Domestic and family violence:
Role of the general practitioner

Wei-May Su

Trigger warning: Domestic and family violence content

This issue of *AJGP* includes a series of articles that explore the patterns, impacts and clinical relevance of domestic and family violence, including coercive control, trauma and abuse.

These articles may be distressing, particularly for readers with lived experience or those affected through their clinical work. We encourage you to care for your wellbeing as you engage with this material – whether by pausing, seeking support, debriefing with trusted peers or supervisors, or accessing personal or professional support services.

Understanding domestic and family violence is crucial to providing safe, compassionate and trauma-informed care – but it is also emotionally demanding work. Please read at your own pace and take care of yourself.

If you need support, consider contacting:

- your general practitioner
- professional counselling or employee assistance services
- general practitioner support services (eg Drs4Drs [1300 374 377], The Royal Australian College of General Practitioners' GP support program [1300 361 008])
- domestic and family violence support organisations (eg 1800 RESPECT [1800 737 732], Men's Line [1300 789 978])
- other community support services (eg Lifeline [13 11 14], Beyond Blue [1300 224 636]).

DOMESTIC AND FAMILY VIOLENCE is common.[1] In Australia, one in four women (and one in eight men) report ever being affected by abuse or violence by a family member or intimate partner.[2] General practitioners (GPs) therefore will be exposed to domestic family violence because of the high community prevalence and the impact on health.[3]

Despite the high prevalence, some GPs feel uncertain about their role in addressing domestic and family violence, with a perception that this might be a sociocultural issue and not within their role as a medical practitioner.[4] For GPs who do recognise their role in caring for patients affected by domestic and family violence, detecting and knowing how to respond to underlying abuse and violence can be a challenge.[5–7]

There is strong evidence that the presence of abuse and violence has considerable health effects.[1,3] However, as outlined in the paper by Neil et al in this *AJGP* issue, the presentation of domestic and family violence might be unrecognised by clinicians.[8] It is common that a person who has experienced or uses violence might not readily self-disclose. Instead, domestic and family violence might underlie undifferentiated, frequent and/or complex health presentations, including chronic pain, suicidal ideation, depression, addiction or gynaecological issues.[9] Children should always be considered when any domestic and family violence is present.[1] Research shows that there is an expectation and acceptability that health practitioners do ask about the possibility of domestic and family violence.[10] Domestic and family violence is a social and community issue, but it is also a health issue, and there is an increasing recognition for the need to also address the intergenerational impact within families,[1,11] which should not be ignored by health professionals.

Our definitions and understanding of what constitutes abuse, violence, coercion and control are evolving, as discussed by Lynch et al in this *AJGP* issue.[12,13] This Focus edition on domestic and family violence explores the concept of coercive control and expands our understanding of trauma to include sociocultural enablers and systemic health responses. Trauma work is an essential process in general practice, as highlighted by Lynch et al in this issue.[13] We encourage a paradigm shift towards empowering recovery rather than rescue. In this model, recovery is patient-centred, and the health practitioner accompanies the person on their recovery journey, with pragmatic assistance as requested, while bringing to attention potential collusion with patterns of abuse, violence or control.[14]

Many GPs might describe working in this area as 'difficult' and can feel unsure they are responding appropriately or report feel unsupported.[5,7] This can be further affected by pre-existing relationships, often with multiple family or community members. GPs might also hold preconceived beliefs about the use of behaviours by a person affected by, exposed to or using violence.[15] Practitioners might have personal experiences that influence professional interactions.[16] GPs might have their role extended with further organisational and legal dimensions of care.[17,18] Some GPs might advocate against (or be demoralised by) the moral injustice of structural processes within the practice, health system, community or sociocultural issues,[19] especially when they feel these issues are beyond their control. Some health practitioners might appreciate being able to 'give back' in supporting survivors of abuse or violence.[16] Acknowledging and normalising the challenges of working with anyone affected by or using violence, ensuring sufficient personal and professional support and access to resources, can be helpful.[11,20]

GPs appreciate education and training in how to identify and respond to domestic and family violence, alongside adequate support when delivering care.[10,21] Safe disclosure and care are likely to improve health outcomes for survivors who have been affected by family or intimate partner abuse. In this *AJGP* issue, the study by Giles et al outlines the health practitioner response to disclosure of abuse and violence suggested by survivors.[22]

This Focus edition of *AJGP* overviews evidence-based pragmatic guidance on how GPs can identify and respond to a person

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who might be experiencing or using intimate partner violence, including coercive control tactics.[8,12,13,22] This collection of articles is curated to provide insight as individual pieces or together as a more holistic overview of abuse, violence and control within domestic or family relationships, including throughout the recovery journey.

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