

## Primary Care Physicians' Attitudes to Battered Women and Feelings of Self-Competence Regarding their Care

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### Abstract

**Background:** Previous descriptive studies have demonstrated the problematic nature of physicians' attitudes toward battered women. However, little empirical research has been done in the field, especially among the various medical specialties.

**Objectives:** To compare the approach and feelings of competence regarding the care of battered women between primary care and non-primary care physicians. The non-primary care physicians who are likely to encounter battered women in the ambulatory setting are gynecologists and orthopedists.

**Methods:** A self-report questionnaire formulated for this study was mailed to a random sample of 400 physicians working in ambulatory clinics of the two main health maintenance organizations in Israel (300 primary care physicians, 50 gynecologists and 50 orthopedists).

**Results:** In both physician groups, treating battered women tended to evoke more negative emotional states than treating patients with infectious disease. The most prevalent mood state related to the management of battered women was anger at her situation. Primary care physicians experienced more states of tension and confusion than non-primary care physicians and had lower perceived self-efficacy and self-competence in dealing with battered women.

**Conclusions:** Though both physician groups exhibited negative feelings when confronting battered women, the stronger emotion of the primary care physicians may indicate greater sensitivity and personal awareness. We believe that more in-service training should be introduced to help physicians at the undergraduate and postgraduate levels to cope both emotionally and professionally with these patients.

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The incidence rate of abused women today is extremely high (close to 40% during their life-time) [1,2]. Although battered women are major consumers of medical services,

domestic violence is often not recognized by physicians [3]. Battered women present at emergency departments at least three times more often than women of equal age and socioeconomic status who do not suffer violence at the hands of their partners. According to Bergman et al. [4], battered women have four times as many hospitalizations for trauma (70 vs. 8 controls) and three times as many hospitalizations for other reasons (284 vs. 96).

The primary care physician is frequently the first in the community to encounter the battered woman, either in the emergency department where she presents with visible bruises, or in the clinic where she presents with various somatic and/or psychological complaints [5]. Yet, battered women tend to rate the assistance of medical service workers as least effective, after shelters, lawyers, social workers, policemen, and clerics [6]. In his review of battered women treated in the emergency department of a major hospital, Kurz [7] found that in 40% of cases the physician did not react at all to the fact that the women had been battered. Likewise, Stark et al. [8] reported that over 40% of battered women present to their physician with visible bruises, yet in the majority of cases the doctor does not acknowledge the problem. Furthermore, even when physicians do identify the cause of the trauma they frequently ignore it. A survey of general practitioners in Australia revealed that although nearly all physicians believed they had a professional responsibility to prevent interfamily violence, most of them admitted failing to do so [9].

Recently, our group investigated the experience and knowledge of Israeli physicians in the care of battered women [10]. Results were similar to those in other countries: the respondents estimated the prevalence of wife assault in Israel as significantly lower than indicated by reports in the medical literature; they had rarely been in contact with relevant community services; and had had very little exposure to the subject at medical school, in their practice, from the media or from medical publications. The specialists in family medicine, however, reported more exposure to the subject and were better

\* Deceased

informed about its prevalence and risk factors than non-specialist general practitioners in family medicine.

The present study focuses on the subjective response of primary care physicians to battered women and their feelings concerning their care. Specifically, we investigated: a) their perceived self-efficacy in the care of these patients; b) the combined effect of their experience, attitudes and feelings regarding battered women on their perceived self-efficacy; and c) the feelings of primary care physicians versus the non-primary care physicians who are likely to encounter them, namely gynecologists and orthopedists.

## Materials and Methods

### Participants

Over 90% of the general population in Israel are under the care of the two major HMOs – the General Health Services (Kupat Holim Clalit) and Maccabi (Kupat Holim Maccabi). Members are free to choose any primary care physician employed by the particular fund they belong to. For the present study 300 primary care physicians (140 general practitioners, 160 specialists in family medicine), and 100 specialists (50 gynecologists, 50 orthopedists) employed by the two major HMOs and practicing in the northern, central and southern parts of the country were selected at random from the HMO directories. Each was sent a structured self-report questionnaire and was requested to return it by mail within 2 months. Non-responders were reminded by telephone (not more than twice).

### Sample size

To the best of our knowledge, there are no reports in the medical literature regarding the proportion of physicians in each of our selected groups (family physicians and general practitioners, and non-primary care physicians) who reported feelings of competence in providing care to battered women. Therefore, in selecting a sample size we opted for a 50% rate, which represents the “safest” choice when  $P$  is unknown. A Confidence Level of 95% ( $\alpha=0.05$ ) and an absolute precision of 10% points on either side of the proportion was taken for the statistical calculation. Using the formula,  $n = Z^2_{1-\alpha/2} P(1-P)/d^2$  [15], a minimum sample size of 96 was found to be necessary for each population. This figure was rounded to 100. Since we considered family physicians and general practitioners together (primary care physicians), the sample size for this group was increased to 267 (300 for practical purposes) in order to analyze the data in a regression model with greater “absolute precision” (0.06).

### Questionnaire

We developed a questionnaire on the basis of one already published regarding primary care physician response to domestic violence [11,12] and according to the previously

validated instruments used by McClair et al. [13] and Bandura [14]. The sections of the questionnaire relevant to the present study were as follows:

- **Demographics:** physician's age, gender, place of birth, residency status (specialized/resident), and area of specialization.
- **Feelings** [Table 1]: Respondents were presented with five types of feelings (tension, anger, depression, fatigue and confusion), according to the previously validated instrument. They were requested to indicate the extent to which these feelings are evoked during their treatment of a battered woman as compared to feelings aroused in treating patients with an infectious disease. The items were rated on a scale of 2 (not at all) to 10 (very much/to a large extent). In addition, we calculated the difference in the intensity of each mood state associated with care of the battered woman from that associated with care of the patient with an infectious disease.
- **Perceived self-efficacy:** In accordance with the work of Bandura [14], physicians were requested to rate their agreement with six statements on their self-perceived personal and professional capability of caring for battered women and improving their situation. The items were rated on a scale of 1 (absolutely disagree) to 7 (absolutely agree); the total (summed) score ranged from 6 to 42. The items related to: a) ability to express empathy, b) ability to make the woman feel better, c) inadequacy of professional skills in making the woman feel better, d) not being the right “personality” to cope with the needs of patients in a crisis, e) not feeling embarrassed treating battered women, and f) being able to allocate/invest enough time for treating battered women.
- **Outcome expectations:** Physicians were asked to rate on a scale of 1 to 7 the possible benefit (or damage) they believed their intervention would yield [14]. Four items were presented, with a total score ranging from 4 to 28 (a higher score indicated more benefit).
- **Knowledge:** Physicians were requested to rate their knowledge about battered women. Results of this item were previously reported [10].
- **Perceived self-competence:** Physicians were asked to answer three questions in relation to their perceived self-competence in the case of battered

**Table 1.** Mood states during management of battered women (scale 2–10)

Mood state	Physician group		P*
	Primary	Non-primary	
Tension	5.39	4.32	0.01
Anger	7.06	6.74	NS
Depression	6.10	5.56	NS
Fatigue	4.62	4.75	NS
Confusion	3.31	2.77	0.02

\* ANOVA

Based on the POMS, McClair et al. [13].

HMOs = health maintenance organizations

women. These questions, evaluated also in previous studies [14], are related to: a) physicians' ability to provide efficient help to battered women, b) ability to provide efficient care, and c) ability to contribute to the woman's improvement of her situation. The items were rated on a scale of 1 (absolutely disagree) to 7 (absolutely agree). The total range score varied from 3 to 21.

The items of the English-language instruments were translated into Hebrew from English and checked for context validity by back-translation into English by another member of our team. Those items that did not match were retranslated until a perfect match was achieved. The final Hebrew version was tested in a pilot study of 10 general practitioners and 10 family physicians who were excluded from the main study.

A peer review group of 10 independent family physicians (recognized experts on the subject) analyzed the hypothesis formation and data analysis in work-progress sessions.

### Statistical analysis

All data were analyzed with the BMDP Statistical Software. Data for each section were compared between the professional groups. The Kurskal-Wallis test was used for categorical variables (up to 5 values) and analysis of variance (ANOVA) for continuous variables or variables with at least 7 values. Results were considered significant when *P* was less than 0.05. In order to evaluate the relationship between possible different explanatory variables and the variability of self-efficacy and outcome expectations, two stepwise regression models were defined for primary care physicians. The dependent variables for each model were the total (summed) score range. Independent variables utilized in the model were all those showing a significant relationship in a univariate analysis.

### Results

Of the 400 questionnaires sent, 312 (78%) were returned – 236 by primary physicians (111 specialists in family medicine, 19 residents in family medicine, 106 general practitioners) and 76 by non-primary physicians (36 gynecologists, 40 orthopedists). The descriptive analysis of the results is shown in Tables 1 to 3.

### Feelings

The most prevalent mood state in both groups was anger. The primary care physicians reported significantly more tension and confusion when caring for battered women than the non-primary care physicians. There was no difference between the groups regarding anger, depression and fatigue. In general, in all respondents, treating battered women tended to evoke more tension, anger, depression and confusion than treating patients with infectious disease [Table 2].

**Table 2.** Comparison of mood states between management of battered women and of patients with infectious disease (scale 2–10)\*

Mood state	Physician group		P
	Primary	Non-primary	
Tension	1.89	1.34	NS
Anger	3.00	3.16	NS
Depression	2.98	2.59	NS
Fatigue	-0.40	-0.43	NS
Confusion	0.13	-0.21	0.02

\* Difference in score for battered women minus score for patients with infectious disease.

Based on the POMS, McClair et al. [13]

**Table 3.** Feelings of self-efficacy and outcome expectations in the care of battered women (overall scores)

Score	Physician group		F (df)	P
	Primary	Non-primary		
Self-efficacy (scale 6–42)	29.66	31.93	7.04 (1,292)	0.01
Outcome expectations (scale 4–28)	22.65	23.60	48.51 (1,301)	NS
Self-competence (scale 3–21)	11.93	12.35	0.90 (1,306)	NS

### Perceived self-efficacy

Although overall the primary physicians' perceived self-efficacy scores were a little lower than those of orthopedists and gynecologists, this difference was significant [Table 3]. In particular, there was a significant difference between the groups in the ability to express empathy and in the belief that they had the "right personality" to cope with the needs of patients in crisis.

### Regression analysis [Table 4]

The model utilized to study self-efficacy, which explained 46% of the variance, showed that two variables were positively correlated with self-efficacy: *self-competence* and the *overall score of outcome expectations*, and two negative variables were negatively correlated: "*confusion*" during case management and the belief that *violence is the result of the mental instability* of the woman or man. When the overall score of outcome expectations was used as the dependent variable, our model predicted only about 40% of the variance, and the explanatory variables were physician failure (fatigue) during the management of the battered woman (negative correlation) and the positive influence of both the perceived self-efficacy and the perceived competence.

### Discussion

The findings of this study confirm the complexity of the emotional questions physicians face when treating battered women, as noted in previous descriptive studies [16]. In general, both the primary care and non-primary care physicians reported having negative feelings, mostly anger and depression, when treating battered women.

**Table 4.** Stepwise regression analysis: predicting primary physicians' perceived self-efficacy and outcome expectations

Variable	Coefficient
<b>Self-efficacy*</b>	
Y-intercept	14.73
Attitude: Wife assault results from woman's and/or man's mental instability	-0.21
Mood state evoked during management of battered women: confusion	-0.53
Score for expectation outcome of the care of battered women	0.48
Score for perceived self-competence for the care of battered women	0.68
<b>Outcome expectations**</b>	
Y-intercept	13.18
Mood state evoked during management of battered women: fatigue	-0.51
Score for perceived self-efficacy for the care of battered women	0.26
Score for perceived self-competence for the care of battered women	0.34

\* Multi *R*: 0.68. Equation for predicting 46% of the variance: self-efficacy = 14.73 intercept - 0.21\*stability - 0.53\*confusion + 0.48\*outcome expectations + 0.68\*self-competence. Variables with no significant influence (rejected for inclusion in final equation): knowledge about prevalence and risk factors of spouse assault; physician's experience with battered women, tension, depression, fatigue, and confusion.

\*\* Multi *R*: 0.62. Equation for predicting 39% of the variance: outcome expectations = 13.18 - 0.51\*fatigue + 0.26\*self-efficacy + 0.34\*self-competence.

These feelings were more intense during management of battered women than patients with infectious diseases. Nevertheless, both groups had a relatively high sense of self-efficacy and medium to high expectations of the success of care.

As to the relationship between the approach to the care of battered women and the medical specialty, the results are interesting. The present study showed that primary physicians experience stronger feelings when caring for battered women than the non-primary care physicians who are likely to encounter them (orthopedists and gynecologists). These findings probably demonstrate greater sensitivity and personal awareness on the part of the primary care physician, or they could be due to more involvement with the situation of patients who they have known for a long time. We also suggest that the primary care physician may be more tense because he feels that the problem falls into his field, whereas other physicians can more easily shift the responsibility elsewhere. On the other hand, the primary care physicians expressed a *lower* perceived self-efficacy than orthopedists and gynecologists in treating these patients, with non-significant differences in their expected results of the intervention.

Primary care physicians provide comprehensive, integrated care and treat patients over the life cycle. Therefore, they may at times hesitate to actively intervene in order to avoid creating an imbalance in the holistic care of the family system. Furthermore, ethical aspects may be a

factor, as intervention could affect not only the battered woman but the whole family unit.

The application of regression models to evaluate the effect of physician experience, knowledge, attitudes and feelings on their self-perceived ability and expectation of outcome in the care of battered women indicated that perceived self-efficacy is a positive explanatory variable of outcome expectation for primary physicians. This finding suggests that the better training of physicians in this area could increase their confidence as well as their competence in caring for battered women. This, in turn, may lead them to perceive their ability more realistically.

This is an important issue and has already been addressed by others, who found that professional training in the detection, care and referral of battered women to community services can significantly improve the medical care provided [9,12,17]. In a previous report [18], we recommended the use of protocols for the routine identification, treatment and referral of victims of domestic assault as training tools at medical schools, during internship and residency programs, and in continuing medical education. McLeer and Anwar [19] introduced a protocol for direct questioning of women admitted to emergency departments for traumatic injuries (other than those due to vehicle accidents or disasters). Its use revealed a 30% rate of trauma due to domestic violence compared to only 6% before the intervention. Kurz [7] found that when efforts were extended by the hospital administration to raise physician awareness and knowledge as well as cooperation with support services in the community, the number of cases of violence decreased from 40% to 23%. Obviously, knowledge of the risk factors of domestic violence is also important for the identification of potential victims by physicians. Recent studies [20] indicate that women at greatest risk are those with male partners who suffer from alcohol or drug abuse, are unemployed, or have a low level of education. The risk increases when these women are on the point of leaving their abusive partners or have just left them [21].

In conclusion, the present study sought to systematically investigate the feelings and sense of professional competence of medical specialists in the management of battered women. Physicians, particularly those specializing in primary care, are the professionals most likely to encounter battered women and must therefore serve as "gatekeepers" for both detection and intervention. Proper training in this area is essential. Since our study suggests that physician-perceived self-efficacy is determined more by their perceived self-competence and outcome expectations, more educational activities should focus on these aspects. More in-service training opportunities both at medical school and in continuing medical education settings should be provided to help physicians cope emotionally with this patient population. In addition, physicians should receive instruction on their legal and ethical responsibilities in relevant cases.

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