Victims of violence and the general practitioner

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SUMMARY

Background. *Violent crime is on the increase in Britain, with 17% of the 15 million incidents of crime reported in 1991 being of a violent nature. Although there is some information on the role of accident and emergency departments for victims who sustain physical injury, little is known about the role of the general practitioner (GP) in managing the acute and longer-term sequelae of violence.*

Aim. *To examine the links between experiencing physical or sexual assault and seeking help from GPs in London.*

Method. *A cross-sectional survey of all adult attendees in one large group practice was carried out. The main outcome measures were prevalence of assault, reporting to the doctor and other people, and scores on the General Health Questionnaire (GHQ) and the Impact of Events scale.*

Results. *Of the 195 people who took part, 33 (17%) reported a physical or sexual assault in the previous year. Women were three times more likely than men to report any type of assault. Women rarely spontaneously disclosed these experiences to the GP and yet the experience of violence was associated with higher levels of distress, as measured on the GHQ and the Impact of Events Scale.*

Conclusions. *Assault is a relatively common event in the lives of people who consult their GP. Doctors could help these patients through gaining an awareness of the problem and by fostering links with voluntary services, such as victim support schemes, which can provide support, practical assistance, and advice on compensation claims and legal procedures.*

Keywords: victims of violence; sexual abuse; general practitioner; General Health Questionnaire.

Introduction

VIOLENT crime is common in British urban society.[1] Between 1981 and 1991 there was an estimated increase of 24% in reported violent crime in England and Wales. Of the 15 million incidents of crime recorded in 1991, 17% were crimes of violence. Sexual offences were not included in this survey as they were considered too sensitive to investigate and the data too unreliable. One in four women in North London reported having ever experienced domestic violence.[2] Reactions to assault include anxiety, depression, sleep problems, loss of confidence, guilt, self-blame and anger, and post traumatic stress disorder (PTSD).[3,4] Victims of assault report deterioration in their actual and perceived physical health leading to increased medical consultation.[5] Although there is some information on the role of accident and emergency departments for victims who sustain physical injury,[6] less is known about the role of the GP in managing the acute and longer-term sequelae of violence. We aimed to examine links between experiencing assault and seeking help from GPs in London.

Method

Consecutive attendees to a South London group general practice, aged 18 years and over, gave informed consent to take part in the study. The practice consisted of seven full-time doctors and one part-time doctor. Data were collected over six months in 1992. Each person was asked to complete a semi-structured questionnaire designed for the study, which contained questions about their experiences of violence suffered during the past year, including physical assault and unwanted sexual experiences. The questionnaire asked whether victims had requested or received help or treatment and enquired about their level of satisfaction with the responses from those professionals, agencies, or organizations they had approached. It also included questions on why each person had visited the GP on the day of the survey. We piloted the questionnaire with 20 attendees before making final modifications.

We asked all respondents to complete the 12-item version of the GHQ.[7] This questionnaire, which has been subjected to repeated assessment for reliability and validity, is used widely as a screening instrument for psychiatric disorder in the community, particularly within British general practice. Those patients who indicated that they had been assaulted in the past year also completed the Impact of Events scale.[8] This 15-item, self-report instrument measures two key elements of PTSD: event-related intrusion (intrusively experienced ideas, images, feelings, or dreams) and event-related avoidance (consciously recognized avoidance of certain ideas, feelings, or situations). Responders indicate the frequency with which they have experienced each item during the preceding week. In addition to a global distress mean, intrusion and avoidance sub-scale means are calculated.

We analysed the data using the Statistical Package for the Social Sciences (SPSS), Windows PC version 6.0. We conducted bivariate analyses using the chi-square statistic (with continuity correction) for differences in proportions, Student's *t*-test for differences in means, and the Mann-Whitney U statistic for median differences in skewed data. We examined independent predictors of reporting using multivariate, logistic regression.

Results

Response rates and demography

We approached 211 (154 female, 57 male) consecutive surgery attendees, of whom 195 (92%; 143 female, 52 male) agreed to answer the questionnaires. Only two people refused categorically to take part; the remaining 14 gave reasons of poor health or an inability to read the questionnaire. Many responders did not give their name, which precluded the use of the general practice records as a source of additional data. The median age of those participating was 33 years (interquartile range 16). There was a non-significant trend for men to be older than women. Over half the sample were white, married women (Table 1).

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Table 1. Demographic factors and reasons for consulting.

Civil status	Number (%)
Married	105 (54)
Single	64 (33)
Separated	19 (10)
Widowed	5 (3)
Not known	2 (1)
Ethnicity	
White European	136 (70)
White other	19 (10)
African Caribbean	15 (8)
Black African	7 (4)
Black other	3 (1)
Indian	7 (4)
Asian	6 (3)
Not given	2 (1)
Reason for consulting GP	
Non-specific symptoms	50 (26)
Accompanying another person	32 (16)
Gynaecological problems	25 (13)
Psychological problems	12 (6)
Gastrointestinal problems	4 (2)
Heart disease	2 (1)
Respiratory complaint	1 (0.5)
Other	49 (25)
Not determined	20 (10)

History of assault

Thirty-three people (17%) reported a physical or sexual assault, or both, in the past year (Table 2). These included 29 women (20%) and four men (8%). In only one case did the assault involve more than one assailant. A weapon was used in one instance (a physical assault outside the home). Five victims of physical assault required medical attention. One man reported a sexual assault. A history of assault was not related to the reason given for consultation.

We entered age, sex, and ethnicity (white versus other) into a logistic regression to assess the independent predictive effects on the likelihood of assault. Only younger age was a significant predictor (OR = 0.94 per year of age; 95% CI = 0.90–0.98; P = 0.007) of reporting a history of assault. Although there was a trend for more women to report a history of assault, this was not significant (OR = 2.7; P = 0.09). Ethnicity was not a significant predictor.

Reporting the assault to others

Assault victims had told a variety of people about the assault (Table 3). Although only four had told their doctor, three had found this helpful. Of those who did not report the assault, 18 thought it was not a medical matter, 12 did not think it would help, seven were too embarrassed, and one patient was concerned about confidentiality (subjects could give more than one reason).

Psychological measures

Median scores on the GHQ were higher for those who reported an assault than for the remainder of the patients (4 versus 2, Mann-Whitney U = 1902.0; P = 0.02). There were no significant differences in median GHQ scores between victims of physical and sexual assault, between those who had told their doctor and those who had not, or between male and female victims. Mean total score on the Impact of Events scale was 25.4 (SD = 17.9), with 12.7 (SD = 9.7) on the intrusion sub-scale and 12.7 (SD = 9.0) on the avoidance sub-scale. Thirteen of the 33 people who had been assaulted (40%) scored 20 or above on either the intrusion or avoidance sub-scale, indicating that they were likely to be suffering from PTSD.[9] There were no significant differences in mean total scores between victims of physical and sexual assault, between those who had told their GP and those who had not, or between male and female victims. Scores on the GHQ and Impact of Events Scale were highly correlated in patients reporting an assault (Spearman ρ = 0.46; P = 0.007).

Table 2. Type of assault.

Type of assault	Number	Per cent
A. Physical assault only outside the home	8 (5 W; 3 M)	24
B. Physical assault only in the home	3 (3 W)	9
C. Physical assault in and out of the home	2 (2 W)	6
D. Sexual assault only	19 (19 W)	58
E. All three types of assault (A, B & C)	1 (1M)	3

W = women; M = men.

Table 3. Reporting the assaults to others.

Type of reporting[a]	Number (%)
Told general practitioner	4 (12)
Told other primary care staff	2 (6)
Would tell if doctor enquired	20 (61)
Told other people	9 (27)
Told police	10 (30)

[a]Each person could give more than one response.

Discussion

Despite the relatively small sample, one of the strengths of this study was its high response rate. General practice provides the right environment to ask questions of a highly sensitive nature. Patients consider it a safe and legitimate place in which to discuss these matters. The study also had direct relevance for general practice, whereas crime surveys often have little direct bearing on day-to-day family practice.

Reported assault was common, but rarely spontaneously disclosed to the doctor. Our data reveal, however, that experiencing assault is associated with higher levels of emotional distress and symptoms of PTSD. Scores on the Impact of Events scale were not as high as those in people who have suffered a recent assault.[8] We enquired about assaults over the preceding year and thus cannot link the time of assault with subsequent symptoms. Nevertheless, people with a history of assault in the previous year remained troubled by the event and 40% were likely to have PTSD. At least one report indicates that mean scores on the intrusion and avoidance sub-scales of the Impact of Events scale for women, up to two years after a rape, are 11.2 and 16.0 respectively.[10] Even if the GP detects their emotional distress, unless the aetiology is recognized and addressed, the help offered may not be useful.

After controlling for age, the sex of the patient was not a significant predictor of assault. Nevertheless, a strong trend remains for higher rates of reported assault in women: it may not have reached significance because of the relatively small numbers studied. We raise a similar caution about our comparison of ethnic groups. The trend for higher rates of reported assault in women runs counter to other evidence.[11] Official crime surveys show that young men suffer the highest rates of physical vio-

lence.[1] This may be because women are reluctant to disclose personal, and possibly stigmatizing, experiences in the context of a large, anonymous survey.[12] An alternative explanation for our results is that suffering an assault may have a greater effect in increasing consultation rates in women than in men.

We cannot categorize the types of assault into domestic and non-domestic violence because we do not have information on the identity of the perpetrators and the nature of their relationship with the victims. Domestic violence is the physical or sexual abuse of women by partners, ex-partners, or others with whom they are in (or have had) a close relationship. It is usually accompanied by emotional abuse. There has been at least one survey of domestic violence among women who consult their family doctor.[13] Twenty-one per cent of the women reported being the victim of violence in the previous year, with the highest rates occurring for young, single women. Depression (as indicated in the medical records) was the strongest predictor of reported violence. Only three cases of physical abuse were noted in the medical records. There has been no systematic research in Britain into the role of GPs with victims of domestic violence.[14,15]

A number of researchers have demonstrated that physical and sexual assaults are associated with poor psychological and physical health.[4,16] Our results show that most patients will tell their doctor about the violence if asked directly. Psychological scores were similar in those patients who had discussed the violence with their doctor and those who had not done so. Our study is limited however, as we could not use patients' records and the number of subjects reporting an assault was small.

Experiences of assault are common in people consulting their GP and may be associated with considerable distress. The problem is hidden in that many patients do not take the initiative to tell their GP, even when prepared to do so if asked. This confirms other evidence that victims of violence want their doctors to recognize their plight and provide immediate advice and information about what they can do and where they can go.[17] Doctors need guidance on how to formulate appropriate questions about physical and sexual violence. They can help by establishing links with voluntary services, such as victim support schemes, which can provide support, practical assistance, and advice on compensation claims and legal procedures. We are not suggesting that family doctors should take on the role of counsellor for victims of violence; however, even listening to and acknowledging the victim's distress may be enough to enable them to take greater control of the situation, decrease their sense of isolation, and, where appropriate, remove themselves from high-risk situations.

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