Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry

L. Kevin Hamberger, PhD; Daniel G. Saunders, PhD; Margaret Hovey, BS

Background: *National surveys show that each year in the United States approximately 2 million women are battered by their husbands. Only a small percentage of these women are identified by physicians. The objective of this research was to determine the incidence and prevalence of spouse abuse among women seeking health care in a family practice clinic (or setting).* Methods: *During a two-month period, all adult women seeking health care from a family practice clinic in a medium-sized Midwestern community were asked to complete an anonymous questionnaire about whether they had ever been physically assaulted by their partners.* Results: *Of 476 consecutive women seen in practice, 394 (82.7%) agreed to participate. Of these, 22.7% had been physically assaulted by their partners within the last year. The lifetime rate of physical abuse was 38.8%. Only six women in the sample had ever been asked about abuse by their physicians.* Conclusions: *Although spouse abuse is common, physicians rarely ask about it. Physicans should be trained to detect and assess abuse among female patients.*

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In the past fifteen years, nationally representative surveys show that, each year in the United States, about 2 million women are battered by their husbands (about 4% of married women). Lifetime prevalence rates for all forms of violence are about 30%.[1,2] Other research[3] indicates even higher rates of violence among nonmarried couples. Many of these women are injured and require medical treatment.[4-6] Recent reviews by Burge[7] and Candib[8] conclude that violence against women constitutes an important health care issue confronting medicine. Both authors call upon family medicine to take a more active role in assisting battered women.

A recent review in the *Journal of the American Medical Association*[9] indicates that although large numbers of battered women seek medical care, both generally and for acute injuries, only a small percentage are identified by their physicians as battered. A number of studies have examined incidence and prevalence rates of battered women seeking emergency care services[4,10-13] and found that between 20% and 35% of women using such services were battered. They sought either direct services for injuries or treatment for medical or psychosocial problems associated with living in a battering relationship.[11] A common interpretation of studies of emergency services is that battered women are underidentified and that many of the estimates of incidence and prevalence underestimate the true rates of victimization in such settings. As an illustration, McLeer et al[12] found that implementation of a specific protocol for identifying battered women increased official identification rates from 5.6% to 30%. An earlier study by Stark et al[13] demonstrated that battered women were underidentified in the emergency setting by a factor of 10.

In addition to seeking medical treatment in emergency departments,[14] battered women are also likely to seek outpatient care for both routine health maintenance and the physical and psychosocial sequelae of victimization.[15,16] The sequelae include psychosomatic complaints, depression, anxiety, vague pain reports, and sleep disturbances.[13] To determine the effectiveness of physician education programs and protocols for detecting battered women among outpatients, it is important to determine a baseline of incidence and prevalence against which to measure intervention results. One very early study of battered women in outpatient practice found an incidence of less than 1%.[17] Although the author spoke of the importance of directly asking patients about abuse, the study is of limited use scientifically due to the lack of information about the methods used to sample the patient population and assess the presence of abuse.

A recent, more comprehensive survey of battered women in outpatient settings was conducted by Rath, Jarratt, and Leonardson.[18] Studying female patients at two locations, they reported that 44% acknowledged abuse. However, a number of methodological problems make interpretation of the results difficult. For example, the study did not specify whether the abuse was current or lifetime, an

From the Department of Family Medicine, Medical College of Wisconsin (Dr. Hamberger, Ms. Hovey), and the Department of Social Work, University of Michigan (Dr. Saunders).

important distinction for the purpose of treatment planning. Second, chart reviews were used to determine physician inquiry about domestic violence. However, previous research in emergency room settings found that chart audits might not be a valid means of assessing physician behavior.[12,19] A more appropriate measure would be to ask battered women directly about physician inquiry regarding violence. Furthermore, the survey was not randomly administered by independent surveyors. Clinic nurses recruited patients for participation. Patients were not recruited in a systematic fashion. Hence, the recruitment method could have been vulnerable to recruiter bias based in part on prior knowledge of the family situations of the female patients.

The purpose of our present study was to extend the work of Rath et al[18] attending to the methodological issues raised above. Based on rates found in national studies,[2] as well as the normally higher rates of abuse found among help-seeking women,[20] we predicted that about 20% of women surveyed would report being victimized within the past year and that lifetime victimization rates would appraoch 50%. Based on surveys of physician inquiry cited above, we predicted that detection rates would be about one tenth of the reported rate of violence.

Methods

The center in which the study occurred was a large, community-based family practice residency training clinic located in a medium-sized Midwestern community with a population of about 75,000. All ethnic, racial, and socioeconomic groups from the community were represented in the patient base of the clinic. The monthly unduplicated female patient census was about 180.

All consecutive eligible female patients attending the clinic for regular appointments during the eight-week period of June 1, 1991, through July 31, 1991, were asked to participate. Women included were between ages 18 and 75, with a history of a committed relationship of at least six-months duration. The women in the study were willing to participate, free of dementia, and able to speak English.

The survey questionnaire asked first about demographic data, including race, age, religion, and educational attainment. It next assessed relationship status, history of domestic assaults, and whether, during the participant's most recent visit, the physician had inquired about relationship stress and abuse.

The Conflict Tactics Scale (CTS)[21] was used to assess verbal and physical aggression experienced either within the past 12 months or at any time during the intimate relationship. The CTS presents 19 items in increasing order of abuse severity. Beginning with nonabusive tactics (eg, "discussed the issue calmly"), the scale progresses through verbal abuse (eg, "insulted or swore at the other") to minor physical abuse (eg, "pushed, shoved") to severe physical abuse (eg, "used a knife or a gun"). The CTS is the most widely used instrument for measuring severity and frequency of intimate violence. The validity and reliability of the instrument have been well established.[21,22] For purposes of this study, any woman who reported having at least been pushed or shoved was considered to have experienced assault.

All eligible female patients who attended the clinic for a regular appointment during the study period were asked to participate in the survey. Before the physician's visit, prospective participants were usually approached by a research assistant after they had been taken to the examination room. The research assistant was a female medical student with no prior knowledge of the individuals in the patient sample. If the patient could not be approached (due to an extremely busy schedule, for example), one of two alternatives was implemented. If possible, the patient was asked to participate after the doctor visit but before leaving the clinic. The final alternative was to contact the patient at her home on the day of their visit.

Participants were first provided with a verbal description of the survey study. If the prospective participant indicated willingness to participate, she was screened for study inclusion. If appropriate for the study, the participant was provided with the informed consent form to read, discuss, and sign. The survey was then administered, followed by discussion of any questions raised by the participant. Support was also given to any battered women who experienced emotional distress while completing survey items.

Survey participation was anonymous and confidential. Participants were assured that unless they directed otherwise, their surveys would not be included in the medical chart and that their physicians would have no knowledge of the results. This was done to prevent disclosure of victimization without the authorization of the patient and to reduce any anxiety on the part of the participant regarding her relationship with her physician.

Results

During the study period, 476 potentially eligible women attended the clinic. Of the potential participants, 394 consented to complete the survey, for a response rate of 82.7%. There were 20 surveys found to be inadequately completed, yielding 374 complete data sets. Descriptive characteristics of the sample are presented in Table 1. Analyses were conducted comparing recently battered women with nonvictims on the demographic variables. The two groups did not differ significantly on race and educational attainment. Victims were younger than nonvictims (age 28.9 versus age 37.8, t=5.96, df=210, P<.0001), and they were more likely to be separated or divorced than nonvictims (X^2= 18.5, df=4, P<.0001). Finally, compared to nonvictims, victims reported relationships of shorter duration (7.6 years versus 14.5 years, t=3.91, df=282, P<.001).

A total of 85 women reported having been physically assaulted by their partners within the past year. For the entire sample of 374, the incidence rate was 22.7%. Considering only those women who were "at risk" in the past year (ie, in an intimate relationship, recently separated, or divorced, n = 338), the incidence rate was 25.1%. Many of the assaults in the past year are severe. For example, 7.5% of the total sample reported that their partners had attempted to or actually hit them with an object. Three percent reported having received multiple blows. Slightly over 5% were choked, and almost 3% reported having been threatened or victimized with a knife or gun. Of the 85 women who reported being physically assaulted in the past year, 50 reported having sustained an injury of at least a small bruise. The injury rate for all women in the past year due to domestic assault was 13.3%; at-risk women had an injury rate of 14.8%. These data are summarized in Table 2.

Table 1

Demographic Characteristics of Sample (n=338)*

	Battered (%) (n=85)	*Nonbattered (%) (n=253)*
Religion		
Protestant	16.7	26.5
Catholic	36.9	45.4
Jewish	0.0	0.4
Other	29.8	17.7
None	16.7	10.0
	(*P*<.001)	
Marital status		
Married	37.6	58.4
Separated	8.2	1.5
Divorced	12.9	12.4
Widowed	1.2	2.0
Never married	40.0	26.0
	(*P*<.001)	
Race		
Caucasian	87.1	89.6
African-American	10.6	6.4
Native American	0.0	0.8
Hispanic	2.4	2.8
Other	0.0	0.4
Education		
Completed high school	40.0	35.3
Some college	31.8	30.5
Completed college	7.1	12.4
Some post college	3.5	6.4
Other	17.6	14.9

	M	(SD)	M	(SD)
Age	28.9 (*P*<.001)	(10.4)	37.8	(15.3)
Years in relationship	7.6 (*P*<.0001)	(8.2)	14.5	(14.7)
Visits to doctor per year	4.4	(4.1)	4.0	(3.3)

*Of those in a close relationship in the past year

Due to incomplete data, lifetime prevalence rates of victimization were based on responses from 335 participants. A total of 130 women reported having been physically abused by an intimate partner at some time in their lives, yielding a prevalence rate of 38.8% for the total sample; almost 19% reported having been hit or almost hit by an object. Between 12% and 13% reported having been beaten and/or choked. Ten percent reported having been threatened with a knife or gun. Hence, for women reporting both recent and lifetime intimate violence, sizeable numbers sustained serious, often life-threatening, assaults. The lifetime injury rate, based on responses of 351 participants, was 24.7%, including bruises as well as more severe injuries.

Respondents were asked whether, during their most recent office visit, their physicians had inquired about problems in close relationships, verbal abuse, or physical assault. For all types of visits, 6.5% of the women reported that their physicians asked about relationship problems; 2% were asked about verbal abuse, and 1.7% were asked about physical assault.

Table 2

Rate of Victimization and Injury in the Past Year for the Entire Sample (n=374) and for At-risk Women (n=338)

	Victimization		*Injury*	
	n	(%)	*n*	%
Total sample	85	(22.7)	50	(13.3)
At-risk sample	85	(25..1)	50	(14.8)

Table 3

Rate of Physician Inquiry

	Extended visit (%) (n=106)	*Brief visit (%) (n=187)*	*Total (%) (n=356)*
Type of Inquiry			
Problems in relationship	15.8 (*P*<.05)	7.5	6.5
Verbal abuse	9.4	5.9	2.0
Physical abuse	7.7	4.4	1.7

The above rates do not take into account the possibility that the most recent visit may have been brief and, therefore, not very amenable to asking about family issues. Therefore, a subsequent analysis was conducted on those survey participants (n=111) for whom it could be documented that the most recent visit was extended to include a complete history, physical examination, and first OB or psychosocial assessment/counseling session. Results of this analysis showed higher inquiry rates: relationship problems, 15.8%; verbal abuse, 9.4%; physical assault, 7.7% (Table 3).

Comparing inquiry rates for brief and extended visits, results were in the predicted direction for each variable and significant for inquiries about general relationship problems (extended visit participants, 15.8%; domestic violence, 13%; nonextended visit participants, 6.5%).

A chi-square analysis was conducted to determine whether victims of assault in the past year were more likely to be asked about verbal abuse and relationship problems than nonvictims. The results were significant (X^2=9.12, df=1, P<.002). Victims of current or very recent violence were more likely than nonvictims to have been asked about general relationship problems (20.5% vs. 7.5%, respectively).

Table 4

Questions for Uncovering
Suspected Abuse in Female Patients

Ask the patient direct, nonthreatening questions in an empathetic manner. Examples are:

1. I noticed you have a number of bruises. Could you tell me how they happened? Did someone hit you?
2. You seem frightened of your partner. Has he ever hurt you?
3. Many patients tell me they have been hurt by someone close to them. Could this be happening to you?
4. You mention your spouse loses his temper with the children. Does he ever lose his temper with you? Does he become abusive when he loses his temper?
5. Have there been times during your relationship when you have had physical fights?
6. Do your verbal fights ever include physical contact?
7. Have you ever been in a relationship where you have been hit, punched, kicked, or hurt in any way? Are you in such a relationship now?
8. You mentioned your spouse uses drugs/alcohol. How does your spouse act when drinking or on drugs?
9. Does your spouse or boyfriend consistently control your actions or put you down?
10. Sometimes when others are overprotective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
11. Your partner seems very concerned and anxious. Was he responsible for your injuries?

You may find it difficult to ask these questions. However, asking the question and identifying the woman as battered is the first step toward appropriate assessment.

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Discussion

The present study assessed rates of current and lifetime domestic violence among women seeking outpatient care at a family practice clinic. In general, the results were supportive of the predictions. About 23% of all eligible participants and 25% of at-risk women reported victimization in the past year. The survey found an overall prevalence rate of almost 40%, which is somewhat lower than the predicted lifetime prevalence rate of 50%. Finally, we predicted a physician inquiry rate of between 2% and 5% (one tenth of observed victimization rates). In terms of the overall survey, this latter prediction was well supported, with 2% of survey participants reporting inquiry about verbal abuse and 1.7% reporting inquiry about physical abuse. When only those participants with a previous extended visit were considered, physician inquiry rates were higher—9.4% for verbal abuse and 7.7% for physical abuse. The latter finding also suggests an important methodological implication: Survey research should use extended visits as the index for assessing physician inquiry.

The overall findings for current and lifetime victimization rates among outpatients were consistent with a number of studies of women seeking emergency services. In general, these studies[10-12] have found victimization rates of between 20% and 35%. The results, particularly for lifetime victimization rates, are similar to the rates reported by Rath et al[18] with outpatients. The present study extended the findings of Rath et al by distinguishing between recent and lifetime victimization. This distinction is important, particularly for intervention planning. Women in current or recent battering relationships are in immediate crisis, and crisis intervention methods, including lethality assessment and safety planning, are needed. Women who report lifetime victimization, but no immediate danger, may require assistance for a variety of problems arising from the violence, including depression, anxiety, and post-traumatic stress disorder.[13,23] Therefore, we recommend training physicians to specifically distinguish between recent and lifetime violence when inquiring about violence victimization.

The survey also showed that, compared to nonbattered women, battered women reported higher rates of physician inquiry about relationship distress and abuse. Our methods could not reveal whether this finding was explained by physicians' awareness of subtle indicators of abuse or if battered women presented obvious indicators. Further research in outpatient medical settings should clarify this issue.

With respect to rates of physician inquiry, the present results have several implications. First, the overall rates of inquiry were quite low, especially for physical abuse. This suggests the need for training in specific skills for assessing abuse victimization among female patients. There may be a general reticence among physicians to ask about violence. This is supported by the finding of much lower inquiry rates for verbal and physical abuse than for relationship problems. Such reticence could be due to a lack of skill in making such inquiries.

At least one study in an emergency setting showed that by using a specific protocol, detection rates initially increased dramatically.[12] Training physicians to use an assessment protocol among outpatients could also increase inquiry and detection rates. Suggested questions for assessing the presence of abuse are contained in Table 4. Other protocols and training materials are available elsewhere.[12,24] Once abuse is detected, the victim's safety must be the chief concern. She may need help finding shelter or filing a criminal complaint. Pictures taken of her injuries can be invaluable in criminal prosecutions. Follow-up visits are recommended. Some planning steps are given in Table 5. Judgmental statements and questions should be avoided. For example, Rath et al note: "A question like, 'Why don't you leave?' or a statement such as, 'I can't believe that Romeo beats you,' will place blame on her or lower her self-esteem, and she may not come back to her physician or anyone else."[18]

Although everyone on the health care team needs to play a role in the detection of abuse, not everyone may have the time or sensitivity to provide the necessary intervention. A specialist on the staff or someone on call from a local domestic abuse agency may be in a position to provide more comprehensive intervention and follow-up.[25] Women specialists may be preferable because there is evidence that they are less inclined to blame victims for their predicament.[26]

Although the present study extended previous research in this area by using methodological refinements, some limitations call for caution in its interpretation. First, the

Table 5

Follow-up Plan

- ✔ Determine the need for emergency shelter and work with the woman in analyzing whether the plan for emergency shelter is adequate.
- ✔ Develop a concrete plan for mobilizing help when violence erupts at home.
- ✔ Design a long-term planning process with a scheduled follow-up visit within the week.
- ✔ Give the woman the name and phone number of a contact person with the local group working with battered women.
- ✔ Give the woman the name and phone number of a contact person who can help her navigate through the legal process when necessary.
- ✔ If children are at risk, involve the child neglect/abuse team in the situaton and file an official report of suspected child abuse.

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study took place at only one clinic and, thus, should be replicated at numerous settings, including private community clinics. Second, the study asked women to recall whether, on the occasion of their most recent visit, a physician had inquired about abuse. Such retrospective inquiry could be biased by demand characteristics of the study. Furthermore, memory for such specific events as inquiry about abuse could be affected by the immediacy of the visit, even if it was extended. For some participants, the most recent extended visit was as much as one year prior to the survey.

Conclusions

Despite progress in this area, more work remains to clarify the factors involved in the help-seeking of battered women in outpatient settings. Even more work remains to identify and clarify reasons why some physicians do not detect domestic violence.

Our study found that substantial numbers of women seeking outpatient medical services had been battered either recently or at some time in their lives. Furthermore, many of these women had sustained physical injuries. Nevertheless, the vast majority of battered women reported that they were not asked about victimization by their health care providers. The high rates of incidence and prevalence, together with low rates of inquiry, call for the development of programs for training family physicians to identify, assess, and intervene with victims of spouse assault. Future research should focus on implementation and evaluation of such programs.

Corresponding Author: Address correspondence to Dr. L. Kevin Hamberger, St. Catherine's Family Practice Center, PO Box 598, Tallent Hall, Kenosha, WI 53141.

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Erratum

Two errors inadvertently appeared in the article "Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry," by L. Kevin Hamberger, PhD; Daniel G. Saunders, PhD; and Margaret Hovey, BS. The article was published in the May-June issue of *Family Medicine* (Fam Med 1992; 24:282-6).

In the abstract, the sentence that reads "Only six women in the sample had ever been asked about abuse by their physician" should read "Only six women in the sample had been asked about abuse by their physician in a recent visit."

The second correction involves the first two columns of Table 3, which show the rate of inquiry for *all* health care providers, not just physicians, as indicated. The correct data for physicians for extended and brief visits appear below.

Table 3

Rate of Inquiry for Physicians

Type of Inquiry	*Extended Visit (%)*	*Brief Visit (%)*
Problems in relationship	8.6	5.9
Verbal abuse	3.8	1.1
Physical abuse	1.9	1.1