the involved research group for final conclusions.

Part of the male doctors held women responsible for the abuse because of denial of sexual relationships. In contrast female doctors emphasised the danger of opposing to a partner’s sexual demands. Female groups talked about children as witnesses and in the male groups children were not mentioned. Female doctors restricted their availability for abused women due to the distress it brought about while male doctors only restricted their availability because of time constraints. Doctor’s gender in discussing partner abuse had not been investigated earlier to this extent and appears to be an important factor.

Chapter 3 describes the main study, a randomised controlled trial (RCT), investigating the effects of a one and a half day training on recognising and responding to abused female patients. The training was specially designed for the main study and incorporated the results of the focus group study. Fifty-four family doctors participated in the RCT. At first participants were divided into strata (gender-
district-practice type), next they were randomly assigned to one of the three study groups: a ‘full-training’ group, a ‘focus group-alone’ group and a control group. The primary effect-measure was the number of reported cases wherein partner abuse was discussed or suspected. The ‘full-training’ group reported 4.5 times more cases compared to the control group. The ‘focus group-alone’ group reported 2.2 times more cases compared to the control group.

The secondary effect-measure was the number of cases with non-obvious signs wherein a doctor suspected abuse. Comparison of the ‘full-training’ group to the untrained groups (‘focus group-alone’ and control) resulted in an odds ratio of 5.92 in the ‘full-training’ group, a significant effect.

This study shows that our training leads to increased awareness resulting in more active questioning and a rise in identification of female patients with ‘non-obvious’ signs of partner abuse.

Chapter 4 describes the construction of an ‘attitudes towards intimate partner abuse’ scale with 14 items. Feasibility, reliability and validity were tested. As a consequence of restricted views, prejudicial attitudes and lack of knowledge, family doctors, in general, fail to detect partner abuse in daily practice. The training proved to be the most influential factor to explain the respondents’ shift on the scale into a facilitating direction. The ‘attitudes towards partner abuse’ scale shows sufficient reliability (Cronbach’s $\alpha$: .74). To establish construct validity an adequate number of items were tested. Intelligibility and feasibility of the scale were pilot tested. This short scale is the first one to be tested in a randomised controlled trial. It provides a feasible and reliable instrument, able to measure progression on items that reflect common barriers to discuss partner abuse with a female patient in family practice.

Chapter 5 represents an evaluation of the ways in which the training on partner abuse had been affecting family doctors’ daily practice. A qualitative method was used and in-depth interviews were held with twenty randomly chosen respondents, ensuring equal numbers male and female. An interview guide was pilot-tested and the interviews were recorded. All interviewees had followed the training between 5 to 10 months earlier. Eighteen transcripts were analysed qualitatively. The interviews showed that the training greatly increased doctors’ awareness of partner abuse in female patients; criteria to suspect abuse and made them feel more confident and equipped to handle the problem. The training dealt with any questions and frustrations the doctors had before.

The male doctors expressed a greater level of confidence in their own abilities before training, compared to the female. Female doctors expressed more benefit from the training than male doctors did. The favourite method of education to male doctors was the role-playing while female doctors preferred more the lectures on theories of
partner violence and the diagnostic instrument. Female doctors considered partner abuse to be much more of a healthcare issue than the male doctors did.

**Chapter 6** presents the views and experiences of identified female patients with the disclosure of partner abuse to the family doctor and its role in handling the abuse situation.

From the 118 identified abused female patients, 86 women were asked by their family doctor to participate in the interview and 36 women gave their consent. Fear of the partner was an important reason for denial. The women were interviewed in-depth by one of two female interviewers, using an interview guide. The conversations were not recorded to ensure confidentiality. The notes were analysed qualitatively. Most women went to see their doctor for a medical/physical complaint and only three women had planned to discuss the abuse. The majority of the women valued the communicative approach with listening and asking questions about their situation. Part of the women valued mostly the instrumental/medical approach but wanted it combined with a communicative approach. In the communicative approach we distinguished an **empathetic approach** with showing concern, listening kindly and attentively together with emotional support and an **empowering approach** with doctors stimulating women to act, not treating them as a victim and offering directive support.

The greater part of the women perceived a real change in possibilities to handle the abuse situation after talking to their doctor. These women started to contemplate on real change or act and they appeared to be in a state we named: ‘in transition’. A smaller part did not perceive any change after the disclosure, seemed to be the captive of their partner/situation and appeared to be in a state we named: ‘locked-up’. Only few women reacted detached towards any change and appeared ‘reserved’.

Unplanned disclosure and talking about partner abuse to the family doctor mattered to women’s abuse situation.

**Chapter 7** presents the follow-up interviews with 25 women. The interviews were held between 8-12 months after the initial one. We categorised the abuse situation of the women at the time of the second interview and asked about the most important changes in their lives in the past period. Two-thirds of the women started or continued their process of change regarding the abuse situation and appeared: ‘in transition’, whilst one third of the women fell back or remained in a ‘locked-up’ position. Having received a doctor’s assistance or from a support agency, did not seem to matter in the latter cases. In the interviews it was discovered that many children suffered from the abuse situation, showing behavioural problems which needed treatment. Doctors should monitor both women and their children after disclosure of abuse.
Chapter 8 shows the results of a study on abused women’s healthcare utilisation in family practice. Of the 118 identified female patients we succeeded to retrieve (anonymised) data from 92 electronic medical records. Compared to an average female patient in family practice, abused women’s pattern displays an almost double consultation-rate together with a seven-fold prescription rate of pain-medication in the youngest and middle age-categories and three-fold in the oldest age-group. Pain, in all its manifestations, appeared to be the most presented health problem. The ‘symptomatic’ abused woman in family practice appears to be: one who consults her doctor twice as often than the average for unexplained chronic pain and using a lot of painkillers.

Chapter 9 discusses the main findings and conclusions of the study and links these studies to each other. Implications for daily practice and medical education are discussed.

In contrast to the general international consensus, we found that training family doctors to recognise abused female patients resulted in increased awareness and identification of abused women, especially those with non-obvious signs. In the focus group study we found differences between male and female doctors in their views and practices, regarding abused women. The post-training interviews with the doctors revealed that the training increased their suspicion criteria greatly and dealt with all questions and frustrations they had regarding the subject. Male and female doctors differed for the most valued part of the training and experienced benefit. A newly constructed 14-item attitudes scale, measuring family doctor’s (prejudicial) views pre and post-training, was tested. Trained doctors had moved significantly into a more facilitating direction.

Our study on healthcare utilisation of abused female patients showed an almost double consultation rate and a three- to sevenfold use of painkillers. Pain complaints by far exceeded depression, sleeping problems and anxiety.

Exploring abused women’s experiences with their family doctor revealed that most disclosures were unplanned. In spite of the fact that most women presented a physical complaint, the majority valued a communicative approach over the medical/instrumental approach.

After one year two-thirds of the women, interviewed for a second time, perceived a real change in their ability to handle the abuse situation. One-third experienced no change. The negative effect on children, witnessing the abuse for years, was often brought forward.

Onetime asking about abuse is not enough. Abused women and their children should be offered follow-up visits.
Conclusion
With this study we reached more in-depth understanding of family doctors’ barriers to identify partner abuse. A specific training, tailored to meet with these barriers, turned out to be effective in increasing recognition of abused female patients. We found remarkable differences between male and female doctors regarding intimate partner abuse.

The majority of the abused women valued the communicative approach of their doctor in the visit of the disclosure. Talking to the family doctor mattered to women in changing their abuse situation.
Hoofdstuk 1 Huiselijk geweld treft vooral vrouwen en kinderen. Bij vrouwen die mishandeld worden door haar intieme (ex-)partner worden de termen partnergeweld of partnermishandeling gebruikt. Dit type mishandeling wordt internationaal gezien als een ernstige aangelegenheid, verantwoordelijk voor een toename aan gezondheidsproblemen. Mishandelde vrouwen zoeken op grote schaal de hulp van hun huisarts met vage klachten of verwondingen. Het is ook bekend dat deze vrouwen meestal niet over hun geweldservaringen praten met de huisarts. Hoewel partnergeweld een misdrijf is, worden vrouwen veelal zelf verantwoordelijk gehouden voor het geweld dat tegen hen wordt gebruikt (‘blaming the victim’). Huisartsen, die een belangrijke rol kunnen vervullen in het herkennen van mishandelde vrouwelijke patiënten, missen grotendeels het partnergeweld als achtergrond van de gepresenteerde klachten. Tot nu toe leeft er veel angst onder huisartsen om “de doos van Pandora” te openen bij vragen naar mishandeling. De definitie van partnergeweld is: alle handelingen die schade veroorzaken aan het psychisch, seksueel en lichamelijk welbevinden. Ook het uitoefenen van macht en controle door een (ex-) partner valt daaronder.

Het onderzoek is uitgevoerd in Rotterdam. Niet eerder heeft een onderzoek over dit onderwerp plaatsgevonden vanuit de huisartspraktijk. Een grootschalig surveyonderzoek toonde aan dat 1 op de 5 vrouwen ooit te maken had met fysieke mishandeling door een partner en 11% maakte ten tijde van het onderzoek ernstig mishandeling mee. (Römkens, 1992) Dit komt overeen met de cijfers uit buitenlandse onderzoeken.

Dit hoofdstuk geeft een overzicht van studies die uitgevoerd zijn in de eerste lijn en de huisartspraktijk. Het onderwerp is vanuit vele gezichtspunten bestudeerd, uiteenlopend van prevalentie van partnergeweld onder vrouwelijke patiënten in de huisartspraktijk, gezondheidsgevolgen van mishandeling, screeningsinstrumenten en onderzoek vanuit het gezichtspunt van de huisarts en de vrouwelijke patiënt. Recent uitgevoerde systematische reviews en nationale/internationale richtlijnen voor het omgaan met partnergeweld vormen de aanleiding voor een levendig debat tussen voorstanders van het screenen van alle vrouwelijke patiënten op partnergeweld en diegenen die herkenning van ‘symptomatische’ vrouwen aanbevelen. Met dit debat op de achtergrond kozen wij voor de laatste invalshoek (case finding).

Doelstellingen van dit onderzoek:

- Het verbeteren van het inzicht omtrent de drempels van huisartsen in de herkenning van partnergeweld
- Het ontwikkelen van een effectief middel om deze drempels te overwinnen
- Het onderzoeken of dit middel de herkenning van partnergeweld door huisartsen verbetert
Het verbeteren van het inzicht in de betekenis van de onthulling voor mishandelde vrouwen die als zodanig herkend zijn door haar huisarts

Om deze doelen te bereiken zijn de volgende onderzoeksvragen geformuleerd:
1. Maakt een training in het herkennen van partnergeweld huisartsen bewuster van het onderwerp met als gevolg dat herkenning toeneemt?
2. Welke visie, houding, ervaringen en handelwijzen hebben huisartsen aanzien van mishandelde vrouwen en zijn en speelt de sekse van de huisarts daarin een rol?
3. Is het mogelijk om een korte vragenlijst te ontwikkelen waarmee gemeten kan worden welke de (bevooroordeelde) visies en houdingen van huisartsen zijn?
4. Op welke wijze beïnvloedt de training in het herkennen van partnergeweld de houding, de bekwaamheid en het vertrouwen van de huisarts in het omgaan met partnergeweld in de dagelijkse praktijk?
5. Wat vonden vrouwen het belangrijkste in het onthullen van de mishandeling bij de huisarts en welke invloed heeft dit op hun situatie gehad?
6. Welke zijn de belangrijkste veranderingen in de mishandelingssituatie in het jaar na de onthulling van het geweld bij de huisarts?
7. Is het mogelijk om bij mishandelde vrouwen kenmerken of een patroon te onderscheiden in het zorggebruik in de huisartspraktijk?

Het ontwerp van de studie en de onderzoeksmethode worden apart bij elke vraag beschreven.

In hoofdstuk 2 worden de resultaten van de focusgroepen met de huisartsen gepresenteerd. Zes groepen, drie mannelijk en drie vrouwelijke, discussieerden met elkaar over hun visie, houding, ervaringen en handelwijzen ten aanzien van partnergeweld. De transcripten werden door twee onderzoekers, los van elkaar, geanalyseerd op kwalitatieve wijze en in onderling overleg stelden zij de centrale thema’s vast. Hun bevindingen werden bediscussieerd in de begeleidingsgroep om de uiteindelijke conclusies te formuleren.

Een deel van de mannelijke huisartsen stelden vrouwen verantwoordelijk voor het geweld vanwege het weigeren van seks. De vrouwelijke huisartsen benadrukten daarentegen het gevaar dat de vrouw loopt indien zij seks weigert. In de vrouwelijke groepen werden de kinderen die het geweld aanschouwen besproken, dit gebeurde niet in de mannelijke groepen. Vrouwelijk huisartsen beperkten hun beschikbaarheid voor mishandelde vrouwen vanwege de stress die dit met zich meebracht terwijl mannen dat alleen maar deden als zij in tijdnood kwamen. De sekse van de dokter, in het kader van dit thema, is niet eerder zo specifiek onderzocht en het lijkt een belangrijke factor te zijn.
Hoofdstuk 3 geeft een beschrijving van het gerandomiseerde gecontroleerde onderzoek (RCT) waarmee de effecten gemeten werden van de training over partnergeweld. De training werd speciaal ontwikkeld voor deze hoofdstudie en hield rekening met de bevindingen van de focusgroep studie. Vierenvijftig huisartsen namen deel aan de RCT. De deelnemers werden eerst onderverdeeld in strata (groepen) naar: geslacht, wijk en type praktijk om vervolgens willekeurig toegewezen te worden aan een van de drie studiegroepen: ‘interventiegroep’, ‘mini-interventie groep’ (uitsluitend focusgroep als interventie) en de controle groep.

De primaire effectmaat was het aantal gemelde gevallen waarbij de huisarts partnergeweld vermoedde en/of besprak. De ‘interventiegroep’ rapporteerde 4,5 keer zoveel gevallen in vergelijking met de controle groep. De ‘mini-interventiegroep’ rapporteerde 2,2 keer zoveel gevallen in vergelijking met de controle groep.

De secundaire effectmaat was het aantal gevallen met onduidelijke signalen van mishandeling, waarin de dokter partnergeweld vermoedde/besprak. Vergelijking van de ‘interventiegroep’ met de ongetrainde groepen (‘mini-interventie en controle) resulteerde in een odds ratio van 5.92 in de ‘interventiegroep’.

Deze studie toont aan dat onze training tot een verbeterde bewustzijn van partnergeweld leidt en tot actiever doorvragen bij vrouwelijke patiënten met onduidelijke signalen die niet direct wijzen op mishandeling.

Hoofdstuk 4 beschrijft de constructie van een ‘attitude ten aanzien van partnergeweld’ schaal met 14 items. De toepasbaarheid, betrouwbaarheid en validiteit werden getest. Als gevolg van een beperkende visie, vooroordelen en gebrek aan kennis missen huisartsen mishandeling bij vrouwen in hun dagelijkse praktijk. De training bleek de meest invloedrijke factor in de verschuiving op de schaal in een faciliterende richting. De ‘attitude ten aanzien van partnergeweld’ schaal blijkt voldoende betrouwbaar (Cronbach’s α: .74). Om de construct validiteit vast te stellen is een adequaat aantal vragen getest. De begrijpelijkheid van de vragen en toepasbaarheid van de schaal werden in een pilot getest. Deze korte schaal is de eerste in zijn soort, getest in een gerandomiseerd gecontroleerd onderzoek. Het is een toepasbaar en betrouwbaar instrument waarmee bekende drempels om partnergeweld te bespreken gemeten kunnen worden.

Hoofdstuk 5 beschrijft de wijze waarop de training over partnergeweld de dagelijkse praktijk van de deelnemende huisartsen beïnvloed heeft. Een kwalitatieve methode met diepe interviews met 20 willekeurig gekozen huisartsen werd toegepast. Er werden evenveel mannelijke als vrouwelijke huisartsen geïnterviewd. Een lijst met onderwerpen werd vooraf getest in een pilot en de interviews werden opgenomen. Alle geïnterviewden hadden 5 tot 10 maanden eerder de training gevolgd. Achtten transcripten konden gebruikt worden voor kwalitatieve analyse. Uit de interviews
kwam naar voren dat de training de dokters veel bewustzijn had gemaakt van de mogelijkheid van partnergeweld bij vrouwelijke patiënten; hun criteria om dit te vermoeden waren toegenomen. De training bleek dokters meer vertrouwen gegeven te hebben en ze beter toegerust om met dit probleem om te gaan en alle bestaande vragen en frustraties opgelost.

Mannelijke huisartsen hadden al meer vertrouwen in hun bekwaamheid vóór de training dan de vrouwelijke. Vrouwelijke huisartsen gaven aan meer gehad te hebben aan de training dan de mannelijke. De mannelijke huisartsen toonden een voorkeur voor de rollenspellen als onderwijsmethode terwijl de vrouwelijke huisartsen de voordrachten over theorie over partnergeweld en het diagnostisch instrument meer waardeerden. Vrouwelijke huisartsen dachten dat partnergeweld een belangrijker gezondheidszorg thema was dan de mannelijke.

In hoofdstuk 6 worden de visie en ervaringen van de geïdentificeerde vrouwelijke patiënten met de onthulling bij de dokter beschreven en de rol die dit speelde bij het hanteren van haar mishandelingssituatie. Van de 118 geïdentificeerde vrouwen werden 86 gevraagd om mee te doen met een interview en 36 vrouwen stemden toe. Angst voor de partner was belangrijke reden om niet mee te doen. Er werden diepte-interviews gehouden met de vrouwen door een van de twee vrouwelijke interviewsters. Er werd gebruik gemaakt van een interviewgids. De gesprekken werden niet opgenomen om de vertrouwelijkheid te waarborgen. De antwoorden werden kwalitatief geanalyseerd. De meeste vrouwen gingen naar de huisarts voor een medische/lichamelijke klacht en slechts drie vrouwen waren van plan om de dokter in te lichten. Het merendeel van de vrouwen vond het belangrijkste dat de huisarts met hen communiceerde, luisterde en vragen stelde over hun situatie. Een deel van de vrouwen vond de medische/instrumentele aanpak het belangrijkste maar wenste dit gecombineerd met communicatie over haar situatie. In de communicatieve aanpak onderscheidde wij empathie, waarbij betrokkenheid getoond werd met een vriendelijke aandachtig luisterende houding in combinatie met emotionele steun. Daarnaast onderscheidden wij empowerment, waarbij de dokter de vrouw stimuleerde om te handelen, haar niet behandelde als een slachtoffer en haar richtinggevende hulp aanbood.

Het grootste deel van de vrouwen bemerkte een wezenlijke verandering in haar mogelijkheden om met de situatie om te gaan na het gesprek met de dokter. Deze vrouwen begonnen na te denken over verandering of hadden al stappen ondernomen en wij noemden haar positie: ‘in transitie’ (naar een nieuwe fase). Een kleiner deel ervoer geen enkele verandering na de onthulling en zij maakten de indruk de gevangene te zijn van haar partner/situatie, een positie die wij: ‘gevangen’ (in de situatie) noemden. Slechts enkele vrouwen reageerden afstandelijk ten aanzien van haar gepercepeerde mogelijkheden en zij werden ‘terughoudend’
genoemt. Een niet geplande onthulling en praten over het geweld met de dokter, bleek van belang voor de mishandelingsituatie van vrouwen.

**Hoofdstuk 7** beschrijft de vervolg interviews met 25 vrouwen. Deze interviews vonden 8-12 maanden na het eerste gesprek plaats. We categoriseerden de mishandelingsituatie van de vrouwen ten tijde van het tweede interview en vroegen naar de belangrijkste veranderingen in de tussenliggende periode. Tweederde van de geïnterviewde vrouwen was begonnen of ging voort met het veranderingproces in haar leven en bleek ‘in transitie’, terwijl eenderde deel terugviel of onveranderd in dezelfde situatie bleef: ‘gevangen’. Begeleiding door de huisarts of een hulpverleningsinstantie was niet van invloed op deze groep. Uit de interviews kwam naar voren dat veel kinderen te lijden hadden van de geweldssituatie en als gevolg daarvan gedragsproblemen vertoonden. Deze kinderen hadden daarvoor behandeling nodig. Huisartsen dienen zowel vrouwen als kinderen te volgen na onthulling van mishandeling.

**Hoofdstuk 8** bespreekt de resultaten van een onderzoek naar het zorggebruik van mishandelde vrouwen, in de huisartspraktijk. Wij slaagden erin om van 92 van de 118 geïdentificeerde vrouwen, (geanonimiseerde) gegevens uit de elektronische medische dossiers te verzamelen. Uit de vergelijking met de gemiddelde vrouwelijke patiënt uit de huisartspraktijk liet zien dat mishandelde vrouwen bijna tweemaal zo vaak de dokter consula teren. De jongste en middelbare leeftijdscategorie gebruikte zeven keer zoveel pijnstillers en de ouderen gebruikte drie keer zoveel. Pijn, in alle verschijningsvormen was de meest gepresenteerde gezondheidsklacht. De ‘symptomatische’ mishandelde vrouw blijkt dus bijna twee keer zo vaak haar huisarts te bezochten voor onverklaarbare pijnklachten en zij gebruikte veel pijnstillers.

**Hoofdstuk 9** bespreekt de belangrijkste bevindingen en conclusies van deze studie en brengt ze met elkaar in verband. Implicaties voor de dagelijkse praktijk en de medische opleiding worden besproken. In tegenstelling tot de algemene internationale consensus vonden wij dat het trainen van huisartsen, in het herkennen van partnergeweld, wel degelijk een verbetering oplevert. Vooral vrouwen met onduidelijke klachten, niet direct wijzend op mishandeling, bleken beter herkend te worden. In de focusgroepen vonden we dat mannelijke huisartsen en vrouwelijke huisartsen verschillen in visie en aanpak van het probleem. Uit de interviews met de huisartsen, enige tijd na de training, kwam naar voren dat de criteria om partnergeweld te vermoeden aanzienlijk waren toegenomen en dat alle vragen en frustraties,welke vooraf bestonden, opgelost waren. Mannelijke en vrouwelijke dokters bleken verschillende onderdelen van het programma het meest gewaardeerd te hebben. We testten een nieuw geconstrueerde schaal met 14 items, om de
attitude van artsen ten aanzien van partnergeweld te meten, voor en na training. De getrainde dokters bleken significant te verschuiven naar een meer faciliterende houding.

Onze studie over het zorggebruik van mishandelde vrouwen liet een bijna verdubbeling van de consultfrequentie zien en een drie- tot zevenvoudig gebruik van pijnstillers. Pijnklachten werden veel vaker gepresenteerd dan depressie, slaap- en angststoornissen.

Het exploreren van de ervaringen van vrouwen met haar huisarts, bracht aan het licht dat het overgrote deel van de vrouwen aanvankelijk niet van plan was om de dokter in te lichten. Ondanks het gegeven dat de meeste vrouwen een fysieke klacht presenteerde, had de meerderheid een voorkeur voor een communicatieve aanpak. Een minderheid prefereerde de instrumentele/medische aanpak.

Na een jaar bleek dat tweederde van de vrouwen die voor de tweede keer geïnterviewd werden daadwerkelijk een verandering ervoeren in hun situatie. Voor eenderde deel was er niets veranderd. De negatieve gevolgen voor kinderen, als getuige van het geweld, werd vaak besproken. Het is onvoldoende om eenmalig te vragen naar geweld. Mishandelde vrouwen en haar kinderen dienen verder gevolgd te worden.

**Conclusie**

Met deze studie hebben we een diepgaander inzicht verkregen ten aanzien van de drempels die huisartsen ervaren in het herkennen van mishandelde vrouwen. Een training die speciaal ontwikkeld was en zich richtte op het beslechten van deze drempels, bleek effectief. Er bleken opmerkelijke verschillen te bestaan tussen mannelijke en vrouwelijke huisartsen ten aanzien van partnergeweld. De meerderheid van de mishandelde vrouwen vond de communicatieve aanpak van de huisarts het belangrijkste. Praten met de huisarts blijkt voor de vrouwen belangrijk in het veranderen van haar situatie.
Appendices

Appendix 1a

Cursus in het kader van het onderzoek naar: “Partnergeweld en de rol van de huisarts”

Cursus organisatie: CAR Nascholingcentrum Rotterdam
Cursus inhoudelijk: Ellen Nijenhuis en Sylvie Lo Fo Wong

Duur cursus: 3 dagdelen (1,5dg)

Leerdoelen:
- Theorie over geweld in relaties: cyclus van geweld, copingstrategieën, daderprofielen.
- Epidemiologie: voorkomen in de huisartspraktijk, klachtenpatroon, gevolgen.
- Attitude: bewustwording van eigen weerstanden, belemmeringen en vooroordelen.
- Consultvoering: identificeren van slachtoffers van partnergeweld, hanteren van problematiek zonder direct oplossingsgericht te zijn.
- Women Abuse Screening Tool: diagnostisch instrument.
- Bekendheid met mogelijkheden en werkwijze van hulpbronnen waarnaar verwezen kan worden zoals: politie, vrouwenopvang, advocaat.

Dagdeel I

1. Welkom en introductie programma en cursusboek. 5 min
2. Vignetten: eerste scoring. 15 min
3. Kennismaking: focus op partnergeweld, persoonlijk leerdoel. 30 min
4. Theorie en epidemiologie over partnergeweld: introductie van het thema 45 min
5. PAUZE 15 min
6. Belemmeringen, weerstanden, vooroordelen bespreken in 3-tallen: 15 minuten/ plenair verhelderen 30 min; totaal: 45 min
7. WAST: introductie diagnostisch instrument, handvat in het consult; voor- en nadelen, sensitiviteit, welke vragen onder welke omstandigheden toepassen; onderzoeksgereedschap 15 min

Uitdelen rollen, voorbereiding voor morgen. 5 min

Dagdeel II

1. Opwarming: videofragment: ‘Ik red me wel’, situatie mishandelde vrouw bij arts 2 min
2. In 4 subgroepen van 3 deelnemers consult oefenen met de WAST , 3 deelnemers per groep spelen een patiëntenerrol na instructie door Ellen: plenair afronden. 1.30 uur
3. PAUZE 15 min

LUNCH PAUZE 1u 15min

Dagdeel III

1. Clinic: consult oefenen met moeilijke patiënt: video training voor maximaal 3 deelnemers met simulatie patiënt 1u 20 min
2. PAUZE 15 min
3. Juridische aspecten: Jannie Hommes, advocaat: gaat in op verklaringen, dossiervorming/verslaglegging, nieuwe juridische ontwikkelingen 40 min
4. Vignetten: tweede scoring 15 min
5. Logboeken: uitdelen en toelichten : 15 min
6. Afsluiting : evaluatieformulier 5 min

Kennis : 1u voordracht / 30 min toets
Attitude : 30 min kennismaking / 50 min opdracht
Vaardigheden : 2 u 50 min oefenen en bespreking
Informatie verwijsmogelijkheden: 1u 55 min
Organisatorisch 20 min
Appendix 1b

Details of the Training Program Content
“Intimate partner abuse and the role of the family doctor”

Duration: course of 3 consecutive daily periods of 3 hours (1.5 day)
Group size: 12-14 participants
Trainers: Ellen Nijenhuis, senior trainer/psychologist and staff member of the Training Institute for Family Medicine, Erasmus Medical Centre Rotterdam;
Sylvie Lo Fo Wong, family physician and researcher at the Radboud University Medical Centre, Dept. Family Medicine/ Women’s Studies Medical Sciences
Location: the Rotterdam Continuing-Medical-Education Centre for Family Medicine; Capelle a/d IJssel
Costs: none, the course was granted.
CME Credits: 9 points

Contents of the course:

1. **Attitude:** focus on personal learning aims: 30 min; awareness of aversions, impediments and prejudices: small group discussion: 15 min followed by plenary discussion: 30 min; total: 1.15h
2. **Theories:** interactive lecture on violence in relationships, cycle of violence, victim’s coping strategies, profiles of perpetrators, risk factors for abuse: 20 min
3. **Epidemiology:** interactive lecture on prevalence in general population and in family practice; clinical presentation and medical consequences: 20 min.
4. ‘Women Abuse Screening Tool’ as a diagnostic instrument; abused patient’s recommendations: interactive lecture + introduction of role-play and role distribution: 20 min.
5. **Consultation skills:** identifying victims, coping with the problem without solving it immediately. Role-play and feed back in small groups followed by plenary discussion of learning points; 1.5 hours.
6. **Introduction of referral services:** Rotterdam Police Domestic Violence program (1 police-officer) and Abused Women’s Support Agency (2 social workers); 1h15min;
7. **Clinic with a simulation patient in a difficult role:** practising consultation skills with direct feedback from both the trainer and the simulation patient; 1.5 hours.
8. **Legal aspects:** documenting; medical chart; patient rights; law and confidentiality; jurisdiction by a lawyer specialized in domestic violence/partner abuse: 45 min.

**Scoring of written cases:** measuring awareness of partner abuse in female patients at the start and the end of the course by written cases: 2x 10min. Every case consisted of a short description of a patient’s 1) complaint/question, 2) medical history and 3) background. Method: power point presentation with scoring forms; one first set of 10 cases was presented at the start of the training and a second set of 10 similar cases, at the end. Scoring of each case was done on two levels; at the first level suspect was scored: yes-doubt-no; at the second level reason to suspect was scored: patient’s complaint/question - medical history - background. Scoring-time of each case was limited to 40 seconds per level.
Appendices

Appendix 2

Vragenlijst
Partnergeweld en de rol van de huisarts.

Het invullen van deze vragenlijst kost ongeveer een kwartier. Deze vragenlijst gaat over uw ervaring, taakopvatting, houding en kennis ten aanzien van partnergeweld in de huisartsenpraktijk.

Persoonlijke gegevens:
Leeftijd: ................
Geslacht: ........................ m/v
Huisartsopleiding.: ja / nee
Jaar van vestiging: ........................................
Praktijksetting: solo/duo/groep/gezondheidscentrum
Zelfstandig/hidha
Fulltime/parttime: ..........dagdelen (fulltime= 10 dagdelen)
Andere functies: bestuurlijk/onderwijs/onderzoek/overig wetenschappelijk/anders

1. Ziet u wel eens vrouwelijke patiënten die het slachtoffer zijn van partnergeweld in uw eigen praktijk?
   0 nooit
   0 1 – 3 per jaar
   0 4 – 6 per jaar
   0 7 – 9 per jaar
   0 10 of meer per jaar

2. Kent u vrouwelijke slachtoffers van partnergeweld in familie, onder vrienden of collega’s?
Ja / nee

3. Hoe vaak per jaar komt u een vrouwelijke patiënt tegen waarbij u voor het eerst het vermoeden hebt van partnergeweld?  …

4. Bespreekt u dan uw vermoeden met uw patiënt?
   0 nooit
   0 heel zelden
   0 soms
   0 regelmatig
   0 altijd

5. Ervaart u belemmeringen in het vragen naar partnergeweld bij vrouwelijke patiënten?
   0 nooit
   0 zelden
   0 wisselend
   0 regelmatig
   0 altijd

6. Hebt u ooit een cursus/nascholing gevolgd in het omgaan met huiselijk geweld?
Ja / Nee

Indien u deze vraag met nee beantwoord hebt ga door naar vraag 10
7. Was partnergeweld een specifiek onderdeel van deze cursus? Ja / nee

8. Waar hebt u deze cursus gevolgd? .........................

9. In welk jaar? ....

Indien u een cursus over partnergeweld zou volgen, wat vindt u belangrijk hierin?

10. Een cursus over partnergeweld bevat theorie over geweld in relaties.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

11. Een cursus over partnergeweld bevat epidemiologie.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

12. Een cursus over partnergeweld bevat aandacht voor houdingsaspecten van de huisarts.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

13. Een cursus over partnergeweld bevat oefenen in consultvoering.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

14. Een cursus over partnergeweld bevat informatie over verwijsmogelijkheden.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

15. Een cursus over partnergeweld bevat aandacht voor juridische aspecten.
    0 onbelangrijk
    0 minder belangrijk
    0 belangrijk
    0 erg belangrijk

16. In een cursus over partnergeweld hoort.............
17. Met welke van de volgende uitspraken bent u het geheel eens---------geheel oneens

Zet in de onderstaande tabel een kruis bij het niveau dat het best aansluit bij uw mening.

<table>
<thead>
<tr>
<th></th>
<th>Geheel mee eens</th>
<th>Mee eens</th>
<th>Neutraal</th>
<th>Mee oneens</th>
<th>Geheel mee Oneens</th>
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<tbody>
<tr>
<td>a</td>
<td>De huisarts heeft een taak in het identificeren van partnergeweld bij vrouwen op het spreekuur</td>
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<td></td>
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<tr>
<td>b</td>
<td>Vragen naar partnergeweld heeft zin omdat het zelden spontaan gebracht wordt</td>
<td></td>
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<td>c</td>
<td>Het bespreken van partnergeweld tijdens het spreekuur kost teveel tijd</td>
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<td>d</td>
<td>Vragen naar partnergeweld is zinloos omdat je het probleem niet kunt oplossen</td>
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<td>e</td>
<td>Bij trauma’s in huis denk ik ook aan de mogelijkheid van mishandeling in de relatie</td>
<td></td>
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<tr>
<td>f</td>
<td>Mishandeling/partnergeweld is uitsluitend een relatieprobleem.</td>
<td></td>
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<tr>
<td>g</td>
<td>Partnergeweld heeft negatieve gevolgen voor de kinderen in het gezin</td>
<td></td>
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<tr>
<td>h</td>
<td>Vrouwen lokken partnergeweld door hun gedrag zelf uit.</td>
<td></td>
<td></td>
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<tr>
<td>i</td>
<td>Partnergeweld is een privé-probleem en daar bemoei ik me niet mee.</td>
<td></td>
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<tr>
<td>j</td>
<td>Vrouwen die het slachtoffer zijn van mishandeling binnen de relatie gaan altijd weer terug naar hun partner.</td>
<td></td>
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<td>k</td>
<td>Vragen naar mishandeling/partnergeweld is beledigend voor de patiënt.</td>
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<td>l</td>
<td>De partner is ook mijn patiënt, ik kan niets met geweld in een relatie.</td>
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<td>m</td>
<td>De verantwoordelijkheid voor geweld binnen een relatie ligt altijd bij beide partners</td>
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<tr>
<td>n</td>
<td>Vragen naar partnergeweld biedt ondersteuning aan de vrouw</td>
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</tbody>
</table>
## Wilt u bij de volgende stellingen aangeven: juist------onjuist- of weet niet

<table>
<thead>
<tr>
<th></th>
<th>juist</th>
<th>onjuist</th>
<th>weet niet</th>
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<tbody>
<tr>
<td>o</td>
<td>Mishandelde vrouwen lopen een verhoogd risico op miskramen</td>
<td></td>
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<tr>
<td>p</td>
<td>Vrouwen hebben als gevolg van partnergeweld vaker depressieve klachten</td>
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<tr>
<td>q</td>
<td>Partnergeweld is in de wetgeving strafbaar</td>
<td></td>
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<tr>
<td>r</td>
<td>1 op de 20 vrouwen maakt ooit geweld mee in de relatie</td>
<td></td>
<td></td>
</tr>
<tr>
<td>s</td>
<td>Per jaar sterven in Nederland 30 vrouwen als direct gevolg van partnergeweld</td>
<td></td>
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<tr>
<td>t</td>
<td>Problematisch alcoholgebruik bij vrouwen houdt geen verband met mishandeling</td>
<td></td>
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</tr>
<tr>
<td>u</td>
<td>Bij chronische pijn zonder oorzaak komt mishandeling in de relatie vaker voor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**HARTELIJK DANK VOOR HET INVULLEN!**
Appendices

Appendix 3

INTERVIEW GUIDE

1) DEMOGRAPHIC INFORMATION:

- Name and practice address

A reminder of the definition if IPV used in this study:
- Violence is aggressive behavior with the aim to harm.
- Unilateral physical, emotional and sexual abuse in an intimate relationship.
- Perpetrating physical, emotional and sexual integrity of the partner, pain, and/or harming the partner.

Types of intimate partner violence:
Physical abuse, rape, sexual coercion, controlling behavior, neglect, humiliation, threats, withholding finance, prohibition to learn the language and stalking.
I am aware of the education program you received.

2) KNOWLEDGE OF INTIMATE PARTNER VIOLENCE (IPV):

- Have you been reading about IPV lately? (at work, outside of work, in medical literature, in the media)
- Would you consider that you know more than, same as, or less than the average practitioner about IPV?
- What do you think is the prevalence of IPV in the Netherlands, and in your own practice? How often do you see a patient you suspect is an IPV victim?
- Do you think IPV is more of a problem in some groups of people than in others? Which groups?

3) DETECTION STRATEGIES:

- Before the education program, what made you suspect IPV? And now, after the program, has that changed? In what way?
- How well equipped to detect IPV did you feel before the training, and now?
- What difficulties did you find in asking patients about IPV before the training program? And now? What makes you ask? How do you ask?
- Does suspicion criteria change for different people?
- Has your opinion changed on whether or not doctors should ask a patient about IPV?
- Do you experience less barriers talking to IPV patients, the more victims you see? Has this changed since the education?
• Do you find addressing IPV in a caring and sensitive manner is time-
  consuming? Has this changed?
• Do you find it challenging? Has this changed?
• When did you last see a patient in whom you suspected or asked about IPV?

4) EDUCATION PROGRAM:

• Was the education program useful? What did you learn? How, precisely has it
  helped you? Could you please give a specific example?
• Referring to the education program, which part of the training did you find
  most useful?
• Has this education had any effects on your opinion and views? If so, give an
  example
• Do you feel more comfortable talking to patients about IPV, following the
  training? Give an example.
• Were you surprised to learn of the prevalence of IPV?
• Since the training, have you found yourself to be more aware/or the same, of
  IPV in a consultation?
• Following the training, have you asked patients about IPV more/ or the same?
  Have you suspected IPV more/ or the same? Have you detected more cases?
• Are you more aware/or the same of services available to women suffering
  from IPV now? Do you use these services and refer patients more now?
• Is the advice you give to patients and your management of them different
  now? Have you changed your practices? Yes- how? No-why?
• Was the timing of the course good? Too long or too short?
• Was it easy to fit into your busy schedule?
• Is there anything you would like to add about the education program that
  hasn’t previously been asked in the questionnaire or in this interview?

5) FUTURE:

• Would you like more education on IPV at some point in the future?
• Would you recommend to your colleagues that they undergo similar training in
  IPV?
• How could the training be improved?
• Do you think medical school curricula adequately address IPV?
• How do you think we could make all the GPs in the Netherlands take part in
  this course?
• Anything else at all you would like to add?
Appendices

Appendix 4a

1e Interview vrouwen

De interviewer stelt zich voor aan de vrouw als onderzoeksassistent en interviewer. Het gesprek wordt niet opgenomen. De interviewer maakt schriftelijke aantekeningen en zij legt uit dat de gegevens alleen onder een nummer worden opgeslagen om reden van vertrouwelijkheid. Ook de eigen huisarts krijgt hier geen verslag van. Steeds zal de interviewer de antwoorden bij de open vragen samenvatten en herhalen zodat de vrouw hierop kan reageren en zich eventueel kan verduidelijken.

Doel van het gesprek is om inzicht te krijgen in wat de onthulling over partnergeweld aan de huisarts voor haar betekent en wat zij verwacht en vindt van de hulp van de huisarts bij dit probleem.

1. U hebt bij uw huisarts aangegeven dat u mee wil doen met het vraaggesprek. Bent u nog steeds bereid om de vragen te beantwoorden? ja / nee
2. Voelt u zich veilig genoeg om met mij als interviewer te spreken? Ja / nee
3. Waarvoor ging u naar de huisarts, wat was uw vraag? In eigen woorden. Samenvatting door interviewer. Vrouw akkoord?
4. Wat verwachtte u van uw huisarts? In eigen woorden. Samenvatting door interviewer. Vrouw akkoord?
5. Vindt u het een taak van uw huisarts om vragen te stellen over uw achtergrond? ja – een beetje – nee – weet ik niet
6. Wat vond u het belangrijkst in het gesprek met uw huisarts? In eigen woorden. Samenvatting door interviewer. Vrouw akkoord?
9. Heeft uw huisarts u op de hoogte gebracht van de mogelijkheden voor hulp bij uw probleem? ja, genoeg om mee verder te gaan – een beetje – nee – weet niet
10. Heeft uw huisarts u een vervolgafspraak aangeboden om over uw problemen te praten? ja - nee - nee, want mijn huisarts werkt niet volgens afspraak
11. Hebt u behoefte om met uw huisarts verder over uw problemen te praten? ja – een beetje – nee – weet niet
12. Hebt u contact gezocht met de hulpbronnen (voorbeelden) waarnaar uw huisarts u heeft verwezen? ja - nee - overweeg het nog - zal ik nooit doen
13. Had u het gevoel dat u de dokter begrip had voor uw situatie? ja, genoeg – een beetje – nee, niet genoeg – weet niet
15. Hebt u het gevoel dat u nu meer kan doen om uw situatie te veranderen als u dat zou wensen? Eigen woorden. Samenvatting door interviewer. Vrouw akkoord?
18. Zijn er nog dingen die u had willen zeggen tegen uw huisarts over uw situatie? Ja/nee
2e Deel interview: Composite Abuse Scale, vertaald in het Nederlands.

De vragenlijst is bedoeld om zelf in te vullen maar wordt daar waar nodig is door de interviewer toegelicht. Vrouwen die de Nederlandse taal beperkt beheersen en toch graag mee willen doen kunnen bijgestaan worden door een VETCer. Voorlichters Eigen Taal en Cultuur van de GGD Rotterdam uit het project Bruggen bouwen zijn getraind in het praten met vrouwen over psychosociale problemen. Bruggen bouwen was een project van de GGD Rotterdam waarin huisartsen ondersteuning geboden werd in het contact met vrouwen van Turkse en Marokkaanse afkomst.

Aan het einde van het interview:
De interviewer bedankt de vrouw voor haar medewerking en biedt haar een attentie aan.
Appendices

Appendix 4b

2e Interview vrouwen

De interviewer voert het gesprek na .. maanden. In overleg met de vrouw gebeurt dit telefonisch, thuis of op de praktijk van de huisarts.

De vertrouwelijkheid blijft gewaarborgd. Het gesprek wordt niet opgenomen. De interviewer maakt schriftelijke aantekeningen en de gegevens worden onder een nummer opgeslagen.

Doel van het gesprek is om inzicht te krijgen in het vervolg van de situatie van de vrouw na de onthulling van het partnergeweld (actueel of in het verleden) bij de huisarts.

Wat zijn de gevolgen van het gesprek met de huisarts voor haar situatie?

1. U hebt aangegeven dat u aan een 2e gesprek wilde deelnemen. Is dat nog steeds zo? Ja / nee; Voelt u zich veilig genoeg om te spreken? Ja / nee
2. Kunt u vertellen of uw situatie veranderd is sinds het vorige gesprek? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
3. Indien uw situatie veranderd is, kunt u dan aangeven wat de belangrijkste verandering daarin geweest is? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
4. Als u terug kijkt op uw situatie, hoe is het volgens u zover gekomen? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
5. Hoe kijkt u naar uw situatie 5-6 maanden na het eerste gesprek met uw huisarts? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
6. Bent u in de afgelopen maanden nog voor problemen met partnergeweld bij uw huisarts geweest? Ja / nee Bent u het nog van plan? Ja / nee
7. Als u dat niet van plan bent om naar uw huisarts te gaan, kunt u aangeven waarom u dat niet zult doen? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
8. Hebt u in de afgelopen maanden contact gezocht met een van de hulpbronnen waar uw huisarts u naar toe verwees? Bijvoorbeeld het Steunpunt Geweld achter de voordeur? Ja / nee
9. Zo niet, bent u nog van plan om contact te zoeken met een van de hulpbronnen? Ja / nee
10. Als u niet van plan bent om contact te zoeken met een van de hulpbronnen, kunt u aangeven waarom u dat niet zult doen? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?
11. Indien u naar een van de hulpbronnen geweest bent op advies van uw huisarts, hoe kijkt u nu naar uw situatie? Eigen woorden. Samenvatting interviewer. Vrouw akkoord?

2e deel interview: Depressie vragenlijst BDI> zelf in te vullen of met hulp van de interviewer.

De vrouw krijgt een attentie voor haar medewerking.
Deze vragenlijst heeft te maken met uw ervaringen in intieme, volwassen relaties. Met een intieme, volwassen relatie bedoelen wij een echtgenoot, een partner of een vriend met wie u langer dan 1 maand een relatie hebt.

Vraag 1: Hebt u sinds uw zestiende jaar zo’n relatie gehad?  
Ja/Nee

Vraag 2: Hebt u op dit moment zo’n relatie?  
Ja/Nee

Vraag 3: Bent u op dit moment bang van uw partner?  
Ja/Nee

Vraag 4: Bent u ooit bang geweest van uw partner?  
Ja/Nee

Vraag 5: Wij willen graag graag weten of u één van de dingen, die hieronder beschreven staan, ooit hebt meegemaakt en hoe vaak u het hebt meegemaakt in de laatste twaalf maanden. Als u de laatste twaalf maanden geen partner had, kunt u dan antwoorden over de tijd dat u wel een partner had.

Omcirkel het antwoord dat past bij wat u meemaakte de afgelopen 12 maanden

0 = nooit  1 = 1 keer  2 = meerdere keren  3 = 1 keer per maand  4 = 1 keer per week  5 = dagelijks

De partner:

- Zei dat ik niet goed genoeg was
  0 1 2 3 4 5

- Zei dat ik niet naar de dokter mocht
  0 1 2 3 4 5

- Achtervolgde mij
  0 1 2 3 4 5

- Sloot mij op in de slaapkamer
  0 1 2 3 4 5

- Probeerde mijn familie, vrienden en kinderen tegen mij op te hitsen (op te zetten tegen mij)
  0 1 2 3 4 5

- Gaf mij een klap
  0 1 2 3 4 5

- Verkrachtte mij
  0 1 2 3 4 5

- Zei dat ik lelijk was
  0 1 2 3 4 5

- Hield mij tegen als ik mijn familie wilde zien of met ze wilde praten
  0 1 2 3 4 5
| - Gooide mij op de grond                      | 0 | 1 | 2 | 3 | 4 | 5 |
| - Bleeft om mijn huis rondhangen             | 0 | 1 | 2 | 3 | 4 | 5 |
| - Gaf mij de schuld van zijn gewelddadig gedrag | 0 | 1 | 2 | 3 | 4 | 5 |
| - Viel mij lastig door de telefoon            | 0 | 1 | 2 | 3 | 4 | 5 |
| - Schudde mij door elkaar                    | 0 | 1 | 2 | 3 | 4 | 5 |
| - Probeerde mij te verkrachten               | 0 | 1 | 2 | 3 | 4 | 5 |
| - Viel mij lastig op mijn werk                | 0 | 1 | 2 | 3 | 4 | 5 |
| - Duwde, pakte mij of gaf mij een zet         | 0 | 1 | 2 | 3 | 4 | 5 |
| - Gebruikte een mes, een vuurwapen of een ander wapen | 0 | 1 | 2 | 3 | 4 | 5 |
| - Was helemaal van slag als het eten of het huishouden niet klaar was | 0 | 1 | 2 | 3 | 4 | 5 |
| - Zei dat ik gek was                          | 0 | 1 | 2 | 3 | 4 | 5 |
| - Zei dat niemand mij ooit zou willen         | 0 | 1 | 2 | 3 | 4 | 5 |
| - Pakte mijn portemonnee en liet mij zonder geld achter | 0 | 1 | 2 | 3 | 4 | 5 |
| - Probeerde mij met iets te raken             | 0 | 1 | 2 | 3 | 4 | 5 |
| - Wilde niet dat ik met mijn vriendinnen omging | 0 | 1 | 2 | 3 | 4 | 5 |
| - Stoppe vreemde voorwerpen in mijn vagina    | 0 | 1 | 2 | 3 | 4 | 5 |
| - Ik mocht van hem niet buitenhuis gaan werken | 0 | 1 | 2 | 3 | 4 | 5 |
| - Schopte me, beet me of gaf me een vuistslag | 0 | 1 | 2 | 3 | 4 | 5 |
| - Probeerde mijn vrienden, familie of kinderen te overtuigen dat ik gek was | 0 | 1 | 2 | 3 | 4 | 5 |
| - Zei me dat ik een sufferd was                | 0 | 1 | 2 | 3 | 4 | 5 |
| - Sloeg me in elkaar                          | 0 | 1 | 2 | 3 | 4 | 5 |

© Hegarty, K.: Composite Abuse Scale; University of Melbourne
Geachte collega,

In dit schrijven wil ik u uitnodigen om deel te nemen aan het onderzoek: “Partnergeweld en de rol van de huisarts”.

Uit grootschalig onderzoek in de open populatie is gebleken dat een niet onaanzienlijk deel van patiënten met onverklaarbare klachten het slachtoffer is van partnergeweld. Dit treft vooral vrouwen. In de spreekkamer wordt u, veel vaker dan bekend, geconfronteerd met de gevolgen van partnergeweld zonder dat het ter sprake komt. Over de taakopvatting, houding, kennis en beeldvorming van huisartsen in Nederland is weinig bekend.

Het onderzoek zal door mij worden uitgevoerd en zal plaatsvinden onder huisartsen in de regio van de DHV Rotterdam e.o. Het wordt gesubsidieerd door Stichting Theia van Zilveren Kruis Achmea. Het project van de gemeente Rotterdam “Geweld achter de voordeur”ondersteunt dit initiatief.

Het onderzoek bestudeert of een cursus in het hanteren van partnergeweld op het spreekuur leidt tot een verhoogde detectiegraad en een verbetering van de zorg aan de geïdentificeerde patiënten.


Als tegenprestatie voor uw deelname, is in de begroting een vergoeding opgenomen voor het interview en voor elke geïncludeerde patiënt. De cursus van 3 dagdelen, gegeven onder auspiciën van de CAR, wordt u gratis aangeboden en is voor 9 punten geaccrediteerd.

U kunt zich telefonisch aanmelden voor deelname aan het onderzoek of door middel van het antwoordformulier. Heeft u nog vragen dan kunt u mij altijd bellen.

Voor meer specifieke informatie over dit onderzoek kunt u in de bijlage terecht.
Ik ben overdag en ’s avonds bereikbaar op mijn geheime praktijk/privé nummer: 010-4290986, gsm: 06-22984840, e-mail: slofowong@chello.nl

Sylvie Lo Fo Wong
huisartsonderzoeker UMC St Radboud Nijmegen
huisarts te Rotterdam
Appendix 6b

Bijlage

Opzet van de studie

Nodig voor deze studie is de medewerking van 48 huisartsen in dit district, te weten:
36 huisartsen voor de groepsinterviews, waarvan 24 huisartsen een cursus krijgen aangeboden. 12 Huisartsen uit de interviewgroep vormen de mini-interventiegroep en 12 huisartsen vormen de blanco controlegroep.

Groepsinterviews
Het is de bedoeling om het grootste deel van de deelnemers in groepen van 6 huisartsen te interviewen over partnergeweld.
Doel is te richten op de taakopvatting, beeldvorming en houding ten aanzien van partnergeweld bij vrouwelijke patiënten in de praktijk, dit heet een focusgroep interview. De interviews worden opgenomen voor transcriptie en analyse.
De interviews vinden plaats op de afdeling Huisartsopleiding van het Erasmus Medisch Centrum en vinden plaats in de laatste 2 weken van februari 2003.

Cursus
Aansluitend zal een cursus worden aangeboden aan 2x12 huisartsen uit de focusgroepen: dit is de interventiegroep. De cursus duurt 1,5 dag.
Doel van deze cursus is om achtergrond en aanpak van partnergeweld, als context van klachten en aandoeningen, te behandelen om huisartsen vaardiger te maken in het identificeren, bespreken en hanteren van dit probleem tijdens het consult.

Inhoud:
- Informatie over prevalentie in de huisartspraktijk en achtergronden van partnergeweld.
- Introductie van een korte serie vragen die kunnen helpen bij het bespreekbaar maken van partnergeweld tijdens een gewoon consult: een diagnostisch instrument.
- Informatie over de mogelijkheden die er zijn om patiënten te verwijzen voor verdere hulp indien dat gewenst is.
- Oefenen van consultvoering met het diagnostisch instrument.

Kortom een, door de onbesproken gebleven achtergrond van de klacht, onbevredigend verlopend contact kan weer nieuw perspectief krijgen voor beide partijen.

Wat moet u doen
De groep huisartsen die de cursus ontvangen wordt gevraagd om gedurende een interventieperiode van 6 maanden met behulp van het geleerde, tijdens het spreekuur, vrouwelijke patiënten te vragen naar partnergeweld indien zij voldoen aan de inclusiecriteria. Ook voor vrouwen die het Nederlands beperkt beheersen is deze methode bedoeld.

Gevraagd wordt
- Het bijhouden van een logboek waarin casusregistratie plaatsvindt: vermoeden op partnergeweld, daadwerkelijk gevonden partnergeweld.
- De geïdentificeerde vrouw vragen of ze bereid is om mee te doen met onderzoek en haar toestemming verwerven voor interviews door de onderzoeksassistent.

Controlegroepen
Om de effecten van deze aanpak te toetsen zullen 24 huisartsen gevraagd worden om mee te doen en op de gebruikelijke wijze hun werk te doen.

Gevraagd wordt
- Het bijhouden van een logboek waarin casusregistratie plaatsvindt: vermoeden op partnergeweld, daadwerkelijk gevonden partnergeweld.
- De geïdentificeerde vrouw vragen of ze bereid is mee te doen met het onderzoek en haar toestemming verwerven voor interviews door de onderzoeksassistent.

12 Huisartsen uit de focusgroep vormen de mini-interventiegroep. De niet geïnterviewde huisartsen (12) vormen de blanco controlegroep.
De uitkomsten uit alle groepen zullen worden vergeleken.

**Interviews met geïdentificeerde vrouwen**
Om het effect van de interventie door de huisarts te onderzoeken zullen de geïdentificeerde vrouwen (met toestemming) uit alle 3 groepen geïnterviewd worden vrij kort na het consult en 6 maanden later.

De cursus wordt u gratis aangeboden en is geaccrediteerd voor 9 punten. De cursus vindt plaats onder auspiciën van de CAR en wordt gegeven in het Nascholingscentrum in Capelle a/d IJssel.

- De interviews vinden plaats in de laatste weken van februari 2003.
- De cursus wordt gegeven in de eerste week van maart 2003.
- De interventieperiode loopt van de 2e week van maart tot en met 1e week van september 2003.
- Deelnemers worden at random in een groep geplaatst.

De huisartsen worden in november 2002 telefonisch benaderd door de onderzoeker.
Na de interventieperiode zal de cursus aan de deelnemers uit de controlegroepen worden aangeboden.
Appendix 7

VERMOEDEN VAN PARTNERGEWELD

DATUM: ……. …. 2003

Patiënte: lft  Wel/geen relatie  Gehuwd/ongehuwd  Verzekeringvorm:

1 Waarom vermoedt u bij deze patiënte partnergeweld nu of in het verleden?

AANLEIDING(EN): Zelf gepresenteerd: ja / nee

2 Hebt u partnergeweld ter sprake gebracht tijdens het consult?

☐ JA  ☐ NEE

3 Indien u partnergeweld niet ter sprake bracht, om welke reden(en)?

1.

2.

3.

4 Is er sprake van partnergeweld in de huidige relatie of in het verleden?

☐ Huidige relatie

☐ Verleden

☐ Nee

5 Duur consult:

< 10 minuten  10 - 20 minuten  > 20 minuten

6 Voor interview gevraagd?

☐ Ja, ga verder  ☐ Nee, waarom niet

7 Reactie van de patiënte:

☐ Doet mee

☐ Doet niet mee

☐ Weet het nog niet

8 Naam:

Telefoonnr.

Medisch dossier nr.

9 Geef toestem –

mingsformulier en

patiënteninfor-

matie aan patiënte

Als partnergeweld aan de orde is geweest geef dan altijd het roze kaartje mee aan het einde van het consult

Wilt u dit formulier in de antwoord enveloppe naar Nijmegen sturen! A.u.b.
Dankwoord

Mijn laatste taak is het bedanken van allen die hebben bijgedragen aan de totstandkoming van dit onderzoek en proefschrift.


Fred Wester, mijn tweede promotor wil ik bedanken voor de waardevolle methodologische adviezen over het gehele onderzoek en in het bijzonder over de kwalitatieve analyse.
Saskia Mol en Renée Römkens, leden van de begeleidingcommissie en coauteurs, dank voor het meedenken en zeer actieve bijdrage aan dit werk.

Ellen Nijenhuis, wil ik bedanken voor de inspirerende en vruchtbare samenwerking bij de ontwikkeling van het programma en haar excellente optreden als trainer. Voor veel cursusgevers zijn huisartsen een moeilijke doelgroep, maar dit geldt niet voor Ellen.

Door Hezemans, wil ik bedanken voor haar rol als simulatiepatiënt in de cursus, als interviewer van geïdentificeerde vrouwen en bij het analyseren van de interviews. Ellen en Door, oud-maatjes uit mijn periode bij de huisartsopleiding in Rotterdam, ik ben jullie heel dankbaar voor de steun als paranimf bij de verdediging.

Margriet Straver, (onderzoeksassistent) wil ik bedanken voor de goede samenwerking en gezelligheid. Mede door haar goede contacten met het veld, haar grote betrokkenheid en vaardigheden, heeft het project zo soepel kunnen verlopen. Een grote diversiteit aan taken vanaf het administratief verwerken van onderzoeksgegevens tot en met het interviewen van kwetsbare getraumatiseerde vrouwen was in goede handen.

Mijn collega’s op de afdeling: Petra Verdonk en Ank de Jonge, wil ik bedanken voor de interesse in mijn onderzoek, het waardevolle commentaar, de samenwerking bij het analyseren en het aandragen van informatieve artikelen en documenten.

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De expertgroep, bestaande uit leden van de ‘vrouwelijke huisartsengroep’ waar ik al 27 jaar mee optrek, wil ik bedanken voor hun bijdrage aan de ontwikkeling van de vignetten voor de cursus. De vignetten zijn onmiskenbaar een waardevol onderwijs instrument.

Medewerkers aan de cursus: Mr. Jannie Hommes, advocaat; Rien Buiter, Politie Rotterdam-Rijnmond; Evita Noy en Vera van der Horst, Vrouwenopvang Rotterdam wil ik bedanken voor hun goede inhoudelijke bijdrage.

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Mijn collega huisartsen: Elly de Heer, Marjolein Berger, Sonja Handoes, Betsy Fu, Sander de Koning, Marco Blanker, Rik Versteegh en Niek Brandenburg wil ik bedanken voor hun deelname aan de focusgroepen.

In dit dankwoord horen ook de 36 vrouwen die meewerkten aan de interviews. Door hun ervaringen zo openlijk met ons te delen hebben ze onmiskenbaar een grote bijdrage geleverd aan deze studie.

Rest mij nog mijn lieve ouders te bedanken. Zij stonden de afgelopen jaren wekelijks voor mij klaar in Nijmegen met hun zorg, belangstelling en gezelligheid, ondanks hun gevorderde leeftijd. Aan hen draag ik dit proefschrift op.

Eva en Roos, onze dochters die wonen en studeren in Leiden; ik kijk ernaar uit om straks in de weekends meer tijd te hebben om samen weer gezellige dingen te kunnen ondernemen.

Hans, mijn maatje, last but certainly not least, altijd aanwezig op de achtergrond met morele, emotionele en technische steun vanaf het prille begin tot aan de laatste loodjes. We hebben het echt verdiend om weer vakantie te gaan vieren tijdens onze vakanties!

Vanaf 1980 tot heden is zij werkzaam als huisarts te Rotterdam, Oud-Charlois, in associatie met haar echtgenoot.

Van 1992 tot 2001 heeft zij gewerkt als groepsbegeleider/docent aan de huisartsopleiding van de Erasmus Universiteit te Rotterdam. Van 1993 tot 2002 was zij lid/voorzitter van de NHG Adviesraad Standaarden.

In 2001 begon zij als onderzoeker bij Vrouwenstudies Medische Wetenschappen op de afdeling Huisartsgeneeskunde van de Radboud Universiteit te Nijmegen.

Zij is actief in diverse commissies, nationaal en internationaal, die ten doel hebben het bevorderen van onderzoek naar de positie van vrouwen in de huisartsgeneeskunde, aandacht voor de factor sekse en cultuur in de hulpverlening, onderzoek en ontwikkeling van interventies bij partnergeweld.

Sinds 2003 schrijft zij een vraag en antwoord column in het Algemeen Dagblad.


Juli 2006.