

The background of the entire page is a light-colored, marbled paper with a complex, organic pattern of veins in shades of grey, beige, and white. A solid black rectangular box is centered horizontally and positioned in the upper third of the page, containing the title and subtitle in white text.

**Domestic and Family  
Violence in the Riverland**  
A Protocol for General Practitioners

# What is Family/ Domestic Violence?

Family or Domestic Violence is behaviour by one family member that causes physical, sexual and/or emotional damage to others in the family, including causing them to live in fear by threatening to harm people, pets or property.

Family violence is most commonly perpetrated by one partner towards another (when it is sometimes called “domestic violence”) and/or by an adult towards a child or children. Other forms include elder abuse and sibling abuse. Whether the violence is physical, sexual or emotional, it has long term health effects.

This Kit has therefore been developed to provide General Practitioners with information to assist them to identify and respond to the people who are most likely to be the victims of family violence.

**“The medical profession has key roles to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional.”**

**AMA 1998**

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## Acknowledgements

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The Women's Services Network, "Domestic Violence in Regional Australia, A Literature Review," June 2000.

North Western Community Health Service, "Stopping Violence Groups," 1997.

**Produced by the Riverland Domestic Violence Action  
Group, October 2000**

A recent study found that after family and friends, victims are most likely to tell health professionals about violence (Keys Young 1998).

Responding effectively to family/domestic violence in a medical setting requires knowledge of the physical and emotional consequences of the violence, an understanding of appropriate and inappropriate responses, and on having good networks with local family/domestic violence services.

## **Identifying Patient Needs**

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- Some signs of physical injuries may include:
- Injuries during pregnancy
- Bruising in the chest and abdomen
- Multiple injuries
- Minor lacerations
- Ruptured eardrums
- Delay in seeking medical attention
- Patterns of repeated injury

It is rare for physical injury to be the presenting complaint (Koss and Hesslett 1992). Women are often reluctant to disclose abuse because of fear, shame, or a belief that they won't be believed. More commonly presented symptoms may be:

- Stress related illness.
- Anxiety, panic attacks, stress and/or depression.
- Drug abuse, including tranquillisers and alcohol.
- Chronic headaches, asthma, vague aches and pains.
- Abdominal pain, chronic diarrhea.
- Complaints of sexual dysfunction, vaginal discharge.
- Joint pain, muscle pain.
- Sleeping and eating disorders.
- Suicide attempts, psychiatric illness.
- Gynaecological problems, miscarriages, chronic pelvic pain.

## **Other indicators**

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### **The woman:**

- Appears nervous, ashamed or evasive.
- Describes her partner as controlling or prone to anger.
- Seems uncomfortable or anxious in the presence of her partner.
- Is accompanied by her partner who does most of the talking.
- Gives an unconvincing explanation of the injuries.
- Has recently been separated.
- Is reluctant to engage.
- Presents with children, though little seems to be wrong with them.

### **Indicators in Children may include:**

- Aggressive behaviour and language.
- Anxiety, appearing nervous and withdrawn.
- Difficulty adjusting to change.
- Psychosomatic illness.
- Restlessness.
- Bedwetting.
- “Acting out”, such as cruelty to animals.

**“The AMA deplors all forms of Domestic Violence.”**

**AMA 1998**

## Asking about violence

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The detail of your questions will depend on how well you know the patient and what indicators you have observed. Broad questions might include:

- “How are things at home?”
- “How are you and your partner relating?”
- “What other things are happening at home that might be affecting your health?”

**Examples** of specific questions linked to clinical observations include:

- “You seem very anxious and nervous. Is everything all right at home?”
- “When I see injuries like this I wonder if someone could have hurt you.”
- “Is there anything else that we haven’t talked about that might be contributing to this condition?”

Some more **direct questions** include:

- “Are there ever times when you are frightened of your partner?”
- “Are you concerned about your safety or the safety of your children?”
- “Does the way your partner treat you make you feel unhappy or depressed?”
- “I think that there’s a link between your (insert illness) and the way your partner treats you. What do you think?”

## Listen

Being listened to can be an empowering experience for a woman who has been abused.

## Communicate empathy

“That must have been very frightening for you.”

## Validate the decision to disclose

“It must have been difficult for you to talk about this.”

“I am glad you were able to tell me about this today.”

## Emphasise the unacceptability of violence

“You do not deserve to be treated this way.”

## What *not* to say

“Why do you stay with a person like that?”

“What could you have done to avoid the situation?”

“Why did he hit you?”

## Assisting the woman to assess her and her children’s safety

- Speak to the woman **alone**.
- Does she feel **safe** going home after the appointment?
- Are her **children** safe?
- Does she need an **immediate** place of safety?
- Does she need to consider an **alternative exit** from your building?
- If immediate safety is not an issue, what about her **future safety**? Does she have a future plan of action if she is at risk?
- Does she have **emergency telephone numbers**? (police, Women’s refuges)
- Help make an emergency plan. (Where would she go if she had to leave? How would she get there? What would she take with her? Who are the people she could contact for support?)  
**Document** these plans for future reference.

## Documentation

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- Describe physical injuries. This includes the type, extent, age and location of any physical injuries sustained. If you suspect violence is a cause, but your patient has not confirmed this, it may be relevant to include your comments as to whether her explanation accurately explains the injury.
- Consider taking photographs of injuries.
- Record what the patient has said (using quotation marks) and any relevant behaviour you have observed.

**This information may be required as evidence should charges be laid against the perpetrator.**

## Guidelines for continuing care

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- Consider your patient's safety as a paramount issue.
- Empower her to take control of decision making; ask what she needs and present her with choices.
- Respect the knowledge and coping skills she has developed. You can help build on her emotional strengths, for example, by asking: "How have you dealt with this situation before?"
- Provide emotional support.
- Ensure confidentiality – the woman may suffer additional abuse if her partner suspects that she has disclosed the abuse.
- Be aware of appropriate referral services and assist the woman in contacting them if required.

**All available data indicates that the victims of domestic violence are predominantly women, with men being reported as perpetrators in 97% of incidents.**

**(NSW Bureau of Crime Statistics and Research, cited The Women's Service Network June 2000)**

## **To indicate your awareness of family/ domestic violence and willingness to assist**

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- Place domestic and family violence posters in the waiting area.
- Have pamphlets available in the surgery (where women can take them without being seen by other patients).
- Put a folder of health articles, including some on family/domestic violence, in the waiting room.
- Have your appointment cards printed with the phone numbers of domestic violence and sexual assault services on the reverse side.

## **Caring for those who are violent**

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People who are violent towards their partners and children may come to you for a number of reasons. Some of these reasons may include:

- Reasons not directly related to their violent behaviour, such as other medical complaints.
- To inquire about the welfare of their partner.
- To express remorse for their violent behaviour.
- To inquire about or seek assistance in dealing with their violent behaviour.

It is important that when providing care and assistance that this does not take the form of collusion. As some perpetrators of violence describe their actions and experiences there may be the temptation to minimise the violence and abuse, and so shift responsibility away from the perpetrator. An awareness of the effects upon whom the violence is inflicted is usually helpful in maintaining a true perspective of what has taken place.

Encourage those who are violent to name the violence and seek to understand its effects on other people. Encourage them to acknowledge responsibility for their behaviour, drawing attention to their ability to stop the escalation process and so develop confidence in their ability to bring about personal change.

Encourage the person who is violent to develop an appreciation of their partner's/children's experience of the impact of this violence and abuse. This is a process of acknowledging their violent behaviour and attempting to get them to put themselves in their partner's/children's shoes, speculating what it would be like to be on the receiving end of this behaviour.

Seek out appropriate referral agencies that work specifically with those who are violent.

## **Contact Numbers**

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### **Riverland Domestic Violence Unit (Berri):**

- Emergency accommodation for women and children.
- Support for women not needing accommodation but experiencing domestic violence.
- A referral point for other specialist services.
- Appointments and outreach.

**Office Hours: 8582 2100**

**After Hours via Police: 8595 2020**

**Crisis Care: 13 16 11**

**Relationships Australia**

**Men's Resource Line: 1800 182 325 or 8223 4566**

**Relationships Australia**

**Riverland Branch: 8582 4122**

**Child and Adolescent Mental**

**Health Service (CAMHS): 8582 4290**

## Appendix

### Australian Medical Association: Position Statement

#### **Domestic Violence**

1998

#### **Introduction**

The AMA deplors all forms of Domestic Violence. Domestic Violence is an abuse of power. It is the domination, coercion, intimidation and victimisation of one person by another by physical, sexual or emotional means within intimate relationships. Such intimate relationships include adult, parent to child, child to parent, and child to child. Child abuse, elder abuse and, in particular, abuse of a woman by her partner, are common forms of domestic violence. Family members, other than the person who is the direct recipient of the violence may be affected.

Domestic violence is a major social problem in Australia. Australian research reveals:

- a prevalence of domestic violence of one in seven people attending metropolitan Accident and Emergency Departments (Domestic Violence Victims in a Hospital Emergency Department by Roberts GL, O'Toole BI, Lawrence JM and Raphael B, Medical Journal of Australia 1993, Vol 159, 307 – 310),
- in a general practice setting, 22% of women in relationships have experienced physical violence in the past year (Physical, sexual and emotional violence against women: a general practice – based prevalence study, Mazza D, Dennerstein L and Ryan V, Medical Journal of Australia 1996 Vol 164; 14 – 17.), and

- 30% of women attending a public hospital ante – natal clinic during a one month period had a history of experiencing domestic violence (Domestic Violence in Pregnancy).
- A prevalence study by Webster J, Sweett S and Stolz TA Medical Journal of Australia 1994; 161; 466 – 470.).

There are major direct and indirect implications for the provision of health care services for the victims. Research indicates that victims of domestic violence receive more psychiatric treatment and have an increased incidence of attempted suicide and alcohol abuse than the general population (Two Case Control Studies of Domestic Violence in Emergency Department by Robert GL, Lawrence JM, O'Toole B and Raphael B.). Those who are witnesses to, but not victims of, domestic violence may also experience ongoing adjustment difficulties. Research strongly suggests that:

- people who have grown up in a violent household are far more likely to become perpetrators of physical violence in subsequent relationships.
- women who are physically abused are at greater risk of committing child abuse than women who are not physically abused; and
- high levels of physical complaints, school phobia, poor school achievement and adjustment problems are experienced by older children who have witnessed domestic violence.

**The AMA believes that:**

1. The medical profession has key roles to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional.
2. The role and extent of domestic violence, as a determinant of medical and psychiatric morbidity, should be included in undergraduate curricula and postgraduate training programs.
3. Continuing education of the profession is essential to emphasise the extent of domestic violence and the medical and psychiatric consequences for the victims.

4. Continuing education of the profession is also necessary to highlight the critical role of primary health care providers, especially general practitioners, emergency department personnel and midwives, in the early detection of victims of domestic violence.
5. Close collaboration and a coordinated approach with other community agencies is essential when dealing with domestic violence and its consequences.
6. There is a need for continuing research into the emotional and social aetiology of domestic violence. Development and evaluation of intervention programs for both offenders and victims should be significant components within that research. Strategies to prevent domestic violence must incorporate recognition, understanding, and management of underlying problems for the perpetrator.
7. Due attention should be paid to the child witnesses of domestic violence. Intervention may reduce the development of adjustment difficulties, and may modify the risk of those children subsequently becoming perpetrators of domestic violence.
8. Doctors have the responsibility to participate in community – wide efforts to establish and strengthen resources for victims and perpetrators, and to encourage preventive education programs through schools, the media and community organisations.
9. The AMA supports initiatives undertaken by Federal and State Government, which recognise and address issues relating to domestic violence within the community.

- **“Domestic violence is a significant problem within rural and remote communities.”**
- **“Where comparable data exists, they indicate that there is a higher reported incidence of domestic violence in rural and remote communities than in metropolitan settings.”**

**The Women’s Services Network, June 2000**