Identifying and Treating Wife Abuse

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Background. Wife abuse, acknowledged as a critical problem in our society, is often undetected by family physicians. The purpose of this study was to identify the problems and potential solutions encountered by family physicians in the identification and treatment of wife abuse in London, Ontario.
Methods. Family physicians in London were recruited to participate in four focus groups. The groups' discussions were audiotaped and transcribed. The transcripts were analyzed using qualitative methodology to determine relevant themes.
Results. Thirty-two physicians (16 male and 16 female) participated in the focus groups. The majority were in group practice (81%). The average number of years in practice was 11.75. An analysis of the focus group session identified two major clinical themes with subcategories: (1) physician issues (ie, identification, treatment); and (2) patient issues (ie, barriers to identification, symptom presentation).
Conclusions. The focus groups served as an effective method to engage family physicians in isolating their own as well as their patients' difficulties in confronting this serious problem.
Key words. Spouse abuse; family medicine; qualitative research; focus groups. *J Fam Pract 1993; 36:185-191.*

Wife abuse is now recognized not only as a significant social problem, but as a serious health concern.[1–4] Wife abuse has been shown to affect the health of its victims in many ways, causing injury, illness, and death.[3,5–7] Studies have shown that children who witness violence between their parents are at increased risk of childhood behavioral problems and of violence in future relationships.[8] Because of the frequency and severity of problems presented in the family practice setting by abused women and their children, family physicians have an important role in addressing these patients' concerns.[2,3] Also, the extended nature of the physician-patient relationship in family medicine provides opportunities for prevention and intervention in the problem of wife abuse.[9–13]

Despite these compelling data, family physicians typically recognize only isolated cases of wife abuse in their own practices.[4,14,15] The reasons for this low identification rate may be categorized as physician factors and patient factors.[11] Physicians may be reluctant to ask about wife abuse for various reasons, including misconceptions about the natural history of wife abuse, frustration with previous victims, and their own personal past experiences as a child witness or perpetrator.[2,3,9,11,16] Family physicians have also reported dissatisfaction with their skills in treating abused patients.[17] Patients may be reluctant to reveal their abuse because they feel partially responsible for it or because, during previous attempts at disclosure, they have felt blamed or accused.[3,13,18]

The purpose of this study was to identify the problems and potential solutions encountered by family physicians in the identification and treatment of wife abuse in London, Ontario, using qualitative methodology.

Methods

A qualitative method, focus groups, was used to explore the physicians' experience in the identification and treatment of wife abuse. Focus groups provide an opportunity for extensive interaction among the participants, which generates discussion and exploration of the problem under examination.[19] The use of focus groups allows the investigator to assume a participant-interviewer role and promotes the participants' expression of their perceptions.[20] Four focus group discussions were conducted.

Recruitment

The participants were recruited from a mailing list of 250 London area family physicians from the Thames Valley

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Family Practice Research Unit database. The physicians were initially sent a letter describing the project and the focus groups. Attached was a reply card for indicating their interest and preferred time to attend a focus group.

Eighty of the physicians responded, with 43 (52%) indicating an interest in participating in the focus groups. Based on their responses, dates were established for the four focus groups. The required numbers of physicians for the focus groups (eight per group) were recruited. Eleven other physicians expressed an interest in participating in the focus groups but could not attend owing to conflicts.

By telephone, the research assistant described to participants the purpose and goals of the focus group. The time and location of the focus group discussions were later confirmed by mail and telephone. Following their participation in the focus groups, the physicians were sent a thank-you letter acknowledging their contribution.

Demographics

A total of 32 physicians participated in the four focus groups with an equal distribution of male and female participants. The majority of the physicians were in a group practice (81%) and the average number of years in practice was 11.75 (range, 1 to 29 years). The main sources of educational information about wife abuse were the clinical (90%) and lay (81%) literature. Relatively few of the participants had acquired knowledge about wife abuse from workshops (9%) or continuing medical education refresher days (19%).

The male physicians reported identifying an average of 6 cases of wife abuse (range, 1 to 20) over the past year, and the female physicians reported identifying an average of 10 cases (range, 2 to 25), over the same period. (The average identified overall was 8 per physician.)

Focus Group Format

The focus groups were conducted during the summer of 1991, at the Thames Valley Family Practice Research Unit. Each group meeting lasted approximately 2 hours. Before the commencement of each, the participants were asked to complete a questionnaire regarding practice characteristics, previous educational exposure to the topic of wife abuse, and the number of wife abuse victims identified in their practice in the past year. They were informed that the group discussion was being audiotaped for future transcription and analysis. One of the authors (J.B.B.), who was trained in group interaction, acted as moderator of the focus group discussions.

Two broad questions, designed by the investigators in conjunction with community experts in the area of wife abuse, were presented to the groups in order to guide the discussion. The first question invited the participants to describe their experience in the identification and treatment of victims of wife abuse. This included their perceptions of the problems that they encountered in working with this clinical population, as well as successful strategies for intervention. The second question asked the participants to explore various methods that would assist them in increasing their identification of wife abuse and facilitating effective and appropriate treatment. While the moderator would occasionally summarize the discussion points or redirect the group participants when they strayed from the topic, a conscious effort was made to allow a spontaneous flow of additional ideas or issues pertinent to the subject.

Analysis

The audiotapes for each focus group were transcribed verbatim. The transcripts averaged 28 pages in length. When words or phrases could not be deciphered, this was indicated in the transcript and was considered lost data. No attempt was made to interpret the participants' comments. Each transcript was then analyzed to isolate the central issues that emerged in the groups. This was achieved by beginning with the key words, phrases, or concepts used by the participants during the discussion.[19,20]

The next phase of the analysis involved determining the similarities, contrasts, and potential connections among the key words, phrases, and concepts.[19,20] This resulted in the generation of the major themes and accompanying subcategories. The transcripts were reorganized according to these themes, which served to reduce and refine the data. In the final step of the analysis, the themes and subcategories of all four focus groups were combined and contrasted. This allowed the investigators to separate the issues that were pertinent to all the groups from those that were idiosyncratic to only one or two groups. For example, while the issue of treatment of victims was common to all the groups, only one group explored this topic from the perspective of specific intervention.

In addition, the phrases or quotes that most accurately illustrated the themes were identified. Thus, a composite of how the participants experienced the identification and treatment of victims of wife abuse evolved through this process of combining and refining the themes. Throughout all phases of the analysis the investigators participated in a process that included clarification, confrontation, and confirmation.

Focus Group Findings

The analysis identified two major clinical themes with subcategories: (1) physician issues (ie, identification, treatment); and (2) patient issues (ie, barriers to identification, symptom presentation). The following is a description of the major themes and subcategories. It is presented in order of the strength and pertinence to each group. Relevant quotes from the focus groups are offered for illustration.

Physician Issues

FACTORS CONTRIBUTING TO IDENTIFICATION

All of the four groups identified the importance of (1) responding to patient cues, and (2) permission giving. "Permission giving" included providing the patient with information as well as creating an atmosphere that promotes self-disclosure.

It is a lot of, not only cue finding, but cue giving. Are we cuing our patients enough so that it is OK to say that my husband beats me?

If you keep asking them all these open-ended questions . . . in some ways you are giving the message that it is OK to talk, that you are willing to listen, and that it is OK for them to talk about it. . . . you are giving them permission and at some point they are going to tell somebody.

Each of the four focus groups discussed feelings of guilt and discomfort when they felt they were "missing the boat" in terms of identifying wife abuse in their practice.

A more disturbing question to me would be: do I miss cues that are there, and do I precipitate a delay in the diagnosis, whereas somebody who was more accomplished would make the diagnosis when I have missed it?

In one of the journals I was reading, the number came up, 1 in 10, and I thought, 'What am I missing? Am I asking the wrong questions?' It was disturbing to me. . . . I am just not seeing those sorts of numbers and if I am seeing them, it is probably retrospectively.

All the groups thought it was important to "lay the groundwork," acknowledging that this would facilitate the patient's return to discuss the problem in the future.

It is a seed planted in your mind. You might not ask the question the first time, but you identify that there are stressors in the environment. You ask this and that, and then have the patient come back next week. In your mind you are getting an idea, and you make sure they come back and explore a little further.

Often during the physical examination I ask, 'Are you experiencing any stress in life?—is there anything that you want to discuss with me at this time?' Maybe that will be the true starting point. With other patients you can be more direct with the question, and if they know that you are comfortable dealing with it, they open up.

Each of the groups discussed the key role that attitude plays in the identification of wife abuse at three distinct levels: personal, societal, and professional. They also acknowledged that wife abuse is a problem that permeates all levels of society and is not specific to one social class or cultural or ethnic group.

I think that males resist this more than females because there is some sense that just by belonging to the male gender you are somehow part of the guilty side of the equation, which is irrational. . . . It is really a complicated thing to come to grips with . . . for most people and certainly myself.

Maybe as physicians we need to think about doing more than just being with our patient and just being good listeners. We need to be more political and more involved in changing our system and causing new legislation to be passed.

It doesn't matter what social class, what job, it's a problem that permeates all levels of society.

BARRIERS TO IDENTIFICATION

Three of the four focus groups identified the issue of time as a major barrier to the identification of wife abuse. For example:

If you spend time—and it takes time—you can't elicit the problem of wife abuse in less than 20 minutes. . . . Our whole system of general practice does not allow us, or encourage us, to do that.

Three of the four focus groups discussed their feelings of frustration with the patient's lack of change.

You get gratification from coming up with a diagnosis and treating it successfully. . . . We feel uncomfortable when somebody doesn't take our advice and the problem is not solved or we cannot solve it.

But the feelings of frustration are tempered by experiences such as the one described below:

You're always going to have the patients that go back. It's like anything that you deal with, there's a tremendous level of noncompliance, and you can't understand why somebody would ever go back into that relationship. But you also see a patient who's left an abusive situation and really grown in her self-confidence. She's made her way in life and developed a home where her children are secure. Every once in while you see that, and it makes it all worthwhile.

Lack of adequate training in the identification and treatment of wife abuse during medical school was highlighted by three of the groups. Concurrent with this issue was the failure of the medical model to appropriately address the problem of wife abuse.

I don't recall learning about this in medical school.

When I have somebody coming in with a problem, I want to solve the problem. Diagnose it and treat it and put it behind them then and there. That is being a doctor. Putting it into the medical model. But the problem here is that the medical model doesn't work with wife abuse.

Two of the four focus groups discussed the issue of outcomes as it related to the physician-patient relationship. After inquiring about the potential of wife abuse, several physicians had patients leave the practice. Other outcomes included being threatened by the perpetrator either physically or legally.

Nobody ever complained to the College about me, but someone did threaten to blow my head off. There was no question that this man was capable of using whatever verbal or physical violence it takes to suppress opposition, including blowing my head off.

Two of the groups identified physician sex as a key factor that may influence identification.

Another block I find is that you've got a woman who is being abused by her husband, and often it seems that they have been abused by their fathers, and their fathers abused their mothers, and their ideas of men are not real great, so why should they come and tell me what is going on?

TREATMENT

A catch phrase for all the groups regarding the treatment of wife abuse was "You don't identify what you can't treat." This is exemplified by the following statement:

I find it very frustrating, and intimidating, to uncover this thing, and then just sit there and feel totally impotent about what to do. That is probably why I don't go digging for it, because what do I do with this can of worms?

You have to know how to deal with the problem. If you don't know how to deal with the problem, you don't want to find it.

Two of the four focus groups expressed concerns about the lack of resources for the treatment of wife abuse and their lack of familiarity with the resources that do exist in the community.

When I make a referral I don't have a good sense of what is happening to my patients in the community programs. This may inhibit me from actually identifying some cases.

The impact of wife abuse on children was discussed by two of the groups. For example:

If you tell them what they are doing by staying in the situation, regardless of what it is doing to them, it is teaching their son to become an abuser, and if they have a daughter, it is teaching their daughter to be abused; that it is OK to be abused, that it is an expected normal thing—and do they want that? Do they want their daughter to grow up being abused? They don't. The don't want their son to grow up treating another woman the way they are being treated. . . . Once you know somebody well enough, you can bring that out.

Two of the focus groups examined the need for resources for the male partner and the difficulties encountered in securing access to treatment programs for perpetrators.

You talk about it being difficult to get a woman into a shelter—well, that's easy compared with trying to find somebody who's going to help the man change, or somebody who will deal with the relationship.

While all the groups explored the issue of treatment under the above topics, only one group of physicians explored treatment methods in detail. For example:

Maybe all you can do in the meantime is to support them within their relationship over a period of time . . . try to work on self-esteem issues and help them gain some insight into why they are there . . . get them strong enough to either leave or to come to terms with it and stay.

Patient Issues

BARRIERS TO IDENTIFICATION

All of the four focus groups observed that economic issues were a major factor that restricted women from seeking help.

A lot of them are trapped in economic situations.

There isn't a lot of backup that one needs in terms of the social structures to support women in this very difficult situation.

In addition, all of the groups perceived societal and cultural attitudes as central barriers to patients seeking help.

I think there are problems with it at all levels, including the courts and the judges' opinions and what they are saying to people who have gone through the system.

I have a patient who recently told me that she is abused by her husband. She has been a patient of mine for a few years, and I asked her in the end why she waited until now to tell me. She said, 'Because my dad used to abuse my mom, and I thought that this was the thing to do.'

All four of the focus groups discussed the need for patients to be educated about the various roles their family doctor could play in their care. For example:

You try to leave the impression that you are there to do more than sew them up and fix their whatever, that your definition of being a doctor includes other things too. There is a constant need to educate people about this.

All of the groups recognized the significant role that timing plays in the patient's decision to disclose the abuse.

You keep on asking, you ask open-ended questions, you ask specific questions. At a certain point, if people are not ready to discuss it, they are not ready to discuss it.

You keep on making gentle inquiries but they have to come to it in their own time.

All of the groups acknowledged how the patients' feelings about being victims of wife abuse could influence their decision to seek help.

Some people view having to go for counseling as a failure. If they can just keep it quiet, just keep it within their relationship, then they can be perceived in the community as a successful unit. If they actually have to go to the doctor and say, 'This really is a problem, I really do need some help,' they feel a sense of failure and embarrassment.

Living in a physically abusive relationship beats down your self-esteem. A lot of the women start to think they really aren't worth anything and there really isn't anything better for them out there. They'll never cut it if they leave. They feel very fragile. The men often tell them that they are responsible for the beatings, and they have a hard time believing that they're not responsible.

Related to this was the awareness of the patient's tenuous social supports.

The wife really stands to lose not only her marriage relationship but a lot of extended family relationships. If they are the only family she's got in town, and her own family is a fair distance away, there's a tremendous isolation that she's going to feel.

PATIENT PRESENTATION

All of the four focus groups discussed the importance of listening for and acknowledging patient cues.

What cues do people give you? You work in the emergency department, and somebody comes in and says she's fallen down a set of steps or she got a black eye from walking into a door. Do you just accept that or do you take it further at that point?

It's amazing what people will tell you if you give them the chance to tell you, even doing locums, if you look for the right cues and clues.

Concurrent with recognizing patient cues was the physicians' awareness of the breadth of symptom presentation and knowledge of significant risk markers.

People who present, who are being abused, they present to your office for whatever reason, they often want you to find out that they are being abused. They present with what is perceived as a legitimate problem . . . for example, they come in with bowel pain, and you may

wonder if it's gallbladder or an ulcer. . . . We also need to wonder if they are under some stress, if this is related to their job, or whatever. I think what we need to do is make sure that you keep the concept of abuse as one of those problems that might be going on.

It often surfaces out of people having other kinds of problems. When you get beneath the presenting problem, there was a history of abuse either back in their family of origin or in their current situation. That led to other problems that were more on the surface, and so you become aware of it [the abuse] secondarily.

Alcohol was seen as a major risk marker. For example:

A lot of the abuse that I have seen in my practice is tied into both drug and alcohol abuse. It is not an excuse that 'it is okay because I am drunk that I abuse my wife.' If you are looking at high-risk families within your practice and you identify those that have a drug or alcohol problem, you are more likely to pick up those with abusive relationships.

Nonphysical cues such as depression and low self-esteem were also important risk markers.

When I see irritable bowel or depression, I go right to the issues, asking about home life and what is going on.

If anyone comes in with nonspecific complaints and nothing correlates, I begin to wonder about the potential of abuse.

Discussion

The findings indicate that the family physicians in this study were concerned about the problem of wife abuse. Their discussions revealed that it is a complex and multifaceted issue for which there are no easy solutions. The challenges involved in confronting the problem of wife abuse included the physicians' own personal and professional issues as well as the complexities of the patients' experience and presentation in the physician's office. The physicians explored various strategies for improving their identification and treatment of wife abuse. From the physicians' perspective, this included behavior such as giving the patient permission to disclose, sensitivity to sociocultural issues, and awareness of community resources and treatment programs for victims of wife abuse. In relation to patients, the physicians acknowledged the importance of symptom presentation and potential risk markers for wife abuse.

While the findings of qualitative research, such as in this study, are not generalizable to other populations, it is worth noting that similar themes emerged in Sugg and Inui's qualitative study of primary care physicians' response to domestic violence.[16] The focus group method had some advantages in comparison with the long-interview method or the survey technique previously used to study the problem of wife abuse in the family practice setting.[16,21]

The focus groups promoted interaction among the participants and provided immediate feedback. Also, by conducting more than one focus group, the researchers had an opportunity to expand and refine the database.

The use of focus groups not only uncovered valuable information about a problem but also provided direction in creating strategies to learn about and understand the experience. The focus group participants allowed us to enter their world of practice and to examine how some family physicians address the serious health concern of wife abuse.

By sharing their stories of working with victims and their families, the physicians explored problems and solutions in treating and identifying wife abuse. The following vignettes summarize the experience:

A woman came into my office, and 20 minutes into this classic story of tears and anguish, paperbags full of bottles of pills of various kinds, multiple surgical assaults on the body, everything you could possibly imagine, I said, 'What do you mean your husband is aggressive?' One little cue, one little word . . . 'He is an aggressive man.' A follow-up visit provided a story of 30 years of horrendous physical and psychological abuse.

I had a kid sitting in my waiting room where there is a poster showing a man slamming the door on his wife. He's a fairly vocal kid and he said, 'That's what my daddy does to my mommy.' That's one strategy that obviously works. Having a kid see a picture of a father beating a mother up . . . that brings the problem forward.

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