DOCTORS AND SPOUSE ASSAULT VICTIMS:

PREVENTION OR PERPETUATION OF THE CYCLE OF VIOLENCE

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INTRODUCTION

There is a growing awareness that wife battering is a serious problem in western industrial societies including Australia. Medical practitioners are often the first professionals to whom domestic violence victims turn (Dobash & Dobash; Walker 1984). Thus they are in an ideal position to play a vital role in both epidemiological data collection and prevention. Indeed, data from the United Kingdom indicate that hospital casualty units serve an almost entirely different population of victims than do the police (Shepherd et al 1987: 471). In other words, a low proportion of battered women who are attended by police also seek medical attention and a low percentage of those who go to Casualty units have sought police assistance. Hence, if medical practitioners correctly identify victims, their records could provide a useful and distinct source of information. However, studies from the United Kingdom and the United States indicate a low identification rate by doctors and an aetiological orientation that attributes partial blame to victims, making prevention problematic.

In Canada, Burris (1984) finds that physicians identify an extremely small percentage of their patients as victims, in contrast to other professionals. He concludes that this reflects the doctors' failure to look beyond physical injuries, depression, or anxiety to the cause. Clarke (1982), a member of the Faculty of Medicine at the University of Newcastle, addresses the failure of doctors to detect and treat spousal assault victims, often accepting at face value victims' and abusers' accounts about injuries without being alert to multiple episodes or clinical discrepancies between the explanations and the the nature of the injuries. Mullen, a New Zealand physician, corroborates this medical 'blindness' noting that a number of his patients had previously gone to other doctors on numerous occasions with bruising, fractures and marks of strangulation. No adequate inquiries had been made. The 'masked presentation of violence' such as anxiety and depression was also often missed. Stark and Frazier's (1979) analysis of medical records at a New Haven, U.S. hospital also indicate that medical staff do not identify battering as such. Instead, doctors respond to the victim's psychosocial problems such as depression and drug abuse although these afflictions generally arose only after the onset of battering.

Thus, it appears that many victims are passing through emergency departments and private physicians' rooms undetected. Those who first seek medical attention are likely to present with only vague complaints but over time, battering increases in severity and frequency with 75 percent of battered women who seek medical attention experiencing ongoing abuse (McLeer et al 1987: 1156). Thus, identification is critical not only for epidemiological data but in order to implement preventative intervention strategies.

Yet even if identified, research shows that doctors' attitudes about the aetiology of battering and their perception of the limited role they should play further mitigate against effective intervention. Kurz's (1987) study of medical staff in Philadelphia hospitals shows that positive reactions are correlated with practitioners' perception of victims. Patients who express desire to leave their husbands and/or those with 'pleasant personalities' receive the most sympathy and referrals. Those who have been drinking and/or are evasive were treated far less supportively. This hint of victim blaming is also found in another American study (Davis & Carlson 1981). In contrast to other professional groups, doctors most equally apportion responsibility for the violence to **both** spouses; spousal assault is attributed to characterological defects of husband and wife. Given this orientation, it is not surprising that the sample of doctors also regard prevention as problematic and are equally sympathetic to both parties. Such attitudes appear to translate into a response often limited to treatment of injury and/or medication for symptoms of depression or anxiety. (Saunders & Rose 1985:5).

Medical practitioners surveyed in the United Kingdom perceive the victim's personality as a greater cause of the battering than the husband's character (Borkowski 1983). Thirty-four percent believe that the woman's depression results in feelings of frustration for her husband which translate into violence. Alcohol is also seen as a precipitating factor by 90 percent of the sample. One half of the sample would only provide medical help and would not confront, intervene or probe. Thus, it is not surprising that in the United Kingdom, a majority of victims surveyed by Dobash et al (1979, 1985) and Pahl (1985) rate medical professionals as unsatisfactory sources

of support. Respondents report that doctors just deal with any physical injuries, prescribe tranquillizers, and fail to look for or to understand spousal assault. Johnson (1985) discovered similar victim dissatisfaction in the United States.

The failure of many doctors to detect or play a preventative role has been attributed by some to the lack of appropriate training (Canadian Standing Committee on Health, Welfare, and Social Issues, 1982). Kurz's (1987) study examines one hospital that had attempted to medicalise staff members' view of domestic violence, comparing it to three other hospitals without such programs. 'Medicalise' was defined as ongoing efforts to train staff to see battering as a medical problem with diagnostic and referral needs. Although training appeared to improve the quality of service to victims, it was only a matter of degree. The "medicalised" unit still gave **no response** (no advice, sympathy, referral) to almost one third of the victims; 21 percent received partial responses (brief and routine advice). Eighty-nine percent of the victims in non-medicalised casualty wards received either no response or partial responses. Rose and Saunders (1986:434) also find that intensity of training on spouse assault is correlated with practitioners' stronger beliefs that women should be helped and a feeling that the victims are less responsible for the beating. However, in their study of psychiatric and non-psychiatric practitioners, intensity of training is not related after controlling for gender and attitudes toward women (Saunders & Rose 1985:19). Women and those with liberal views of women's roles are the most likely to be helpful to victims and believe that abuse was not justified. Comparison of nurses and doctors also reveals that gender is the most important variable, overriding profession: women are more sympathetic than men.

Clearly, there are abundant indications from overseas data that medical practitioners are ill-informed about domestic violence as a medical problem with diagnostic and treatment needs although training and gender appear to somewhat ameliorate the situation. In Australia, there have been no surveys of doctors aside from the Western Australian Task Force on Domestic Violence (1986), Scutt (1983), and the New South Wales Task Force (1985). However, physicians' comments and attitudes are not differentiated from the other

professional groups in the samples. In fact, the only Australian data on professional's feelings about domestic violence comes from victim surveys. (Western Australian Task Force on Domestic Violence, 1986; Victorian Department of the Premier and Cabinet, 1985; Women's Information Switchboard, 1980; Australian Law Reform Commission, 1986; Crancher, Egger and Bacon 1981, 1983: Hatty 1985; Healy 1984; Naffin, 1985: New South Wales Task Force, 1987; O'Donnell, 1982: Pakula, 1979: Reed, 1982: Scutt, 1983.) None of these studies is exclusively concerned with victims' reactions to practitioners and only three include queries about doctors.

Respondents in these studies generally describe doctors as unhelpful, often limiting their treatment to prescriptions for tranquillizers (Crancher, et al 1981). Reluctant to intervene, doctors are also reported as not amenable to discussing the problem or as advising victims to persevere. The Women's Policy Co-ordination Unit survey finds that police and doctors are evaluated as the least satisfactory of the service providers (Victorian Department of the Premier and Cabinet, 1985). A different assessment is revealed by the Women's Information Switchboard (1980): doctors receive the most favourable ratings by victims; 28 out of 53 state that they had received some help. Unfortunately, the type of assistance is not specified in the findings.

In the present investigation, general practitioners and casualty unit doctors in the A.C.T. Australia were surveyed in order to assess the doctors' attitudes about aetiology of wife battering, and the role that they perceive practitioners should play in identification and prevention. The data are analysed for evidence of variation in attitude associated with gender, training, number of spouse assault victim/patients and length of service as doctors. In addition, spousal assault victims were surveyed concerning their experiences with the medical profession in Australia.

METHODOLOGY

Three sample groups were surveyed for the study. First, in 1989 two hundred surveys were sent to General Practitioners in the A.C.T. area utilising a mailout list provided by the A.C.T. Family Practice Association. Unfortunately names of retired or non-resident doctors were included. Fifty percent returned the survey with 96 used in data analysis; four were not filled out for the reasons above. Composed of short answer queries, questions requiring numerical responses indicative of agreement or disagreement, and comment areas, the instrument was designed to ascertain beliefs about: causation of wife battering; the victims; the assaulters; appropriate treatment, and role of doctors. Questions concerning individuals' training in domestic violence; years in practice; gender; frequency of contact with victims were also included. The distribution frequency of service as G.P.'s indicated two distinct groups: one with less than 17 years service (n=61, median=8) and another with greater than 17 years (n=36, median=26). The former will be referred to as short-term service; the latter as long-term.

Similar surveys, with appropriate modifications, were also distributed to doctors employed at the Casualty units of two public hospitals in Canberra. The percentage of returns was lower for this group, 19:55, 35 percent, which was not unexpected as hospital administrators had forewarned the investigator of general apathy coupled with work load. Significance of associations among variables mentioned earlier was tested for both doctors' samples by computing likelihood ratio chi square values using the CROSSTABS and HI LOGLINEAR programmes from the statistical computer package SPSSX.

Victims of wife battering who had sought medical attention in the ACT were the third group sampled. Difficulty in obtaining sufficient numbers prolonged the survey stage into 1990. Eighteen surveys were filled out by residents in various refuges in the A.C.T. and through the cooperation of the Domestic Violence Crisis Service. The instrument was designed to enable respondents to relate which type of medical service they had sought (private/casualty); gender(s) of the doctors;

whether they had disclosed source of injuries and/or whether doctors had probed about origin; doctors' response, e.g. referral, prescriptions, encouragement to leave violent situation; and doctors' attitude, e.g. sympathetic, helpful, supportive, blaming. Questions were constructed in either a 'yes', 'no' format or with a ranking system ranging from 'excellent' to 'terrible'. Spaces were left for extended comments relating to particular marks given to doctors.

FINDINGS

GENERAL PRACTITIONERS

Background

Sixty-three percent of the sample was male. Gender, however, is not significantly associated with any other background-type variable except for length of service ($\chi^2_3 = 9.77$, $p = .028$); 44 percent of the males have more than 20 years experience compared to 14 percent of the females. Most of the sample (87.5 per cent) have worked outside of the A.C.T.; 57.1 percent of this group have been employed in other parts of Australia, 21.4 percent have worked overseas and 21.4 percent have practised medicine in both location categories.

Training in domestic violence had been infrequent for the sample with only 10.4 percent experiencing any such component in medical school. Lectures are generally described as 'minimal'. Of those 'trained', two report that they were taught the psychosocial aspects of violence in the home; one respondent had learned about legal aspects and counselling; one, the 'whole area of domestic violence and sex abuse'; whilst only one doctor reported any training on the signs of assault and types of injuries.

Almost three quarters of the sample reported seeing less than five 'victims' a month, 12.5 percent - six to ten injured per month, 5.2 percent - 11 to 20, and 8.3 percent treat over 20. For over one third of the doctors (35.4 percent) all of these battered women are regular patients; 15.6 percent of the doctors reported that 51-99 percent are regular patients, whilst almost 40 percent reported one quarter to one half and 9.4 percent of the G.P.'s stated that 0 to 25 percent are women whom they had seen previously.

Fifty-one percent of the sample see 0 to five patients per month who are seeking advice or counselling about their battering situation; 15.6 percent - six to 10 patients; 18.8 percent - 11 to 20; and 14.6 percent reported over 20. For 40 percent of the doctors, all of the women are

regular patients, however for almost the same proportion (38.5), only one quarter to one half have been regularly seen by the doctors.

Almost one half (46.9 percent) of the G.P.'s see five or less women per month whom they **suspect** are victims of spouse assault; 20.8 percent see six to ten, 6.3 percent - 11 to 20, and 26 percent see more than 20.

Almost the entire group (95.7 percent) do not believe that assault is acceptable even if the batterer has been really provoked. No one agreed with the statement but 3.2 percent responded 'sometimes' with 1.1 percent uncertain. There is a statistically significant association between this variable and years of service ($\chi^2_2 = 6.88$, $p = .032$) with all those who believe that it is sometimes acceptable belonging to the long-service group.

On the issue of spouse assault as a private matter, over three quarters (76.6 percent) disagreed, whilst 12.8 percent either agreed or feel that it is sometimes private. One male comments:

> *She is an adult and should make up her own mind if she prefers to stay and be battered.*

A female doctor who feels uncertain about the privacy of wife battering elucidates:

> *I strongly counsel women to get help and change the situation. But, at what stage should the state intervene? We're talking about adults who should take responsibility for their own lives.*

Eighteen percent of the G.P.'s believe that wife battering is more common among the uneducated and lower class. Over one fifth feel uncertain, expressing such comments as,

> *From reading it goes across classes. However, the victims I've seen have been lower sociological class.*

Reasons Doctors Suspect

The doctors enumerate many reasons that prompt them to suspect a woman is the victim of battering. Over one half (56.3 percent) include physical signs/injuries as well as another 'symptom'. Eleven percent

mentioned something to do with alcohol, for example the presence of a drunken husband. The patient's case history was cited by 11.5 percent of the sample. No one just look at problems with children or mention of domestic difficulties, although one percent are prompted solely by the demeanour of the patient, e.g. 'withdrawn, timid or defensive', which is significant ($\chi^2_1 = 4.61$, $p = .032$) by training. The only significant difference by gender ($\chi^2_1 = 4.89$, $p = .027$) is that 42.9 percent of female G.P.'s are apparently more sensitive to emotional problems, such as sleep disorders, as a possible indicator of abuse whilst only 21.3 percent of male doctors mentioned it.

Causation

Responses to various questions that relate to doctors' beliefs about the cause(s) of spouse assault are shown in table 1.

Table 1: G.P.'s Beliefs about Cause(s) of Spouse Assault

Cause	Agree	Disagree[1]	Sometimes	Uncertain
Sociological factors	69.1	13.8	4.3	12.8
Alcohol	86.3	7.4	4.2	2.1
Victims psychological problems	33.0	39.4	9.6	18.1
Bashers' psychological problems	77.0	3.2	8.5	10.6
Victims provoke bashers	4.3	63.8	16.0	16.0

[1] Some respondents who marked 'disagree' qualified that such factor(s) contribute to the problems but are not causative.

Those who had received some training about domestic violence were more likely to agree with a sociological explanation ($\chi^2_3 = 7.89$, $p = .048$). No one believes exclusively in sociological-type causation; however 5.2 percent only agree with alcohol/drug abuse as an explanation. As one male explains:

> *When the alcoholism is addressed, the wife battering is addressed and improves as a matter of course; it is that simple. Other factors contribute but addiction is the primary cause.*

Five percent believe exclusively in the bashers' psychological problems as cause while one percent attributed cause solely to the victims' psychological problems. Further, 5.2 percent believe that the victim's personality is causative but not the basher's while 47.9 percent agreed that the reverse is accurate. No significant difference appears in these beliefs by gender, incidence of battered patients, training or service length.

Years of service is significant however in views about victim provocation ($\chi^2_2 = 6.29$, $p = .043$). Those with long service were more

likely to agree or to agree that sometimes wives provoke their husbands (27.8 percent as compared to 15.5 percent). However, fewer of the long service group were uncertain about this question (5.6 percent in contrast to 22.4 percent of the short-term service sample).

Table 2: Wife Battering and Doctors' Views by Gender

Question	Agree		Disagree		Sometimes		Uncertain	
	Male	Female	Male	Female	Male	Female	Male	F emale
Doctors should play same role as in child abuse	66.7	63.6	31.6	21.2	0	0	1.8	15.2
Wife battering should be taught as a medical syndrome	70.7	93.9	10.3	3.0	1.7	0	17.2	3.0

A number of questions were designed to elicit data on doctor's perception of their role in wife battering cases. The data presented in table 2 are statistically significant by gender; no significant differentiation by training, incidence or service is apparent. A greater proportion of males disagreed with playing the same role as in child abuse, while a higher percent of females were uncertain ($\chi^2_2 = 6.4$, $p = .041$). Those who disagreed clarify their position:

> *Children are unable to alter the situation by their own actions.* (male)
>
> *Adults are in a position to make their own decisions. One cannot ram one's own set of values down another's neck.* (male)
>
> *The wife can walk away - the child can't.* (male)

Table 2 also shows that women in the sample were more likely to agree that medical training should include medicalising wife battering; the male G.P.'s were more uncertain and more apt to disagree ($\chi^2_3 = 8.3$, $p = .040$).

Only 2.1 percent of the sample agreed that doctors should just treat the injuries in spouse assault cases. Most (92.6 percent) believe that referrals to other agencies should be provided. Ninety percent appear to perceive physicians as potentially capable of playing a preventative role by 'being on the lookout' for such cases. However, there is a significant difference ($\chi^2_2 = 12.37$, $p = .002$) between the long-serving

and short-serving practitioners. All but one of the latter group agreed whilst only 77.8 percent of the long-servers agreed, with 11.1 percent uncertain and 11.1 percent disagreeing.

If a patient does not disclose, almost three quarters of the doctors agreed that the practitioner should query the patient. For example, one male wrote *'...next bashing may be fatal. Children may be bashed too.'* The 9.6 percent who disagreed about an interventionist role clarified their feelings in comments such as those below:

> *...you will not be heeded or thanked for interfering.* (male)
>
> *...not confront but leave an opening that maybe there is another reason.* (female)

Three fourths of the sample also believe, that at least sometimes, doctors should encourage the patient to leave the violent situation, although one female respondent warned, *'But beware that they may get even more violent treatment (if they leave), so they need plenty of support.'*

Half of those surveyed disagreed that doctors should prescribe tranquilizers to battered women patients with a number choosing to elaborate with comments such as : *'A recipe for disaster; does not solve the problem...increases the risk of battering continuing and carries the risk of drug dependence.'* (male) Sixteen percent believe that tranquillizers are sometimes appropriate since, *'clarity of mind is important so assistance with sleep may be required'* (male) and, *'...only in the context where one is trying to change the situation, e.g. with refuge referral'* (female). Those with more than 17 years of experience are significantly more apt to believe that tranquillizers are always or sometimes appropriate ($\chi^2_3 = 12.04$, $p = .002$); over one half of that group (54.3 percent) compared to 22 percent of short-term practitioners.

Responses to open-ended queries concerning the informants' views about appropriate action by general practitioners revealed more information and some data that contradict that provided above. In their narrative responses, fewer doctors (33.3 percent) included referral as a recommended practice with a highly significant differentiation by

gender ($\chi^2_1 = 7.99$, $p = .005$); more than double the proportion of females (51.4 percent/23 percent) included referral.

Gender is also statistically significant ($\chi^2_1 = 4.83$, $p = .028$) for those who included counselling the husband as an aspect of doctors' 'treatment' of battering; a higher proportion of males (19.4 percent) than females (2.9 percent). Slightly less than half the sample wrote that doctors should do some counselling for the patient; 55 percent of short-term in contrast to only 30.6 percent of long service ($\chi^2_1 = 5.52$, $p = .019$). Training is also significant ($\chi^2_1 = 5.48$, $p = .019$) with 80 percent of the 'trained' sample including patient counselling as a part of their response, while only 41.9 percent of untrained advocated it.

Also, in contrast to the 75 percent who agreed that at least sometimes doctors should advise the patient to leave the violent home, only 2.1 percent of the sample (two doctors) mentioned that their role should include counselling of this nature. Since both respondents had over 17 years experience, this proves to be statistically significant ($\chi^2_1 = 3.99$, $p = .046$). Four percent believe that G.P.'s should encourage the reporting of the incident(s) to the police with a significant difference by training ($\chi^2_1 = 4.25$, $p = .039$); one fifth of those trained compared to 2.3 percent of the untrained.

Attitudes about Bashers and Victims

Slightly more than one third of the sample agreed that bashers should receive sympathy due to their emotional problems. However, 32 percent agreed that perpetrators should go to prison with only a quarter disagreeing and the remainder uncertain about this issue. Training proves to be a statistically significant ($\chi^2_3 = 7.86$, $p = .049$) variable. Sixty percent of those who had received some classes on domestic violence agreed with prison as a sanction in contrast to only 28.2 percent of the 'untrained'.

Table 3: Victims Stay in Violent Homes Due to Masochism

Gender	Agree	Disagree	Sometimes	Uncertain
Males	5.0	65.0	11.7	18.3
Females	0	95.1	5.9	0

There is significant gender differentation ($\chi^2_3 = 15.75$, $p = .001$) in attitudes about battered women's masochism. As table 3 indicates, almost all female doctors disbelieve such a perception while one third of the males are either in agreement totally, or sometimes, or are uncertain. As one male doctor commented *'Some do seem to stay despite repeated abuse.'*

Almost all of the G.P.'s (98 percent) feel sympathetic to patients who have been abused whilst 91.6 percent believe that they should also behave sympathetically. When queried about whether their behaviour remains the same if a battered patient returns having been beaten again, 70 percent agree. Those who responded negatively or were uncertain explained:

> *I more strongly advise recourse to legal help.* (male)
>
> *More probing is needed.* (male)
>
> *I am sympathetic but encourage working out a solution more strongly.* (female)
>
> *I engage other agencies to assist the victim; suggest separation or counselling, or confront the woman.* (female)
>
> *I become more actively involved in helping to stop the abuse.* (female)
>
> *I still feel and behave sympathetically but may also be exasperated. We are not helping the situation.* (female)
>
> *I tend to feel a little exasperated with recurrent bashings, as the wife often will not leave and will not contact support agencies.* (female)

CASUALTY UNIT DOCTORS

Background

Twelve of the 19 casualty doctors who returned surveys were male; 36.8 percent female. Two had experienced minimal training about domestic violence; 89.5 percent reported no classes on the subject. The sample's mean number of patients per month who admit to spousal assault victimisation is 0.9. The average number whom doctors **suspect** have been bashed is marginally higher, 1.2. The number who seek advice or counselling from those in the sample is also low, 0.4 per month.

The majority of presenting injuries reported by this sample are facial and torso bruising. Lacerations and rape were also cited.

Almost all (94.5 percent) of those surveyed do not believe that it is acceptable for a husband to hit his wife, even if really provoked. More than three quarters (78.9 percent) disagreed that wife bashing is a private matter. One female doctor comments:

> *It is as private as murder is between the victim and the murderer.*

Eight doctors (42.1 percent) agreed that domestic violence is more common among the uneducated and lower class whilst almost one third disagreed.

Reasons Casualty Doctors Suspect

'Emotionally upset', 'patient's emotional display', 'her emotional condition', 'patient's distress', 'anxiety' were the most frequently stated reasons that doctors working in Casualty suspect battering. Three respondents also mentioned the nature of the injuries and either the vagueness or 'unmatching' history given to account for them. Failure to contact the police and the presence or smell of alcohol on the patient or her husband were other reasons cited.

Causation

Table 4: Casualty Doctors' Beliefs about Cause(s) of Spouse Assault

Cause	Agree	Disagree	Sometimes	Uncertain
Sociological factors	42.1	5.3	36.8	15.8
Alcohol/Drugs	47.4	5.3	42.1	5.3
Victims' Psychological problems	15.8	31.6	42.1	10.5
Bashers' psychological problems	57.8	0.0	31.6	10.5
Victims provoke bashers	5.3	75.7	15.8	5.3

As table 4 shows, 'bashers' psychological problems' is the most widely adhered to causation belief, followed closely by alcohol/drugs and sociological factors. Almost all female doctors (85.6 percent) agreed with a 'bashers' aetiology; in contrast, only 41.7 percent of the male sample marked 'agree' although another 41.7 percent believe it is 'sometimes' the cause.

No significant gender differentiation is apparent in 'victims psychological problems' causation beliefs with more than half of the sample believing that at least sometimes, this is true. Only one of the 19 doctors, a male, agreed with the statement that victims provoke the bashing; however the three doctors who believe this is sometimes accurate are all female.

Casualty Doctors' Perceived Role

Slightly more than half of the sample believe that doctors should play the same role as in child abuse cases. Comments such as the following clarify disagreement with such a role:

> *Adults, being less helpless than babies do not require the same level of unrequested intervention by professionals.*

Forty-two percent of the casualty doctors also agreed that spouse assault should be taught as a medical syndrome. However, a statistically significant

(χ^2_1 = 5.88, p = .015) higher proportion of males (41.7 percent) disagreed in contrast to females (0.0 percent).

Almost all surveyed (18:19) disagreed that doctors should only treat injuries with the same number agreeing that casualty practitioners should be 'on the look out' for such cases. However, some commented that, *'...in Casualty, you have another ten patients waiting to see you with asthma, heart attacks and bleeding to death.'*

Two thirds of respondents agreed that doctors should query patients whilst 26.3 percent believe that this type of role is only sometimes appropriate. Further, all but one of the sample agreed that referrals should be provided since, *"most doctors are unable to provide the specialized help that is available in this country"*. The question of whether the doctors' role should include encouraging battered patients to leave the violent situation met with a mixed response; although only two doctors agreed, ten respondents think that it is sometimes merited and five are uncertain.

There is significant difference by gender in response to the use of tranquillizers (χ^2_1 = 7.51, p = .006). Although no one believes that such medication should be prescribed to battered women, all the female doctors disagreed entirely while 41.7 of the males believe it is sometimes appropriate.

In an open-ended question about doctors' actions if battering is suspected, 13 of the 19 mentioned referral by casualty doctors to other support services with hospital social workers most frequently cited. Three believe that the police should be brought in. Several informants commented that they may attempt to admit the patient to hospital to provide at least a temporary removal from the violent situation. Another suggestion was made by a male who proposes that a register should exist in each hospital for documenting incidence and cases of repeated violence.

Attitudes Toward Bashers and Victims

Almost 60 percent of the respondents did not agree that bashers should receive sympathy; 17.6 percent feel that it is sometimes appropriate. Over four fifths of the sample further believe that perpetrators should at least sometimes go to prison. Over two thirds of the female doctors marked agree as compared to one third of the men.

Although no one concurs fully with the concept that battered women stay in the violent situations due to masochism, almost one third (with no significant gender difference) feel that it is sometimes true. Two thirds of the respondents believe that they behave sympathetically to victims while 72.2 percent feel sympathetic toward such patients (81.9 percent of males, 57.1 percent of females). The remainder 'sometimes' feel sympathy.

Only 35.3 percent of the doctors behave the same to patients who return to them with injuries; again, a lower proportion of the female doctors. A number commented on how or why their attitude and/or behaviour changes:

> *Less sympathetic.* (female)
>
> *Probably less sympathetic.* (female)
>
> *I usually feel more despair about human inhumanity.* (female)
>
> *If the wife has made no attempt to remove herself from the situation, it is harder to feel sympathy.* (male)
>
> *There are stronger feelings on my part of something has to be done about this!* (male)

VICTIMS

Eighteen victims of wife battering who had sought medical attention for their injuries constitute the sample. However, since some respondents had seen more than one doctor, the sample size for most of the analysis is greater than 18. Eighty-one percent of the total sample reported that doctors were the first professionals whom they had seen for bashing-related reasons. General practitioners were more commonly consulted than Casualty Departments; 20 G.P.'s, six Casualty doctors. Asked how many times they had seen a G.P. for treatment of

assault injuries, six responded 'once', five had 'lost count' or stated 'many', and the remaining three women averaged six visits. Casualty attention was sought once by two victims, twice by two, three times by one woman and 'many' times by one.

Types of injuries that prompted medical attention include; *'physical and emotional exhaustion', 'black eye and fractured foot', 'bruising to head', 'black eyes', 'broken ribs and rape', 'depression, sprains, burns, and bruising', 'bruising and pain', 'black eye', 'bruises and cuts', 'head, arm, neck, and ribs',* and *'neck injury'.*

Two reported going to the doctor immediately after the assault while four went for medical attention the day after the battering. Others report: *'...depended on amount of pain,' 'two weeks', 'five years', 'six years', 'never on the first time',* and *'...not until I was pregnant and went into premature labour.'*

Of those who did not voluntarily disclose, doctors only queried the origin 28.6 percent of the time. For example, one woman reported that she saw a female casualty doctor for neck bruising from where her hushand tried to choke her. *'Without asking what happened, she said that the bruising was coming out nicely. I felt too embarrassed to just tell her. We just didn't talk about how it happened.'*

Two thirds of the victims had seen a doctor without the practitioner or the patient identifying spouse assault as the cause. In response to the query, 'How many times have you seen a doctor without battering being identified as the cause?' five women reported never; three had gone once without identification of the bashing; two went twice; one saw doctor(s) four times without disclosure; one, a few times; two, many times; and one woman had seen various doctors for $12\frac{1}{2}$ years without disclosing the battering. She explains:

> *For $12\frac{1}{2}$ years my husband always took me and stood over me so that I had to lie about my injuries. My doctor didn't ever ask my husband to leave the room so I couldn't tell him I was being threatened with death if I told how I got the injuries.*

Tranquillizers and other Treatment

Eighty-three percent of the general practitioners whom the sample had seen for bashing injuries had prescribed tranquillizers. Three quarters of the Casualty doctors had also prescribed them. Doctors' gender is not significant. Two of the victims comment on such visits:

> *I went for help and as it was very difficult to talk about, I cried and the doctor diagnosed me as being depressed and started me on tranquillizers and I never finished what I'd gone in to ask for help for!*
>
> *I became addicted to tranquillizers for 12 years. All were prescribed by doctors to treat my distress from battering, emotional and psychological abuse.*

When the women told the doctor that they had been battered, five doctors encouraged them to leave the violent situation, nine did not. In these victim disclosure-type interactions, four doctors (all G.P.'s) made some type of referral, while ten practioners did not (two were casualty doctors).

Evaluation of Doctors

Victims were asked to evaluate the doctors they had seen on a number of variables, assigning a value of one through five (one-excellent; two-good; three-O.K.; four-poor; five-terrible).

Table 5: Victims' Numerical Mean Evaluation of Doctors.

Variable	General Practitioners			Casualty Doctors		
	Male (n=16)	Female (n=4)	Total (n=20)	Male (n=5)	Female (n=2)	Total (n=7)
Sympathetic	3.8	2.5	3.5	4.0	3.5	3.9
Helpful	3.7	2.3	3.4	3.8	3.0	3.6
Friendly	3.3	2.3	3.1	3.2	2.5	3.0
Kind	3.4	2.0	3.2	3.8	2.5	3.4
Supportive	3.8	2.8	3.6	3.8	3.0	3.6
Unblaming	3.8	3.3	3.7	3.4	3.0	3.3

Table 5 indicates the numerical means of the numbers which the respondents assign to the doctors. The scores in general fall between an 'O.K.' and 'poor' rating with slightly more positive perception of practitioners on friendliness and kindness. However, it should be noted that few doctors actually receive an average score; for example, of the 16 male general practioners, half were graded as 'terrible' on the sympathetic variable; two as 'excellent'; two as 'good' and two as 'O.K.'.

Table 5 also shows some differentiation by gender of the doctor. Males were consistently evaluated more negatively than female doctors. However, the latter sample size is very small; only two female doctors.

Many respondents chose to comment on particular scores they had given with most elaboration on terrible or poor performance. A few did relate positive or mixed experiences:

> *He* (male G.P.) *referred me to the Domestic Violence Service and told me it was not my fault.*
>
> *She* (female G.P.) *was kind and supportive and helped me leave him. I liked her telling me about refuges and giving me information.*
>
> *The woman G.P. I saw was sympathetic, helpful, friendly and kind but could have given more support. I felt that she saw me as to blame for the violence.*

The latter comment on blaming is typical of many who felt either directly or implicitly blamed for their injuries by the G.P. they had seen.

> *He said that if I was a better wife, I wouldn't be getting bashed.*
>
> *He told me I should get a psychiatrist and enter a psychiatric ward. As I walked out through the waiting room, He called out after me, 'I wouldn't leave it too long if I were you'.* (Victim had told doctor that she was in a state of physical and emotional exhaustion due to psychological abuse.

A woman who had seen a male G.P. for neck injuries and had disclosed the source ranked him as a '5' in blaming because:

> *He didn't acknowledge my injuries and hurt at all, but made friends with my husband by talking about C.B. radios when we went to him for counselling. He referred my husband to a psychologist after praising him for having come forward with the problem. As it turned out, my husband was totally reinforced in his opinion that it was all my fault and that he was the poor person driven to such behaviour by his wife. The doctor gave no word of support or acknowledgement for me. I felt like he was blaming me for the violence all along.*

Others write:

> *I was seven months pregnant the first time I went into premature labour as a result of being thrown down a flight of stairs. The doctor acted as if he thought my husband and I had just had an argument and I'd overreacted.*
>
> *I gave the male G.P. all 5's because of his comment that I was more emotionally upset than anything else, disregarding bruising to my head and continued headache since the beating. He implied that I was a neurotic overreacting female.*
>
> *He seemed disinterested; just wanting to check if anything was broken.*

The latter remark was written by a woman who has rated her male G.P. as 'poor' in all categories since she feels her concerns were trivialised.

Few positive comments were made for Casualty doctors. One woman evaluated the male doctor as 'terrible' on all counts because *'I was referred to a psychiatrist, kept waiting four hours and nobody asked about my injuries (head, arms, neck, ribs).'* Another victim went to Casualty for broken ribs poking into her lung and reported the details:

> *At Casualty, it was the nurse who asked all the questions, yelling at me when I could hardly talk and in extreme pain from broken ribs which meant I couldn't breath properly. When the doctor finally came, it was a cursory check, then off to X-ray. The doctor didn't talk to me at all to my recollection except to prod the ribcage and ask if it hurt! ...the experience was a nightmare which I couldn't talk about for years. I was treated like a lump of meat, given tranquillizers and doped up for three weeks. The ribs have never knitted properly.*

Another woman who has been to Casualty *'too many times to count'* said that, *'The Casualty Department just doesn't seem to have the time; and half the time, they suggest that it is my fault that these things are occurring.'*

However, one male Casualty physician received all 'excellent' ratings from a woman who had sought medical attention for a fractured tailbone and ruptured kidney area. This doctor said that if the patient needed any help in the future, *'to please come back and see him'*. Another doctor (female) was rated 'good' in all areas with the respondent noting that, *'she didn't act like it was my fault'*.

A.C.T. Doctors Typical?

Six of the victims had also seen doctors outside of the A.C.T. Half do not feel that there is any difference in attitude or treatment, noting that *'they all give valium'*, and *'they are all still prejudiced'*. Of the three who perceive a difference, one feels that her Canberra doctor was

more sympathetic; another wrote that a New South Wales *'town physician was not as prejudiced and more caring'*; the third believes that in the country areas, doctors just don't believe that it happens.

DISCUSSION

With prevalence data unavailable in Australia, it is not possible to conclude from doctors' responses about incidence whether they are in fact identifying few, most, or all of the battered women patients or are merely treating the symptoms. Since prior research shows that the presenting problems are often not actual physical injuries but emotional consequences of violence, it is disturbing that only about one third of the G.P. sample report emotional problems as 'symptoms' they look for in determining assault cases. All of the women in this research consulted physicians about physical injuries. It is therefore alarming that many of these women passed through doctors' offices and/or Casualty units without initial or ultimate disclosure. If one considers the undoubtably high number who do not present with injuries but with depression, anxiety and other 'masked presentations', one might speculate that both patient candour and doctor intervention would be even less frequent than in this sample.

Why did two thirds of patient/practitioner interactions maintain the secrecy of domestic violence? It might stem from doctors' mind set about their role in such cases and/or their feelings about spouse assault itself, including its aetiology. In response to queries about role, about two thirds of the G.P.'s and slightly more than half the Casualty doctors agree that they should function in the manner prescribed with child abuse patients. Further, almost three quarters of the G.P.'s agree that doctors should query the woman if bashing is suspected; two thirds of Casualty doctors also agree. Therefore, failure to identify may not be due to the practitioners' failure to perceive that as their role, but to their inability in recognising the symptoms. Alternatively the respondents may be stating an ideal (not uncommon in survey research) but not in fact acting it out.

As stated above, perception of role may be influenced by causation beliefs which also can impact on treatment model. For example, if a physician believes that a woman's psychological problems are the cause of her situation, prevention might be seen as problematic and treatment restricted to symptomatic chemical relief. Eighty-three percent of the G.P.'s whom victims had seen prescribed tranquillizers.

(It should be noted that half of the G.P. sample disagreed with the use of such medication). The G.P. data indicate that, although only one percent solely attribute bashings to the victims' psychological disorders, one third do include it in their aetiological beliefs while almost another third are uncertain or agree that it is sometimes the case. Further, more than a third of respondents either agree entirely or sometimes, or are uncertain that victims do provoke the bashers. Similar responses are found with Casualty doctors although three quarters disagree with the concept of victim provocation. Certainly, some victim blaming has been picked up on by the victim sample with many examples cited.

Practitioners' responses indicate sympathy toward battered women patients and for the most part a belief that they behave sympathetically toward them. Few believe that spouse assault is ever acceptable and only 12.8 percent agree or sometimes agree that victims stay in the violent situation due to masochism. However, again the victims' perception conflicts somewhat with the doctor's articulated views. They evaluated doctors as close to 'poor' on the sympathy variable.

Similar mean scores are given by victims for 'helpfulness' and 'supportiveness' of doctors. Practitioners who received excellent marks had referred the patient to other agencies which appears to be a fairly uncommon practice. The doctors' responses concerning referral are contradictory. Although almost all agreed that patients should be referred, only one third actually included this option in open-ended queries concerning treatment course and appropriate role. An active interventionist role, e.g. encouraging the patient to leave the home, is agreed upon theoretically by three quarters but is only mentioned in the nartative sections by two doctors. As mentioned earlier, for those women who had ever voluntarily disclosed, less than one third of their doctors (28.6 percent) volunteered referral information; 35.7 percent encouraged the women to leave the violent home.

It is interesting that few doctors receive average, 'o.k.'- type scores; they are overwhelmingly either perceived as excellent or terrible. Female G.P.'s are ranked as moderately more sympathetic, supportive

etc. with little differences between the G.P.'s and the Casualty groups as a whole. Some doctors in the sample do indeed appear to be more helpful and less blaming. In the present research several variables emerge as significantly differentiating some attitudes held by G.P.'s. For example, those who believe that assault is sometimes acceptable; that wives sometimes provoke their husbands; that G.P.'s need not be on the lookout for wife battering; that tranquillizers are always or sometimes appropriate; that doctors' role does not include counselling the patient/victim, are more apt to be long-service practitioners. Thus, the most conservative group is a consequence of years as a doctor and not of gender or training. Although the latter two variables are both correlated with duration of service, the model that best explains the data is a simple association between length of service and attitudes.

Some gender differences are apparent however, with female G.P.'s who are more aware of or attuned to the emotional symptoms of abuse; are less apt to disagree that doctors should play a similar role as in child abuse; are more amenable to medicalising wife battering; are more prone to include referral as part of the doctor's function; and are less likely to believe that they should counsel the husband. Female doctors also overwhelmingly disbelieve the concept of victim as masochist. Females working in Casualty also appear somewhat more liberal in their views with a significantly higher percentage agreeing with the medicalising of wife battering and disagreeing with the prescribing of tranquillizers in such cases.

Training correlates less frequently with differentiation in opinion. However it is important to remember that the actual 'training' had been minimal. Those who identified themselves as the recipients of some academic background in the area of domestic violence are more likely to believe in: sociological theories of causation; counselling of victims; reporting cases to the police; and prison as a sanction for bashers.

No significant differences result when numbers of patient/victims are contrasted. Apparently, increased experience with battered women does not alter the beliefs or behaviour of practitioners.

Some of the medical practitioners' comments seem to indicate a lack of understanding about the dynamics of battering, the cycle of violence and its consequences for victims' self esteem and ability to act, e.g. leave the violent situation. For example, almost two thirds of the G.P. respondents and Casualty doctors would not behave in the same manner to a patient/victim who returned, battered again. Most comments indicate frustration with the woman's inability to leave the home and consequently, less sympathy. Also, those who do not equate wife bashing with child abuse focus on the former's ability to act, make decisions, walk away.

The above perception may be a consequence of lack of education. Failure to recognise the masked presentation of violence and battering as a medical syndrome may also be attributed to the dearth of information provided in medical schools. It does appear that in Australia, as overseas, a high proportion of doctors are not being trained to recognise wife battering symptomology nor to perceive their role as interventionist. The limited victim sample shows that G.P.'s are sought for medical attention more frequently than Casualty doctors, and indeed in most cases, they are the first and only professionals that these women turn to for help. A large percent of the victims are patients regularly seen by the doctor, which could promote both rapport and trust plus a knowledge of the women's medical history. In addition, G.P.'s are generally not under the time constraints of a Casualty department setting where critical and urgent cases are more likely to hamper the doctor's ability to gently query the patient. Yet, the obvious potential for diagnosis, prevention and treatment is, in many cases, not acted upon or developed. The result instead for some of the women in this survey has been increased feelings of guilt and blame and continued battering.

Given the ultimate personal and societal costs and the undoubted numbers that pass through doctors' rooms and Casualty units undetected and unassisted, change is imperative. Although fundamental attitudinal modification cannot in all liklihood be taught or legislated, symptomology, dynamics of abuse, detection and appropriate treatment should be integrated into medical school curriculum and offered by appropriate agencies as mandatory in-service training programs. With

such workshops, at the least perhaps doctors would be sensitised to the critical nature of spouse assault and women would not leave doctors' offices saying,

> *The doctor I saw didn't even ask how I got the bruises and I felt too embarassed to tell her. We just didn't talk about how it happened . . .*

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