management of the whole family when intimate partner violence is present:

guidelines for primary care physicians

Council against violence

Introduction

In many countries with primary care physicians (family physicians (FPs) or general practitioners (GPs), their confidentiality and, where universal, their accessibility means they may be the first source of potential help for those experiencing intimate partner violence (IPV).

Intimate partner violence is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

Acts of physical aggression—such as slapping, hitting, kicking and beating.

Psychological abuse—such as intimidation, constant belittling and humiliating.

Forced intercourse and other forms of sexual coercion.

Various controlling behaviours—such as isolating a person from their family and friends, monitoring their movements, and restricting access to information or assistance.

(Krug EG, Dahlberg et al, WHO 2002).

Partner violence and abuse exists in all types of relationships, including heterosexual, gay and lesbian, bisexual and transgender relationships. There are overlapping domains of abuse in families – elder and carer abuse, child and sibling abuse. In some communities, partner abuse may involve extended family members. Indigenous families experience high rates of family violence and cultural sensitivity is required when dealing with patients from different cultural backgrounds. Clinicians are encouraged to integrate this broader perspective into their practice when using these guidelines or developing protocols or multi-agency collaboration.

Women consult physicians frequently when they are pregnant; other patients may attend in couples or with small children or for their own needs. Primary care physicians are family doctors and may also see the abusive partner or children and adolescents. Previous advice to family physicians and GPs focused on victims only and did not address the dilemmas that practitioners can face when they see the whole family, or work in group practices or clinics.

An international collaboration of practitioners and researchers, using a formal consensus method, developed guidelines for primary care physicians on whole family care. See the appendix on page 8 for more detail.

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Consensus recommendations and associated commentary

These recommendations are intended to guide primary care physicians in the identification and management of patients experiencing partner violence, those who abuse, and their children. The principles guiding these recommendations are those of safety and confidentiality when dealing with partner violence. The recommendations are intended to guide individual practice as well as staff training, protocols, accreditation and clinic administration. While the recommendations are intended to be internationally relevant, the commentary below each one may need to be adapted to the local legal and resource context.

Differences between women experiencing partner violence and between men who perpetrate abuse against their partners

There are no consistent demographic features of women experiencing partner violence nor of men who abuse partners; both groups are heterogeneous. We do not believe there is enough evidence of distinct categories to guide physicians in their response to different groups (1, 2). We nevertheless draw attention to the range of severity and types of IPV that women experience and men perpetrate, and refer to this in our recommendations when we believe the differences are salient to practice.

The guidelines refer to female survivors and male perpetrators. From a public health and clinical perspective, partner violence of men against women dominates all other types (3).

Identification

There is consensus amongst health care organisations and experts that health providers have a responsibility to identify and support victims of partner violence. However, there is a vigorous debate about whether we know enough at present to recommend that all family practitioners ask all women and all men about partner violence (4–8).

There are currently two approaches to identification.

Screening: consistent use of a validated set of short questions to detect partner violence in all of an asymptomatic population in order to prevent further violence, illness and death.

Case finding: using the opportunity of the clinical encounter to check for partner violence and associated health problems in symptomatic people in order to prevent further violence, illness and death.

The choice between screening and case finding depends on (a) the emphasis one places on whether health systems and all practitioners (not only those sensitive to the issue) are well prepared, supported and resourced sufficiently to respond appropriately to disclosure; and (b) one's views on the strength of evidence that intervention is beneficial and not harmful for women and children in the longer-term. Whatever method of identification one uses, there is a need to respond appropriately to disclosure, which is the main focus of these recommendations.

Consensus recommendations: identification

1 Family practitioners should routinely ask all pregnant adult and adolescent women about partner violence (7, 1–9)[1]

Because of the opportunities for early intervention provided by regular antenatal checkups and the particular risks to pregnant women and potential adverse pregnancy outcomes, all pregnant women and girls should be asked about the possibility of violence in their relationship. See recommendation 19 on page 5 and reference 9 on page 9 for consideration of the consequence of disclosure by adolescents.

1 Reported scores: median scores are indicated in brackets, then the range after the recommendation to indicate the level of consensus.

2 In other situations, doctors should ask patients with symptoms of partner violence and those with symptoms of abusive behaviour (case finding only) (9, 1–9)

There was a wide range of opinions about the recommended approach. While the majority do not support screening, a minority of group members do. Victimised women stress the importance of a trusting doctor-patient relationship, confidentiality, respectful and non-judgmental attitudes to achieving disclosure as well as acceptance of nondisclosure and a supportive response. It is crucial for safety reasons that any questions are asked privately, when the patient is alone – not when another family member, adult or child over the age of two years old is present. It is a clinician's responsibility to ask and support women regardless of their response. Asking about abuse may 'plant a seed' for later action. The collaborative group believed that GPs should ask women who are 'symptomatic' (e.g. symptoms of mental illhealth, chronic unexplained, physical symptoms, unexplained injuries, frequent attendance).

In addition, GPs should ask men who are 'symptomatic' (i.e. those who ask for help with their 'anger', have 'marital problems', are 'wife mandated' to change their behaviour, have alcohol or other substance abuse problems or were abused or witnessed IPV as children) about their relationship and any abusive or controlling behaviours, unless they exhibit suggestive antisocial or psychopathic tendencies. Funnelling questions about abusive behaviour from the general to particular acts and asking about their impact on the partner and children are encouraged (see references 2, 10 and 11 on page 9).

Consensus recommendations: management

Initial response

Primary care physicians should:

3 Acknowledge and validate disclosure (9, 9–9)

A supportive and appropriate response to disclosure includes acknowledging the courage needed to disclose abuse, emphasising that the violence is not the victim's fault but the abusive partner's choice. However, for either the victim or the perpetrator to disclose is initially a very difficult step which the practitioner should validate.

4 Express the unacceptability of any abusive behaviour but not of the patient (9, 5–9)

Stating to the victim that the violent behaviour is neither acceptable nor her fault can be a powerful first therapeutic step. It is also important to say to the perpetrator that his behaviour is unacceptable, but not he himself and that he can be helped to change if he is willing to do so.

5 Encourage a patient who has disclosed their abuse of a partner to take responsibility for their behaviour and change (9, 5–9)

If a man expresses willingness to change, physicians are encouraged to recommend referral to accredited behaviour change programmes where the man and his partner will be offered separate support to make beneficial changes. Always check with the man's partner and children if appropriate and with the man himself about family safety and his progress.

6 Ensure and emphasise confidentiality within limits of harm to herself/himself or others (9, 9–9 women, 9, 3–9 men)

It is critical that family physicians emphasise that patient confidentiality will be maintained within legal limits. If a woman has disclosed, doctors should never attempt to raise the issue of partner violence with the perpetrator without her permission. A careful assessment of her safety and level of fear is crucial. However, it is important to state that there are limits to confidentiality if patients indicate they will harm themselves or other family members. (Responses to confidentiality in relation to child disclosure are complex, see recommendation 19 on page 5 and reference 9 on page 9).

7 Monitor personal and professional attitudes to patient and patient's partner for management bias (9, 7–9)

Doctors' attitudes and beliefs about victims and perpetrators based on their own religion, culture, class or gender can prejudice the care they offer to individual victims, perpetrators or those who consult them as couples. Doctors should reflect on their attitudes and address their prejudices. If this is problematic, consider referring patients experiencing partner violence to another physician.

8 Offer education and support (9, 8–9 women, 9, 2–9 men)

It is beneficial to talk to the woman yourself (or another colleague if available and trained in the practice, e.g., a nurse practitioner or social worker) about the common patterns of violence and abuse and their damaging effects on themselves and their children. If you are aware of them, inform the woman and encourage the use of her legal rights and her options for action, especially if she is from another country and is worried about her status. It is important to listen carefully to the individual's perspective and avoid cultural stereotyping. Offer long-term support for any course of action she feels able to choose now or into the future. Talk to an abusive man (only with her permission) about the impact on his own health and his family and tell him of the legal ramifications of his actions. Offer him hope and resources to change and offer to support him in the long-term if he is willing, for any beneficial action he chooses now or later.

Safety

9 If previously seeing the couple, consider referring one partner to another colleague (9, 5–9)

When either partner of a couple you have seen together has disclosed to you, and if you think it would be difficult to maintain a professional relationship with both, consider referring one partner to another colleague. It is more dangerous to do so if a woman has disclosed to you and her partner is unaware that she has done so. Do not attempt to raise the issue of violence or abuse with any partner without the express permission of the other. Breaking confidentiality, even if driven by concern about the patient, can result in further harm.

Consensus recommendations: management

10 Assess the patient's safety, risk of harm to themselves and others (9, 9–9)

It is very important to ask the victim whether she is afraid of her partner. This is a good indicator of her safety, but further questions should be asked (see reference 12 on page 9). Depression, risk of suicide, homicide or femicide and abuse of children is a possibility with both abusive and abused patients. Doctors should consider discussing these risks with patients who disclose partner violence.

11 Assess whether anyone else is using abusive behaviour against an abused woman (9, 5–9)

When women are abused, it is possible that others in the family, such as her in-laws or older children, especially sons who have witnessed the abuse, are also abusing her. Consider asking about this risk when you are taking a history.

12 Ask about any weapons (9, 8–9)

It is important to ask whether any lethal weapons are available in the house when assessing a patient and their children's safety. This is especially important in rural areas and in countries where firearms are easily available. If there are weapons, you may want to advise the patient to inform the police or give you permission to contact them about the weapons if she is threatened.

13 Discuss a basic safety plan with abused patients (9, 7–9)

If a woman has disclosed abuse, suggest that she hide money and copies of important documents such as birth certificates or passports. Discuss what she would do if she did feel afraid, who she would contact and how. If she is severely abused or afraid, offer her immediate referral to a specialist domestic violence agency that will prepare a more detailed plan with her.

Children and parenting

14 Discuss any parenting concerns in the partner abuse context (9, 1–9 women, 7, 5–9 men)

Abused women may be concerned about the impact of partner abuse on their parenting. Consider discussing parenting concerns, while being careful not to imply any criticism or judgement. Similarly, consider discussing with men who have disclosed violence (but not patients with antisocial, psychopathic or over controlling tendencies) about their parenting concerns, including the future impact of their behaviour on their children. This may be a catalyst for men to attend behaviour change programmes. Refer to parenting support, if appropriate.

15 Assess the risk to and adult perception of the impact on children (9, 4–9)

Often victims can be unaware of the impact of the abuse on children. Witnessing violence can have damaging effects on children and young people. When either victim or perpetrator has disclosed partner violence in the home, it is important for a family physician to ask about the risk to and impact on children. Discussing the impact on children can lead to parents seeking additional help to make beneficial changes.

16 Consider the risk to and children's perception of the impact on their lives (8, 1–9)

If you have an opportunity to speak to children safely or young people by themselves, consider asking whether they feel safe at home. If they choose to disclose and discuss issues further, there may be opportunities to discuss keeping themselves safe. It is also important to say to children and young people that the violence is not their fault and, if appropriate, that you are available to help and support them. When a child discloses, do not document this in any records to which the perpetrator has legal access. It is also important not to breach confidentiality (within the confines of recommendation 19 on page 5).

17 Consider children's access to significant supportive others (8, 5–9)

As there is evidence that having a non-abusive parent or another adult with whom they share their fears and concerns is beneficial for children and young people, consider asking about whether children have access to supportive others. In some cases it may be that the doctor is the only person in whom children or young people will confide.

18 Offer referral of children to therapeutic support services (9, 5–9)

In some countries, there has been rapid growth of therapeutic support services for children and young people who have experienced partner violence in the family. If there is access to such services, consider referring the children for support or therapy.

19 Report children at risk according to mandatory laws (9, 7–9)

In some countries, reporting direct physical or sexual abuse of children is mandatory. In others, witnessing violence may be included in mandatory reporting laws. Child protection services may assess for partner violence and act to protect the woman and her children, however this may not be the case and clinicians should consider a preliminary discussion with a non-abusive parent if safe about the implications of reporting. In countries where reporting is not mandatory, clinicians should consider reporting following a discussion with the non-abusive parent about implications and outcomes for her and the children (for fuller discussion see reference 9 on page 9). The children's health and well being should be the priority in any of these decisions.

20 Consider the patient's level of fear about the children's removal (9, 1–9)

For both victims and perpetrators, fear about their children's removal can be a barrier to further beneficial action. Ensure that you are fully aware of this issue when seeing women, although if mandatory reporting of child abuse is law, you are required to report in some cases without telling the woman if that is in the child's best interest (see recommendation 19 above and reference 9 on page 9). If, following physicians' best efforts to assist adult patients with family safety, they perceive that the children are unsafe; the use of child protection procedures is a last resort.

21 Assess patient's level of social support (9, 8–9 women, 9, 1–9 men)

There is evidence that social support is important in the recovery and well-being of women who are abused. Often abused women and their children are isolated, so it may be of benefit to refer an isolated woman to a program of social support. Perpetrators of violence may also be isolated.

22 Offer options for referrals (including referral of certain types of men who abuse to accredited behaviour change programmes when available) (9, 8–9 women, 8, 5–9 men)

Family physicians should consider offering assisted referral of victims to support services and of perpetrators to accredited behaviour change programmes where available, even though evidence of benefit is mixed (13–15). The collaborative group did not think that men with antisocial or psychopathic tendencies should be referred to behaviour change programmes; however, other men, if willing, may find it useful. Doctors should also consider men's referral to drug and alcohol or mental health services where co-morbidities exist. It is important to make sure an abused patient and her children are aware that a man will not necessarily change and that they are not necessarily safe because he is attending a programme.

It is often frightening for patients to take the first step on a path of challenging but potentially beneficial action. It is helpful if family physicians describe what may happen when a patient contacts another service, or indeed to offer to make the referral directly while the patient is present in the practice. It is important when seeing a patient again to ask how effective the referral was. Do not be discouraging if the patient has not taken the first step, and offer to help them again when they are ready.

23 Do not offer couple counselling in practice (9, 9–9)

The collaborative group was unanimous that family physicians are not generally trained to offer the specialist relationship counselling required when there is partner violence. An abused patient can never be perfectly honest or unafraid when her abusive partner is present. Such counselling requires specialist skills. If there is no physical or sexual violence, couples could be referred to domestic violence aware relationship counselling services (see reference 16 on page 9). The evidence regarding the effectiveness of couple counselling is unclear.

24 Ongoing monitoring of the woman, her partner and children for safety and progress (9, 7–9 women, 9, 1–9 men)

It is important that family physicians take every opportunity to inquire, if and when there is an opportunity to ask, how safe each person in the family feels. When men attend behaviour change programs, it is common for them to minimise their abusive behaviour and exaggerate their progress. It is therefore very important always to ask his partner and her children about their levels of fear.

Documentation

25 Document comprehensively and carefully (9, 9–9)

Documentation, clear and precise, including perpetrator's name if given, photographs and body map identification of injuries may be very important for future court cases. It may remove the necessity for the physician to attend court. An excellent guide to documentation in cases of family violence has been published (see reference 17 on page 9).

Consensus recommendations: group practice or clinic management

A family physician may find that their practice is enhanced if other members of the clinic and their staff and clinic protocols are appropriately prepared with safety and confidentiality as priority principles. It is also important to have effective joint protocols with the broader community-based services relevant to working with partner violence in a family.

26 Ensure posters and leaflets in clinic waiting area offer support and referral to patient (9, 7–9 women, 9, 5–9 men)

Often, the first stage of a patient's comfort in discussing partner violence with their family physician is recognition (either through a poster or leaflets) that the clinic acknowledges that partner violence is unacceptable, and that community-based agencies can provide support. It can also be beneficial to place these in private areas such as toilets.

27 Seek own and staff family violence training for management of all family members experiencing partner violence (9, 7–9)

Identifying and managing patients who are victims and perpetrators of partner violence and their children is a challenging task for family physicians, but should be an integral part of their practice. It is important that family physicians know the boundaries of this role and the support available in the community to assist them. It is therefore vital for primary care teams to attend training to improve their knowledge, attitudes and skills in this challenging area. If training is not available, practitioners and other health providers should advocate for it with their respective associations. Regular training updates are important to sustain awareness, skills and knowledge in this difficult area.

28 Ensure patient file is confidential and not accessible to other family members (9, 9–9)

Some perpetrators may seek access to their partners' files and contact details, using excuses such as the need for medication or her next appointment. Additionally, as women can be most vulnerable to being killed just after they have separated, it is important for clinic staff to have a protocol around safety and confidentiality of files, especially when there is a history of partner violence in the family and women have recently separated from their partners. Consider this, especially in antenatal care, when records may be shared between general practices and hospitals.

29 Use a clinic protocol for monitoring danger to patient and other family members by any clinician seeing patient (9, 5–9)

All clinicians seeing patients and/or family members should follow an established clinic-wide protocol to monitor patient safety. In any group practice, it is common for patients to see different members of the practice. It is also possible that one member of a practice may see the victim and another, the perpetrator and either may see the children. It is important for all members of the practice to know if there are increasing levels of fear and consequent danger to the victim and her children. It is therefore important to establish methods of marking medical records with a confidential and agreed symbol or acronym for partner violence and increased danger.

30 Ensure quality assurance and accreditation includes the needs and confidentiality of these patients (9, 7–9)

Clinical audits, quality assurance and other quality mechanisms relevant to effective and safe partner violence management are available in some countries. If one is not currently available from your professional organisation, consider developing one of your own or advocating for its development.

31 Ensure staff safety protocol includes the risk from and needs of these patients (9, 8–9)

Staff safety protocols should include suitable protection when abusive patients seek information about separated partners, those in shelters or refuge, or use any inappropriate behaviour that may be threatening to clinic staff. In addition, supporting patients experiencing partner violence is stressful and clinicians and their staff may need opportunities for clinical supervision, peer support and debriefing.

Appendix: Methodology

32 Ensure inter-agency collaboration for the benefit of patient, partner and children (9, 8–9)

Protocols need to be developed in the context of inter-agency collaboration, including the criminal justice system (police, legal aid, the courts etc), domestic violence services, child protection and financial and housing services. Aim to develop collaborative protocols with relevant community-based services, which may include the immigration and education systems.

The guidelines development group was led by Dr Angela Taft and Associate Professor Kelsey Hegarty (Australia) and Professor Gene Feder (UK) in collaboration with Associate Professor Lorraine Ferris (Canada), Professor Kevin Hamberger (US), Dr Elizabeth Hindmarsh (Australia), Dr Sylvie Lo Fo Wong (Netherlands), Professor Harriet MacMillan (Canada), Dr Judy Shakespeare (UK), Associate Professor Carol Warshaw (US), and Associate Professor Mary Zachary (US).

The summary statements and consensus recommendations below have followed from a comprehensive review of evidence-based guidelines and supporting literature for health professionals about identification and management of partner violence, which focussed mainly on female victims, men who abuse partners, and rarely addressed their children.

In summary, following the review, each guideline was assessed by the authors according to the AGREE criteria – Appraisal of Guidelines for Research and Evaluation (18).

Recommendations that were supported by three or more selected guidelines and new draft recommendations to address the gaps we identified were subjected to two rounds of a consensus process (modified Delphi method) among the international collaborative group.

Participants were asked to score each recommendation from 1 (strongly disagree) through 5 (don't know) to 9 (strongly agree).

Recommendations were included if the median score was from 7–9.

The draft recommendations were reviewed by external stakeholders (see acknowledgementson page 9 for specific respondents) and suggested changes were considered by the collaboration and final recommendations then agreed.

Appendix: Acknowledgements

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United Kingdom

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Canada

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