Domestic Violence: Prevalence among Women in a Primary Care Center – A Pilot Study

Mirta Grynbaum MD[1], Aya Biderman MD[1], Amalia Levy PhD MPH [2] and Selma Petasne-Weinstock MD[1]

[1] Department of Family Medicine, Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer Sheva, Israel
[2] Department of Epidemiology, Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer Sheva, Israel

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Abstract

Background: Domestic violence is a prevalent problem with serious consequences, including the risk of death. The lifetime prevalence ranges from 21 to 34%, with 8–14% of them reporting abuse in the previous year. The incidence seen in primary care practice is about 8%. Despite this high rate, domestic violence is under-diagnosed in primary care.

Objectives: To estimate the prevalence of domestic violence among women visiting a primary care center, to characterize them and to evaluate a screening tool.

Methods: A brief anonymous questionnaire (in Hebrew and Russian) for self-completion was used as a screening tool. During October 1998 we distributed the questionnaires in a primary care clinic in Beer Sheva to all women aged 18– 60 years whose health permitted their participation. A woman was considered at high risk for domestic violence when she gave a positive answer to at least one of the three questions related to violence. The risk factors for domestic violence were calculated by odds ratio with 95% confidence intervals.

Results: The response rate was 95.7%. We found 41 women (30.8%) at high risk for violence. Women preferred talking about this issue with their family physician. Women at highest risk were older than 40 years, had emigrated from the former Soviet Union during the last 10 years, were living alone, and were unemployed. None of the women visited the Domestic Violence Center during the study period and 2 months thereafter. Only three women tore off the Center's address and phone number attached to the questionnaire.

Conclusions: The anonymous questionnaire was well accepted and had a high compliance rate. Its disadvantages are that respondents must be literate and that it permits the woman to continue with her "secret-keeping" behavior. A high prevalence of domestic violence among women visiting a primary care clinic should convince family physicians to be more active in diagnosing the problem accurately among their patients, providing treatment and preventing further deterioration and possible danger. Further effort should be directed at improving the clinic staff's ability to detect domestic violence among patients, and at developing management programs in the health system to help combat domestic violence.

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Domestic violence against women has become a prevalent social and health issue that has serious consequences [1]. The lifetime prevalence in the literature ranges between 21% and 34% [2–4]. The lifetime risk for severe injury is 9%, and in the United States 30% of all murdered women were killed by their partner [1]. Domestic violence during the past year is estimated to affect 8–14% of women [3,4], and 5% are currently afraid of their partner [3]. In a primary care setting in the USA, the incidence of battered women was 9% [5]. Among women who are treated for psychiatric symptoms or attempted suicide, 25% have been battered [4].

In Israel, 23% of women who visit a primary care clinic have suffered violence during the previous year, and the lifetime rate is 39% [6]. A recent national survey in Israel found that 11.5% of adult women were victims of partner violence during their lifetime [7]. Of these, 3% were abused during the previous year. The rate was higher in those who were Hebrew or Arabic speaking, divorced, and with less than 12 years of education. Abused women rated their health status as worse, had a higher rate of depressed mood, and had more need for psychological treatment during the previous year.

A high risk period for domestic violence is during pregnancy: 20% of pregnancies have violence-related complications, such as fetal trauma that sometimes results in death, premature delivery, fetal-maternal bleeding, amnionitis, abruptio placentae, etc. [8]

A "battering syndrome" has been described, in which a physical assault is followed by an increase in medical and emotional problems [2]. Abused women make frequent visits to emergency rooms, are high consumers of health services, and frequently visit the family physician. Common symptoms include somatic and functional complaints such as abdominal pain, headache, irritable bowel disease, pelvic pain and others [2,4,9,10]. Women who suffer domestic violence have a high incidence of psychiatric problems, such as depression, anxiety, sexual dysfunction, post-traumatic stress disorder, and suicide attempts [2,4,11–14]. Domestic violence is a major risk for serious injuries and for death [1,4,8,14].

The problem of under-diagnosis of domestic violence can be attributed to several factors [5,14] – which are related to both the abused woman and to the healthcare provider. The woman is afraid and feels threatened, financially insecure and helpless.

She is often unaware of her rights and the resources available for help. The healthcare provider feels insecure and lacks awareness of the relevant laws and regulations as well as the options to ensure the patient's safety [4,14]. The law in Israel considers abused women legally as adults, who can decide for and defend themselves and therefore report their abuse themselves. This is in contrast to the law's category of "helpless people" (elderly, children) for whom there is a legal obligation that mandates anyone aware of the abuse to notify the authorities [15].

The objectives of our pilot study were to estimate the prevalence of domestic violence among female patients who visit a primary care clinic, to characterize those women who report being abused, and to evaluate the use of a brief anonymous screening instrument. The screening questionnaire was based on the Partner Violence Screening tool [14]. We also wished to estimate the influence of our screening on the rates of consultation with the Domestic Violence Prevention and Treatment Center in Beer Sheva.

Methods

The design was a quantitative descriptive pilot study. We used a brief anonymous questionnaire for self-completion, based on the "Brief screening questionnaire for detecting partner violence in the emergency department" (Partner Violence Screening tool) (14). The questions included:

- Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

We included questions regarding demographic characteristics and the women's wish to talk about the issue:

- Would you want to talk with someone about this issue? If so, with whom? (Options: your family physician, your nurse, your social worker, a policeman, someone else).

The questionnaire was translated to Hebrew and Russian using the double translation method [16]. Demographic data collected included the woman's age, education, occupation and religion, the number and ages of her children, her family status, and number of household members. Attached to the questionnaire was the address and phone number of the Domestic Violence Prevention and Treatment Center in Beer Sheva, which treats domestic violence at all levels of care.

During October 1998, physicians and nurses in the primary care center distributed the questionnaires to all women aged 18–60 years who could read and write in Hebrew or Russian and whose health permitted their participation. For assessment of compliance, the physicians and nurses conducted a register of all questionnaires distributed and collected the demographic data of those women who were not included due to their refusal to participate or to their medical situation.

In the waiting rooms of the clinic we posted signs with information about the screening process and asking women to participate in the study. The completed questionnaires were put into a sealed envelope and into closed boxes located in the waiting rooms. The envelopes were collected at the end of each workday.

A woman was considered at high risk if she answered a positive answer to at least one of the three independent questions related to violence.

For contingency table analysis, the chi-square or Fisher's exact tests were used as appropriate. Analysis of continuous variables was performed using one-way ANOVA. The comparison of socioeconomic risk factors in abused women and non-abused women was calculated by odds ratio with 95% confidence interval.

Results

During October 1998, 169 questionnaires were distributed to women visiting the clinic; 139 matched the inclusion criteria and 133 questionnaires were completed (response rate 95.7%).

Table 1. Characteristics of women included in the study (n = 133)

Characteristics	%	No.
Age (mean ± SD)	39.2 ± 10. 5	133
Degree of religiosity*		
Orthodox	12.4	15
Traditional	46.3	56
Secular	41.3	50
Family status *		
Married	75.0	99
Single	12.1	16
Divorced	11.4	15
Widowed	1.5	2
Years of education*		
<8	6.8	9
9–12	43.9	58
>12 (not university)	27.3	36
University	22.0	29
Occupational status*		
Housekeeper	39.8	51
Unemployed	6.3	8
Self-employed	2.3	3
Employed	51.6	66
No. of children		
0	18.0	24
1	16.5	22
2	25.6	30
3	18.8	25
4+	24.1	32
Country of birth*		
Israel	32.5	38
Eastern Europe	37.6	44
Asia/Africa	25.6	30
Europe/America	4.3	5
Duration of residency in Israel*		
> 10 years	21.6	21
< 10 years	39.2	38
Born in Israel	39.2	38

* Total number is not 133, due to missing data.

Table 2. Distribution of positive answers among women who were defined as high risk for domestic violence (n = 41)

Violence status*	%	No.
Physically abused once or more during the previous year	21.7	13
Felt insecure with current partner	45.0	27
Felt insecure with former partner	33.3	20

* Women could answer positively for any of the questions. The total no. of positive answers was 60.

Table 3. Socioeconomic and demographic risk factors for domestic violence (n = 133)

Variable	Odds ratio	95% Confidence interval	*P*
Age			
(> 40 vs. ⩽40 years)	2.6	1.1–6.1	0.01
Family status			
(others vs. married)	4.4	1.8–11.0	<0.001
Country of birth			
(Former USSR vs. other)	2.3	1.1–5.4	0.03
Duration of residency in Israel			
(for those not born in Israel)			
(<10 vs. ⩾ 10 years)	4.3	1.2–16.0	0.01
Occupational status			
(not working vs. working)	2.4	1.1–5.6	0.02

Table 1 shows the demographic characteristics of all the women in the study.

By our definition, 41 women (30.8%) reported one or more kinds of violence and were considered high risk. Table 2 shows the frequencies of the different responses to the domestic violence questions. A relatively high proportion of women reported feeling insecure with a current partner, which might be related to all kinds of violence and not only to physical abuse. No direct questions were asked about sexual abuse, psychological or other kinds of abuse.

Table 3 depicts the different risk factors associated with domestic violence. Women who were unmarried, older than 40, new immigrants from the former USSR, and not working were at the highest risk. Almost all women said they were willing to talk about this issue with their family physician (92%), both those who were at high risk and those who were not.

During the study month and for 2 months thereafter, there were no new visits of women from the clinic to the Domestic Violence Prevention and Treatment Center. Only three women tore off the Center's address and phone number that were attached to the questionnaire.

Discussion

The compliance with the screening tool was 95.7%, higher than reported in other studies – namely 81.6% [2] and 76% [14].

In our study the high risk women represent 30.8% of the respondents. The incidence of physical abuse during the last year was 10% among all respondents. This result is close to the incidence of 9% found in a large study in primary care clinics in the USA [5]. A national Israeli survey found a lifetime prevalence of domestic violence of 11.5%, with 3% occurring during the previous year [7]. This may be a clue to the higher incidence of violence among women who visit the clinics than in the general population. We also found a high number of women who felt threatened by their partners, both a current partner and a former one, probably reflecting the result of all kinds of abuse among women.

In our study the age of 40 years or more was found to be a risk factor for intimate partner violence. This result differs from other studies, where age younger than 36 was found to be a risk factor [2,8]. Lack of a partner was also associated with domestic violence in our study, as in other studies [1,2,7]. In Israel, divorced or pregnant women were at higher risk for domestic violence [7,8]. We also found that immigration to Israel during the last 10 years was a powerful risk factor, especially immigration from the former USSR. This contrasts with findings in a recent survey in Israel, where Hebrew and Arabic-speaking women were at a higher risk [7]. Women who did not work outside their home were at a very high risk, which concurred with almost all studies [1,8,14]. Other studies found that low income was also an important factor [1,2,8], but this question was not included in our brief questionnaire.

Thus, immigration, unemployment, pregnancy, and low income are all stressful situations in which the risk for domestic violence is higher. Lack of a partner may represent a cause or a consequence of intimate partner violence. It may contribute to the woman's instability and low self-esteem, which can play an important role in domestic violence. Our finding that women who have recently immigrated to Israel from the former USSR are at a higher risk may also be related to the stress of immigration.

In this study we did not include some relevant variables, such as the partner's characteristics and the woman's psychiatric and physical complaints. We did not directly ask about other kinds of domestic violence such as psychological and sexual abuse. We preferred a short questionnaire that would improve the response rate.

We did not include women who spoke languages other than Hebrew or Russian and who could not read and write, and therefore our results may not be generalizable to all adult patients visiting a primary care clinic in Israel. Another limitation of the brief questionnaire is that it was self-completed, without the involvement of the healthcare professional and patient in an open and direct discussion and without a therapeutic relationship. This permits the woman to continue with her "secret-keeping" behavior that is so typical for abused women. Although these limitations were known, our anonymous questionnaire had a high compliance rate, contained vital information for the woman at risk, and could open a dialogue if she desired such.

We conclude that screening for domestic violence in primary care is effective. We found a high percentage of abused women, and the characteristics of these high risk women may contribute

to our awareness. Thus, clinic staff should devote more attention to women who are over 40, not married, new immigrants from the former USSR, and unemployed. The family physician has a key role in detecting high risk women, inquiring about possible abuse, and diagnosing the problem. In addition, family physicians could help in working out a management plan and a support system as a part of the patient's healthcare.

During the screening month, the awareness of the physicians and nurses regarding this issue had increased. Further work should be directed at improving this ability and helping the healthcare personnel, the women and their families, to combat the epidemic of domestic violence.

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Correspondence: Dr. A. Biderman, Dept. of Family Medicine, P.O. Box 653, Beer Sheva 84101, Israel.
Phone: (972-8) 647-7436
Fax: (972-8) 647-7636
email: sbider@netvision.net.il