

Recognising and responding to domestic and family violence in general practice

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Background

Domestic and family violence (DFV) is often difficult to recognise despite its high prevalence in the community. General practitioners require specialised skills to elicit a history of DFV, remain aware of the complex patterns of DFV, respond to potential risk and maintain engagement as part of a team involved in ongoing care.

Objective

The aim of this article is to outline the principles of recognising, responding, referring, recording and reflecting on care for those who may be experiencing DFV.

Discussion

GPs have unique opportunities to identify, assess and respond to DFV because of the trusting therapeutic relationships they develop with patients. Managing DFV requires a safe place to disclose, skilled risk assessment, careful documentation, safety planning and ongoing therapeutic processes that soothe, validate, empower and connect to wider social supports. Trauma-informed general practice is a key element of integrated systems responses to DFV in our community.

DOMESTIC AND FAMILY VIOLENCE (DFV)

is a significant international public health problem.¹ Exposure to DFV has lifelong impacts on physical health and life expectancy²⁻⁵ and increases hospitalisation and healthcare usage of children and women in Australia.⁶⁻⁹ Chronic threat causes multisystem physiological dysregulation affecting lifelong health across the generations.^{2,10,11} It has been estimated that a full-time Australian general practitioner (GP) will not recognise up to two women (and their children) a week who are experiencing some form of DFV.¹²

DFV is a complex ongoing pattern of behaviour. GPs can identify and care for people experiencing DFV with integrated community and specialist support.¹³ This article will help GPs become more skilled at creating a safe climate for disclosure,¹⁴ recognising patterns of DFV across the spectrum of severity; responding with appropriately gentle probing questions, risk assessment and safety planning, early intervention and ongoing care for the whole family; making meaningful referrals; carefully recording harm; and reflecting on their own vicarious trauma.¹⁵⁻¹⁷

Creating a safe climate for disclosure

There are strong forces that silence victim survivors and keep their private terrifying or shameful experiences out of the consulting room.¹⁷ DFV is part of a wider pattern of family, intergenerational,

cultural and historical experiences that can further silence the victim survivor. These include sexism (most victims of DFV are women and children), racism, colonisation and other processes that dehumanise, objectify and exploit.^{18,19} GPs can offer a safe experience from the waiting room to the consulting room and a healing non-judgemental and empathic relationship²⁰ that reduces shame, invites disclosure and affirms that any next steps will be at the patient's pace.¹⁴

Patients may also accurately assess that their safety will be jeopardised by disclosure as they or their loved ones are still at risk from those who harmed them.²¹ Creating opportunities for the patient to speak safely with their GP without anyone who may affect or be affected by their answers (eg partner, children) is essential. Sometimes creativity is required to ask the patient to go to a treatment room for physical assessment or use allied health staff consultations in order to create privacy or distance from any potential monitoring devices in the room. It is also important to ensure that telehealth consultations are conducted in private, safe places that facilitate disclosure.

Recognising patterns of domestic and family violence

Broad generalist awareness of the whole person in their relationships and context and sophisticated pattern recognition²² can help GPs identify the underlying

threat of DFV inside very ordinary clinical presentations. A high index of suspicion for DFV is warranted in presentations of vague physical symptoms of arousal or distress (eg headaches, abdominal pain, hypervigilance). Screening for DFV should occur during routine pregnancy and mental health planning (refer to Table 2.2 in The Royal Australian College of General Practitioners' [RACGP's] *Abuse and violence: Working with our patients in General Practice* [White Book] for more detail).²³ Patterns of unexplained injuries, self-harm or psychosocial distress in the patient's or their children's medical records can also be helpful.

GPs can recognise patterns of DFV in threat to integrity (physical and personal), connection (to self and others) and sense of coherence.²⁴ Threats to integrity include physical, sexual or emotional abuse and all forms of coercive control. Threats to connection include ignoring, ostracism, ghosting and other forms emotional or physical disconnection. Threats to a sense of coherence include processes that confuse or intentionally decrease the person's trust in their own perception of reality ('gaslighting'). These patterns impact the patient's and their dependents' safety, physiological arousal, sense of self, capacity to trust and ability to engage in therapeutic relationships.

Awareness of coping patterns may also aid pattern recognition of DFV. These include movement away (flight towards addictions, compulsions and avoidant behaviours), movement towards (fight for control and mastery) and paralysis (freeze or fawn/appease behaviours that decrease risk of inciting the person using violence, including recanting, denying or minimising their experience).²⁵

Table 1 describes a number of these warning signs that can be identified in the therapeutic relationship, in reports of other relationships (including those with GP reception staff) and in patterns expressed over a life story and across generations. Maintaining a high level of awareness of co-occurring patterns of neglect and abuse of children in DFV is also important.²⁶ All forms of DFV (even when not witnessed by children) cause harm to children in that home.²⁷

Responding to domestic and family violence: Initial steps

DFV often goes unnoticed. Any disclosure of DFV is therefore an opportunity to increase a survivor's safety. Be aware that timely and sensitive intervention, ongoing therapeutic relationship, and connection to wider services can improve outcomes for the victim survivor and any dependants at home living with DFV and other forms of child abuse and neglect.²⁶⁻²⁸

GPs are an essential part of integrated community responses to any person experiencing DFV.²⁹ Their capacity to Listen, Inquire, Validate, Enhance Safety and Support (LIVES)³⁰ within the context of a therapeutic relationship and respectful collaborative care³¹ are key elements of trauma-informed care in general practice.

Inquiring through sensitive open and direct questions is part of the process of initial responses to DFV³²⁻³⁴ (refer to Table 2 for sample questions to be used as appropriate clinically^{23,24,30,35,36}). These questions are part of an ongoing commitment to journey with the patient over time and may involve regular appointments until the patient feels safe to disclose.

Prioritise safety

Offering choice and building trust in each interaction is an important part of high-quality medical care. Reliable continuity of GP care can offer an alternative experience to the significant betrayal and loss of trust that is part of DFV. Providing a calm, soothing environment to empower the patient to regulate their distress (Box 1), validating the person and their decisions (Table 2), screening for DFV risk factors and making safety plans (Table 3) are all part of prioritising safety.

The survivor's knowledge of their own risk is central to any assessment.¹³ GPs can offer culturally appropriate assessment that takes into account the diverse needs and heightened risk in some patients.¹³ It is essential that GPs are aware of safety risk factors for DFV, well addressed in the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM Framework) for DFV,³⁷ and

integrate those risk factors into any safety planning (Table 3).

Foster capacity to soothe physiological arousal

Acute arousal after disclosure of DFV may disrupt a patient's capacity to take in any new information or make coherent decisions, especially if arousal reactivates past trauma.³⁸ A trauma-informed response to this arousal includes soothing and comforting the patient (such as through deep breathing and grounding exercises that bring them back into the present), distracting in order to titrate the dose of emotion they are experiencing, and offering practical help with decisions that increase their safety (Box 1).

Box 1. Practical skills for the general practitioner to soothe acute distress

Soothe and comfort:

- Offer your presence to co-regulate through attuned available attention
- Soothe through your tone of voice with slowing speech and breathing
- Facilitate grounding to soothe their body by tuning into their senses, bringing them into the present and away from distressing memories (eg ask them to name out loud three things they can see, hear and feel through touch; connect them to their favourite music; or ask them to hold their car keys that remind them they are not trapped)
- Create a safe environment, offering tissues, time, comforting silence and physical touch when appropriate

Distract:

- Do an ordinary physical medical ritual, such as take the patient's blood pressure or temperature
- Use empathic interruptions to pace the emotional content of the narrative
- Ask a question, make a comment or use your sense of humour (if appropriate) to shift attention away from the emotional content and keep emotion within a tolerable therapeutic window
- Teach distress reduction behaviours such as breathing, mindfulness, self-compassion and exercise to help the patient manage emotions that have previously caused them to feel overwhelmed

Table 1. Patterns of loss of sense of safety in domestic and family violence

	Patterns to notice in the general practice consultation	What the threatened person experiences	What the person using violence and control does
Loss of integrity: Invasion	<p>Overly submissive, reticent, deferential, defensively self-critical or expectant of harm</p> <p>Presents very carefully curated image to keep the shame a secret</p> <p>Difficulty managing boundaries with other people</p> <p>Sometimes uses aggression to manage threat</p> <p>Experiences medical illness as threatening invasion</p> <p>Not allowed to attend the doctor on their own, and partner/carer/parent may answer for them</p> <p>Person using violence may present as victim or deny or minimise use of family violence</p>	<p>Bodily and/or emotional violation</p> <p>Feeling disrespected</p> <p>Boundaries violated</p> <p>Loss of autonomy</p> <p>Sense of shame or failure for not being able to protect self</p> <p>Loss of trust in self and others</p> <p>Moral injury of being forced to go against beliefs</p> <p>Sees own body as an object</p> <p>Sense of embarrassment, disbelief and denial that this is happening</p>	<p>Manages image and seems attentive/kind to mask their underlying drive to control</p> <p>Limits access to finances, transport and phone, and controls interactions with others</p> <p>Treats others as objects and has a jealous sense of ownership</p> <p>Feels victimised, minimises what they have done and only apologises to regain control or connection</p> <p>Assaults verbally, physically, sexually</p> <p>Uses coercive behaviour that:</p> <ul style="list-style-type: none"> • exploits, blames, criticises, demeans or intimidates • demands, manipulates, blackmails • shames using religion or beliefs • traps, dominates or controls
Loss of connection: Disconnection	<p>Minimises their own experiences (including late presentation of illness)</p> <p>Pre-emptively disconnects in order to protect themselves</p> <p>Has few social supports</p> <p>Finds it difficult to connect or build therapeutic rapport</p> <p>Moves clinics regularly and may not be allowed to attend freely</p> <p>May only be allowed to attend with children – not for own care</p> <p>Fears mentioning children for fear of losing them to child protection system</p> <p>Fears visa or immigration services</p>	<p>Isolation</p> <p>Loneliness</p> <p>Hopelessness</p> <p>Powerlessness</p> <p>Loss of key supportive relationships</p> <p>Loss of sense of self as worthy of love and connection</p> <p>Shame and self-loathing – feeling there must be something wrong with them that makes others disconnect</p> <p>Loss of respectful connection and sense of belonging to others and to self</p>	<p>Neglects other person’s emotional needs</p> <p>Employs non-verbal emotional abuse (including social media ghosting and ‘silent treatment’)</p> <p>Ignores or dismisses other person’s desires, beliefs or hopes</p> <p>Disapproves, discourages or deprives access to social supports</p> <p>Rejects attempts to connect</p> <p>Uses repeated relocation and movement</p> <p>Disconnects from community (including forcing cancellation of medical appointments)</p> <p>Manages image to seem calm and cast the threatened person as ‘emotional’</p>
Loss of cohesion: Confusion	<p>Seemingly incoherent communication of recollections and timelines</p> <p>Hypervigilant and distractible</p> <p>Emotionally dysregulated with altered or narrowed perception</p> <p>Expresses ambivalence about decisions or contradicts themselves</p> <p>Show signs of loss of confidence to make even small decisions</p> <p>Often confused about who to trust and may collude with threatening partner in keeping secrets</p> <p>Cycles in and out of denial that there is a problem</p> <p>Person who uses violence may also confuse clinician with inappropriate flattery or denigration</p>	<p>Vigilant for next unpredictable event (‘walking on eggshells’)</p> <p>Confusion exacerbated by executive function shutdown, disorientation and amnesia caused by life-threatening events</p> <p>Loss of trust in own intuition, perceptions and capacity to assess truth of a situation</p> <p>Loss of trust in others and self</p> <p>Loss of sense of own credibility in comparison to carefully managed persona of their abuser</p> <p>Questioning of own sanity and feeling they are ‘crazy’ or gullible and can’t work out when they have been tricked</p>	<p>Behaves unpredictably</p> <p>Has chaotic or neglectful household management</p> <p>Intoxication and addiction increasing confusing behaviour/communication</p> <p>Switches mood states</p> <p>‘Gaslights’ (intentionally grooms confusion, undermines credibility)</p> <p>Betrays trust or previous promises</p> <p>Denies wrongdoing and responsibility and switches blame (eg ‘I only hit you because you make me so mad’)</p> <p>Manages public image to appear highly respectable and reasonable</p> <p>Activates victim towards ‘recantation cycle’ by minimising abuse, gaining sympathy, invoking belonging and instigating deception</p>

Table 2. Approaches to domestic and family violence (adapted LIVES framework³⁰)

Listen	<p>As part of creating a climate for disclosure and facilitating safe trauma-informed care, general practitioners (GPs) can listen to words, to what is not said, and to signs of physical and psychosocial distress.</p> <p>Allowing the patient to be heard in their own language is part of good listening, and ensuring access to interpreters from other states is often important due to confidentiality risks within small communities.</p>
Inquire	<p>Gentle questioning gives permission to those who are ready to disclose. Questions can focus on physical injuries, relationships, mechanisms of harm that might remain unspoken or minimised (eg sexual abuse or strangulation) or on strength-based acknowledgement of their resources and survival.</p> <p>Example questions to ask patients:</p> <ul style="list-style-type: none"> • ‘Your injuries are unusual for the incident you describe – can you tell me again what happened?’ • ‘Do you feel safe to go home today?’²³ • ‘What do you need in order to feel safe?’²³ • ‘Has anyone in your family done something that made you or your children feel unsafe or afraid?’³⁵ • ‘Is there anyone who controls your day-to-day activities (eg who you see, where you go, how much you spend) or monitors you electronically?’³⁵ • ‘Have you ever been forced to do sexual behaviours you are not comfortable with?’³⁰
Validate	<p>Validation is part of the process of recovery. GPs can offer reflections that counter the invalidation of domestic and family violence (DFV) and reinforce the fundamental dignity of the person.</p> <p>Example phrases for clinicians to use:</p> <ul style="list-style-type: none"> • ‘Everyone deserves to feel safe at home.’ • ‘It is not OK that you have been treated like this, this is not your fault.’ • ‘You are worthy of care.’
Enhance safety	<p>In the consultation, physical and psychological safety takes precedence over detailed history-taking.^{24,39,40} In acute situations, reassessing the survivor of DFV for exacerbation of symptoms or social situation within 36–48 hours offers another way to increase physical and emotional safety.</p> <p>Key considerations:</p> <ul style="list-style-type: none"> • The retelling or reliving of traumatic experiences should be carefully managed.⁴¹ The clinician’s calm presence and soothing tone of voice, reassurance of confidentiality, medical care and practical advice are all part of facilitating safety • Consider safety and risk in environment (place), relationships (people), intrapersonal experiences (personhood and inner dialogue), body (physiology) and meaning (perspective) to facilitate long-term health²⁴
Support	<p>Facilitating ongoing connection through regular appointments, empowering the patient to make immediate decisions to keep themselves and dependants safe, and connecting them to a wider systemic community response to DFV and sexual assault are key elements of trauma-informed care for DFV.^{42,43} 1800 RESPECT is a source of support for both the patient and GP.</p>

Validate person and perceptions

DFV produces patient experiences of shame, a sense of powerlessness, disconnection, loss of dignity and doubt that they will be believed. Shame is an overwhelming and isolating physiological experience caused by sensations of threat to relational connection.²⁴ GPs can offer connection within the steadiness of the therapeutic relationship to support the person’s sense of self, build dignity and validate their experience.

Collaborate and empower

Choice, collaboration and empowerment can build autonomy,³⁹ offering an alternative experience to invasion, disconnection and confusion. It is important to maintain an attitude of collaboration and respect that includes facilitating autonomy through careful consent regarding written documentation and examination of the patient’s injuries (ensuring they know they can cease or have a break from the examination at any time).

Connect and stay involved

DFV is a complex experience with chronic sequelae requiring long-term follow up and assurance that you will stay involved in the patient’s care. It is important to respect that the patient may not be ready to exit the situation or may have valid safety concerns about trying to do so immediately, so their attempts to feel safe may not align with any suggestions you offer. GPs can provide ongoing connection through proactively offering regular appointments even when there is no acute crisis.

Refer to other help

It is important to offer warm referral (where you actively contact the service on the patient’s behalf, often with the patient present) to specialised DFV, legal, housing, financial and child protection services. Wherever possible these referrals should be offered before the patient considers leaving the abusive relationship as the highest risk time for serious violence is at the end of a relationship. General practices are often the only safe place where survivors of DFV can go out of the

house, particularly if their movements and interactions are monitored by the abusive partner. Some DFV services offer co-location within general practices in order to support both GPs and patients.²⁹ In the long term, survivors of DFV should be offered trauma-specific psychotherapy and family therapy that promotes intergenerational healing.

Where acute risk of imminent serious harm to the patient or children is identified, safety is a priority that may outweigh the principle of autonomy. Ideally, patient consent should be sought for referral to police or DFV agencies, but in some situations patients may need to be referred without their consent. Medical defence

organisations can be consulted if there is uncertainty regarding each state’s legal information-sharing processes, as jurisdictions vary. These information-sharing networks are designed to prioritise patient safety, increase perpetrator accountability and allow clinicians to share the load with other key community services. They represent a change to limits of clinical confidentiality – to include protection from harm from others alongside harm to self or others.

Record domestic and family violence

Although the main clinical task is to prioritise the safety and long-term wellbeing of the patient and their family,

detailed GP notes (Table 4) recording the examination findings and reported assault or patterns of abuse can be used in legal proceedings years later to corroborate patterns of chronic abuse. If a clinical forensic medicine service is available, GPs can consult and refer for formal forensic interview and examination (including photographs and victim impact statement).

Reflective self-care

The work of caring for those with DFV may be vicariously traumatising and can trigger clinicians’ own personal or family experiences of trauma. It is important that GPs do not try to carry the images and stories of DFV alone. It is appropriate self-care for GPs to care for their own health needs and seek professional trauma-specific therapy. Although not yet a part of everyday continuing professional development for GPs, formal clinical supervision and debrief are also essential tools to undertaking this work sustainably – a number of case consultation groups and communities of practice are available for GPs in Australia through the RACGP, Australian Society for Psychological Medicine, Mental Health Professionals Network, the Black Dog Institute and some Primary Health Networks. In addition, 1800 Respect is a national resource offering 24-hour counselling support to professionals working within the context of family violence.

Conclusion

GPs are positioned at the interface of health and social distress. Their generalist approaches to the whole person are an important part of integrated responses to DFV within our community. These generalist skills include building safe therapeutic rapport; continually noticing contextual, relational and personal impacts on health; keeping whole families in mind over the lifecycle (caring for children and adults as well as the elderly); referring appropriately to community supports; and maintaining continuity of care. These skills can be refined to build general practice capacity to recognise and respond to DFV.

Table 3. Assessing for safety risk and planning for immediate safety*

Risk factors	Safety planning
<p>Consider safety risks that have an impact on both the patient and their dependants:</p> <ul style="list-style-type: none"> • Self-assessed level of risk – person feels they are not safe • Increasing frequency and/or severity of violence • Recent or planned separation from partner • Imminent changes to access due to court orders or perpetrator release from correctional facility • Children witnessing or in the home where their caregivers experience domestic and family violence • Weapon accessible (or used recently) in the home • Previous strangulations • Assault while pregnant or postpartum • Sexual assault (especially if pregnant) • Abuse of children or pets • Perpetrator threats of suicide/homicide • Isolation or stalking of victim (including electronic stalking) • Perpetrator unemployment or disengagement from education • Drug and alcohol misuse/abuse • Controlling or jealous behaviours • Child intervention in violence • Children victim of other forms of harm (including neglect) 	<p>Empower, inform and support the person to make plans for the next few hours to:</p> <ul style="list-style-type: none"> • Identify and reconnect to a support person (if safe to do so) • Make practical plans to support any children, pets or other dependents • Plan an emergency bag with copies of important documents, medical supplies, spare keys, cash and clothes to be kept in a safe place or with a safe person • Create a secure digital storage location for scanned important documents and valued photographs only accessible to the patient and a safe person • Ensure access to transport (including a full tank of petrol or public transport card) ready for an emergency escape if needed • Ensure access to safe and secure technology (ie phone, computer) for access to finances and ongoing contact with support (refer to e-safety guide⁴⁴ for advice about apps or services that may be used to track location and apps that can support security such as the Daisy app)

*Refer to the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) resources and The Royal Australian College of General Practitioners’ Abuse and violence: Working with our patients in general practice for more information^{23,35,37}

Table 4. Tips for recording domestic and family violence

Gain consent	Record notes with patient's consent and make sure they know that while confidential, the notes could be subpoenaed in future. It is best practice to confirm what specific elements they are comfortable being recorded by reading out your notes for them to check.
Record now	Keep specific, accurate, factual and contemporaneous records. It is possible to expand or clarify in an explanatory note logged in the notes later.
Reinforce confidentiality	Do not enter the phrase 'domestic violence' into electronic records (eg My Health Record) or in the diagnosis field of the patient's medical records as this may compromise their confidentiality.
Remember when recording	<p>Your medical notes are intended to support you to provide medical care and protect the patient from having to repeat their story. They are not intended to replace a police statement.</p> <p>Keep any verbatim quotes brief and relevant to your medical history.</p> <p>All notes must be objective, without emotional overlay. All events are described according to the patient's recall and any action of a person not in attendance should be recorded as 'alleged'.</p> <p>Don't write your personal conclusions about the situation or fall into the trap of describing an amount of force or a diagnosing definitive mechanism of injury. Let others draw conclusions from the facts you have documented.</p> <p>In some jurisdictions, notes related to current or historical sexual assault counselling can be protected from exposure in court. General practitioners are considered trained counsellors who listen, support, encourage or advise. Stating 'counselling provided' in your notes can help protect those parts of the notes that are related to supportive counselling for the patient regarding a sexual assault.</p>
Tune in to experience	<p>While validating and grounding the patient, use questions focusing on their capacity and their experience (Forensic Experiential Trauma Interview^{45,46}); for example:</p> <p>'What are you able to tell me about the experience?'</p> <p>'What are you able to remember about ... [five senses]?'</p> <p>'What was the most difficult part of this experience for you?'</p> <p>'What, if anything, can't you forget about your experience?'</p>
Record other party	Record the name and date of birth of the alleged person using violence and control, and describe their actions with active verbs.
Record harm done	<p>Record facts and clearly document the anatomical location and physical appearance of injuries as well as the patient's general appearance and demeanour (eg agitated or crying, state of clothes).</p> <p>It is possible to photograph the wounds (with a ruler to enable size to be evaluated) and add that to the medical record if the patient consents and you are concerned they may not access police or forensic photography.</p> <p>Your goal is to report harm, not to verify facts (you are not a journalist or a detective).</p>
Refer	Refer to a clinical forensic medicine service if available.

*Legal aid services and medico-legal indemnity providers run useful courses and provide education resources on record keeping within each jurisdiction.

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