

DOMESTIC ABUSE PREVALENCE

ARGYLL and CLYDE (DAP) STUDY

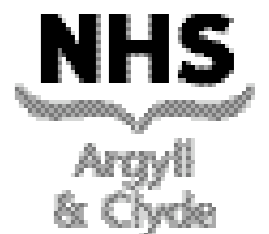


ARGYLL AND CLYDE DOMESTIC ABUSE PREVALENCE (DAP) STUDY

A report on a study examining the prevalence of domestic abuse among women patients attending Primary Care in the Lomond LHCC area including establishing reasons for non-disclosure to medical personnel.

By

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For Emily Midwood and Annie Elvin

This report is dedicated to all the women living in Argyll and West Dunbartonshire who took part in this study. Without their honesty and courage this report and its findings could not have been published.

“it wasn’t talking about it. It was people not listening”

Further copies of this report are available from

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ACKNOWLEDGEMENTS

The West Dunbartonshire Domestic Abuse Partnership (WDDAP) is committed to tackling domestic abuse through the implementation of its local strategy. The West Dunbartonshire Strategy reflects the Scottish Executive's National Strategy on Domestic Abuse, which recommends a co-ordinated strategic multi-agency approach as the most effective method of intervention. WDDAP's main partners are Clydebank Women's Aid, Dumbarton District Women's Aid, NHS Argyll and Clyde, NHS Greater Glasgow, Scottish Children's Reporter's Administration, Strathclyde Police, and West Dunbartonshire Council.

Our warmest thanks are extended to all the women who took part in this research exercise in all the participating surgeries in the Lomond Local Health Care Cooperative (LHCC) – we acknowledge their courage and honesty in agreeing to participate in this research and we dedicate this report and its findings to them.

Many thanks to Anne Clark, Cath Krawczyk and Imogen Stephens, all formerly of NHS Argyll and Clyde, who identified the research need, designed the questionnaire, secured funding and prepared the proposal for the Ethics Committee; to Irene Campbell for her sensitive, patient and professional approach to the fieldwork and for all the support she offered to women and researchers alike during this research project; to everyone in the research team for their invaluable moral, administrative and editorial support throughout the project; to the medical and administrative staff at all participating surgeries for their help, support and hospitality throughout. Finally we would like to thank West Dunbartonshire Community Safety Partnership for the use of its display and literature during the fieldwork stage of the research.

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EXECUTIVE SUMMARY

Introduction

Tackling domestic abuse in Scotland has been a national priority for the Scottish Executive since 2000 (Scottish Executive, 2000). The West Dunbartonshire Domestic Abuse Partnership (WDDAP) is committed to tackling domestic abuse through the implementation of its local strategy (WDDAP 2000). This reflects the Scottish Executive's National Strategy on Domestic Abuse, which acknowledges that a co-ordinated, strategic multi-agency approach is the most effective method of intervention.

In 2003, WDDAP gained funding and ethical approval from NHS Argyll and Clyde to carry out a major study into the prevalence of domestic abuse among women patients in Primary Care in the Lomond Local Health Care Cooperative (LHCC) area. The study was a joint venture between NHS Argyll and Clyde, WDDAP and Glasgow Caledonian University. (See Appendix 1. Research Proposal).

Methodology and Sampling

This Domestic Abuse Prevalence (DAP) Study is the first of its kind to be undertaken in a primary care setting in Scotland. A total of 893 women took part – a response rate of 94%. The use of a self-completion questionnaire in a research context where women's safety was protected ensured greater confidentiality and resulted in high participation rates. Over one third of the general sample of women who participated had experienced mental health problems and many had experienced the symptoms to such a degree that they had consulted their doctor about them. Symptoms of panic and depression were particularly prevalent with many women reporting sleep problems, feelings of worthlessness or guilt, panic attacks and depressed mood lasting at least two weeks.

Prevalence and nature of domestic abuse

Domestic abuse (as gender-based abuse), can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape), financial abuse, and mental and emotional abuse.

The study found that two hundred and sixty six women – almost one third of the sample - reported experiencing at least one form of domestic abuse at the hands of their partner or ex-partner at some time in their lives. For 45% of the women the abuse lasted at least five years. This suggests that when domestic abuse happens it is not a single isolated event but a prolonged repeated experience. For just over a quarter of the women who experienced abuse, the abuse was still happening or had only ended within the last year.

Of those who experienced abuse, 78.3% women had experienced emotional abuse often in combination with other types; 62.4% of the women had experienced physical abuse, 56% financial and 22% sexual abuse. The majority of women experienced at least two forms of abuse with almost 40% reporting three or more types.

Women who had experienced domestic abuse were found to be predominantly white, heterosexual and without a disability. The majority were mothers with children under sixteen living with them. The women who had experienced domestic abuse were significantly more likely to report not having a current partner when compared to women who had not been abused.

Women who experienced domestic abuse were asked whether or not they had experienced domestic abuse during pregnancy. The study found that 30% were abused by their partner or ex-partner while they were pregnant. Of those, only 35% talked to their doctor about the abuse while they were pregnant.

The mental health of women who experienced domestic abuse

60.2% of the women who experienced domestic abuse reported some form of mental health problem. In comparison, of the women who did not report experiencing domestic abuse, 21.6% reported some form of mental health problem. This difference is significant and indicates that those women who experience domestic abuse are more likely to report mental health problems than women who have not experienced domestic abuse. In particular, symptoms of panic (53.4%) and depression (39.5%) were found to be particularly prevalent among women who experienced domestic abuse. The study found that experiencing domestic abuse increases the likelihood of a woman reporting mental health symptoms. The study found that women who are abused are more likely than women who are not abused to have mental health symptoms of such severity that they have consulted their doctor about them.

The women who had been abused were also asked if they believed that the mental health symptoms they experienced were the **result** of domestic abuse. The majority of women who experienced domestic abuse felt that their symptoms of panic, anxiety and depression were a result of the abuse: 74.7% of the women attributed their symptoms of panic, 64% their symptoms of depression and 64.2% their symptoms of anxiety to the domestic abuse they had experienced.

Disclosing domestic abuse

The majority of the women (76.4%) covered up the abuse. When women did disclose the abuse they were experiencing, they were most likely to disclose to their G.P. (32%). Overall, health service employees are the largest professional group to whom women who have experienced domestic abuse disclose. Of those women who disclosed to their G.P., 89.4% reported he/she had been either 'helpful' or 'very helpful'. In general, the majority of the women who disclosed the abuse to workers from health or other support services found them to be helpful.

The most commonly identified way of coping with domestic abuse was through the use of prescription drugs. Given that the number of those identifying prescription drugs as a means of coping with domestic abuse (n = 93), is higher than the number of women who disclosed their abuse to their General Practitioner (G.P.) (n = 85), these findings show that at least some women are being prescribed drugs when the true cause of their difficulties is unknown to the G.P. Second only to prescription drugs, was the use of legal or illegal substances as a means to cope with domestic abuse, with either alcohol or illegal drugs being used by over 30% of the women.

Women commented on their main reasons for non-disclosure to medical personnel. These included feeling too ashamed or embarrassed to speak to their G.P, not wishing to bother their G.P., or feeling that it was inappropriate. Some women felt their doctor would not understand and many were afraid to disclose. Women's reasons for non-disclosure to others, including agencies, were similar: principally they found it hard to talk to anyone and feared repercussions, some blamed themselves for the abuse or felt that they would not be believed.

The findings that only small numbers of women disclose the abuse to their G.P. may be a consequence of the symptoms themselves. If domestic abuse results in low self-esteem, self-blaming, feelings of worthlessness and other symptoms which lead to depression, anxiety and panic then a woman's state of mental ill-health will in itself create a significant, additional barrier – alongside fear - to disclosure to G.P.s or others. Few women are able to speak to health professionals about their symptoms in relation to the abuse they have experienced, and fewer still are confident that when they do so they are likely to be met with a sensitive and constructive response.

Conclusion

The high prevalence of domestic abuse which is indicated by the results of this study, the detrimental impact which domestic abuse has on women's mental health and the barrier it creates to help-seeking suggests that a more pro-active approach by G.P.s and others is needed. Since many of the women rely heavily on prescription drugs, these are women who are likely to attend their G.P. on a regular basis. The true reasons for their mental health needs however are clearly not always being recognised. The women who participated in this study did so willingly and in large numbers; many commented on how much they valued it being done and how pleased they were to take part. Some disclosed their abuse for the first time on the questionnaire and were amazed that what they had experienced was worthy of note by researchers. They clearly did not mind being asked to take part. The evidence from the use of this research methodology and the results themselves suggest that a more pro-active approach by health professionals would allow more women to access the increasingly helpful response to their plight that a small number of them have already found among health professionals and other service providers.

Recommendations

The Prevalence of Domestic Abuse

- 1 *DAP studies should be carried out in other areas of Scotland using this definition, sampling and methodology and should explore the influence of other demographic factors such as ethnicity, sexual orientation or disability.*
- 2 *Further research should be carried out in other areas of Scotland in order to provide more accurate local and national figures for the number of children affected by domestic abuse in Scotland. This would inform those planning children's services and agencies concerned with child protection.*
- 3 *Further research should be carried out to determine the prevalence of domestic abuse during pregnancy and its impact on the physical and mental health of a general sample of women.*

The Health Service Response to Domestic Abuse

- 4 *Primary Care and Community Care staff should be made more aware of the potentially high prevalence of domestic abuse in the general population.*
- 5 *Primary Care and Community Care staff should be alerted to the signs and coping mechanisms of women who experience domestic abuse, such as covering up the abuse, mental health problems and use of prescription drugs and should consider taking a more proactive approach to women in this situation. This could lead to earlier identification of women with significant health needs and improve their treatment and care.*
- 6 *Primary Care and Community Care staff should have access to sources of information about other non-clinical service provision for women and children affected by domestic abuse.*

Multi-Agency Working

- 7 *This report should be disseminated in Health settings, through local Multi-agency Domestic Abuse Partnerships and via Scottish Domestic Abuse Training Consortia (see Scottish Executive 2004) and the implications of its findings and recommendations considered.*
- 8 *The implications of such high hidden prevalence and the associated mental health impact on women should be examined by every sector involved in multi-agency working. The capacity, nature and extent of local service provision should be reconsidered on the basis of these findings.*

- 9 *The availability and contact details of local support services should be more extensively publicised in order to encourage more women to come forward.*
- 10 *Community Safety Partnerships, Children's Services Planners, Child Protection Committees, the legal, law enforcement and Criminal Justice systems and other statutory agencies should implement effective multi-agency risk assessment and safety management procedures to protect women and children from the behaviour of violent men.*
- 11 *The development of an integrated multi-agency approach to work with abusing men.*
- 12 *Staff of local service agencies should be provided with more extensive multi-agency training and local information on other sources of support for women and children.*
- 13 *Mainstream funding should be made available to integrate education programmes on domestic abuse and gender-based violence into the PSE school curriculum Scotland-wide.*

Further Research

- 14 *Further research should be carried out to examine, in more depth, the association between women's experience of the different forms of domestic abuse and their short, medium and long term mental health outcomes.*
- 15 *Women's experience of living or coping with domestic abuse and the strategies used to prevent it should be more thoroughly researched.*
- 16 *A statistical study should be undertaken of the number of Scottish men using violence against women partners or ex-partners.*

OVERVIEW

'...the true yardstick with which to measure real equality is the state's commitment and actions to combat violence against women – in all its forms and in all areas of life. For as long as violence against women persists and is condoned, true equality will never be attained' (Fuchs, 2000 p.1).

Tackling domestic abuse in Scotland has been a national priority for the Scottish Executive since 2000 (Scottish Executive, 2000). The West Dunbartonshire Domestic Abuse Partnership (WDDAP) is committed to tackling domestic abuse through the implementation of its local strategy (WDDAP 2000). This reflects the Scottish Executive's National Strategy on Domestic Abuse which acknowledges that a co-ordinated, strategic multi-agency approach is the most effective method of intervention.

In 2003, WDDAP gained funding and ethical approval from NHS Argyll and Clyde to carry out a major study into the prevalence of domestic abuse among women patients in Primary Care in the Lomond LHCC areas. The aims of the study were as follows,

- 1 To determine the prevalence of domestic abuse perpetrated by a partner or ex-partner on women over the age of 16 years attending general practice.
- 2 To seek to determine the impact of domestic abuse on women patients' health and wellbeing.
- 3 To review current access to support services within primary care relevant to women who experience domestic abuse.
- 4 To establish reasons for non-disclosure to medical personnel.

The study was a joint venture between NHS Argyll and Clyde, WDDAP and Glasgow Caledonian University. Funding for the study was obtained from the Health Improvement Fund. The proposal included plans to undertake a one-day pilot programme to test the research instrument and all elements of the research process prior to undertaking the main fieldwork (See Appendix 1. Research Proposal). The pilot study was carried out in May 2003.

DEFINITION OF DOMESTIC ABUSE

The Scottish National Strategy on Domestic Abuse acknowledges that,

Domestic abuse is most commonly perpetrated by men against women and takes a number of specific and identifiable forms. While the existence of violence against men is not denied, nor is the existence of violence in same sex relationships, nor other forms of abuse, domestic abuse requires a response which takes account of the gender-specific elements and the broader gender inequalities which women face...

Thus

...Domestic abuse (as gender-based abuse), can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family or friends). (Scottish Executive 2000 p.5)

This broad definition, including the term 'domestic abuse', acknowledges the gendered nature of domestic abuse and is the currently agreed form in use by many local authorities, statutory and voluntary agencies and multi-agency partnerships in Scotland (See Argyll and Bute (2003), Barnardos (2004), Highland Wellbeing Alliance (2004), WDDAP (2000)). The definition has also been adopted by the NHS in Scotland (NHS Scotland 2003), The Association of Chief Police Officers in Scotland (representing all Scottish Police forces), and the Crown Office and Procurator Fiscal Service (COPFS).

As far as possible, the term 'domestic abuse', as defined by the Scottish Executive above, will be used in this report. Occasionally, other terms such as 'domestic violence', 'intimate partner violence', 'family violence', 'wife battering' may be used in the context of research carried out in other countries. The use of a broader definition, as recommended by the Scottish Executive in the National Strategy (Scottish Executive 2000), removes the tendency of agencies working in the field to concentrate on the most dramatic manifestations of the impact of domestic abuse which occur as a result of the physical injuries which women endure at the hands of partners or ex-partners. The Scottish Executive recommends that multi-agency working in the field of domestic abuse be founded upon the adoption of this shared, broad definition (Scottish Executive 2000). This facilitates the harmonisation of statistics and data collection and permits a more sensitive and inclusive approach to service planning for women survivors of domestic abuse. This shift in focus from a concentration solely on the visible, physical effects of violence illuminates the need to investigate the possible presence of internal injuries and the emotional impact of domestic abuse upon women. The adoption of the broader definition by support agencies, particularly those in health settings, has brought about changes to the types of interventions which women survivors of domestic abuse might be offered (for a fuller discussion on the implications for health services see p.25 below).

The Known Prevalence of Domestic Abuse - The Tip of the Iceberg

Amnesty International '**believes that governments' first measures towards eradicating violence against women should include a comprehensive recording and statistical monitoring of its prevalence, no matter how intractable the problem seems.**' (Amnesty International 2004a p.1). It has been recognized that there is a need for in-depth research into the prevalence of domestic abuse among general populations and that domestic abuse has one of the highest hidden figures of any crime. (For a discussion see Mooney 2000)

It is important, in statistical terms, to distinguish between incidence and prevalence of domestic abuse. Incidence refers to the number of violent incidents occurring; prevalence to the numbers of individuals affected. Prevalence is always lower than incidence as some women are victims more than once over time. This is true of all types of crime, and particularly so with domestic abuse. (Amiel and Heath, 2003)

Worldwide prevalence of domestic abuse

According to Amnesty International, which has collated global statistics on violence against women, the figures are a '**worldwide human rights catastrophe**' (Amnesty International (2004a). They estimate that one in three women worldwide has been beaten, coerced into sex or otherwise abused in her lifetime. In the USA, estimates of violence against women suggest that almost 2 million women are physically assaulted annually and more than 50 million are assaulted in their lifetime; women accounted for 85% of all victims of domestic violence in the US in 1999 (671,110 women compared to 120,100 men) (Amnesty International 2004a). The World Health Organisation (WHO) reports that up to 70% of female murder victims are killed by their male partners. (WHO 1999)

The first national study of female homicides in South Africa found that in 1999, one South African woman is killed every six hours by an intimate partner. In Russia in 1999, 14,000 women were killed by partners or relatives – one woman is killed every six hours. In Turkey, estimates suggest that up to half of all Turkish women are affected by domestic violence. (Amnesty International 2004b)

An analysis of 10 separate domestic violence prevalence studies by the Council of Europe found that one in four European women experience domestic violence over their lifetime and they experience between 6 and 10 incidents of domestic violence in a given year. (Council of Europe 2002)

Prevalence of domestic abuse in UK and Scotland

Statistics about the prevalence of domestic abuse in the UK are derived from surveys and research published by bodies such as the Scottish Executive Central Research Unit and Justice Department, United Kingdom Home Office, Lord Chancellor's Department, police forces, Scottish and British Crime Surveys, Scottish Women's Aid, the Women's Aid Federation of England and other women's refuges.

In the UK

- Every minute, the police receive a domestic violence call
- Every day, thousands of children witness domestic violence
- Every week, two women are killed by a partner or ex-partner (HM Crown Prosecution Service 2004)

While violence against men is not denied, Scottish research found that '**men's experiences of abuse were generally much less severe than women's and that men were less likely to be repeat victims or report feeling fearful in their own homes**' (Gadd et al 2002, p.1).

The number of incidents of domestic abuse recorded by Scottish Police forces increased from 39,643 incidents in 2003 to 43,678 incidents recorded in 2004 - an increase of 10%.

The police figures showed that

- in 2004, incidents with a female victim and male perpetrator represented 88% of all incidents of domestic abuse where this information was recorded
- 52 per cent of the cases involved known repeat victimisation
- when looking at the incidence per 100,000 population, females are at most risk of being victims of domestic abuse when aged between 26 and 30.
- nearly 45 per cent of incidents of domestic abuse recorded by the police involved co-habitees or spouses
- the overwhelming majority of incidents of domestic abuse took place in the home (91 per cent of all incidents where the location was recorded). (Scottish Executive, 2005)
- West Dunbartonshire had 1296 incidents of domestic abuse in 2004. This was the highest number of incidents of domestic abuse per 100,000 of population in Scotland. (Scottish Executive 2005)

According to Scottish Executive estimates, more generally, between one in three and one in five women will experience domestic abuse from a male partner in her lifetime (Scottish Executive 2000). For the period April 2003 – March 2004 a total of 82,226 women contacted Scottish Women's Aid for information and support – this represented a 15% increase on the previous year. A third of the women who approached Women's Aid Groups in Scotland for refuge accommodation could not be accommodated. (Scottish Women's Aid 2005) Scottish Women's Aid also estimates that in Scotland, 100,000 children and young people are currently experiencing the effects of domestic abuse (Scottish Women's Aid 2004). In 2003 Scotland's National Domestic Abuse telephone helpline received 230 calls per week. (Brown 2004)

These statistics conceal the associated pain, fear, isolation, shame, loss of self-esteem and identity of the women and children who experience domestic abuse. According to Mooney, 'It is well documented that police figures suffer from the problem of the **'hidden figure of crime'**...that is, the non-reporting of crime to the police by the public and the failure of the police to record crime that is reported.' (Mooney 2000, p.24) Typically domestic abuse involves a pattern of abusive and controlling behaviour that tends to get worse over time. Some forms are directly and indirectly physical, such as assault, indecent assault, rape, destruction of property and threats. Some are non-physical, such as destructive criticism, pressure tactics, belittling, breaking trust, isolation, oppressive control of finances and harassment. The physical manifestations of domestic violence are more clearly identifiable as criminal offences; the non-physical forms may not be. Data derived from that collected by emergency services and other agencies responding to the former may lead to an over-emphasis in the figures on these more visible manifestations and to the less obvious impacts going unrecorded.

The hidden extent of Domestic Abuse

Recent research on findings from The British Crime Survey (BCS) of 2001 revealed that **'up to half of all UK women have experienced domestic violence at some time in their lives.'** (Walby & Allen 2004, p.8). These findings were achieved by the use of a new self-completion module on domestic violence, sexual assault and stalking. This ensured greater confidentiality and is regarded as the main reason for the higher rates of reporting. The findings from BCS in 2001 also found that in the year prior to interview,

- There were 15.4 million incidents of domestic violence (12.9 against women and 2.5 against men).
- The average number of incidents among women subjected to domestic violence was 20 per woman.
- There were 190,000 incidents of serious sexual assault of women and 54% of these assaults were by husband/partner or former husband/partner.
- One fifth of the worst incidents of domestic violence suffered in the last year were from former partners/spouses. For 7% of women survivors of domestic violence, the worst incident took place after they stopped living with their violent partner. Leaving the relationship is the most dangerous time for a small but significant minority of women.
- Police came to know about less than one in four cases of domestic violence and less than one in seven cases of sexual assault. The police were slightly more likely to be told about stalking.

Reasons for non-disclosure

Other findings from the British Crime Survey 2001 (Walby & Allen 2004), show that women do not report incidents of domestic abuse to the police for a number of reasons e.g.,

- did not want more humiliation (7%)
- incident too trivial (4%)
- they feared more violence or that the situation would get worse if the police became involved (13%) i.e. 1 in 8 women suffering domestic violence thought that the police would make matters worse rather than better

Other reasons for under-reporting include

- fear of reprisals
- embarrassment
- psychological blocking

Mooney's research found that G.P.s and the police are the two agencies in the front line when women seek help. **'The reporting rate to G.P.s is in line with the findings of the percentage of women who need medical attention and with the emphasis on keeping domestic violence private.'** (Mooney 2000, p.25) The British Crime Survey found that only a quarter of women subjected to domestic assault saw a doctor and an even smaller proportion disclosed the cause of their injuries or complaints. (Home Office 1999) G.P.s and other health professionals **'are amongst the most likely to have contact with women in violent, sexually and emotionally abusive domestic situations.'** (Hamner 2003, p.297)

DOMESTIC ABUSE AND WOMEN'S HEALTH

Domestic Abuse as a Health Service Issue

Domestic abuse can no longer be viewed as solely a criminal justice or social problem and has more recently been acknowledged as a health care problem. Women may present to health services before they present to criminal justice or social service agencies. The profound and adverse impact of domestic abuse on women's physical and mental health has, since the late 1990s, been acknowledged in Scotland and worldwide as a serious public health issue with implications for health services. (WHO 1997; Scottish Needs Assessment Programme 1997, British Medical Association 1998)

Poorer mental and physical health, more injuries and higher consumption of medical care including prescriptions and admissions to hospital occur among abused women than non-abused women. One Canadian study showed that abused women sought accident and emergency services and medical professionals three times more often than non-abused women; strong evidence from this study also suggests that use of medical services increases with the severity of physical assault. (Kramer et al, 2004)

The impact of Domestic Abuse on Women's Health

The impact of domestic abuse on women's physical and emotional health is profound and the health consequences immense. Women living with domestic abuse are more likely to have physical symptoms, low self-esteem and higher levels of depression and anxiety. They are also more likely to seek health care services for stress-related conditions than those who are not. Research on the mental and physical health sequelae of domestic abuse shows increased health problems such as injury, chronic pain, gastrointestinal, gynaecological or obstetrical complaints, sexually transmitted diseases, depression and post-traumatic disorder. (For reviews of the literature see Gerlock 1999 and Campbell 2002)

Since the 1990s there has been a significant expansion in evidence from research findings, which further illuminate the impact of domestic abuse on women's health. Evidence drawn from a wide range of disciplines has increased knowledge about its impact on the physical and mental health of women and children. This evidence has also contributed to debates and research on health service responses to the issue.

Domestic Abuse and Women's Physical Health

Domestic abuse is one of the most common causes of injury in women. Studies carried out in Scotland (Wright & Kariya 1998), the United Kingdom (Boyle & Todd 2003), The United States (Abbott et al 1995) and Australia (Hegarty & Roberts 1998) have shown that the prevalence of domestic abuse is high among patients attending for emergency care. The UK Department of Health estimates that women on average experience 35 episodes of domestic violence before seeking help (Dept. of Health 2000) A survey of case files of 129 women survivors of domestic abuse carried out in Hackney, London in 1998 (Stanko et al 1998), found that

- one in nine reported domestic abuse serious enough to require medical attention in the previous year
- 76% of the women reported a wide range of physical injuries including burns, fractures, bruises, abrasions, miscarriages, cuts, knife wounds
- 30% of those injuries were substantial and included attempts to kill, strangle, stab and broken bones

Abused women are more likely

- to have multiple injuries than those injured in accidents
- to sustain injuries to the face, neck, thorax, breast, chest and abdomen
- to suffer serious injury from strangulation, stabbing, fractures or attempts to be killed or set on fire

Compared with accident victims, women experiencing domestic abuse have been found to have higher rates of internal injuries and unconsciousness.

The British Crime Survey 2001 found that injuries were often sustained as a result of domestic violence, especially among women. During the worst incident of domestic violence experienced in the previous year, 46% of women sustained a minor physical injury, 20% a moderate physical injury, and 6% severe injuries, while for 31% it resulted in mental or emotional problems. Among the women who were subjected to rape or sexual assault, 52% suffered depression or other emotional problems while 5% attempted suicide and 4% became pregnant. (Walby & Allen 2004)

DOMESTIC ABUSE AND WOMEN'S MENTAL HEALTH

The effect of domestic abuse on the physical health of its victims is well documented but its impact on mental health is a more recent focus of research interest. The impact on mental health should however not be ignored as while physical scars will mostly heal, the mental scars may remain for many years. (Fischbach & Herbert, 1997)

The International Picture

The domestic abuse literature is dominated by studies conducted in North America and to a lesser extent Australasia. A range of North American and Australasian studies have utilised populations drawn from various sources including emergency rooms and psychiatric hospitals, and have suggested an association between mental health and domestic abuse. (Mouton et al 2004; Dienemann et al 2000; Roberts et al 1998)

In the United States for example it was found that

- almost a third of psychiatric inpatients and outpatients have a history of domestic violence
- in 60% of women the health problems post-dated abusive injury. i.e. abused women were psychologically normal individuals who developed a complex psychosocial profile in the context of ongoing partner assault
- 40% of women experiencing domestic abuse had difficulty sleeping, and 46% experienced depression and loss of confidence (Stark & Flitcraft 1996 p.163)
- women who had experienced domestic violence were more likely to be prescribed minor tranquillisers in comparison to those women who had not (Stark and Flitcraft, 1996)

The same study also found that abused women are

- **3 times more likely to be diagnosed as depressed or psychotic,**
- **5 times more likely to attempt suicide,**
- **15 times more likely to abuse alcohol,**
- **9 times more likely to abuse drugs,**
- **6 times more likely to report child abuse.** (Stark & Flitcraft, 1996)

A Canadian study showed that physically and psychologically abused wives [sic] had more somatic complaints, higher levels of anxiety and insomnia, greater social dysfunction and more symptoms of depression than non-abused wives. Alcohol dependency was associated with abuse; 16.3% of physically abused and 11.3% of psychologically abused wives were alcohol-dependent, compared to 2.4% of non-abused wives. (Ratner 1993)

Two reviews primarily focussing on North American literature have concluded that there is an association between domestic abuse and mental health problems. (Weaver & Clum 1995; Campbell, 2002) Weaver & Clum's (1995) meta-analysis estimated that the relationship between interpersonal violence and psychological distress has a composite effect size of 0.24, which is both statistically and practically significant. Moreover, they found that the more recently the domestic abuse had occurred, the greater the psychological distress observed; this gives an indication that a causal relationship may be present.

A meta-analysis on the occurrence of mental health problems among women who had experienced domestic abuse concluded that while there was variability in the prevalence of mental health problems between studies, domestic abuse increases the risk to victims of mental health problems (Golding, 1999). Specifically, evidence was found for an increased occurrence of depression, Post Traumatic Stress Disorder (PTSD) and substance misuse associated with domestic abuse victims. Most of the studies involved in the meta-analysis were however drawn from shelters for victims of domestic abuse, which may not be representative of domestic abuse victims as a whole. This limitation is recognised by Golding and she calls for further research utilising broader sampling procedures. (Golding, 1999)

While the aforementioned North American and Australasian literature is fairly consistent in its findings, the paucity of cross-cultural studies limits the generalisability of North American research to other countries. As a result, little is known about the global prevalence of mental health consequences for domestic abuse victims. Fischbach & Herbert (1997) attempted to review the limited literature on the impact of domestic abuse on mental health within developing countries. They found evidence of substance misuse and affective disorders being associated with domestic abuse but noted that domestic abuse is often culturally specific and thus direct comparisons may not be appropriate.

Sampling issues

There have been two main issues arising from research into the links between domestic abuse and women's mental health. The problem of multiple definitions of domestic abuse in health care settings has prevented the development of a consensus about its causes and consequences. (Mason 1993) Further, much of the research discussed thus far has focused on self-selected samples drawn from victim agencies. This group may be unrepresentative of those who have experienced domestic abuse as they may be skewed towards the upper end of the severity index with regard to physical and mental health consequences of domestic abuse (Golding, 1999). Research carried out in Scotland on the mental health of women survivors of domestic abuse has largely concentrated on current or former residents of Women's Aid refuges. (NHS Argyll & Clyde, Greater Glasgow, North Lanarkshire 2003; and McIndewar 2004) Therefore, the limited and specialised nature of the sampling prohibits generalising to a more generic population.

One of the few population based studies to consider the impact of domestic abuse on mental health was a large scale random-digit-dial telephone survey of 6790 women in the USA. (Coker et al, 2002) Coker et al. (2002) found that self-reported depressive symptoms and substance use was associated with experiencing physical domestic abuse. While causality could not be established – participants' mental health problems may have predated their experience of domestic abuse – there does appear to be some evidence, at least in North America, that domestic abuse is associated with mental health problems in the general population.

Gerlock (1999) attempted to assess causality by asking women whether they thought their mental health problems were caused by their experience of domestic abuse. Although only a relatively small sample of women victims were interviewed, 58% (n=18) felt they had depression because of the domestic abuse they had experienced. The same did not hold for anxiety however, with only one of the six who reported anxiety believing it was due to domestic abuse. This suggests that domestic abuse may be associated with some, but not all mental health problems.

Research within Primary Health Care Settings

Studies carried out in primary health care settings around the world have found lifetime prevalence rates of domestic abuse to be 39-41% in the United Kingdom (Cosgrove and McCartney 1998; Richardson et al 2002; Harris 2002; Donaldson and Fryer 2003;) 39% in Ireland (Bradley et al 2002), 21% - 61% in the United States (McCauley et al 1995; Van Hightower and Gorton 1998; Peralta et al 2003; Kramer et al 2004), 25-37% in Australia (Hegarty and Bush 2002), 21.5% in South Africa (Marais et al 1999), 30.8% in Israel (Grynbaum 2001) and 19-37% in Sweden. (Swahnberg et al 2004) These studies show that there is a high prevalence of domestic abuse among women patients in Primary Care, that it has a significant impact on health outcomes and should be treated seriously by health professionals.

Within the United Kingdom there is limited research on the prevalence or impact of domestic abuse in those attending Primary Care. One study in Hackney, London estimated that approximately one in nine women visiting G.P. surgeries would have a history of domestic abuse but their relatively small sample size prohibits generalisation to a rural Scottish population. (Stanko, et al. 1998) Another prevalence study carried out in a family planning clinic setting in the UK, showed that during a woman's childbearing years, one-third of women may experience domestic abuse from their partner, one in three women experienced domestic abuse at some time in their life and that a significant relationship existed between the age of the woman and experiencing abuse within the last year. Women in full-time employment experienced the highest rates of abuse. (Keeling & Birch, 2004)

With regard to the impact of domestic abuse on mental health, an Australian study was recently published on the relationship between depression and domestic abuse. (Hegarty, et al. 2004) Conducted in G.P. surgeries, it was found that depressed women were significantly more likely to have experienced severe abuse compared with women who were not depressed, and as a result, concluded that doctors treating depressed women should ask about their experiences of domestic abuse.

We found only one study specifically examining mental health problems associated with domestic abuse within a Primary Care setting carried out in the United Kingdom. (Coid, et al. 2003) This study was carried out in London and although only 55% of those approached completed the questionnaire, this still resulted in a sample of 1207. Adjusted odds ratios were calculated to examine the relationship between mental health problems and domestic abuse. They found that self-reported anxiety, depression and Post Traumatic Stress Disorder (PTSD) were more prevalent in those who had recently experienced domestic abuse compared to those who had experienced it over 12 months before. It is clear that while causality cannot be established, there is some evidence of an association between domestic abuse and mental health problems in victims. Psychopathology appears to be a common feature of women who have experienced domestic abuse, and whether those who are mentally ill are more at risk of domestic abuse, or whether domestic abuse precipitates or prolongs mental health problems (Frank & Rodowski, 1999), the association found in samples outwith Scotland was worthy of further investigation and confirmation in a Scottish sample.

DOMESTIC ABUSE IN PREGNANCY

A recent review of literature on pregnancy and domestic abuse in the United States found that

- pregnancy-related violence is a serious public health issue
- hospital and clinic-based studies find pregnancy a time of increased risk for violence
- the severity of domestic abuse seems to escalate during pregnancy (Gazmararian et al 1996)
- the consequences of pregnancy-related violence include later entry into prenatal care, low birth weight babies, premature labour, foetal trauma, unhealthy maternal behaviours and health issues for the mother (Jasinski, 2004)

Recent UK studies carried out among pregnant women found:

- the lifetime prevalence of domestic abuse ranged from 13.4% - 23.5%
- prevalence of domestic abuse in the previous 12 months was 3 - 6.4%
- pregnancy in the past year was associated with an increased risk of current violence (Richardson, et al 2002)
- that women were 10 times as likely to experience domestic abuse in their current pregnancy if they had also experienced it before the last 12 months
- 7.7% reported feeling unsafe or afraid in the last 12 months
- 7.8% reported being threatened with violence in the last 12 months
- domestic abuse was significantly associated with maternal health problems (Bacchus L., Mezey G., Bewley S., 2004)
- domestic abuse was highest in the age group 26-30 years, punching and slapping were the most common pattern of violence and boyfriends were the main perpetrators
- 10% of women experiencing domestic abuse had had forced sexual activity (Bacchus L., Mezey G., Bewley S., 2004)

Studies examining the prevalence of domestic abuse and its associations with obstetric complications and psychological health in women on antenatal and postnatal wards found that domestic abuse can be regarded as an important risk marker for the development of obstetric complications and depressive symptomatology. (Bacchus, et al 2004. Large numbers of pregnant women often suffer silently with depression throughout their pregnancy. (Smith, et al 2004)

HEALTH SERVICES' RESPONSE TO DOMESTIC ABUSE

Domestic Abuse in Primary Health Care Setting

As has been shown above, health services are uniquely placed to provide a route to medical or other support for women who are being abused. One study in Israel found that women preferred talking about this issue with their family physician. (Grynbaum et al 2001) As a universally available service, which is free to all in the UK, almost all women will be in contact with health professionals at some point in their lives; almost all women are

registered with a general practitioner and nearly all pregnant women receive health services. Women with children are very likely to have contact with health professionals. Given the high prevalence of domestic abuse indicated above, women experiencing domestic abuse will be known to health professionals even though the abuse may not.

It has been acknowledged that health service professionals are amongst those most likely to have contact with women following violence or sexually and emotionally abusive domestic situations. G.P.s in particular have a key role to play in relation to women experiencing domestic abuse (The Royal College of General Practitioners, 1998) as women are more likely to approach their G.P. than other agencies when seeking help. (Munro, 2001) The British Crime Survey 2001 (Walby & Allen, 2004) found that 27% of women who suffered injuries in the worst incident of domestic abuse in the last year sought medical assistance on that occasion. Of the women who sought medical assistance, 94% were asked the cause of their injuries by the attending doctor or nurse, 74% disclosed a cause, but only 26% of those who disclosed were referred on to someone else who could help them.

The British Medical Association (BMA, 1998), The Royal College of Obstetrics and Gynaecology (Bewley et al, 1997), the Royal College of Midwives (The Royal College of Midwives, 1997) and The Queen's Institute of Nursing (Queen's Institute of Nursing Scotland 2003), have all issued guidelines for practitioners in responding to domestic abuse. The Royal College of General Practitioners acknowledges that the G.P.'s role is crucial as the surgery is likely to be the first place to which a woman will go for help, though it is estimated that only a quarter of the women who seek medical help admit they have been abused. (Royal College of General Practitioners, 1998)

The gap in knowledge about the extent to which domestic abuse impacts on health in UK has been recognised. There is also a growing acknowledgement of the need to carry out research in relation to domestic abuse within primary care settings in the UK. (Davidson et al 2000)

A recent evaluation of health projects funded through the Crime Reduction Programme (CRP) Violence against Women Initiative in England and Wales indicated that short surveys on the prevalence of domestic abuse amongst women attending general practice was one way of confirming the importance of the issue in each practice. The project also showed the importance of introducing routine enquiry in G.P. practices and the need for appropriate training. (Taket et al 2004)

The most dramatic manifestations of the impact of domestic abuse in health settings have occurred as a result of the physical injuries, which women endure at the hands of partners or ex-partners. This focus on the effects of violence has tended to obscure internal injuries and the emotional impact. Living with the threat of domestic abuse, trapped within a coercive relationship, which degrades, isolates and controls, women survivors have been described as living in '**small hidden concentration camps created by tyrants who rule their homes**'. (Herman 1994, P.3) Herman also compares their experiences to those of combat veterans, political prisoners and the survivors of concentration camps. The impact of the coercive techniques used by men to maintain control over the women they live with is not always apparent to health professionals. More recent studies on the adverse impact of coercion on women's health have shifted the emphasis away from Accident and

Emergency Departments to include other health settings, notably Primary Care. (Grynbaum et al 2001, Hegarty & Bush 2004, Marais et al 1999, Kramer et al 2004, Mazza et al 1996)

CONCLUSION TO LITERATURE REVIEW

What is currently known about national and international rates of lifetime prevalence of domestic abuse among adult women gives serious cause for concern. Much of the research reviewed above has focused on self-selected samples drawn from agencies providing support to women survivors. The limited and specialised nature of the sampling prohibits their generalisability to a more generic population. It has been acknowledged that the hidden prevalence of domestic abuse among the general population in the UK is likely to be much higher than current sources indicate - five times higher according to findings from the British Crime Survey (Walby and Allen 2004) - therefore more research is needed to uncover the 'hidden' figures among the general population of women.

The definitions of domestic abuse widely used by academics, policy makers and service providers in the UK acknowledge the broader nature of the abuse women suffer. Domestic abuse is now less likely to be regarded as consisting of only physical abuse: the extensive emotional and sexual nature of intimate partner violence which women also experience has been recognised. The complexity of women's experience of domestic abuse highlights the need for coordinated community responses to the issue. Now that domestic abuse is widely acknowledged as a health care as well as a criminal justice and social problem, health professionals and their governing bodies acknowledge that the role of health professionals in relation to domestic abuse has been recognised.

Domestic abuse has been clearly established as a gendered phenomenon, which mainly affects women. While domestic abuse perpetrated against men is not denied there is sufficient evidence of its widespread and adverse impact on women to justify further examination of its prevalence among women in society. Evidence from a wide range of disciplines has increased knowledge about the impact of domestic abuse on women's physical and mental health and contributed to debates and research on health service responses to the issue. G.P.s and other health professionals working in Primary Care settings are identified as having a key role to play in responding to women experiencing domestic abuse: they may often be a woman's only opportunity for contact with professionals who might recognise domestic abuse and intervene; they can facilitate access to health services for a complex range of symptoms and to other local sources of support and information. However, within the UK there has been limited research carried out on the prevalence or impact of domestic abuse on women attending G.P. surgeries. Studies carried out in Primary Care settings in Scotland have largely concentrated on G.P. responses to women survivors of domestic abuse. (Cosgrove and McCartney 1998; Munro 2001; McKie, Fennell and Mildorf 2002)

Only one UK study examined mental health problems associated with domestic abuse within Primary Care settings. Psychopathology appears to be a common feature among women experiencing domestic abuse and whether those who are mentally ill are more at risk of domestic abuse, or whether domestic abuse precipitates or prolongs mental health problems, the association is worthy of further investigation. Domestic abuse can also be regarded as an important risk marker for the development of obstetric complications and depressive

symptomatology among pregnant women - many of whom often suffer silently with depression throughout their pregnancy.

There is a gap in knowledge about the prevalence of domestic abuse among the general population of women in Scotland, the extent to which domestic abuse affects their health and why they are reluctant to disclose the abuse to health professionals. Undertaking research on the prevalence of domestic abuse among a substantial sample of women in Primary Care settings in Scotland could illuminate the hidden prevalence, confirm the importance of the issue to health care professionals; identify why women are reluctant to disclose abuse; provide further evidence to enhance the coordination of community responses to domestic abuse in Scotland and contribute to the growing body of international research on the issue.

THE RESEARCH EXERCISE

Aims

In 2003, WDDAP gained funding and ethical approval from NHS Argyll and Clyde to carry out a major study into the prevalence of domestic abuse among women patients in Primary Care in the Lomond Local Health Care Cooperative (LHCC) area. The aims of the study were,

- to determine the prevalence of domestic abuse perpetrated by a partner or ex-partner on women over the age of 16 attending general practice
- to seek to determine the impact of domestic abuse on women patients' health and wellbeing
- to review current access to support services within primary care relevant to women who experience domestic abuse
- to establish reasons for non-disclosure to medical personnel. (See Appendix 1)

Lomond LHCC covers a geographical area, which crosses both West Dunbartonshire and Argyll and Bute Council boundaries. Its boundaries extend west and north from Dumbarton on the River Clyde Estuary to the Vale of Leven, Helensburgh, Arrochar, Garelochhead, Kilcreggan, and Lochgoilhead (NHS Health Scotland, 2004). There are 31,772 females aged over 15 in the Lomond LHCC area (NHS Health Scotland 2004: Census 2001).

Methodology

Ethics

As a precursor to carrying out the pilot, it was necessary to obtain approval from the NHS Argyll and Clyde Ethics Committee. Research Ethics Committees (RECs) are the committees convened to provide independent advice to participants, researchers, funders, sponsors, employers, care organisations and professionals to ensure that proposals for research studies comply with ethical standards.

The aim of Argyll and Clyde Health Board Research Ethics Committee in reviewing the proposed study was to protect the dignity, rights, safety and well-being of all actual or potential research participants. It shares this role and responsibility with others, as described in the Research Governance Framework for Health and Social Care. (See Appendix 2)

The project also had to be passed by the Research and Development Department of NHS Argyll and Clyde to ensure that it conformed to research governance guidelines. The Ethics Committee had a number of concerns about the project due to the subject matter of the questionnaire. Their concerns (in italics) and how they were addressed were

- ***asking questions in the G.P. surgery may bias the women***
The questionnaires were completed in the waiting area and placed in an envelope in a box so it was not possible for the G.P.'s to see them. No women raised concerns about this issue when asked to complete the questionnaire.

- **asking only women who attended the G.P. surgery would not be representative of society (selection bias)**

The research question being addressed was to look at the prevalence of domestic abuse among women within a Primary Care setting, not society as a whole.

- **the REC were unhappy with the definition of domestic abuse used**

The broad definition recommended by Scottish Executive was used i.e. 'Domestic abuse may include psychological, emotional and economic as well as physical and sexual abuse of women by partners, or ex-partners. Abuse may take place within or outwith the home.' (Scottish Executive 2000)

- **confidentiality issues**

Each surgery was asked to provide a room where, if required, the women could meet with a woman's support worker.

- **doubts about whether G.P.s would agree to the study**

All members of the LHCC agreed to take part in the research. By agreement with the practice there, Lochgoilhead, was not included in the study as the numbers of women likely to attend the surgery was very small and women's anonymity could not be guaranteed.

- **concerns about the safety of the women being asked to complete the questionnaire**

Women would only be approached if they were on their own or had young children with them to minimise the likelihood of any repercussions.

- **concerns that asking why women had not spoken to their G.P. could adversely affect the subsequent G.P. consultation**

None of the G.P.s were concerned about this and there were no reported incidences of this occurring.

- **concerns about the follow-up arrangements for women identified as experiencing abuse**

The free and confidential services of WDDAP's CARA (Challenging and Responding to Abuse) Project were made available to all women participating in the study.

The Ethics Committee also suggested including a question about the gender of the G.P. and this was incorporated into the questionnaire.

A combination of correspondence and telephone calls between the Committee and representatives of the research team addressed all of these concerns to the Committee's satisfaction.

Pilot Study

A one day pilot study was carried out in one surgery within the Lomond LHCC area in May 2003. The pilot study tested and evaluated the research instrument and process (Donaldson & Fryer 2003).

A total of 90 questionnaires were issued during the one day pilot and 86 were returned – a response rate of 94% - 85 completed questionnaires were returned. It should be noted however that some women who did not indicate any experience of abuse in Q. 11 did not answer all of the questions. Some women chose not to answer all questions in the questionnaire. The key findings can be summarised as follows:

- nearly half of all respondents were aged 26-40
- 56% women worked outside the home
- 56% stated that the G.P. they usually saw was female
- 39% women identified themselves as being abused now or having been abused in the past

Of the 34 (39%) who had experienced or were experiencing abuse,

- 37% of women were experiencing or had experienced domestic abuse for less than one year for 21% of women the abuse lasted for between 2 and 5 years
- 21% of women the abuse lasted for between 5 and 15 years
- 25% women experienced abuse during pregnancy
- 21% women spoke to their doctor about the abuse
- no women spoke to their nurse or midwife about the abuse
- when asked why they did not disclose the abuse to their doctor, most replied that they felt it was their own problem
- to help them cope with the abuse,
 - 41% used prescription drugs
 - 35% used alcohol
 - 20% self harmed
 - 14% used illegal drugs

Pilot Study Conclusions

- The questionnaire required only minor alterations.
- Following the pilot stage of the project, a modified version of the self-administered questionnaire was developed. The only substantive change arising from the pilot was an expansion of the definition of the perpetrator of the abuse to include non-partner family members. Feedback from participants involved in the pilot had indicated a desire by some to record non-partner abuse as this often interacted with abuse by a partner to the further detriment of the woman's health. Those who did comment on their experience of abuse by those other than partners were not included in the analysis. The only remaining changes introduced as a result of the pilot were minor alterations to the wording and layout.

- G.P.s, the Practice Manager and staff at the Medical Centre experienced no disruption to the running of the surgery or any increase in their workload as a result of the fieldwork for the study.
- Two staff training sessions were carried out prior to the pilot study. These were important to the overall success of the study, for raising staff awareness of the issue of domestic abuse and for informing them of local support services.
- A key element in the success of the pilot was that the fieldworker was also an experienced domestic abuse women's support worker.
- Promoting the study discretely from within a Community Safety display was effective.
- Women's safety, anonymity, privacy and confidentiality were assured.
- The availability of immediate and follow-up support for women was essential.

IMPLEMENTING THE MAIN STUDY

Design & Procedure

A survey design was utilised to obtain a cross-section of the population under investigation. In all, 15 general practices within the Lomond LHCC agreed to participate in the study. One practice, which had agreed, was excluded as less than ten participants were likely to be recruited and therefore anonymity could not be assured. Researchers spent two days in each practice and invited all adult women attending the surgery alone or with children, who met the inclusion criteria, to participate in the study. The study was promoted in surgeries as part of a Community Safety Display, which helped to reduce the visibility of the study. The display also included leaflets with information from both Argyll and Bute and West Dunbartonshire Domestic Abuse and Community Safety Partnerships, local Women's Aid Groups and other support services available to women experiencing domestic abuse.

Eligible women were approached by the fieldworker/support workers after they had booked in with the surgery. After introducing themselves to the woman, the purpose of the study was explained and anonymity assured. Women were informed that participation was voluntary and that their responses would be anonymous, with only the research team having access to the raw data. The women were informed that a support worker with access to a private room was available if they wished further information or support. Women were also informed of the availability of other local support services.

If women indicated they would be interested in participating they were provided with an information sheet and the questionnaire. Women were given the option of completing the questionnaire in the surgery and utilising the drop-boxes provided or completing it at their own convenience and returning it using the Freepost address provided. Most women preferred to complete the questionnaire in the surgery; only a few women utilised the Freepost option.

Participants

All women attending the G.P. surgeries who met the inclusion criteria were invited to participate in the study. Women were included if they were 16 years or above and were not attending the surgery accompanied by an adult male. The second criterion was considered important due to the nature of the study as it was felt there was a risk that the woman's safety may have been compromised if the male accompanying her was her abuser. A total of 1071 women were invited to participate and 951 accepted questionnaires. Of those who did not wish to participate, the majority refused because they either did not have the time or did not have reading glasses with them. Women returned a total of 893 completed questionnaires - a response rate of 94%.

Questionnaire

The questionnaire began with a request for standard demographic details before moving on to a symptom checklist for mental health problems and six screening questions for lifetime prevalence of domestic abuse. Questions screened for emotional, physical, sexual and financial abuse. If any of the domestic abuse questions

were answered in the affirmative the woman was requested to complete the remainder of the questionnaire, which solicited more details of the nature and consequences of the abuse. Those women who did not self-report an abusive experience were asked to return the questionnaire at this point. The remainder of the questionnaire focused on the impact of abuse on mental health, barriers to disclosure and coping strategies. A copy of the questionnaire is provided in Appendix 3.

Participants' comments on the research exercise

In a recent research exercise carried out in the field of domestic abuse it was found that questionnaires can become therapeutic tools which **'help clients put a name to the various behaviours they had experienced from their partners.'** (Robinson 2005 p.13) With a few exceptions, participants' comments from this research support this view.

Some women found being asked about such a sensitive subject upsetting,

"it was very sore completing the form"

However there were a number of positive comments that affirmed the value of the research, for example

"I thought it was great research"

"Excellent study, as a nurse I did a small study on abuse to pregnant women about 15 years ago. Very little on subject – medical, midwifery and nursing staff denied problem as well as females"

A woman came in with partner, but came back later as it was ***"something she wanted to do"***

"Really glad you are doing this research"

"Thank you for doing this"

Staff Training Sessions

The research team carried out staff training sessions in each host health centre/practice. A total of 35 members of staff from Dumbarton, Alexandria, Helensburgh Health Centres and practices in Arrochar, Garelochhead and Kilcreggan participated in short 20 minute training sessions. The majority of administrative staff attending the sessions had had no previous training on domestic abuse – although many health visitors, midwives and nursing staff had dealt with cases where domestic abuse was an issue, the majority welcomed the sessions. The sessions consisted of

- a definition of domestic abuse
- a briefing on the aims and methodology of the research study
- a quiz: 'What do you know about domestic abuse?' followed by a discussion
- guidance on how to respond to women disclosing abuse
- information about local services available for women and children.

Everyone attending received an information pack which contained a copy of:

- The research proposal and the research questionnaire
- The NHS Scotland (2003), Responding to Domestic Abuse – Guidelines for Health Care Workers in Scotland;
- Queens' Institute of Nursing/Scottish Executive, (2003) Resource leaflet - Responding to Domestic Abuse in NHS Scotland: Guidelines for Health Care Workers
- Scottish Women's Aid Leaflet, Domestic Abuse – Myths and Realities
- Information leaflets from local Women's Aid Groups and the CARA Project
- Domestic Abuse –Directory of Services (WDDAP)

Participants found the sessions informative and many requested more information and training on the topic. The majority completed a brief evaluation at the conclusion of the sessions. Appendix 5 contains a summary of the comments from one of the sessions.

RESULTS

General Population Sample

A total of 1071 questionnaires were distributed, and 951 women accepted questionnaires. In all 893 were completed - a response rate of 94%. It should be noted that some participants chose not to answer every question; the percentages quoted in these results and in all tables will reflect the numbers of women (participants) who answered the question.

Demographics

Table 1 presents demographic information (for those who reported it) for the whole sample of women in the study. The women who answered the question were predominantly white, heterosexual, aged between 26 and 60 years, not disabled and with between one and three children. Slightly under half of the women had children under 16 years of age living at home and slightly over half were employed outside the home. These demographics correspond broadly to those of the most recent census figures for the Lomond LHCC geographical area. This indicates that the sample reflects the demographic profile of the adult female population of the area. (NHS Scotland 2004: Census, 2001)

The women were also asked about their current relationship status and its duration (Table 2). The majority of the women were in a relationship with the vast majority of those relationships being of at least five years duration.

Mental Health

The questionnaire also attempted to gain some understanding of the mental health of the women who participated in the study. Time constraints prevented a detailed diagnostic assessment of mental disorder, instead participants were asked to report on their experience of common mental health symptoms. These symptoms were grouped by a clinical psychologist into four clusters namely symptoms of depression, panic, anxiety and post-traumatic stress (see Appendix 4 for details). In order to gain some understanding of the severity of the symptoms experienced, participants were also asked to record whether they had visited their G.P. about their symptoms.

The findings show that a sizeable proportion (32.4%, n = 289) of the sample had experienced mental health problems and many had experienced the symptoms to such a degree that they had consulted their doctor about them (Table 3). Symptoms of panic and depression were particularly prevalent with many women reporting sleep problems, feelings of worthlessness or guilt, panic attacks and depressed mood lasting at least two weeks.

Table1: Whole Sample: Demographics

	Number of participants	Percentage
Age		
16-25 years	137	15.7
26-40 years	311	35.5
41-60 years	276	31.5
Over 61 years	151	17.3
Ethnicity		
White	863	98.5
Black	2	0.2
Indian	3	0.3
Pakistani	2	0.2
Bangladeshi	2	0.2
Chinese	2	0.2
Other	2	0.2
Disability		
Yes	59	7.1
No	770	92.9
Gender of Doctor		
Male	446	55.6
Female	315	39.2
Both Male and Female	42	5.2
Sexual Orientation		
Heterosexual	738	95.5
Lesbian	1	0.1
Bisexual	15	1.9
Other	19	2.5
Number of Children		
None	176	20.6
1-3	595	69.5
4 and above	85	9.9
Children under 16yrs living at home		
None	433	53.3
1-3	361	44.4
4 and above	19	2.3
Employment outside the home		
Yes	448	51.7
No	418	48.2
Ticked both boxes	1	0.1

Table 2: Whole Sample: Relationship Status

	Number of participants	Percentage
Current Partner		
Yes	630	72.2
No	230	26.3
Widow	2	0.2
Never had a partner	11	1.3
Duration of Current Relationship		
Less than one year	40	6.2
More than one year but less than 2	26	4.0
More than 2 year but less than 5	69	10.7
More than 5 years but less than 15	207	32.2
More than 15 years	301	46.8

Table 3: Whole Sample: Experience of Mental Health Problems

	Number of participants	Percentage
Symptom Clusters		
Anxiety	120	13.4
Post-traumatic stress	17	1.9
Depression	162	18.1
Panic	263	29.5
Visited GP because of Symptoms		
Anxiety	96	10.8
Post-traumatic stress	17	1.9
Depression	107	12
Panic	117	13.1

Prevalence of Domestic Abuse

Participants were asked six questions regarding domestic abuse. Physical, financial and sexual abuse are relatively easy to define and therefore were allocated one question each. Emotional abuse is more difficult to define and therefore three questions were asked with women being classified as experiencing emotional abuse if they acknowledged at least two of the symptoms (see Questionnaire in Appendix 3).

Two hundred and sixty-six women (29.8% of the sample) reported experiencing at least one form of domestic abuse at the hands of their partner or ex-partner. Of those who experienced abuse, 78.3% (n = 208) had experienced emotional abuse often in combination with other types of abuse. Regarding physical abuse the figure was 62.8% (n = 167), financial abuse 56.0% (n = 149) and sexual abuse 22.0% (n = 58). As many of the women had experienced more than one type of abuse, the breakdown of the different combinations is presented in Table 5. It is clear that the majority of women experienced at least two forms of abuse with almost 40% (n = 105, 39.6%) reporting three or more types of abuse (Table 5).

For twenty-eight women the domestic abuse was still happening (13.1% of those who reported domestic abuse) with a further 31 (14.5%) stating it had only stopped in the last year. Regarding the duration of the abuse almost 45% reported that it had lasted at least five years suggesting that when domestic abuse happens it is not a brief single event but a prolonged repeated experience (Table 4)

The women were also asked their experiences of abuse by other family members. Eighty-eight women (10.3% of the total) reported that they had been abused by a parent, sibling, child or other relative.

Table 4: Onset, Duration and Termination of Abuse

	Number of participants	Percentage of those reporting domestic abuse
Onset of Abuse		
Within the last year	8	3.8
More than one year ago but less than 2	16	7.5
More than 2 years ago but less than 5	51	23.9
More than 5 years ago but less than 15	61	28.6
More than 15 years ago	77	36.2
Duration of Abuse		
One year or less	43	19.4
More than one year but less than 2	32	14.4
More than 2 years but less than 5	50	22.5
More than 5 years but less than 15	59	26.6
More than 15 years	38	17.1
Termination of Abuse		
Within the last year	31	14.5
More than one year ago but less than 2	23	10.7
More than 2 years ago but less than 5	43	20.1
More than 5 years ago but less than 15	58	27.1
More than 15 years ago	31	14.5
Abuse has not stopped	28	13.1

Table 5: Prevalence of Domestic Abuse and multiple forms of Domestic Abuse experienced by Women

Types of Domestic Abuse	Number of participants	Percentage of those reporting domestic abuse
Emotional alone	39	14.7
Physical alone	18	6.8
Financial alone	19	7.1
Sexual alone	9	3.4
Emotional and Physical Abuse alone	40	15.0
Emotional and Financial Abuse alone	25	9.4
Emotional and Sexual Abuse alone	1	0.4
Physical and Financial Abuse alone	8	3.0
Physical and Sexual Abuse alone	1	0.4
Financial and Sexual Abuse alone	1	0.4
Emotional, Physical and Sexual Abuse alone	9	3.4
Emotional, Physical and Financial Abuse alone	59	22.2
Physical, Sexual and Financial Abuse alone	2	0.75
Sexual, Financial and Emotional Abuse alone	5	1.9
Emotional, Physical, Sexual and Financial Abuse	30	11.3

The Sample of Women who Experienced Domestic Abuse

Demographics

Tables 6 and 7 present demographic information for the women in the sample who experienced domestic abuse. As with the total sample of women, those who had experienced domestic abuse were found to be predominantly white, heterosexual, without a disability and to have children. There were however some significant differences found between those who had experienced domestic abuse and those who had not. The women who had experienced abuse were significantly more likely to have children under 16 years of age living with them ($\chi^2(1, N = 893) = 3.94, p < .05$) and were also significantly more likely to report not having a current partner, when compared to women who had not been abused ($\chi^2(1, N = 893) = 25.10, p < .0001$).

Domestic Abuse during Pregnancy

Women who had experienced domestic abuse were asked if they had been abused during pregnancy. Of the women who answered this question, almost 30% (n= 68, 29.6%) were abused by their partner or ex-partner while they were pregnant. Of those, only 35% (n = 24) talked to their doctor about the abuse while they were pregnant.

Table 6: Demographics for Women who Experienced Domestic Abuse

	Number of participants	Percentage of those reporting domestic abuse
Age		
16-25 years	42	16
26-40 years	104	39.7
41-60 years	96	36.6
Over 61 years	20	7.6
Ethnicity		
White	255	98
Bangladeshi	2	0.8
Pakistani	1	0.4
Other	2	0.8
Disability		
Yes	20	8.1
No	226	91.9
Gender of Doctor		
Male	120	49.6
Female	110	45.5
Both Male and Female	12	5.0
Sexual Orientation		
Heterosexual	229	94.6
Lesbian	0	0.0
Bisexual	5	2.1
Other	8	3.3
Number of Children		
None	45	17.2
1-3	181	69.3
4 and above	35	13.5
Children under 16yrs living at home		
None	118	47.6
1-3	120	48.4
4 and above	10	4.0
Employment outside the home		
Yes	131	51.0
No	126	49.0

Table 7: Relationship Status of Women who Experienced Domestic Abuse

	Number of participants	Percentage of those reporting domestic abuse
Current Partner		
Yes	163	62.0
No	100	38.0
Duration of Current Relationship		
Less than one year	17	10.6
More than one year but less than 2	12	7.5
More than 2 year but less than 5	26	16.1
More than 5 years but less than 15	53	32.9
More than 15 years	53	32.9

Mental Health Problems

The rates for mental health problems among the women who experienced domestic abuse were calculated and it was found that 60.2% (n = 160) of the women experienced some form of mental health problem. In comparison, of the women who did not report experiencing domestic abuse, 21.6% (n = 126) reported some form of mental health problem. This difference is significant ($\chi^2(1, N = 893) = 121.81, p < .0001$) indicating that those women who experience domestic abuse are more likely to report mental health problems than women who have not experienced domestic abuse. When examined in their symptom clusters, symptoms of panic (53.4%) and depression (39.5%) were found to be particularly prevalent among women who experienced domestic abuse (Table 8). Pearson chi-square analyses were carried out to investigate whether the women who experienced domestic abuse were significantly more likely than women who had not experienced domestic abuse to report mental health symptoms. All symptom clusters were found to be significant with women who experienced domestic abuse more likely to report mental health problems compared to women who had not been abused:

- PTS: $\chi^2(1, N = 893) = 12.46, p < .0001$
- Depression: $\chi^2(1, N = 893) = 108.05, p < .0001$
- Anxiety: $\chi^2(1, N = 893) = 64.80, p < 0.001$
- Panic: $\chi^2(1, N = 893) = 94.75, p < 0.001$

These analyses demonstrate that experiencing domestic abuse increases the likelihood of a woman reporting mental health symptoms.

In order to gain some understanding of the severity of symptoms, women were asked if they had experienced the symptoms to such a degree that they had consulted a doctor about them (Table 8). Pearson chi-square analyses were again carried out and all were found to be significant:

- PTS: $\chi^2(1, N = 893) = 12.46, p < .0001$
- Depression: $\chi^2(1, N = 893) = 83.24, p < .0001$
- Anxiety: $\chi^2(1, N = 893) = 41.76, p < 0.001$
- Panic: $\chi^2(1, N = 893) = 23.92, p < 0.001$

Women who are abused are therefore more likely than women who are not abused to have mental health symptoms of such severity that they have consulted their doctor about them.

The women who had been abused were also asked if they believed that the mental health symptoms they experienced were the **result** of domestic abuse. For depression 64% (n = 67) of women believed their symptoms were due to the abuse they had experienced; for women experiencing symptoms of panic, 74.7% (n = 101) attributed these to the abuse and for anxiety, 64.2% (n= 47), attributed their symptoms to the abuse.

Table 8: Experience of Mental Health Problems among Women who Experienced Domestic Abuse

	Number of participants	Percentage of those reporting domestic abuse
Symptom Clusters		
Anxiety	75	28.2
Post-traumatic stress	12	4.5
Depression	105	39.5
Panic	142	53.4
Visited GP because of Symptoms		
Anxiety	51	19.2
Post-traumatic stress	12	4.5
Depression	72	27.1
Panic	59	22.2

Hiding Domestic Abuse

A large proportion of the women reported that they had covered up the abuse (n = 159, 76.4%). When women did indicate that they had disclosed the abuse they were experiencing to workers and professionals, they were most likely to disclose to their G.P. (32%) (Table 9). A smaller proportion of women disclosed to 'someone else' (13.9%): this person was generally a friend of the woman. A number of women also disclosed to Women's Aid workers (11.7%), Community Psychiatric Nurses (CPN) (9%) or Health Visitors (8.6%). Although some women may have indicated that they had disclosed to more than one person, these figures suggest that health service employees are the largest professional group to whom women who have experienced domestic abuse disclose.

The women were also asked how helpful the person they had disclosed to had been. In general the women reported that the person they told had been helpful with, for example, 89.4% of those who disclosed to their G.P. reporting he/she had been either helpful or very helpful (Table 10). In general, the majority of the women who disclosed the abuse to workers from health or other support services found them to be helpful.

Table 9: Disclosure of Domestic Abuse

Profession chosen to disclose abuse to	Number of participants	Percentage of those reporting domestic abuse
Doctor	85	32.0
Community Psychiatric Nurse (CPN)	24	9.0
Nurse	11	4.1
Midwife	10	3.8
Health Visitor	23	8.6
Samaritans	9	3.4
Women's Aid	31	11.7
Social Services	25	9.4
Someone else	37	13.9

Table 10: Helpfulness of Person Chosen to Disclose Abuse to

	Number of participants	Percentage of those reporting domestic abuse
Doctor was helpful/very helpful	76	89.4
CPN was helpful/very helpful	20	83.3
Health Visitor was helpful/very helpful	17	73.9
Women's Aid was helpful/very helpful	30	96.8
Social Services was helpful/very helpful	23	92.0
Someone else was helpful/very helpful	32	86.5

Coping with Domestic Abuse

Women reported using a variety of ways to cope with the domestic abuse they experienced (Table 11). The most commonly identified way of coping was through the use of prescription drugs. Given that the number of those identifying prescription drugs as a means of coping with domestic abuse (n = 93), is higher than the number of women who disclosed their abuse to their G.P. (n = 85), it is clear that at least some women are being prescribed drugs when the true cause of their difficulties is unknown to the G.P.. Second only to prescription drugs, was the use of legal or illegal substances as a means to cope with domestic abuse, with either alcohol or illegal drugs being used by over 30% of the women.

Table 11: Coping with Domestic Abuse

	Number of participants	Percentage of those reporting domestic abuse
Prescription Drugs	93	35.0
Over the Counter Medication	17	6.4
Alcohol	62	23.3
Illegal Drugs	28	10.5
Self-harm	21	7.9
Other strategies	11	4.1

Reasons for non-disclosure to health professionals

Many women commented on why they did not disclose the abuse to their G.P. or other health professionals. The reasons given were that they were too ashamed or embarrassed to speak to or bother their G.P.

“Think they have more than enough to do without dealing with my personal life”

Some women did not know why they had not disclosed or did not want to disclose:

“It didn’t seem appropriate”

“Didn’t feel I could”

Others were scared or frightened and did not think the doctor would understand.

Reasons for non-disclosure to others

The reasons women gave for non-disclosure to others were similar. Some covered up the abuse through feelings of fear, shame and embarrassment. One woman wrote:

“More a case of I loved him + didn’t want people to think bad of him”

Many women found it hard to talk to anyone because they felt too ashamed or embarrassed and thought it was their own fault:

“Blamed myself for it”,

“I had let it happen”

Women commonly did not think they would be believed and felt they were a failure or stupid:

“Didn’t think anyone would believe it”

“The feeling of failure in a relationship”

The fear of repercussions from the abuser and others was a significant barrier to disclosure:

“I would have got a kicking”

“Afraid that social workers would remove children”

“because I was always licked [locked] in the house”

There was also often an assumption that no one would understand. This was most tellingly expressed by one woman who wrote:

“it wasn’t talking about it. It was people not listening”

Women's Additional Comments

Space was made available at the end of the questionnaire for women to comment on their experiences. A total of 65 women did so and these can be summarised, with examples, as follows,

- 16 gave details of the abuse,
I have never suffered domestic abuse but my mother went through it. And me and my younger brother witnessed it. We even saw my father breaking my mother's jaw. It will be something you never forget.
- 13 discussed support and who to talk to
When amidst DV you feel that no-one can help. If you tell the police, doctor, family or anyone else, what can they do for you? To take the man out of the home for a night or day would only anger him more. He still has to come back and deal with you for telling on him. The law does not do much better in most cases. My husband was caught strangling me (one of many times) and the social work dept phoned me up a few days later stating that "If I ever let my children witness that again, they would be removed from my care!" I was in a new home (having left him) he snuck in the back door. I would not approach them for help at all. It is now 18 years since I first suffered DV, he continues every so often to threaten my parents and me. I still live in hiding always looking over my shoulder. There is 18 years worth of complaints to various police stations and there is nothing they can do.
- 27 described the effects of the abuse
Now I have made myself a lot stronger and would never ever let any man do that to me ever again

Makes you feel worthless and takes years to get over if ever

It happens to people of all ages and because I was young, I was told I was stupid by older people
- 7 gave details of the abuser
Husband does not believe he does this. He is basically a kindly person despite the intermittent rages; and at present we have a relationship which I need. He is very supportive most of the time

Couldn't believe that someone I loved and he told me he loved me since we were 15 and 16 year olds, would do this to me and make our children a statistic for research like this one
- 16 miscellaneous comments included advice to others
Get help. It won't stop until you do

DISCUSSION

The Prevalence of Domestic abuse in Lomond LHCC

Several studies have highlighted the need for in-depth research into the prevalence of domestic abuse among the general population of women in the UK (Mooney 2000; Amnesty International 2004a). Davidson et al (2000) and Taket et al (2004) also highlight the need for surveys on the prevalence of domestic abuse amongst women attending general practice as a way of confirming the importance of the issue for Primary Care health services. This Domestic Abuse Prevalence (DAP) Study examined the extent of domestic abuse among a general population of adult women within the Lomond LHCC area and is the first of its kind to be undertaken in Scotland. Given the sensitive and hidden nature of domestic abuse and the need to protect participants' safety and anonymity, Primary Care settings were identified as appropriate sites. Within the UK in general and Scotland in particular, limited research has been done on the prevalence or impact of domestic abuse in those attending G.P. surgeries. Unlike many other studies, those who took part in this study were not drawn from agencies providing services to women survivors of domestic abuse but were drawn from the general population.

The use of self-completion questionnaires in domestic abuse research, in situations where women's safety could be protected, has been shown to ensure greater confidentiality and to convey higher rates of reporting. (Walby & Allen 2004) The study was promoted in surgeries as part of a Community Safety Display which helped to reduce the visibility of the study and the fieldwork team was led by an experienced women's support worker. A survey design was utilised to obtain a good cross-section of the population under investigation and a total of 893 women took part - an overall response rate of 94%. The DAP Study's research process confirms that by being mindful of women's safety and confidentiality and by utilising a broad sampling procedure a high response rate can be achieved.

The broad definition of domestic abuse used by the Scottish Executive in its National Strategy on Domestic Abuse was used in the questionnaire and throughout this study. The findings show that,

- ❑ almost 30% of the sample of participating women within the Lomond LHCC area have experienced domestic abuse at some point in their lives
- ❑ 30% of this group of women experienced domestic abuse during pregnancy and one third of them talked to their doctor about the abuse while they were pregnant

In addition, 10.3% of the overall sample reported experiencing one or more forms of abuse from a family member.

This study confirms that in the Lomond LHCC area, almost 30% of women have experienced domestic abuse during their lifetime. This figure corresponds to the higher Scottish Executive estimates for lifetime prevalence of between one in three and one in five women (Scottish Executive 2000). However while the figures are higher than the overall European figure of one in four they are lower than recent findings from the British Crime Survey which indicate lifetime prevalence of almost 50% (Walby & Allen 2004, p.8). The figures show a higher

prevalence than the study carried out in G.P. surgeries in Hackney, London which estimated one in nine women would have a history of domestic abuse (Stanko, et al.1998). Taken overall, this study confirms that the prevalence of domestic abuse among women patients in Primary Care in Lomond is consistent with the results of similar studies carried out in Primary Care settings outside the UK: in Europe, the US, Israel, Africa and Australia lifetime prevalence rates range from 21% - 41%. These findings also support the view that domestic abuse is largely unreported and that its true prevalence is likely to be much higher than police figures suggest. (Mooney 2000)

Using the Scottish Executive's definition of domestic abuse has allowed this study to obtain a more detailed picture of the types and combinations of abuse which women have experienced. It is clear that the majority of women experienced at least two forms of abuse: three quarters had experienced emotional abuse often in combination with other types. More than two thirds of the women experienced physical abuse, over a half experienced financial abuse and 22% experienced sexual abuse either on its own or in combination with other forms. The figure for sexual abuse is considerably higher than the study by Bacchus et al which found that 10% of women who had experienced domestic abuse in their survey had had forced sexual activity. (Bacchus L, Mezey G, Bewley S, 2004)

Domestic Abuse in Pregnancy

The severity of domestic abuse has been shown to escalate during pregnancy. (Gazmararian et al 1996) Pregnancy also offers women increased opportunity for contact with the medical profession. However, this study found that although almost one third were abused by their partner or ex-partner while they were pregnant, only around one third of this group of women talked to their G.P. or midwife about the abuse while they were pregnant. Although the sample of women in this study who had been abused showed a high predominance of mothers and a high proportion of women who experience adverse mental health symptoms only a tiny number disclosed the abuse to a health professional during pregnancy. These findings suggest that pregnant women may experience adverse mental health symptoms in pregnancy without disclosing either the abuse or the mental health symptoms to health professionals.

Demographic Information

Those who had experienced domestic abuse in the sample were found to be predominantly white, heterosexual, without a disability and to have children. There were however some significant differences found between those who had experienced domestic abuse and those who had not. The women who had experienced abuse were significantly more likely to have children under 16 years of age living with them. The women who had experienced domestic abuse were also significantly more likely to report not having a current partner when compared to women who had not been abused.

Mental Health Problems: Domestic abuse – cause or effect?

An important limitation on much research on mental health among women experiencing domestic abuse has been that participants are often drawn from survivor agencies. The use of broader sampling procedures in this

study as recommended by Golding (Golding 1999) has permitted comparison of the self-reported mental health symptoms of **all** the women who took part in the study with those who later indicated that they had been abused. Women in this study who experienced domestic abuse were more likely to report mental health problems – with all symptom clusters being found to be significant - compared to women who had not experienced domestic abuse.

The women who took part in this study were asked to indicate whether they had experienced particular symptoms as a **direct result** of the domestic abuse they had experienced. Gerlock, working with a small sample (Gerlock 1999), found that only a small number of women attributed their depression to domestic abuse and even fewer attributed their symptoms of anxiety to domestic abuse. However, this study confirms both the value of broader sampling techniques as recommended by Golding (Golding 1999) and that, when examined in their symptom clusters, symptoms of panic and depression were found to be particularly identified as being the result of domestic abuse. These analyses demonstrate that experiencing domestic abuse increases the likelihood of a woman reporting mental health symptoms. The results also show that women who are abused are more likely than women who are not abused to have mental health symptoms of such severity that they have consulted their doctor about them. These findings are also consistent with the results of a small-scale study carried out among former residents of Women's Aid Refuges in West Dunbartonshire. Most of the women surveyed reported a range of symptoms including stress, anxiety, depression, panic attacks, self-harm, paranoia and loss of confidence as a result of domestic abuse. (McIndewar 2004) As the results have shown that the majority of women who disclosed domestic abuse experienced more than one form, these findings suggest that women's experience of systematic patterns of multiple abuses over time, lead to a complex range of adverse mental health outcomes.

While women who are abused are more likely than women who are not abused to have mental health symptoms of such severity that they have consulted their doctor about them, most women, 76.4% (n = 159), covered up the abuse and did not consult their G.P. about their mental health symptoms. This would suggest that the complex relationship between different forms of domestic abuse and women's experience of mental health symptoms is not coming to the attention of G.P.s. These findings are consistent with results of US studies which indicate that a majority of women experiencing domestic abuse suffer from mental health problems and that there is a strong association between mental health and domestic abuse. (Moulton et al 2004; Dienemann et al 2000; Roberts et al 1998)

Women were asked what they did to help them cope with the abuse. The most commonly identified way of coping was through the use of prescription drugs. Given that the number of those identifying prescription drugs as a means of coping with domestic abuse (n = 93), is higher than the number of women who disclosed their abuse to their G.P. (n = 85), it is clear that at least some women are being prescribed drugs when the true cause of their difficulties is unknown to the G.P.. Second only to prescription drugs, was the use of legal or illegal substances as a means to cope with domestic abuse. Either alcohol or illegal drugs were being used by 33.8% of the women. The adverse mental health outcomes highlighted by this study and women's reliance on prescription drugs, alcohol and illegal drugs further supports Stark and Flitcraft's conclusions that abused women are more likely to abuse alcohol and drugs and to be depressed. (Stark and Flitcraft 1996)

Psychopathology appears to be a common feature among the women in this study who had been abused. The study provides further evidence of a causal link between domestic abuse and self-reported mental health symptoms among women survivors.

Disclosure/Non-disclosure to Medical Personnel or Others

The majority of women did not disclose their abuse to anyone. In line with other studies (Mooney 2000; Hamner 2003; Home Office 1999), the findings here show that those who did disclose the abuse spoke to their G.P.s about it. When women disclosed to G.P.s or other statutory and voluntary service providers, they found the service helpful. If the small numbers of women who are disclosing domestic abuse find G.P.s and other service responses helpful this suggests that many more women are unaware that disclosure to professionals, particularly G.P.s, is likely to receive a positive response. The reasons women gave for non-disclosure to health professionals and other service providers seems to bear this out. Their reasons also correspond to those found elsewhere. (Walby & Allen 2004) Women in this study did not disclose domestic abuse because of embarrassment, shame or fear. Most considered the abuse to be their fault and not something that G.P.s could help with. As this study has shown, domestic abuse survivors report feelings of depression, worthlessness, low confidence and guilt. These are all potential indicators of mental ill-health. This would suggest that the adverse impact of domestic abuse on women's mental health is, in itself, a major barrier to disclosure to G.P.s and others.

CONCLUDING REMARKS

This study successfully attracted a total of 893 women to take part in research into the prevalence of domestic abuse within a Primary Care setting. The use of an anonymous and confidential self-completion questionnaire and a safe, non-stigmatising and broad sampling procedure achieved a response rate of 94%. Using the Scottish Executive's definition of domestic abuse, the findings show that a sizeable proportion of women in the Lomond LHCC area have experienced domestic abuse at some time in their lives. This figure is higher than current Scottish Executive estimates but consistent with findings carried out in Primary Care settings elsewhere in the UK and abroad. The majority of the women are mothers with children under the age of 16 years currently living at home and a third of them reported experiencing domestic abuse during pregnancy. Figures cited in Table 6 suggest that there are at least 160 children under 16 years living in the Lomond LHCC area whose lives have been affected by domestic abuse.

Few women experienced only one form of domestic abuse and many experience a complex pattern of abuse comprising all four forms (emotional, physical, sexual and financial). For many women in this study, the complexity of their experience of abuse yields an equally complex range of adverse mental health outcomes.

Women are more likely to disclose abuse to their G.P. than to other health professionals. Over half of the women who indicated that they had been abused in this sample, and who self-reported clusters of symptoms associated with mental ill-health did not generally report their symptoms to their G.P. or other health professionals. However, the majority of women who experienced domestic abuse felt that their symptoms of panic, anxiety and depression were a result of the abuse. The findings that only small numbers of women disclose the abuse to their G.P. may be a consequence of the symptoms themselves. The onset of the panic, anxiety, depression and PTS clusters of symptoms may aggravate the isolation women already experience when being abused. The reasons given for non-disclosure suggest that the symptoms themselves may create a barrier which further inhibits women from discussing their situation with G.P.s or other service providers. The women cope with the abuse mainly through prescription drugs, alcohol, illegal drugs and self-harming.

The small number of women who disclosed the abuse to their G.P. or other agencies found they received 'helpful' responses. However, although this is an encouraging finding it must be concluded that, for the reasons shown above, few women are able to speak about their experiences in relation to the abuse they have experienced, and fewer still are confident that when they do so they are likely to be met with a sensitive and constructive response. The high prevalence of domestic abuse which is indicated by the results of this study, the profoundly detrimental impact which the abuse has on women's mental health and the barrier it creates to help-seeking suggests the need for a more pro-active approach by G.P.s and others. Given that many of the women rely heavily on prescription drugs, these are women who are likely to attend their G.P. on a regular basis. The true reasons for their mental health needs are clearly not always being recognised. The women who participated in this study did so willingly and in large numbers; many commented on how much they valued it being done and how pleased they were to take part. Some disclosed the abuse for the first time on the questionnaire and were amazed that what they had experienced was worthy of note by researchers. They clearly did not mind being asked to take part. The evidence from the use of this research methodology and the results themselves suggest that a more pro-active approach by health professionals would allow more women to access the increasingly helpful response to their plight that a small number of them have already found among health professionals.

RECOMMENDATIONS

The Prevalence of Domestic Abuse

The sampling, methodology and definition of domestic abuse used in this study revealed a higher lifetime prevalence of domestic abuse among a general sample of Scottish women than had been previously estimated. The high response rate achieved suggests that women are willing to participate in research of this kind and that Primary Care settings are appropriate locations. The research methodology used has shown that it is feasible for Primary Care settings and local Multi-agency Partnerships to support the implementation of multi-disciplinary Domestic Abuse Prevalence (DAP) studies. The methodology also enabled the more comprehensive definition of domestic abuse adopted by the Scottish Executive to be used. It would be useful to establish whether, if applied consistently in other areas of Scotland, this definition, sampling and methodology would reveal similarly high rates in more diverse population samples compared with previous estimates.

Recommendation 1: DAP studies should be carried out in other areas of Scotland using this definition, sampling and methodology and should explore the influence of other demographic factors such as ethnicity, sexual orientation or disability.

This research showed that the majority of women who experience domestic abuse were mothers with children under the age of 16 living at home.

Recommendation 2: Further research should be carried out in other areas of Scotland in order to provide more accurate local and national figures for the number of children affected by domestic abuse in Scotland. This would inform those planning children's services and agencies concerned with child protection.

These findings indicate a relatively high prevalence of domestic abuse during pregnancy.

Recommendation 3: Further research should be carried out to determine the prevalence of domestic abuse during pregnancy and its impact on the physical and mental health of a general sample of women.

The Health Service Response to Domestic Abuse

The results have shown the barriers which both domestic abuse and mental health symptoms create for women. Large numbers of women who had previously not disclosed abuse responded to the pro-active approach taken by the researchers for the purposes of this research. The results also indicate the positive response received by those women who did disclose domestic abuse to G.P.s and others.

Recommendation 4: Primary Care and Community Care staff should be made more aware of the potentially high prevalence of domestic abuse in the general population.

Recommendation 5: Primary Care and Community Care staff should be alerted to the signs and coping mechanisms of women who experience domestic abuse, such as covering up the abuse, mental health problems and use of prescription drugs and should consider taking a more pro-active approach to women in this situation. This could lead to earlier identification of women with significant health needs and improve their treatment and care.

Recommendation 6: Primary Care and Community Care staff should have access to sources of information about other non-clinical service provision for women and children affected by domestic abuse.

Over time, this could lead to increased awareness among more women that they will receive a sensitive and positive response from health professionals and this in turn can contribute to the secondary prevention of domestic abuse as outlined in Scottish Executive's National Domestic Abuse Prevention Strategy (Scottish Executive 2003).

Multi-Agency Working

Despite improving service provision for women and children, and more accurate recording of police statistics in relation to domestic abuse, this study reveals an unacceptably high hidden prevalence of domestic abuse in West Dunbartonshire in parallel with the rising levels of recorded incidence and repeat victimisation in the area. Too many women continue to live in fear. While the study was conducted in health-based settings, the findings have important implications for all service sectors involved in multi-agency working in this field. Multi-agency working in Scotland has matured over the last five years and an effective strategic infrastructure for tackling domestic abuse has been created. However, it is important that the Scottish Executive, the statutory and voluntary sectors and all local Multi-agency Partnerships seriously consider the implications of these findings. Such high hidden prevalence should inform the future direction of national and local strategies for the planning and provision of services, the protection of women and children and for the long term prevention of domestic abuse.

Recommendation 7: This report should be disseminated in Health settings, through local Multi-agency Domestic Abuse Partnerships and via Scottish Domestic Abuse Training Consortia (see Scottish Executive 2004) and the implications of its findings and recommendations considered.

Recommendation 8: The implications of such high hidden prevalence and the associated mental health impact on women should be examined by every sector involved in multi-agency working. The capacity, nature and extent of local service provision should be reconsidered on the basis of these findings.

Recommendation 9: The availability and contact details of local support services should be more extensively publicised in order to encourage more women to come forward.

Recommendation 10: Community Safety Partnerships, Children's Services Planners, Child Protection Committees, the legal, law enforcement and Criminal Justice systems and other statutory agencies should implement effective multi-agency risk assessment and safety management procedures to protect women and children from the behaviour of violent men

Recommendation 11: The development of an integrated multi-agency approach to work with abusing men.

Recommendation 12: Staff of local service agencies should be provided with more extensive multi-agency training and local information on other sources of support.

Recommendation 13: Mainstream funding should be made available to integrate education programmes on domestic abuse and gender-based violence into the PSE school curriculum Scotland-wide.

Further Research Areas

This study exposed two particular areas of enquiry which it was beyond the scope of its original aims to explore. Further study could contribute to the current international debate about the links between domestic abuse and women's mental health and provide evidence for those involved in the protection of women and in the provision of health and advocacy services.

Recommendation 14: Further research should be carried out to examine, in more depth, the association between women's experience of the different forms of domestic abuse and their short, medium and long term mental health outcomes.

Many of the women in this study who had experienced domestic abuse were either no longer in an abusive relationship or the abuse had ended.

Recommendation 15: Undertake further research into women's experience of living or coping with domestic abuse and the strategies used to prevent it.

Recommendation 16: A statistical study should be undertaken of the number of Scottish men using violence against women partners or ex-partners

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Appendix 1:

Research Proposal

A study to determine the prevalence of domestic abuse among women patients attending Primary Care in the Lomond LHCC area including establishing reasons for non-disclosure to medical personnel.

Outline

A research project will be undertaken to study the prevalence of domestic abuse among women patients in Primary Care in the Lomond LHCC area. This will create an evidence base of data in relation to domestic abuse within the Primary Care setting. The project will begin in the spring of 2003 and will be managed jointly by a Project Team comprising representatives from NHS Argyll and Clyde, and West Dunbartonshire Domestic Abuse Partnership. The support, personnel and resources required will be drawn from local statutory and voluntary agencies and services. The Study is supported by the Tobacco Tax (Health Improvement) Fund.

Aims

- 1 To determine exposure to domestic abuse by a partner or ex-partner among women over the age of 16 attending general practice.
- 2 Seek to determine the impact of domestic abuse on women patients' health and wellbeing.
- 3 Review current access to support services within Primary Care relevant to women who experience abuse.

Design: Cross sectional, self administered, anonymous survey.

Setting: Primary Care settings within Lomond LHCC (i.e. potentially 16 practices)

This study has Ethics Committee approval.

The study will

- last for **one week** in each available practice during the period April 2003 – Sept. 2003
- seek to include all adult women visiting the practice alone during that week
- capture women's views of their experience of domestic abuse via a self-completed anonymous questionnaire.

The Project Team will provide

- a detailed Project Plan
- information packs about the Pilot Study to staff and patients
- information and resources on domestic abuse for the use of practice staff
- a domestic abuse support worker for each practice during their participating week
- support/counselling services for women participants and staff from locally available counselling services or local mental health services.
- staff training and information sessions
- Directory of Services
- data analysis
- final report

In return, Primary Care teams will be asked to

- Support and commit to the aims and objectives of the Project
- Facilitate practice staff's attendance at short briefing sessions
- Accommodate Project support worker/ during designated week
- Provide private space for immediate use if required.
- Facilitate access to women over 16 who use the Health Centre/practice
- Refer women to the counsellor/support worker if appropriate
- Display literature provided by the Project Team.

For further information please contact:

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Appendix 2

Research Ethics Committees (REC)

The roles and responsibilities of Argyll and Clyde Health Board Research Ethics Committee correspond to those described in the Research Governance Framework for Health and Social Care. This can be downloaded from the following website: www.doh.gov.uk/research/rd1/researchgovernance/researchgovindex.htm

RECs are responsible for acting primarily in the interest of potential research participants and concerned communities, but they should also take into account the interests, needs and safety of researchers who are trying to undertake research of good quality. However, the goals of research and researchers, while important, should always be secondary to the dignity, rights, safety, and well-being of the research participants. RECs also need to take into consideration the principle of justice. This requires that the benefits and burdens of research be distributed fairly among all groups and classes in society, taking into account in particular age, gender, economic status, culture and ethnic considerations. In this context the contribution of previous research participants should also be recalled.

RECs should provide independent, competent and timely review of the ethics of proposed studies. Although operating within the Governance Framework determined by the Department of Health, in their decision-making RECs need to have independence from political, institutional, profession-related or market influences. They need similarly to demonstrate competence and efficiency in their work, and to avoid unnecessary delay.

In common with all those involved in research in the NHS and Social Care environments, RECs should have due regard for the requirements of relevant regulatory agencies and of applicable laws. It is not for the REC to provide specific interpretation of regulations or laws, but it may indicate in its advice to the researcher and host institution where it believes further consideration needs to be given to such matters.

Appendix 3

The Questionnaire

Please take 5 minutes to answer the following questions. Most of them just need a tick in the box. The first section of the questionnaire is to find out about the range of women that have visited the surgery today and we would appreciate it if everyone answered these questions. The next section is your experiences. Irene is around if you would like to talk to someone today, or she can arrange to come and meet with you wherever it would suit you. **Thank you for taking the time to answer our questions.**

About you

1. How old are you?

16-25 26-40 41-60 over 61

2. What is your ethnic origin?

White	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Black other	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	



3. Are you disabled?

Yes No

4. How would you describe your sexual orientation?

Heterosexual Lesbian Bisexual Other (please specify)

5a. Do you have a partner at the moment?

Yes No Never had a partner

5b. If yes, how long have you been in the relationship?

One year or less More than one year but 2 years or less More than 2 years but 5 years or less More than 5 years but 15 years or less More than 15 years

6. How many children do you have?




7. How many children under 16 live with you?

8. Do you work outside the home?

Yes No

9. Have you ever experienced any of the following and did you see a doctor about them?

(Please tick all that apply)

	Suffered	Consulted Doctor	
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of self confidence or self esteem	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches or muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive or eating problems	<input type="checkbox"/>	<input type="checkbox"/>	
Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	
Physical pain	<input type="checkbox"/>	<input type="checkbox"/>	
Feelings of worthlessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	
Irritability or restlessness	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed mood lasting 2 weeks or more	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	
Other symptoms (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

10. Is the Doctor you usually see

Male Female

	No	Yes	If yes, please circle who did these things?
11a. Has your partner, ex-partner or anyone close to you ever called you names, or said things to make you feel bad about yourself as an adult?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other
11b. Has your partner, ex-partner or anyone close to you ever put you down in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other
11c. Have you been afraid of your partner, ex-partner or anyone close to you?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other
11d. Have you been raped or forced to have any kind of sexual activity by your partner, ex-partner or anyone close to you?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other
11e. Have you been kicked, hit, slapped or otherwise physically hurt by your partner, ex-partner or anyone close to you?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other
11f. Has your partner, ex-partner or anyone close to you ever left you short of money or control the amount you spend?	<input type="checkbox"/>	<input type="checkbox"/>	Partner/Parent/Child/Sibling/Other relative/Other

If you answered No to ALL of the questions in question 11 then **thank you for taking the time to complete this questionnaire. Please put this form back in the box provided or post it back to us using the Freepost address on the last page. If you answered Yes to ANY of the questions, please go on to the next questions about your experiences.**

12. Are any of these things happening now?
 Yes No

All the actions in Q11 are forms of domestic abuse

13. How long did you experience/have you experienced abuse?
 Within the past year More than one year but 2 years or less More than 2 years but 5 years or less More than 5 years but 15 years or less More than 15 years

14. When did the abuse start?
 Within the past year More than one year but 2 years or less More than 2 years but 5 years or less More than 5 years but 15 years or less More than 15 years

15. When did the abuse stop?
 Within the past year More than one year but 2 years or less More than 2 years but 5 years or less More than 5 years but 15 years or less More than 15 years

15a. Why did it stop?

16. Did/do you experience abuse during pregnancy?
 Yes No



17. Did you talk to a doctor or midwife about it?
 Yes No



We know that it is hard to tell others about being abused.

18. If you have spoken to or contacted someone from any of the following services, how helpful/unhelpful were they? Please tick all those you spoke to.

Service	Very helpful	Helpful	Unhelpful	Very unhelpful	Did not contact
Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Visitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Samaritan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women's Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. If you did not speak to your Doctor, please tell us why.

20. What made it hard for you to talk to anyone about your abuse?

21. Women who are experiencing or have experienced domestic abuse often feel ashamed or embarrassed about what is happening to them. Have you ever felt the need to cover this up?
 Yes No

22. Have you ever experienced any of the following or seen a doctor as a result of the abuse?
 (Please tick all that apply)

	Suffered	Consulted Doctor
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Loss of self confidence or self esteem	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or muscle tension	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Digestive or eating problems	<input type="checkbox"/>	<input type="checkbox"/>
Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>
Physical pain	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>
Irritability or restlessness	<input type="checkbox"/>	<input type="checkbox"/>
Depressed mood lasting 2 weeks or more	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Other symptoms (please specify)	<input type="checkbox"/>	<input type="checkbox"/>



23. As a result of the abuse, have you used any of the following to help you cope with the effects of the abuse?
 Prescription drugs Over the counter medicine Alcohol Illegal drugs Self harming Other (please specify)



24. Please use this space for any other comments about your experience of domestic abuse that you would like to tell us about?

Thank you for filling out this questionnaire. We would like to reassure you that the questionnaire is completely anonymous and no attempt will be made to identify you. Please leave the completed form in the box provided or post it to: WDDAP, FREEPOST SC06758, Glasgow G81 1BR. If you would like to talk in confidence to someone who understands, please speak to Irene who is at the Surgery. If you would prefer to speak to her later on, please leave a message on her answer machine (01389-738-680) giving details about how you would like her to contact you or when you will try and phone again.

1. How successful was the session in achieving its aims?	2. Please write up three questions / concerns you may have about any aspect of the session or the research project.	3. Please use the space below to write down up to three things you have learned during the session.	4. Would you like to learn more about the topics covered during the session?	5. If Yes to Q4, please tell us what topics you would like to explore further.
Very Successful	<ol style="list-style-type: none"> Are women always truthful about being abused i.e. do they lie sometimes for attention? Re Q4, I think men may say they would use physical violence, but would they? Talks about abuse of women, what about men? 	<ol style="list-style-type: none"> Statistics - - 	No	
Successful	<ol style="list-style-type: none"> - - - 	<ol style="list-style-type: none"> - - - 	No	
Very Successful	<ol style="list-style-type: none"> - - - 	<ol style="list-style-type: none"> More widespread than realised. Children emotionally abused (hearing) - 	Yes	Generally
Very Successful	<ol style="list-style-type: none"> Important for all staff to have an understanding of aims of project. How staff can access help for those who need it. 	<ol style="list-style-type: none"> Domestic abuse occurs over all social classes. Figures associated with domestic abuse. Effects of domestic abuse on children. 	Yes	Effects of domestic abuse on children.
Successful	<ol style="list-style-type: none"> - - - 	<ol style="list-style-type: none"> A woman is assaulted 35 times before seeking help. Knowledge about abuse in Black and Ethnic Minority Groups is the same. - 	-	-
Very Successful	<ol style="list-style-type: none"> How do you approach women with children to ensure children don't tell partner. - - 	<ol style="list-style-type: none"> Domestic abuse is more prevalent than I thought. - - 		

Appendix 4

Mental Health Symptom Clusters

Post-Traumatic Stress (PTS) cluster:

Post-traumatic stress arises out of the experience of a traumatic event (such as domestic abuse). Flashbacks were used as a defining symptom with at least two of the following symptoms also being required: difficulty concentrating; sleep problems and irritability or restlessness.

Depression cluster:

The defining symptom for this cluster was “depressed mood lasting two weeks or more”. In addition at least two of the following symptoms were required before a participant was classified as falling under the depression cluster: sleep problems; irritability or restlessness; feelings of worthlessness or guilt and difficulty concentrating.

Anxiety cluster:

This is a general cluster that required four or more of the following symptoms: difficulty sleeping; difficulty concentrating; loss of self-confidence or self-esteem; headaches or muscle tension; digestive problems and irritability or restlessness.

Panic cluster:

A more specific cluster for panic was included with a defining feature of panic attacks. Additional symptoms included: headaches or muscle tension; difficulty concentrating and loss of confidence/self-esteem.

