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ABSTRACT

Although many battered women seek help from their family physicians as outpatients, rates of current and lifetime victimization among outpatient female patients have not been well studied. This study tested two hypotheses regarding whether battered women presented to the clinic in a different manner than did nonbattered women. First, within the past year women in current abusive relationships would attend the clinic more frequently than nonbattered women. Second, compared to nonbattered women, battered women would have been diagnosed more often with psychological and psychosomatic problems. Incidence and prevalence of spouse-abuse victimization was investigated among 374 consecutive female outpatients seeking routine health care in a large community-based family practice residency training clinic. Women were aged 18 to 75, had a history of a committed relationship of at least 6 months duration, willingness to participate, free of dementia, and able to speak English. The Conflict Tactics Scales was used to assess abusive and violent behavior experienced either within the past 12 months or at any time in the context of an intimate relationship. Twenty-five percent reported victimization in the past year, and 39 percent in their lifetime. Rate of inquiry about actual violence was entremely low--a total of six physicians. Compared to nonbattered women, battered women had more psychological and psychosomatic diagnoses, but did not make more doctor visits. (LLL)

Battered Women in Nonemergency Medical Settings: Incidence, Prevalence, Physician Interventions

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Battered Women in Nonemergency Medical Settings: Incidence, Prevalence, Physician Interventions

Incidence and prevalence of spouse-abuse victimization was investigated among 374 consecutive female outpatients seeking routine healthcare. Twenty-five percent reported victimization in the past year, and 39% in their lifetime. Only six reported being asked about violence by a physician. Compared to nonbattered women, battered women had more psychological and psychosomatic diagnoses, but did not make more doctor visits. The study is discussed in terms of psychologists' roles in physician training, using knowledge of patient data to cue domestic violence inquiry and to assess effectiveness of such training programs in identifying and intervening with battered women.

Battered Women in Nonemergency Medical Settings: Incidence, Prevalence, Physician Interventions

Although many battered women seek help from their family physicians as outpatients, rates of current and lifetime victimization among outpatient female patients have not been well studied. One recent survey of female outpatients found that 44% reported abuse (Rath, Jarratt, and Leonardson, 1989). However, that study did not specify whether the abuse was current or lifetime, an important distinction in terms of treatment planning.

Other methodological problems with the Rath et al. (1989) survey also make interpretation difficult. First, the survey was not randomly administered by independent surveyors. Clinic nurses recruited patients for participation. Furthermore, patients were not recruited consecutively or in some other systematic fashion. Hence, the recruitment method could have been vulnerable to recruiter bias, based in part on prior know. edge of the family situations of the female patients.

Second, Rath et al. (1989) used chart reviews to determine physician inquiry about domestic violence. However, previous research in emergency room settings has found that chart audits may not be the most reliable means of assessing physician behavior (e.g., Flitcraft, 1977). A more reliable measure would be to ask battered women directly about physician inquiry into violence issues. The present study extended that of Rath et al. (1989) in the following ways. First, <u>all</u> consecutive female patients attending an outpatient family medicine clinic and eligible to participate were recruited for the survey. The surveyor was an independent research assistant with no prior knowledge of the patient or her family situation. Third, the survey questioned respondents about <u>both</u> ongoing violence (i.e., within the past year) and lifetime violence victimization in an intimate relationship. Fourth, the women were asked, as part of the survey, whether their physician had inquired about (a) relationship stress and (b) abuse. If so, the respondents also indicated whether the physician assisted in safety planning

and referral.

The present study also tested two hypotheses generated from the clinical literature as to whether battered women presented to the clinic in a different manner than did nonbattered women. First, within the past year women in current abusive relationships would attend the clinic more frequently than nonbattered women. Second, compared to nonbattered women, battered women would have been diagnosed more often with psychological and psychosomatic problems.

The center in which the study occurred is a large community-based family practice residency training clinic. All ethnic, racial, and socioeconomic groups are represented. The monthly census of unique female appointments is about 180. All female patients attending the clinic for regular appointments during an eight-week period were asked to participate. Inclusion variables included being ages 18 to 75, history of a committed relationship of at least six months duration, willingness to participate, free of dementia, and able to speak English.

The Conflict Tactics Scale was used to assess abusive and violent behavior experienced either within the past twelve months or at any time in the context of an intimate relationship. The respondents were also asked to indicate whether a physician had, on the most previous visit, inquired about abuse victimization. Finally, respondents reported whether the physician also initiated safety planning or referral with the battered woman.

The medical charts of each respondent were surveyed for (1) the number of outpatient visits in the past twelve months and (2) all diagnoses listed on the "problem list" at the front of each patient's chart. The lists are regularly updated and were cross-checked against diagnoses listed in the actual chart notes.

Of 476 potentially eligible women attending the clinic during the survey period, 394 completed the survey and 374 were useable--a response rate of about 78%. Within the past year 29% reported being assaulted, minimally at the level of push or shove. Also, within the past year 15% reported

experiencing physical injuries at a minimal level of a bruise or scratch. Lifetime prevalence of victimization was 39%, with a lifetime injury rate of 25%.

Women assaulted in the past year were significantly more likely than non-victims to have been asked about relationship stress. However, rate of inquiry about actual violence was extremely low--a total of six physicians. Rates of safety planning and referral were equally low.

Compared to nonbattered women, currently battered women did not make more visits to the doctor in the past year. Preliminary analyses, however, suggest that battered women have been given more diagnoses reflecting depressive symptomatology and psychosomatic problems than nonbattered women.

The results are discussed in terms of opportunities for psychologists in medical settings to develop and measure programs for training physicians in identification and intervention with female patients who are battered. Specifically, the rates of 25% recent and 39% lifetime

victimization, and 2% inquiry rates can be used to assess the effects of physician training in the identification of battered women in outpatient settings. Furthermore, the findings regarding differential diagnostic characteristics of battered and nonbattered women can function as risk-markers that physicians can be trained to use as clues to initiate inquiry about victimization.

These results add to a growing body of literature demonstrating the high incidence and prevalence of battered women utilizing ambulatory medical settings, but the low rate with which they are detected. In addition to demonstrating the need for physician training, the differential diagnostic categories of battered and nonbattered women provide some concrete training leads. These results, however, must be viewed as preliminary and requiring further replication.

References

Flitcraft, A. (1977). Battered women: An emergency room epidemiology with a description of a clinical syndrome and critique of present therapeutics. (Doctoral dissertation, Yale Medical School).

Rath, G. D., Jarratt, L. G., and Leonardson, F. (1989). Rates of domestic violence against adult women by men partners. J Amer Board of Fam Prac, 2, (4), 228-233.

Table 1

Demographic Characteristics of Sample
(of those in a close relationship in past year, n = 310)

	Non-battered	Battered
Religion:		
Protestant	26.7%	14.6%
Catholic	45.7	40.8
Other	17.2	30.3
None	10.3	14.5
Marital Status:		
Married	58.8	40.3
Separated	0.9	9.1
Divorced	11.6	10.4
Widowed	2.1	1.9
Never married	26.6	39.0
Race:		
Caucasian	89.7	89.6
African-American	6.0	7.8
Native American	0.9	0.0
Hispanic	3.0	2.6
Other	0.4	0.0
Education:		
Completed High School	34.8	39.0
Some college	30.5	31.2
Completed college	12.0	6.5
Some post college	6.9	3.9
Other	15.5	0.0

	M	(SD)	M	(SD)
Age	37.3	(15.1)	28.7	(10.1)
Years in relationship	14.7	(8.3)	7.6	(14.4)
Visits to MD/year	4.0	(3.4)	4.2	(3.8)

Table 2

ICD-9 Combined Psychological/Psychogenic disorders categories reported for battered and nonbattered women

Categories	ICD-9 Number
Anxiety Disorders	300.00-300.09
Neurotic Depression	300.4
Neurasthenia	300.5
Other Neurotic Disorders	300.8
Unspecified Neurotic Disorder	300.9
Personality Disorder	301
Physiological Malfunctions arising from mental disorder	306
Special symptoms or syndromes not elsewhere classified	307
Acute Reaction to Stress	308
Adjustment Reaction	309

	Battered Women		Nonbattered Women	
	n	percent	n	percent
Category Listing	28	31	39	22
No Listing	53	69	136	78

$X^2 = 3.71$, df = 1, p = .054

Table 3

ICD-9 Physiological disorder categories reported for battered and nonbattered women

Categories	ICD-9 Number
Hypertension	401
Ulcers	534
Back Pain	724
Migraine	346

	Battered Women		Nonbattered Women	
	n	percent	n	percent
Category Listing	10	12	48	27
No Listing	71	88	127	73

$X^2 = 6.35$, df = 1, p = .012