Depression or Oppression?

Duluth (Minn) police officers respond to a report of a couple arguing loudly: "He slapped me and kicked my butt. He picked me up by the hair and threw me against the wall."

"She lies, you know," George G. confides to an officer, who remains stone-faced. Jenny M. starts crying again. "I don't want him hurt. This is my fault. I'm the drinker. He's not a bad guy."

Following protocol, the officers determine that the couple live together. And that she is afraid of him. Next, they snap Polaroids of her bruised face, and of his swollen, cut knuckles. Then the police head toward George G. with handcuffs. He looks at her beseechingly. "Jenny, do you want me to go?"

An officer cuts him short. "George, it's not her choice."

George G. thrusts his chin out and his fists deep into the couch. "But this is just a domestic fight!"

(*The New York Times Magazine*. February 16, 1992:23-24)

That feeling of a weight on my chest and I can't get my breath that happens in certain situations. . . . I realized for the first time last week that what my first husband did was sexual abuse, and those feelings occur as physical reminders of it!

A female physician, 1993

DO WE as physicians often diagnose depression (or another medical problem) when our patients are suffering the results of oppression? How would we act differently if we acknowledged this? Saunders et al[1] and Hamberger et al[2] have added to the growing body of published evidence that domestic violence pervades our practices but is usually unacknowledged. They used a well-validated questionnaire to elicit a history of recent physical abuse by a partner in 24% of women aged 18 to 75 years visiting a family practice, and a lifetime prevalence of 39%. The questionnaire, the Conflict Tactics Scale, has been criticized as being too nonspecific, defining women who have experienced a single episode of "mild" aggression, such as pushing or shoving, as victims of domestic violence, along with those who have been injured and assaulted repeatedly. Such criticism tends to ignore the power imbalance that characterizes relationships in which a violent act is but one in "a pattern of coercive behaviors" aimed at dominating and controlling the victim.[3] Furthermore, since most abuse is recurrent and escalates in frequency and severity,[3] identifying the potential for injury may prevent some severe abuse. Finally, as Saunders et al[1] and others[3] have noted, the majority of partner assaults do result in injury; in their study,[1] 60% of women assaulted in the past year reported being injured. I awoke dramatically to the need to consider seriously the first episode of domestic violence when a patient suffered retinal detachment and permanent blindness in one eye the first (and last) time her former husband struck her.

In the primary-care practice studied by Saunders et al,[1] younger and single or divorced women had the highest likelihood of recent assault. Clinicians must not assume that separation or divorce eliminates the risk of spouse abuse. Likewise, unmarried women are at greatest risk (31% victimized by partners in the past year) but may have the least legal protection.[4,5] According to a National Institute of Justice publication, "about three fourths of law enforcement reports—as well as hospital emergency reports—of domestic violence occur in cases in which the victim is *not* currently residing with the abuser, either because the parties are divorced or separated, or because the parties never lived together. . . . Indeed, many batterers who kill their partners do so precisely at the time the woman is in the process of separating from them."[5(p10)]

Saunders and colleagues[1] searched beyond demographics for particular symptoms or diagnoses that might provide clues to woman abuse. The study was limited to retrospective review of medical office records rather than asking women about their symptoms and health problems. These women's injuries may have been treated by different practitioners in other settings (eg, emergency departments and urgent-care facilities). Domestic violence was noted as a problem in only three charts. Very few women had disclosed their history; they had usually not been asked.[2] Without awareness of a history of abuse, clinicians had diag-

nosed depression more often in women who were abused than in other women. All three women who had attempted suicide had been assaulted by partners but physicians had not known this. Otherwise, when controlled for age, the women's medical problems did not differ. The most important conclusion from the study by Saunders and colleagues[1] is that *symptoms or medical problems noted in a primary-care setting are not reliable clues to a history of woman abuse; all must be screened.*

Saunders et al[1] also conclude that widely circulated stereotypes about the somatic complaints of victims of domestic violence, based on limited data without comparison groups, may not be typical of primary-care patients. An example of such sterotyping is found in the American College of Obstetrics and Gynecology technical bulletin on battered women[6]:

> . . . a profile of the characteristics of abused wives . . . include[s] a history of having been beaten as a child, raised in a single-parent home, married as a teenager, and pregnant before marriage. . . . These women have frequent clinic visits with a variety of somatic complaints, including headache, insomnia, choking sensations, hyperventilation, gastrointestinal symptoms, and chest, pelvic, and back pain. There is frequently noncompliance with advice and recommendations of the physician.

When we know that one quarter or more of our female patients have been battered, sterotyping and stigmatization of domestic violence victims becomes less conceivable. However, there is good reason to believe that survivors of violence, particularly of sexual abuse, experience bodily distress.[7] Future work may indeed find that many symptoms, apart from injuries, can be healed by changing the life circumstances and self-perception of victimized women.

Why do women in general use almost every type of health service more than do men; describe themselves as less healthy; report more symptoms, disability, and functional impairment than do men; and suffer more ill health, despite the fact that from childhood their age-specific death rates associated with most major causes are much lower than those for men, and their life expectancy longer?[8] Is battering only one aspect of a social environment that tends to make women sick? Perhaps many women, even those who have not been in abusive intimate relationships, experience powerlessness, develop distressing symptoms, and seek medical care.

What would a family practice be like if it were organized to address the major problem of woman abuse? First, it would be respectful of women in their various life circumstances. Practice routines would promote patients' self-esteem and their feeling of control over their situation and their own decision-making capacity. In my view, intolerance of woman abuse implies that the clinician has an obligation to advocate nonviolence in other contexts, for example, to speak against corporal punishment of children and gun ownership. A value on patients' safety would be clearly communicated. Perhaps in the context of inquiries about tobacco and substance abuse, seat-belt use, and firearms in the home, the practice would screen all patients for a history of sexual and physical abuse. Women might be asked, "Are you (have you ever been) in a relationship in which you have been physically hurt or threatened by your partner?" and other more specific questions.[3] Moreover, children and men, as well as women, should be asked, "Have you ever been required to engage in sexual behavior against your choice?" and "What happens when you and your partner (girlfriend, sibling) fight or disagree?"[3] A history of domestic violence or its precursors would elicit a clear communication from the clinician that such violence is unacceptable and that no one deserves to be hit or abused. A history of violence would prompt concern about abuse of any children and about effects on them of witnessing family violence.[9] With the victim's safety paramount, revelations of abuse would be kept confidential from the perpetrator(s), and joint therapies would not be considered.

What help can a primary-care practitioner offer to women who reveal that they have been threatened or injured? The American Medical Association recently published its guidelines.[3] A woman may be helped by a clinician who respectfully witnesses her suffering, and continually serves as a touchstone that violence is unacceptable behavior of the batterer and not a result of her own imperfections.[10] Physicians can remind themselves that women's economic dependence on men is one of the most compelling forces that limit women's freedom to leave abusive relationships. As members of a community we can work to eliminate pay and status differentials between men and women. As physicians, we can appreciate what is practical for our own patients and not despise them for appeasing men who both beat and support them. Before taking any action that causes the perpetrator to feel that he is "losing control" over her behavior, a woman needs to be adequately protected against violent retaliation from her partner. Practitioners should assess and unequivocally promote women's safety and provide information about shelters, support networks, and available legal protections. We should prod people at risk of injury to develop an escape plan to take practical steps such as those outlined in the *Technical Bulletin* of the American College of Obstetrics and Gynecology.[6]

Although no program has yet been proven to prevent domestic violence, the legal system is developing new measures that are believed by victims and jurists to offer some protection (*The New York Times Magazine*. February 16, 1992: 22-27, 64-66, 72). A civil order of protection is available to married or cohabiting women in 49 states.[5] This is an emergency court order for the perpetrator to stop his abusive actions, including, in many cases, provision for his eviction, and prohibition against any contact with the victim other than support payments or supervised child visitation. Violation constitutes contempt of court or a misdemeanor in most states; a civil order of protection provides the most safety in jurisdictions where violators can or must be arrested immediately without a warrant and where resources

are devoted to enforcing such orders.[5] Women who have not been injured or do not have proof of injury, who depend on the perpetrator for financial support, and who fear retaliation or for other reasons do not press criminal charges may find it in their best interest to file for a civil order of protection. However, knowledge of the local law and enforcement system would be helpful in making this decision. Clinicians can advocate in their own communities for enactment and enforcement of laws that protect women from attack, for justice systems that give clear messages and provide supervision to perpetrators of domestic violence, and for support services for abused women and children. We can struggle against racism, economic inequality, and all forms of oppression that perpetuate ill health.[11] Ultimately, we, along with the rest of society, will need to develop routines for primary, rather than secondary, prevention of family violence.

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The Family Doc Answers

Early Detection of Domestic Abuse

EARLY DETECTION of the batterer is as important as early detection of cancer. Undiagnosed, both cancer and the batterer do not improve; cancer invades the body and, in the case of the batterer, his battering escalates.

Batterers can be easily identified by the type of behavior they use to dominate and victimize their families. I use the following mnemonic (*PISTOL*, a symbol of violence) to help anyone easily identify the batterer and warn his potential victims.

P	Physically	He hurts you physically.
I	Isolates	He isolates you from family and friends.
S	Sex	He forces you to have sex.
T	Threatens	He threatens and yells at you.
O	Zero	He makes you feel worthless and powerless.
L	Lovable	He sometimes acts bad, but other times he is so lovable and sweet.

I care for battered women and their children in my office and at several battered-family shelters that include shelters in prime locations, eg, next to a luxurious four-diamond–five-star resort, in an abandoned motel that is fenced and has a guard gate to keep out the prostitutes and drug dealers, and even one in the "barrio" that shelters only battered Latin American women and their children.

As a physician, what I am seeing is very terrifying and sad. This battering, wife abuse, and child abuse is affecting the entire human race. It is pandemic. No one *ever* deserves to be battered, and as a physician I will not sit idly by and be a cobatterer. We must all work together to eliminate this violence.

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