SRH clinical consultations: domestic abuse (DA)

Zeynep, a 24 year-old beautician, sees her GP practice nurse about contraception. She starts the consultation by saying, “My husband wants to start having babies now, but I want to wait a bit”. The practice nurse discusses her contraceptive options and Zeynep opts to start the combined hormonal contraceptive pill.

The nurse is curious about Zeynep’s initial statement and asks about her relationship and directly about domestic abuse. Zeynep says her husband can be quite controlling and when stressed calls her names and throws things. He insists she texts him when she comes home from work, and if she doesn’t, he rings incessantly until she answers. He has banned her from going to evening work events, as he fears she will cheat on him. Recently, he became threatening and abusive about her wearing make-up, accusing her of having an affair. She is now careful about how she dresses and only wears subtle make-up. He has never physically or sexually assaulted her, and he does not have financial control over her.

The nurse responds by acknowledging the abuse and explaining about services that could help her. Zeynep is not sure whether she wants to speak to any specialist services but does agree to a follow-up appointment with her GP. She is concerned her partner may be able to access her notes online. The nurse retracts the consultation from online access.

Over the following months Zeynep has several conversations with her GP about the abuse. She later agrees to speak with an Independent Domestic Violence Advocate (IDVA) at the local Domestic Abuse service. She decides to end the relationship and engages with counselling through the DA service. Her next relationship is healthy and fulfilling.

DA definition

The UK Domestic Abuse Act 2021 defines domestic abuse as abusive behaviour occurring between persons each aged 16 or over who are ‘personally connected’ to each other. Behaviour is “abusive” if it consists of—

(a) **physical or sexual** abuse
(b) **violent or threatening** behaviour
(c) **controlling or coercive** behaviour
(d) **economic** abuse
(e) **psychological, emotional** or other abuse

This includes behaviour which is a single or a series of incidents. Reproductive coercion is a form of abuse. Cases involving children are beyond the scope of this article.

DA prevalence in a community setting

Intimate partner violence contributes more to the disease burden for women aged 18 to 44 years than any other well-known risk factor, like tobacco or illicit drug use or high cholesterol.[1]

A cross-sectional survey of women attending a London GP practice found that 74% had experienced controlling behaviour by a partner, 46% had been threatened and 41% had experienced physical violence. And 17% had experienced physical violence in the previous 12 months. Less than one in five had any reference to DA in their medical records.[2]

Asking about DA in a meaningful way

a) Introducing the topic

Like all sensitive topics, it is important to signpost the change in subject, and explain why you want to explore this. In Zeynep's case, the nurse could simply state, "I'm interested in your comment about your husband wanting a baby when you don't, would it be ok to ask you more about this?" Other effective techniques to raise the topic include linking DA with symptoms, e.g.:

- "When people have [low mood, headaches, drink excessive alcohol etc], it's important to understand more about what's going on at home, so I'd like to ask you some questions about that, if that's ok with you?"
- "Often people with chronic pain can have a lot of pain or tension in their lives which is reflected in their bodies. Is this something that's happening to you do you think? Could we talk about what your home life is like?"
- "Some people describe these symptoms/feelings when they are at risk of abuse from another person. Could I ask you a bit more about things at home?"

If you use a proforma, e.g. HARKS (Humiliate, Afraid, Rape, Kick, Safety) [3] that includes questions about DA, think about how to ask these in a way that is different to routine medical questions. If patients feel rushed to give a yes or no answer, they might be less likely to open up. Changing your speed, rhythm and tone, can help indicate you are interested in hearing a fuller response.

b) Specific questions about domestic abuse

After starting with an open question or two (e.g. how are things at home? Can you tell me more about your relationship with your partner/family? Can you tell you me more about your home life?), ask more focused questions about DA (see Box 1).

Box 1: More focussed questions about domestic abuse

- Do you feel safe? Do you ever feel unsafe at home?
- Do you ever feel controlled by your partner?
- Do you feel you have to 'walk on eggshells'?
- Do you ever feel afraid or humiliated by anyone at home?
- Has anyone at home ever hurt you?
- Are you having problems with your partner/husband/anyone at home?

If your patient reports domestic abuse...
Assess safety

- Is it safe to go home?
- What are you afraid may happen?
- What has the perpetrator threatened?

Don't forget CHILD SAFEGUARDING

- Are any children involved? How?
- Has the abuser hurt the children?
- Has the perpetrator threatened to harm the children?

Responding compassionately to patients who report domestic abuse

Gather information about the abuse, allowing your patient to share their story in their own words. Thank them for telling you and, although it may seem simplistic, emphasise it is not their fault, and everyone has a right to be safe. Acknowledging this and the impact of the abuse is important to survivors. Tell the patient that you believe them, and that support is available. Empower the patient and do not encourage them to leave a high-risk situation without planning and support.

A referral to specialist DA services (e.g. IRIS services in general practice) is recommended, as they have experience in identifying and meeting the psychological and emotional needs of survivors and access to expertise in housing, legal and immigration matters. They can also assist with Multi-Agency Risk Assessment Conference (MARAC) [4] referrals for high-risk cases (see Box 2 [5] and Supplementary Box 1). Ending a relationship is a high-risk period as violence can often escalate; involving DA services can help with planning this safely. GP practices can be safe places to arrange meetings with IDVAs.

Box 2: SPECSS+ Indicators of Higher Risk DA [5]
S eparation (including child contact dispute)
P regnancy (including new birth)
E scalation (of violence)
C ulture (community isolation and barriers to reporting)
S talking
S exual assault

Plus

- Abuse of children
- Abuse of pets
- Access to weapons
- Either victim or perpetrator being suicidal
- Drug and alcohol problems
- Jealous and controlling behaviour
- Threats to kill
- Mental health problems

If a patient does not want a referral to DA services, consider referral to a generalist talking therapy service. If you are not based in general practice, ask the patient for consent to inform their GP.

Agree when and how you will follow up. In general practice, encourage patients to let you know about future incidents so these can be documented contemporaneously. Document your consultation carefully (medicolegal reports may be needed). Consider restricting access to patient notes online if there are concerns perpetrators could look at these – find out how to do this if you are unsure.

Recovery from domestic abuse is a process that takes time and space; with enormous benefits for the survivor's health and wellbeing in many different ways.

References

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