



## *Women, Health and Domestic Violence*

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**ABSTRACT** *‘Domestic’ violence is a health problem for women, and not just because of the injuries they receive. It leads to acute and chronic physical injury, miscarriage, loss of hearing or vision, physical disfigurement and often depression, alcoholism and sometimes suicide. The medical and caring professions are in the best position to act as the ‘front line’ in helping women who are assaulted by their partners, because most of the female population visit doctors, are visited by health visitors or use the services of midwives during their twenties and thirties, but the pervasive ‘medical model’ and the individualistic stance of modern medicine mitigate against this role. This article gives the first results from a survey of medical professionals—doctors, practice nurses, health visitors and midwives—in one English county. It looks at how often they are aware of seeing cases of domestic violence in their practice, what they know about it, what they would be prepared to do about it and how they see their own role and that of the health service.*

### **Introduction**

The Labour government Ministers for Women have listed six priorities, one of which is ‘tackling violence against women’ (Ministers for Women Web Page, 1997). Social policy initiatives to provide for women who experience violence from known men (domestic violence) date in Britain from the mid-1970s, following campaigning work and voluntary action by the Women’s Movement. Despite a recognition that health and social services have important roles to play, most of the initiatives have related to the legal system, policing and housing (McWilliams & McKiernon, 1993; Mullender, 1996). While these policy initiatives have undoubtedly helped women, they involve the provision of services that are reactive—they intervene when women (or others on their behalf) request assistance. The Women’s Movement and especially Women’s Aid have played the major role, and continue to do so, in bringing domestic violence onto the political and policy agenda and keeping it here. While campaigns such as Zero Tolerance play a public education role, much of the voluntary work in Women’s Aid is reactive—assistance is provided when it is requested by women. The provision of services for women has itself been hampered by a lack of co-ordination; no one organisation or service has

responsibility for coordinating services for women who experience violence from intimates. The development of inter-agency projects is undoubtedly resulting in more co-ordination of services, but the projects depend on local initiatives and have primarily been concerned with coordinating reactive service provision.

The Health Service and health care professionals have tended not to participate in inter-agency projects, yet health care professionals are in a good position to play a health screening role—that is, to provide women with the opportunity to talk about the violence they are experiencing, to give appropriate advice and to refer women to appropriate agencies. Most importantly of all, they can empower women by explaining to them that it is not their fault, that they should not have to ‘put up with it’ and that they do have choices. This is not to suggest that domestic violence is a medical problem (although the physical injuries and mental health disturbances undoubtedly are)—that the women or their partners have a medical problem that ‘causes’ the violence and can be treated. It is rather to suggest that health care professionals can and should play a role in empowering women living with violence.

This paper is concerned with women’s health and the consequences for it of being involved with men in violent relationships, specifically with respect to the understanding, knowledge and intervention of health care professionals. We review the mainly US literature which demonstrates that health care professionals have not taken on a central role in working with women who experience violence from known men despite the fact that they are often the first (and only) agency that women turn to. The medical model, familial ideology and the individualisation of the ‘problem’ mean that, without appropriate education, health care professionals are unable to make an effective contribution, although they are frequently the only workers with whom women are in contact and in a powerful position to help them.

Doctors play a particularly powerful role in the diagnosis and legitimisation of illness. However, to the extent that they intervene, they diagnose and treat the *symptoms and signs*—the physical injuries or the mental health problems—which reifies the view that it is these that are the problem. By acknowledging that women *have* a problem and that it is not their own fault but a social and political issue in a patriarchal society, doctors would play a powerful role in empowering women who experience violence from known men and in raising domestic violence as a political issue. Medical diagnosis is a social construction and is influenced by ideologies as well as scientific knowledge. The diagnosis of the symptoms (problems) of women who have experienced violence from known men involves doctors construing what the causes of the problem are. This can vary from a diagnosis of the physical injuries to an acknowledgement of how the injuries were caused, to a recognition of domestic violence as a political issue with men as the perpetrators. It is only when health care professionals take the latter perspective that they are able to play a central role in empowering women who experience violence from intimates.

### **Domestic violence as a social problem**

Despite the campaigning and voluntary support work of women the response by social services, the legal system (see, e.g. Mullender, 1996) and the health care system has been uneven and often unhelpful. The recognition of domestic violence as a social problem—a political as opposed to a personal issue—has yet to become the norm. It is women who fear mental, physical and sexual assault from the men they know (see, e.g. Dobash & Dobash, 1992) and women who are physically injured and experience the long-term health problems (Smith, Tessaro & Earp, 1994). Prevalence studies across the world

demonstrate that women are overwhelmingly the victims and men the perpetrators of violence in intimate relationships (United Nations, 1993). Studies in Britain have demonstrated a high incidence rate—between 1 in 4 (WAFE, 1992) and 1 in 10 intimate relationships involve ongoing violence (Morley & Mullender, 1994; Mullender, 1996; for a global estimation see Heise, Pitanguy & Adrienne, 1994). Domestic violence is probably the most under-reported and under-recorded crime, and complexity of definition and variation in incidence make it difficult to uncover in surveys (Smith, 1989). It is also a multiple-victim crime, escalating in incidence and severity over time (Hanmer & Stanko, 1985; Andrews & Brown, 1988; Heise *et al.* 1994; Mooney, 1994).

## Health and Domestic Violence

Given the extent of physical, mental and sexual violence that women experience from their partners, it is important to investigate its health consequences and the role of health care professionals. Heise *et al.* (1994), in assessing the health consequences of gender-based violence, estimated that in industrialised countries rape and domestic violence take about five healthy years of life away from women aged 15–44. In the USA it has been estimated that violence from intimates is the largest cause of women's injury—a larger number of injuries result from this than from auto accidents, muggings and rapes combined. Of women seen in hospital emergency rooms 30–35% have symptoms or injuries secondary to battery, although only about 5% are identified as such (Keller, 1996; Stark & Flitcraft, 1986; Hendrick-Matthews, 1993; Hadley, 1992). Women frequently experience violence during pregnancy, and some research has suggested that violence may first begin during pregnancy (Casey, 1989; Evason, 1982). The American Medical Association (AMA) (1992) has indicated that the prevalence of domestic violence is such as to justify routine screening for all female patients seen in emergency, surgical, primary care, prenatal and mental health settings. A survey at the Royal Women's Hospital in Brisbane, Australia found that 30% of the women interviewed had been victims of domestic violence, and 6% were in violent relationships at the time of the interview (Webster, Chandler & Battistutta, 1996). In London it is estimated that 100,000 women a year seek medical treatment for injuries they receive as a result of violence inflicted on them by their male partners (*Punching Judy*, BBC1 TV programme, 1989).

Physical injuries can include bruises, cuts, burns and scalds, concussion, broken bones, penetrative injuries from knives and other objects, as well as miscarriages, permanent injuries such as damage to joints, partial loss of hearing or vision and physical disfigurement from burns, bites or knife wounds. Women in violent relationships also frequently experience depression and somatic complaints such as migraine and non-specific pains in the stomach and joints. Women living in violent relationships have significantly poorer health than women who do not live in such relationships. The psychological impact of domestic violence can be more debilitating than physical injuries. Miller (1990) found that having been in a violent relationship was, for women, the strongest predictor of alcoholism, and women experiencing violence from an intimate are more likely to attempt suicide (Stark & Flitcraft, 1991). There are also long-term health problems—especially arthritis, hypertension and heart disease (AMA Council on Scientific Affairs, 1992). Women who live with violent men tend, then, to develop serious health problems as a consequence of the repeated violence and fear they experience. Stark & Flitcraft (1996) have identified this as 'Battered Woman Syndrome', characterised by recurrent assaultative injuries, stress-related injuries, isolation, substance abuse and mental illness. (It is important to note that the syndrome has been defined more

around white than Black or hispanic women's responses to violence.) Women seek medical help for health problems that are consequent on being assaulted by their partners (Elliott, 1993; Mazza, Dennerstein & Ryan, 1996; Jaffe *et al.* 1986; Campbell *et al.*, 1994).

However, the research in the USA (and the more limited research in the UK—Pahl, 1995) suggests that few doctors or other health workers identify injuries as being caused by male partners (e.g. Kurz & Stark, 1988) and that this failure is itself psychologically damaging for the women (Warshaw, 1993). Doctors treat the physical injuries and thereby satisfy their medical obligation (Flitcraft, 1992; Warshaw, 1993) but fail to acknowledge and address the underlying cause of the women's injuries. Working within a medical model, doctors medicalise the women's problems and come to see them as the cause of their health problems. The secondary health problems that women develop are individualised and psychiatric labels are commonly given. Kurz and Stark argue that medical staff are uncomfortable when treating women who have been assaulted by their partners, and by labelling them as 'evasive' and 'repeaters' they shift the blame for the lack of an effective outcome onto the woman; it is the woman who will not take steps to change her situation—she is seen as the problem, rather than as having problems created for her by her assailant. They argue that health care professionals fail to recognise/acknowledge that domestic violence is the problem; the violence in women's lives is the cause of her symptoms. This can exacerbate the women's sense of entrapment and hence contribute to victimisation.

Bograd (1987) identifies four myths that influence medical conceptions—that domestic violence is rare, that women are battered because of their psychopathology, that women are responsible for the violence, and that violence, if not acceptable, is an inevitable part of female existence (see also Stark & Flitcraft, 1996). Warshaw (1993) suggests that doctors are likely to see the situation as just domestic, to see the family as sacred and not to want to get involved in people's 'private' lives. However, she goes on to argue that the major impediment to medical diagnosis and intervention is the dominance of the biomedical model, which results in the medicalisation. The medical framework means that women's injuries are disembodied and decontextualised—the physical injuries are diagnosed and treated without any acknowledgement as to how they were caused—or, frequently, any attempt to discover how they were caused. Medical notes rarely record how the injuries were caused or who inflicted them. The role of the doctor is seen as treating the injuries; good medical practice is treating individual bio-psychiatric dimensions of the problem—yet prescribing painkillers can actually prolong violent relationships by deadening the pain and clouding judgement, making it more difficult for women to assess their options or take action to protect themselves.

[The] medical approach reduces male violence—a social process rooted in gender identity—to biological, individual or situational factors and focuses prevention on the individual level. This focus minimises the historical and social dimensions of women's experiences that are so crucial to understanding and responding appropriately to wife-battery. Clinicians learn to catalogue abuse alongside other 'illnesses'. Whether abused women are received like other patients requiring 'treatment' or as 'victims' requiring 'rescue', medical interventions inevitably reproduce and extend female dependence. (Kurz & Stark, 1988, p. 262)

Medical intervention thus creates or exacerbates dependency rather than encouraging the autonomy and independence of women. The medical response should be to support women—to acknowledge that they have been hurt

by their partners, that they are not responsible for this and that their future safety is of central concern. (Stark & Flitcraft, 1996)

In Britain there are three main medical services to which women can turn: (1) GPs, (2) Hospital Accident and Emergency Departments, and (3) the Health Visitor. In addition, pregnant women see a Community Midwife. Members of the Primary Health Care Team are in a unique position to empower women who are experiencing violence from known men. It is safe to argue that GPs and health care professionals could play a large role in enabling women to see that they are not to blame, empowering women, helping them to recognise that their safety is of importance and giving them information on services. Dobash, Dobash & Cavanagh (1985) found that 80% of the women in their Scottish sample had been in contact with their doctor during the period of the violent relationship—and that the longer they were in the violent relationship the greater the number of contacts. McWilliams & McKiernan (1993) indicate that studies in the UK suggest that between 52 and 80% of women who have been abused seek help from their GPs at some point. Most women have access to a GP; GPs can have an impact on the health of women and need to recognise domestic violence as a health problem rather than women having health problems (see, e.g. Herman, 1992; Glass, 1995). However, the medical model is a major obstacle to doctors and other health care workers taking on this role, and technical training would be insufficient (see, e.g. Flitcraft, 1995). It might be that the female-dominated occupational groups—health visiting, midwifery and nursing—who work with a more social model and within a ‘caring’ paradigm (Abbott & Wallace, 1990) would be able to work more effectively with women than doctors. (However, the concern here may be that their understanding of their role means that they prioritise the needs of children rather than seeing themselves as working with women—see, e.g. Abbott & Sapsford, 1990.) Midwives see all women on a regular basis during pregnancy; screening for domestic violence and empowering women would be possible. One estimate is that one woman in six is abused while pregnant, a much higher proportion than the proportion who develop urinary tract infections (Elliott, 1993). Similarly, health visitors routinely visit most women with preschool children, having a statutory duty to visit women after they are discharged from the midwives’ care. Furthermore, as Smith (1989) has noted, some women are prevented or deterred from seeking medical help by threats of further violence; health visitors and midwives have an important role to play with these women. Inter-agency work is also essential (see, e.g. Mullender, 1996).

Considerably less research has been carried out into the response of health care professionals in Britain. However, the available evidence suggests that, as in the USA, the response is minimal and health care professionals fail to identify physical abuse (see, e.g. Home Affairs Committee, Third Report, 1993; Pahl, 1995). Richardson & Feder (1996) suggest that women do not reveal that they have been assaulted by their partners because doctors are unsympathetic or even hostile. The GPs interviewed by Borkowski, Murch & Walker (1983) saw their role as treating physical injuries and illness—‘real medicine’ (see also Kirkwood, 1993). Clifton, Jacobs & Tulloch (1996) found that GPs, on average, thought they saw about nine women each year who they suspected were being assaulted by their partners. The majority (72%) had received no training, and the training of the remainder was very limited. All the GPs were uncertain of the services to which they could refer women; the Citizens’ Advice Bureau was the one most frequently mentioned. Dobash *et al.* (1985) found that 25% of the ‘abused’ women they interviewed had discussed the beatings they received with their GPs. McWilliams and McKiernan (1993)

in Northern Ireland found that only a sixth of their sample of abused women actively told their GP about the abuse. The women found their GPs hard to approach and felt discouraged from talking to them in their busy surgeries. Some women said that doctors did not ask about the cause of injuries or assumed that they were the result of a fall. The main response of GPs was to prescribe antidepressants or to pass the problem on to agencies such as social services, none was referred to a refuge or a specialist service. A very few doctors were seen as helpful. Two thirds of the women thought GPs should ask more directly if they had been injured by their partners. Interviews with nine doctors suggested that they rarely diagnosed domestic violence and felt they could do little to help women living with it. In the Clifton *et al.* (1996) study health visitors were more likely to see women they suspected of being assaulted and felt able to talk to the women. They referred them to social services, Women's Aid and Victim Support. Although a majority had received no training, the training they had on child protection was of value. The health visitors expressed most concern for children and the health consequences for them of the violence their fathers inflicted on their mothers. The women interviewed by McWilliams and McKiernan (1993) were concerned that the family would be referred to social services if they spoke to the health visitor. They did not see health visitors as helpful—some were reluctant to intervene or offer help and support, though others referred women to Women's Aid and gave information on their rights.

### **The Midshire Research**

The research on which we report below is part of a larger project concerned with Women, Health and Domestic Violence in Midshire (a Midlands county). In this paper our data are from two sources:

- (1) a postal questionnaire sent to all GPs on the Family Health Service Authority list for the county in 1995 (and their practice nurses) and to the community midwives and health visitors employed by the Community Health Care Trust in the county town;
- (2) in-depth interviews carried out with a small sample of GPs, practice nurses, midwives and health visitors who agreed on the postal questionnaire to be contacted for further interviewing.

The latter were selected to explore issues which had arisen in interviews with women who had experienced domestic violence.

The postal questionnaire was sent out in October 1995, and two reminders were sent to increase the response rate. A third of the GPs and practice nurses responded and half the midwives and health visitors. (The response rate for the midwives and health visitors is based on information on number of employees supplied by the Trust as they sent the questionnaires out.) We asked questions about training, prevalence, their professional role and the actions they usually took. In total, 513 usable questionnaires were returned—254 from GPs (49.6% of the sample), 153 from practice nurses (29.7%), 59 from health visitors (11.5%) and 47 from midwives (9.2%). The proportions of the different professions in the sample mirror to some extent the differential access of women to health care. Women are considerably more likely to have contact with a GP than other members of the Primary Health Care Team, and only women with young children are likely to see a health visitor and only pregnant women a midwife. While response rates are relatively low, it seems likely that professionals who recognise the relevance of domestic violence will have responded. To some extent we can therefore assume that the respondents to this questionnaire are representative of those members of the Primary

Health Care Team who are most concerned about domestic violence. The questionnaires were coded and analysed using SPSS for Windows. The agenda interviews were taped and transcribed and analysed for themes.

## Findings

Previous research in Britain has indicated that health care professionals receive little, if any, training/education in domestic violence. Our findings confirm this. The key question that we wished to explore was the extent of health care professionals' knowledge of domestic violence. We were interested in the extent to which there was variation by gender, training and occupational group. All the health visitors and midwives were female, as were all but two of the practice nurses. Just under two thirds (63.6%) of the GPs were male. We found that the major differences were between occupational groups, with some evidence that training might make a difference, but we detected few significant differences between male and female GPs. We refer to these differences where found.

### *Education and Training*

Only a small minority of the health care professionals in this sample, just over 16%, had received some training on domestic violence—58% of health visitors, 10% of GPs, 10.5% of practice nurses and 15% of midwives. A majority of those who had undergone the training found it useful although health visitors were significantly more likely to say they had found it *very* useful than the others ( $p < 0.001$ ). The training had been very limited, however—mainly half- or one-day workshops. One of the GPs gave details in an in-depth interview of the training he had received:

Yes, I actually go to [a] postgraduate education group ... . We did have one lecturer ... who discussed domestic violence and it was vividly brought home when she had a line of tailor's dummies ... . She took off the white sheets at the end and she had a full range of the sort of people that could be abused, from those people commonly considered to be abused, which are low social class, right the way through to the wives of people in high office. (Dr Smith, GP)

Of the respondents 40% had read about domestic violence (70% of health visitors, 34% of GPs, 41% of practice nurses and 33% of midwives). Over 90% of these found the material they had read 'useful' or 'very useful'. The main sources were the medical and nursing press (31% and 22% respectively). GPs had read the medical press, practice nurses and midwives the nursing press, and health visitors were as likely to have read the one as the other. In total, 45% of respondents had received training and/or read about domestic violence—84% of health visitors, 38% of GPs, 44% of practice nurses and 28% of midwives.

Virtually all the respondents said that they were not adequately trained. Only 16% of health visitors, 12% of GPs, 3% of practice nurses and 4% of midwives said they were adequately trained. In addition, 86% said they had an *inadequate* knowledge of available services—84% of GPs, 98% of health visitors, 91% of practice nurses and 94% of midwives. Those with (some) training were no more likely to say that they had an adequate knowledge than those without. All occupational groups said they needed more details of relevant agencies and telephone numbers to which they could refer women. The lack of education and training means not only that health care professionals are

TABLE 1. Frequency of seeing women who are suspected of having experienced violence from known men

	Tot.	GPs	PNs	HVs	MWs
More than once a month	15.5	14.7	9.7	44.1	4.3
Occasionally	76.0	81.3	72.7	52.5	87.0
Never	8.5	4.0	17.5	3.4	8.7
	Not significant				

TABLE 2. Frequency of seeing women who have experienced forceable sex/rape

	GPs	PNs	HVs	MWs
More than once a month	2.4	1.3	5.4	0.0
Occasionally	65.4	38.6	71.4	51.1
Never	32.3	60.1	23.2	48.9 ( $p < 0.001$ )

TABLE 3. Frequency of seeing women who have experienced mental health problems attributed to male partners' behaviour

	GPs	PNs	HVs	MWs
More than once a month	28.0	5.2	28.8	0.0
Occasionally	71.3	74.2	66.1	84.4
Never	0.7	19.6	5.1	15.6

unlikely to be able to provide appropriate assistance for women, but that they will be unlikely to recognise when women's injuries or health problems are 'caused' by violence from a known man, even if they do have knowledge of what assistance it would be appropriate to provide.

### *Perceived Prevalence of and Explanations for Domestic Violence*

The vast majority of the health care professionals see women who they *suspect* are experiencing domestic violence. Only 8.5% of the sample said they never see such women—4% of GPs, 3% of health visitors, 9% of midwives and 18% of practice nurses (Table 1). Those with training appear at first to be significantly more likely to suspect domestic violence (33%) than those without (12%), but in fact the only occupational group where this was true was the health visitors (56% compared with 28%). In an open question, unexplained injuries were seen as the main indicator of domestic violence; other indicators mentioned included depression, being evasive and returning for treatment. Health visitors were more likely to mention being evasive than the other occupational groups. Over three quarters said they would ask about it if they suspected domestic violence; GPs and health visitors (each 90%) were significantly more likely to say they would do so than practice nurses (62%) or midwives (77%). The difference between occupational groups may be a reflection of how well the professional knew the woman—health visitors and GPs being more likely to have an established ongoing relationship than practice nurses or midwives. Training did not appear to increase the

likelihood of asking about domestic violence except among practice nurses, where those with training were significantly more likely to ask.

A majority of the sample (83%) said they see women who they *know* have been assaulted by their male partners, but only 5% said they see them more than once a month, while 12% that they never see them. Health visitors (12%) are significantly more likely to say they see women who have experienced domestic violence more than once a month than GPs (5.3%), practice nurses (1.5%) or midwives (7%). Conversely, 31% of practice nurses, 17.5% of midwives, 12% of GPs but only 4% of health visitors say they never see such women ( $p < 0.001$ ). Health visitors are significantly more likely to say they see women regularly who have had experienced forceable sex than other occupational groups (Table 2), but the numbers are small. A majority say they see such women regularly, but a not insignificant proportion say they never see them. The existence of mental health problems following from domestic violence is also acknowledged, and all groups of professionals see such women occasionally, though GPs and health visitors are the most likely to see them regularly (Table 3). One GP in the in-depth interview study indicated that

You quite often get psychological changes in women ... they become depressed, withdrawn, lack of love, lack of affection, persistently being told you are dumb, stupid etc. To cope with the demoralising effect can make you very withdrawn, they lack confidence, they lack all sorts of things. (Dr Wills, GP)

These figures suggest that health care professionals significantly underestimate the extent of domestic violence and are failing to 'detect' it as the cause of injuries and other health problems reported by their female patients. One midwife who recorded on the questionnaire that she had never in her professional practice seen a woman who was in a violent relationship added at the end,

I *must* have seen women who are in violent relationships in the last two years, but it had not occurred to me until I answered this questionnaire.

On a multi-response question asking for all the factors to blame for domestic violence, 92% of the sample nominated relationship problem, 85% social circumstances, 84% male psychology, 73% male behaviour and 72% domestic circumstances (see Table A in the Appendix). There were no significant differences between occupational groups, but differences did emerge when they were asked to indicate the *main* factor. Nearly a quarter of the sample said relationship problems were the main factor (see Table 4)—but only 14% of health visitors, who were more likely than the other occupational groups to select 'male socialisation' as a factor (14% compared with 5% in the total sample). However, 42% of the sample selected the three categories of 'male psychology', 'male behaviour' and 'male socialisation'; the percentage selecting one of these was 46% for GPs, 36% for practice nurses, 53% for health visitors and 32% for midwives.

The most frequent response on the multiple-choice question asking for all the causes of forcible sex/rape (Table B in the Appendix) was seen as male psychology (79%), closely followed by relationship problems (77%) and male behaviour (67%). Relationship problems and male psychology were most frequently seen as the *main* single factors (each at around 25%), followed by male behaviour (20%)—see Table 5. Health visitors were again much more likely to nominate 'male socialisation' than the other occupational groups—23% compared with around 9% for the total sample. Male psychology, behaviour or socialisation were together seen as the main factor by 53% of the respon-

TABLE 4. Attributions of blame for male physical violence—the main factor  
(% of column mentioning)

	All	GPs	PNs	HVs	MWs
Relationship problem	24.7	23.7	29.5	14.0	29.5
Social circumstances	12.5	9.5	20.5	7.0	11.4
Male psychology	19.4	19.4	19.7	22.8	13.6
Male behaviour	17.6	22.4	12.1	15.8	11.4
Domestic circumstances	4.1	2.6	5.3	7.0	4.5
MIMP*	1.7	2.2	1.5	1.8	0.0
Situational response	3.2	4.7	0.8	1.8	4.5
Female behaviour	0.2	0.0	0.8	0.0	0.0
Female psychology	0.2	0.4	0.0	0.0	0.0
Male socialisation	5.4	3.9	3.8	14.0	6.8
MIFP*	0.0	0.0	0.0	0.0	0.0
Subculture	1.5	2.6	0.0	1.8	0.0
Male biology	0.2	0.0	0.8	0.0	0.0
Female biology	0.0	0.0	0.0	0.0	0.0
Other	9.2	8.6	5.3	14.0	18.2

\* Mental illness, respectively of male and female partner  $p < 0.01$

dents—52% of GPs, 51% of practice nurses, 62% of health visitors and 64% of midwives.

The most common factor selected as responsible for abuse leading to mental health problems, on a multi-response question asking for all causes, was male psychology (86%). This was closely followed by relationship problems (83%), with male behaviour (71%), social circumstances (69%), mental illness of one partner (60%) and domestic circumstances (56%) all being nominated by over half the health care professionals (Table C, in the Appendix). In terms of *main* factor (Table 6) male psychology was most often nominated (29%), followed by relationship problems (24%) and male behaviour (19%). Only 13% of health visitors nominated a relationship problem as the main cause, and 13% male behaviour, but 17% gave male socialisation as the main cause, compared with 6% in the sample as a whole. The combination of the three categories 'male behaviour', 'male psychology' and 'male socialisation' accounts for 55% of the sample's attribution of responsibility (54% for GPs and practice nurses, 71% of health visitors and 53 per cent of midwives).

Relationship problems are seen as a significant cause of domestic violence, marital rape and mental health problems by all the health care professionals, with about a quarter seeing them as the main cause; over nine tenths nominated them as contributing to physical violence and around four fifths as contributing to forcible sex and mental health problems. One of the doctors suggested in the interviews that

you eventually work up to seeing them together, and I think that's a fairly positive step if you manage to get them to come in together, because obviously there's an accepted problem, there between them ... I think there's two sides to all these stories. (Dr Padden)

However, health visitors were less likely to nominate relationship problems as a cause of physical violence and more likely to nominate male socialisation. Male behaviour and male psychology are also seen as significant factors, especially with respect to marital rape and mental health. However, in the interviews the male behaviour was often linked to stress, alcohol or drug abuse. Health visitors were significantly more likely than the

TABLE 5. Attributions as to the main cause of male sexual violence to wives  
(% of column mentioning)

	All	GPs	PNs	HVs	MWs
Male psychology	24.4	20.7	30.3	21.2	29.3
Relationship problem	25.4	23.2	30.3	23.1	24.4
Male behaviour	19.9	27.1	11.5	17.3	12.2
MIMP*	1.9	2.0	3.3	0.0	0.0
Situational response	3.6	4.9	3.3	0.0	0.0
Male socialisation	8.9	4.4	9.0	23.1	12.2
Male biology	5.5	6.4	4.9	3.8	4.9
Female behaviour	0.5	0.5	0.8	0.0	0.0
Social circumstances	1.9	2.5	2.5	0.0	0.0
Female psychology	0.5	1.0	0.0	0.0	0.0
Subculture	1.0	1.0	0.8	0.0	2.4
Domestic circumstances	0.5	0.0	0.8	1.9	0.0
MIFP*	0.0	0.0	0.0	0.0	0.0
Female biology	0.0	0.0	0.0	0.0	0.0
Other	6.2	6.4	2.5	9.6	12.2

\* Mental illness, respectively of male and female partner.

Main factor:  $p < 0.05$ ; GP vs HV:  $p < 0.001$

TABLE 6. Attribution as to blame for abuse leading to mental health problems  
in female partners—main factor (% of column mentioning)

	All	GPs	PNs	HVs	MWs
Male psychology	29.3	27.3	32.5	30.4	27.8
Relationship problem	24.4	27.3	22.0	13.0	30.6
Male behaviour	19.3	23.4	13.8	13.0	22.2
Social circumstances	5.9	4.4	9.8	4.3	2.8
MIMP*	2.9	2.0	4.1	4.3	2.8
Domestic circumstances	1.0	0.0	2.4	2.2	0.0
Situational responses	2.9	4.4	1.6	0.0	2.8
Female behaviour	1.2	2.4	0.0	0.0	0.0
Male socialisation	6.1	3.4	7.3	17.4	2.8
Female psychology	1.5	1.5	1.6	2.2	0.0
MIFP*	1.0	0.5	0.0	0.0	0.0
Subculture	1.7	1.0	1.6	4.3	2.8
Male biology	0.2	0.0	0.8	0.0	0.0
Female biology	0.0	0.0	0.0	0.0	0.0
Other	3.4	2.4	2.4	8.7	5.6

\* Mental illness, respectively of male and female partner.

Main factor:  $p < 0.05$ ; GP vs HV:  $p < 0.001$

other health professionals to nominate male behaviour. However, neither gender of GP nor having had training made any significant difference to what were seen as the causes.

### Actions Taken

Only one respondent—a practice nurse—said she would do nothing if she suspected a woman was experiencing violence from her partner. The two main actions that respondents said would be taken were referring the client to another agency and

TABLE 7. Agencies playing a role (other than social services and counselling)

	Total	GPs	PNs	HVs	MWs	Significance of difference
Health visitors	70.9	63.9	79.1	83.1	66.0	$p < 0.01$
GP	73.4	63.9	87.3	83.1	66.0	$p < 0.001$
Police	72.6	68.2	74.7	86.4	72.3	$p < 0.05$
Solicitor	20.6	26.7	12.7	23.7	10.6	$p < 0.05$
Women's Refuge	18.5	13.7	22.2	22.0	27.7	$p < 0.05$
Voluntary agency	25.8	28.2	19.0	40.7	17.0	$p < 0.05$

TABLE 8. Professional group/agency mainly responsible for domestic violence (%)

Social Services	47.4	Voluntary agency	0.5
HVs	1.8	Mental Health	1.0
GPs	7.3	Inter-agency	9.8
Police	12.1	Probation	0.3
Solicitor	0.3	Women's refuge	1.8
Counsellor	2.5	Other	15.4

TABLE 9. Responsibilities of the health services for domestic violence

	GPs	HVs	PNs	MWs	Total
Information about agencies	73.0	81.0	72.8	78.7	74.4
Welfare	70.9	62.1	51.7	53.2	62.3
Report HV child < 5 yrs	53.6	55.2	57.0	48.9	54.4
Offer to notify appropriate agency	43.9	69.0	49.7	48.9	49.1
Notify Social Services when there is a child	42.6	56.9	37.7	61.7	44.6
Advise	41.4	55.2	35.1	25.5	39.6
Notify GP	24.1	71.0	51.7	31.9	34.1
Always notify appropriate agency	9.7	27.6	11.9	23.4	13.8
Notify Social Services	12.2	17.2	8.6	21.3	12.6
Treat injury only	8.0	1.7	3.3	2.1	5.3

providing further information. The main agency concerned with domestic violence was seen as the social services. Other important agencies were the health visitors, GPs and police. Overall, on a multi-response question 86% mentioned social services, and 38% mentioned counselling, with no significant differences between occupational groups. The remaining agencies mentioned are shown in Table 7. Note that only 18.5% of the sample mentioned the Women's Refuge—although about 26% mentioned voluntary agencies, with 41% of the health visitors doing so. This is perhaps not surprising, given that respondents had indicated that they needed more knowledge of agencies, but it is a cause for concern.

When asked to indicate which agency had the *major* responsibility for domestic violence, social services was nominated by nearly half of the sample (see Table 8). Occupational differences were not significant for those without training, but there were indications that among those *with* training HVs were less likely to nominate social services and more likely to suggest the police. GPs (at 57.4%) were more likely than practice nurses (35%), health visitors (37%) and midwives (47.1%) to see the main

TABLE 10. Main role of own profession

	GPs	HVs	PNs	MWs	Total
Treat injury	13.6	0.0	6.8	0.0	8.5
Refer	13.1	12.1	14.4	18.6	13.9
Support/listen	55.6	74.2	56.8	55.8	58.4
Advise to leave	0.9	0.0	3.0	2.3	1.6
Detect	5.1	8.6	3.8	9.3	5.6
Other	10.3	5.2	12.9	14.0	10.7
DK	1.4	0.0	2.3	0.0	1.3

TABLE 11. Own responsibilities in cases of domestic violence

	GPs	HVs	PNs	MWs	Total
Inform about services	92.4	100.0	95.3	89.4	93.9
Refer to HV	83.7	50.8	87.3	75.5	80.1
Refer to SW	53.8	52.5	24.0	19.4	41.6
Inform police	47.0	45.8	20.7	48.9	39.3
Counsel self	48.6	45.8	17.3	17.0	36.1
Treat injury only	16.0	1.7	16.7	4.3	13.4
No role	2.0	6.8	1.3	4.3	2.4

responsibility as lying with social services. Health visitors (26.1%) were more likely than GPs (26.1%), midwives (15.0%) or practice nurses (8.3%) to nominate the police. Health visitors (19.6%) and practice nurses (15.0%) were more likely to nominate an inter-agency approach than GPs (4.6%) or midwives (8.8%).

Not surprisingly, given what they saw as their role, the respondents thought that the main responsibilities of health services were providing information about agencies and being concerned about the women's welfare (Table 9). Health visitors consistently nominated more responsibilities for health care professionals than the other occupational groups. The main responsibility of respondents' own occupational group was seen as listening and offering support (Table 10); 74% of health visitors mentioned this as their role, but only just over 50% of the others. In terms of their *own* responsibilities (Table 11), the vast majority saw it as their responsibility to inform the women about available services, and just over half of the GPs and health visitors saw it as their responsibility to refer cases to social services; just under half thought they ought to refer cases to the police, and a similar proportion thought they should be undertaking counselling. Given how they see the role of their own and other health care professions, it is perhaps not surprising that they feel they need more education/training.

A similar pattern emerged when respondents were asked what they would do if a patient asked for *advice* on domestic violence that she was experiencing. A very small percentage said they would not be able to advise: 0.8% of GPs, 2.3% of practice nurses and 4.3% of midwives. Some GPs (11%) would advise the woman to change her behaviour. The remaining responses are summarised in Table 12. What is of interest is the high proportion of GPs who would suggest that both partners should seek counselling. This ties in with the responses to the questions on cause and the high proportion who see domestic violence as being caused or at least contributed to by relationship problems. A high proportion of GPs also indicated that they would suggest counselling for the women—indicating a misunderstanding of the 'problem' on their part. Except for

Table 12. Advice that would be given

	GPs	PNs	HVs	MWs	Total
Refer to Women's Aid	38.2	37.7	66.1	38.3 $p < 0.001$	41.3
Refer to social services	54.2	26.0	44.1	66.0 $p < 0.001$	45.6
Suggest counselling for both	63.9	40.9	45.8	36.2 $p < 0.001$	52.3
See partner, suggest he receive counselling	20.1	5.2	1.7	2.1 $p < 0.001$	11.8
Ask to see partner	32.9	2.6	3.4	0.0 $p < 0.001$	17.3
Suggest she be counselled	42.2	29.2	15.3	21.3 $p < 0.001$	33.2
Provide information on agencies	61.4	77.3	91.5	80.9 $p < 0.001$	71.5
Advise to see solicitor	51.8	14.9	50.8	8.5 $p < 0.001$	36.5

health visitors, only just over a third would refer to Women's Aid, which is perhaps surprising, given the major role it plays in working with women and the widespread publicity it receives; it reinforces the respondents' perception that they needed more information on agencies.

Nearly 70% of the sample said there were circumstances in which they would advise women to leave their partners; GPs were significantly more likely to do so than other professionals (Table 13). There were no significant differences by whether they had been trained. In response to an open question:

- 35.5% would advise to leave if they thought there was serious risk of further injuries
- 21.8% if women experienced persistent violence from male partner
- 17.6% if they were concerned about the woman's health
- 12.7% because of concern for children
- 12.6% gave other answers including psychological stress and danger of mental breakdown.

While the fact that this kind of advice may be given is encouraging, in that it seems to indicate some awareness of the difficulty of changing men's behaviour, it may not be based on a sound understanding of the complex and difficult decisions involved for women. One GP, for example, wrote on the questionnaire that he '... frequently advised women to leave but they never did'. GPs stressed concern for health (20%), risk of injury (28.5%) and persistent violence (30.3%). Health visitors stressed concern for children (31.8%), concern for health (22.7%) and risk of injury (20.5%). Practice nurses stressed risk of injuries (51.6%), as did midwives (57.1%). The differences are statistically significant ( $p < 0.001$ ). The occupational differences were significant for those without training ( $p < 0.001$ ) but not for those with it.

The vast majority of the sample said that there were circumstances under which they would report cases of domestic violence to the police. However, practice nurses were significantly less likely to say they would report than other groups (see Table 14). Responses to an open question about the circumstances are given in Table 15. It is worth noting that male GPs were more likely to stress seriousness of injury (40.4% compared with 23.9%), and female GPs consent of patient (44.8% compared with 28.4%). The difference is significant ( $p < 0.05$ ).

While it is interesting that so many health care professionals were prepared to report cases to the police—demonstrating that they accepted that (some) domestic violence is criminal—it is worrying that they are apparently prepared to do so without consent. Not only does this suggest a disregard of the women, but also it infantilises them by suggesting

TABLE 13. Respondents likely to advise women to leave their partners, under certain circumstances

GPs	81.0%
Health visitors	69.0%
Midwives	66.7%
Practice nurses	49.3%

$p < 0.001$ .

Table 14. Would report violence to the police under certain circumstances

	Total sample
GPs	72.8%
HVs	78.2%
Midwives	82.2%
Practice nurses	47.7%

$p < 0.001$ .

Table 15. Nature of circumstances under which would report violence to the police

	GPs	HVs	PNs	MWs
Patient consented	34.4	29.8	23.6	38.9
Seriousness of injuries	34.4	19.1	12.5	11.1
Risk of further injury	15.8	8.5	11.1	13.9
Concern for children	10.4	36.2	27.8	22.2
Other (incl. MH)	4.9	6.4	25.0	13.9

$p < 0.001$ .

that others need to take decisions for them. However, it must be acknowledged that if the health care professionals suspect that a crime has been committed it may itself be a criminal offence not to report it to the police. This raises the complex issues both of mandatory reporting and of what can follow for women when the perpetrators of violence are reported to the police—often resulting in further harm to the women themselves.

## Conclusions

The findings from our research in Midshire indicate that the situation with respect to health care professions' knowledge and understanding of domestic violence and their potential role is very limited. However, it was significant that a high proportion of the sample identified the problem as *men* (whether this was seen as 'male psychology', 'male behaviour' or 'male socialisation') and that a correspondingly low proportion attributed the blame to women. This did not relate to gender of respondent, in that there were no significant differences between male and female doctors. However, relationship prob-

lems, which suggest an attribution of blame to both partners, were seen as a significant factor by the vast majority of respondents (with the exception of health visitors), with about a quarter seeing it as the most significant factor.

Health visitors are more likely to have received domestic violence training than other health care professionals but tend to be concerned with the welfare of children rather than women. However, they do seem to have more awareness of the 'cause' of domestic violence and are therefore more likely to provide appropriate advice and support to women. In general the health care professionals had received little, if any, training in domestic violence and had an inadequate knowledge of available services, and there is little evidence that the type of training currently on offer actually equips them to make appropriate interventions. They were not, in the main, engaged in inter-agency work, with the partial exception of health visitors, and did not work to a formal policy. Hague *et al.* (1994) noted the absence of health care professionals (with the exception of health visitors and midwives) in some areas in their research on inter-agency working. The lack of health care professionals' knowledge of services at least partly accounts for their lack of knowledge of the role of the voluntary agencies—most notably Women's Aid—and their assumption that the main agency is social services. Social workers are in fact likely to become involved only if there is a question of child safety. The role that health care professionals can play is severely limited by their lack of knowledge and understanding. They are not well equipped to empower women and enable them to make informed decisions. It is probable that the greater knowledge and understanding of health visitors is the outcome of their specific professional training, their perceived role in health education and working with families and the role they play in child protection. There is certainly no evidence that gender is a factor—female GPs do not differ significantly from male ones—and the training currently available does not make a significant difference within occupational groups.

The vast majority of the health professionals said that they occasionally saw women who had been, or who they suspected were, being assaulted by their male partners, which is obviously a vast underestimation. (Health visitors were more likely to say they saw such women than the other health care professionals.) One woman in the in-depth interview study referred to the lack of interest her GP showed:

Yeah, the doctor, he knew, he used to get the letters, every time you went to Casualty they used to give you a letter to give to your doctor, but he never, not ever mentioned anything to me about it. I'd go back for like other things, but he'd never mention it. (Mrs Peterson)

Two others referred to the help they had received from psychiatrists:

When I went to the psychiatrist ... he asked me if I ever had suicidal thoughts and I said yes ... . He gave me a prescription ... enough drugs to kill an elephant ... I had sleeping pills, anti-depressants ... four or five different stuff in a big bag like a supermarket carrier, go home and kill yourself. (Mrs Johnstone)

They got this doctor to come down and see me and he prescribed anti-depressants and they like made me lethargic, lazy, all they did was make things not a worry, no more, not a problem, nothing was a problem, he could hit me, and he could kick me, and I'd get up after and be like well that's the way things are. I just felt really worn down, it gave me no life, no spirit. (Mrs White)

There is evidence that the health care professionals were concerned about women's

safety but had neither an understanding of the extent and causes of domestic violence nor effective ways of working with women. Despite their inadequate training and knowledge, they do offer a front-line service to women who are experiencing domestic violence. However, their general lack of knowledge and understanding meant that they are unlikely to offer women who do not reveal that they are in a violent relationship the opportunity to externalise the problems they are experiencing. Indeed, their advice and referrals may at best be inappropriate, and may indeed actually contribute to further victimisation, for the same reason.

In the US the American College of Obstetricians and Gynecologists has suggested a four-part programme for physicians—education, the provision of materials that keep them up to date on resources, campaigning for the provision of adequate services, and working to raise public awareness (Jones, 1993). However, McLeer *et al.* (1989) have demonstrated that education is not enough—that it is necessary to have *institutional* policies and practices for diagnosing and treating women. Hadley (1992) suggests that what is necessary is

to provide advocacy—support, information and education, and hospital or community resource referrals—to battered women during a safety or medical crisis ... . The basis of advocacy is accepting the woman as she is, supporting her choices, and helping her explore her feelings, her options and the possible consequences of her decision. (p. 19)

In Britain the Leeds Inter-agency Project (1996 a,b,c) has identified both the importance of incorporating health care professionals in inter-agency approaches to working with women who experience violence from known men, and the difficulties of doing so. Attention is drawn to both attitudinal and institutional barriers to incorporating health care professionals, but the reports also highlight the key contribution that GPs, casualty staff, health visitors and mental health professionals can make to working with women.

The conclusion of the research reported here is that health care professionals, with the possible and partial exception of health visitors, do not see domestic violence as an issue where they can play a major role. Clearly they are not screening for it or supporting and empowering women. Working within the dominant biomedical model, they individualise the cause, medicalising what is a social problem—they treat the specific biological problem. This reinforces the powerlessness of women and the medical control of them (Daly, 1978; Roberts, 1985; Foster, 1995), reinforcing dependency and compliance. Training for health care professionals has to be concerned with challenging the medicalisation of domestic violence while enabling them to recognise the way in which they can work with women. More research is needed into incidence and prevalence of use of the health care system by women who have experienced domestic violence, its physical and mental health care consequences and its costs for the health care system. With respect to the primary health care system, more research is needed into the understanding of and responses of GPs, health visitors, practice nurses and midwives to women who have experienced violence from known men and the setting up and evaluation of projects designed to harness the potential for health care professionals to play a significant role.

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## Appendix: Further Statistical Tables

Table A. Attributions of blame for male physical violence—multiple-response question (% of column mentioning)

	All causes mentioned				
	All	GPs	PNs	HVs	MWs
Relationship problem	92.0	91.6	95.3	93.1	84.4
Social circumstances	84.7	82.7	90.0	87.9	80.0
Male psychology	84.3	88.4	77.3	86.2	82.2
Male behaviour	72.8	81.5	65.3	69.0	60.0
Domestic circumstances	71.6	67.5	78.7	77.6	64.4
MIMP*	66.3	66.7	66.0	69.0	64.4
Situational responses	59.1	61.4	52.0	69.0	60.0
Female behaviour	53.6	60.6	54.0	39.7	35.6
Female psychology	48.5	59.0	44.7	37.9	17.8
Male socialisation	40.5	38.6	34.7	63.8	44.4
MIFP*	36.8	39.0	39.3	32.8	22.2
Subculture	36.0	40.6	30.0	46.6	17.8
Male biology	19.6	22.1	18.0	20.7	13.3
Female biology	10.8	12.0	10.7	8.6	6.7
Other	13.5	12.4	10.0	20.7	22.2

\* Mental illness, respectively of male and female partner.

Table B. Attributions as to the cause of male sexual violence to wives—multiple-response question (% of column mentioning)

	All	GPs	PNs	HVs	MWs
Male psychology	78.9	79.5	75.7	84.5	79.5
Relationship problem	78.2	74.1	83.8	82.8	77.3
Male behaviour	70.9	76.6	66.2	69.0	61.4
MIMP*	48.8	46.0	52.7	58.6	38.6
Situational responses	39.8	38.1	41.9	43.1	34.1
Male socialisation	39.6	36.4	39.2	62.1	31.8
Male biology	37.3	36.0	37.2	46.6	38.6
Female behaviour	35.5	39.7	36.5	29.3	22.7
Social circumstances	33.9	33.1	38.5	36.2	20.5
Female psychology	27.3	33.5	23.0	27.6	9.1
Subculture	24.3	29.7	14.2	34.5	11.4
Domestic circumstances	24.3	26.4	23.0	25.9	15.9
MIFP*	17.7	20.9	16.9	13.8	6.8
Female biology	9.8	11.1	10.8	8.6	2.3
Other	7.8	7.1	4.7	12.1	15.9

\* Mental illness, respectively of male and female partner.

Table C. Attribution as to blame for abuse leading to mental health problems in female partners—multiple-response question (% of column mentioning)

	All	GPs	PNs	HVs	MWs
Male psychology	86.2	88.3	80.5	87.7	90.9
Relationship problem	83.4	81.9	84.6	86.0	84.1
Male behaviour	71.2	75.0	62.4	75.4	79.5
Social circumstances	69.4	69.8	68.5	71.9	65.9
MIMP*	63.1	60.5	63.1	70.2	65.9
Domestic circumstances	55.6	59.3	51.7	52.6	50.0
Situational response	47.9	48.4	45.6	49.1	47.7
Female behaviour	45.6	51.2	45.6	35.1	31.8
Male socialisation	44.8	37.9	47.0	66.7	50.0
Female psychology	44.6	53.3	40.3	38.6	25.0
MIFP*	34.5	41.9	29.5	29.8	20.5
Subculture	33.7	39.1	24.2	43.9	15.9
Male biology	20.3	21.0	17.4	22.8	22.7
Female biology	8.2	9.7	8.1	5.3	4.5
Other	5.9	5.6	4.0	12.3	6.8

\* Mental illness, respectively of male and female partner.