Patients' Advice to Physicians About Intervening in Family Conflict

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ABSTRACT

PURPOSE We wanted to understand patients' views about physician interventions with family violence and conflict.

METHODS Clinic staff surveyed 253 male and female family practice patients in 6 member offices of the South Texas Ambulatory Research Network (STARNet). The survey instrument addressed demographics, relationship quality, intimate partner violence, and physician interventions with family conflict. Open-ended questions asked respondents to provide advice for "doctors who want to help patients with severe family problems."

RESULTS Among women in relationships, 10% reported being physically hurt by a partner in the past year and 39% in their lifetimes. Among men in relationships, 7% reported physically hurting their partner in the past year and 16% in their lifetimes. Nearly all respondents, including 100% of victims and perpetrators of violence, believed physicians should ask about family conflict (96%), and that physicians could be helpful (93%). Two thirds of the sample reported that their physician had never asked them about family conflict. Investigators used qualitative analysis to summarize patients' advice to physicians. Responses clustered around 3 general themes: communication, assistance, and cautions or encouragement. Patients want physicians to ask about family conflict, listen to their stories, and provide information and appropriate referrals. They raised some cautions and concerns, but also provided words of encouragement.

CONCLUSION Most patients are open to discussions about family conflict with their physicians. The skills they recommend to physicians are well within the domain of family medicine training.

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INTRODUCTION

Family violence has serious physical and mental health consequences that bring many women into the health care system.[1-5] Women who are victims of intimate partner violence make up 34% to 46% of adult female patients in primary care practices.[6-9] Although nearly all physicians believe identification and management of family violence is important,[10,11] in practice routine screening is uncommon.[12-18] Many barriers exist: lack of physician training and time, few local resources for victims, concerns for personal and patient safety, complexity of the problem, and personal discomfort and concern for patients' discomfort.[11,12,15,19-24] Most physicians believe that abuse is not common in their practice[21,22,25] and that screening questions will damage the physician-patient relationship among patients who are not victims.

Most researchers addressing the patient's perspective on physician screening and intervention have queried samples of self-identified battered women.[26-30] Fewer have surveyed nonvictims.[16,31,32] Only 1 study included men,[31] and only 1 used open-ended questions assessing 16 female nonvictims' opinions.[32] Findings show that women who are victims of violence want routine screening for victimization, compassionate support, respect for autonomy, and practical assistance in the form of safety planning and referrals.[26-30]

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Among patients who are not abused, 78% to 99% generally have positive attitudes toward routine screening.[16,31,32]

This study addresses gaps in understanding about patients' views on physician screening and interventions with family violence and conflict. First, we selected a unique sample: (1) adult primary care patients, (2) men and women, and (3) abused, abuser, and not abused. Further, we elicited patients' opinions on screening and intervention using patients' own words. The primary aim of this study was to determine patients' attitudes toward and experiences with family conflict screening and intervention by family physicians. The secondary aim was to evaluate the associations among patient sex, age, relationship status, victimization experience, and those attitudes. Finally, these data allowed us to examine the views of specific subsamples of patients: victims and perpetrators of violence, and patients who preferred not to be screened.

METHODS

Setting

The South Texas Ambulatory Research Network (STARNet) is a practice-based research network of private family practices in San Antonio, Texas. Introducing a study of intimate partner violence engendered a varied picture of enthusiasm and discomfort among network physicians. Several opted not to participate in this project, primarily because they believed their patients would be offended by questions about family violence. In contrast, 6 physicians offered enthusiastic support, providing input into survey questions, response options, and data collection procedures that protected the privacy and safety of the patient.

Table 1. Respondents' Attitudes About and Experiences With Physician Interventions for Family Conflict

Questionnaire Item	n (%)
Should family doctors ask patients about family conflict?	
Never	6 (2)
Sometimes	170 (67)
Often	74 (29)
Can family doctors be helpful to patients with severe conflict at home?	
No	14 (6)
Yes, sometimes	168 (66)
Yes, very helpful	68 (27)
Has your doctor ever asked you about conflict in your family?	
No	172 (68)
Yes, one time	48 (19)
Yes, more than once	29 (12)
If yes, did he/she help you?	
Did not help	24 (33)
Did help	48 (67)
Has your doctor ever recommended that you go to a counselor or therapist for help with family problems?	
No	219 (87)
Yes	28 (11)

Procedure

The study was approved by the Institutional Review Board of the University of Texas Health Science Center in San Antonio. STARNet physicians agreed to sample 50 consecutive adult patients aged 18 to 64 years. As patients checked in with the receptionist, they received a packet entitled "Family Conflict in Family Medicine." The packet included a brief anonymous questionnaire, a short list of community programs that addressed family violence, and an envelope addressed to the principal investigator. Investigators provided the list of family violence programs as a resource for patients who were concerned about their own family situations. Patients completed the questionnaire in the waiting room or the examination room, sealed it in the envelope, and returned it to the receptionist. The practice returned sealed envelopes to the investigators; physicians and clinic staff did not see the individual responses. Two hundred fifty-three consecutive patients returned questionnaires. Practices reported that only 2 patients refused to participate.

Measurement

The first half of the questionnaire elicited demographic information, relationship quality, and relationship violence. The Dyadic Consensus Scale[33] addressed relationship quality. Thirteen items assessed partner agreement on a variety of lifestyle issues, such as finances, major decisions, household tasks, and career. Responses were coded on a Likert-type scale, with high scores indicating high consensus. Relationship violence was assessed using a short form of the Conflict Tactic Scales.[34] Six items addressed the respondents' violent behaviors toward their intimate partner, and 6 addressed the partners' violence toward the respondent. The set of responses was coded as no violence, moderate violence (hitting or pushing), or severe violence (punching, kicking, beating up) occurring within the past year or within one's lifetime.

The second half of the questionnaire focused on physicians' efforts to intervene with family conflict. To avoid the stigma and controversy related to the words "violence" or "abuse," (which caused discomfort to several STARNet physicians), the investigators and participating STARNet physicians selected the following more general terms: family conflict, family stress, and severe family problems. Five closed-ended questions addressed patients' opinions about and experiences with physician interventions for family conflict (Table 1). Two open-ended ques-

tions elicited more specific responses: "What advice do you have for physicians who want to help patients with severe family problems?" and, "How has your doctor helped you with conflict in your family?" The questionnaire closed with an additional opportunity for general comments.

Analysis

This report includes descriptive statistics of all the major variables in the form of proportions and means. In addition, with attitudes toward and experiences with physician intervention as dependent variable, investigators assessed the influence of age, education, patient sex, relationship status, and victimization experience using Student's *t* tests and χ^2 analysis.

Investigators analyzed responses to open-ended items using an editing-style qualitative method.[35] The 4 investigators independently read all respondents' answers to open-ended questions and sorted text units into meaningful categories that related to the central question: "What do patients want family physicians to do with/for patients experiencing family conflict or violence?" Investigators then met to identify, summarize, and find consensus on central issues that emerged from the responses. These issues comprised the codebook. Using these codes, the investigators returned to the data and recoded each response. Discrepancies between coders were resolved through group consensus. Trustworthiness of the analysis was strengthened by the diversity of perspectives of the research team, which included 2 family physicians, 1 social scientist, and 1 health educator; 3 women and 1 man; and 1 Mexican American and 3 nonHispanic white members. The search for disconfirming evidence included a specific examination of subgroups of respondents who had a unique perspective on physician screening for family conflict: self-reported victims and perpetrators of violence, and respondents who preferred not to be screened.

Table 2. Demographic Characteristics of the Sample, N = 253

Characteristic	n (%)
Sex	
Female	169 (67)
Male	84 (33)
Ethnic group	
White	185 (73)
Hispanic	54 (21)
Other	14 (5)
Relationship status	
Married	186 (73)
Important relationship	217 (86)
Education level completed	
Grades 1 to 11	23 (9)
12th grade	83 (34)
Some college	80 (32)
College	41 (17)
Graduate school	20 (8)
Mean number of children	1.9
Standard deviation	1.3
Range	0 to 6
Number with no children	50 (20)
Mean age, years	40.2
Standard deviation	11.2
Range	18 to 64
Mean number of clinic visits in past year	3.6
Standard deviation	3.7
Range	0 to 20
6 or fewer visits	232 (89)
Reason for today's visit	
Prevention	36 (14)
Acute problem	101 (40)
Chronic illness	61 (24)
Mental health or stress	4 (2)
Accompanied patient	46 (18)

RESULTS

Demographics

Six STARNet practices returned 253 completed questionnaires. Most respondents were nonHispanic white and female. The average age was 40 years, and average education was beyond high school. Two hundred twenty respondents were in "important relationships," either married, cohabiting, or partnered living apart. The survey item did not ask the respondent to specify whether the partner was same-sex or opposite sex (Table 2).

Experience With Partner Violence

Among 142 women currently in important relationships, 16 (11%) had been hit or hurt by a partner in the past year. Fifty women (35%) had been hit or hurt in their lifetimes. Among 78 men currently in important relationships, 5 (7%) had hit or hurt their partner in the past year, and 12 (16%) had hit or hurt someone in their lifetimes. Among those 220 in relationships, 20 men (26%) and 59 women (42%) reported current or lifetime physical violence in their relationships, either hurting their partners or being hurt or both.

Physicians' Interventions With Family Conflict

Although nearly all respondents believed physicians should ask about family conflict, and that physicians could be helpful (Table 1), only one third reported that their physician had ever asked them about family conflict. Among those who were asked, two thirds believed the physician was helpful. Eleven percent had been referred to a therapist for family problems.

Table 3. Advice to Physicians: Communication

Advice	Recommendations*
Ask	Ask!
	Ask—get involved
	Be assertive in looking for problems
	Probe and ask
	Don't let them lie about it; get to the bottom of it
Listen	Listen!
	While the doctor cannot be a cure-all, a sympathetic ear helps a lot
	Be willing to listen if you ask. Take time to hear it out
	Listen to what people aren't saying
Other communication skills	Be objective
	Establish comfortable relationship first
	Ask if they can help, but do not insist or demand
	Keep talking on equal grounds
	Don't look down on patients
	Don't try to take sides based on one person's input

* Includes illustrative, verbatim quotes from patients' open-ended responses.

Correlates of Physician Interventions

Clinic utilization and physicians asking about family conflict were positively associated ($F = 6.65$, $P = .002$). Patients who had not been asked about family conflict reported an average of 3.1 visits in the past year, compared with those who had been asked once (mean 4.4 visits in past year) and those who had been asked more than once (mean 5.6 visits in past year). Physicians were also more likely to ask about family conflict if patients had a history of violence in their relationships. ($\chi^2_1 = 4.78$, $P = .029$) Physicians addressed the issue of family violence with 21 of 50 female lifetime victims of violence (42%) and 5 of 12 male lifetime perpetrators (42%) compared with 36 of 141 respondents who reported no history of violence (26%).

Physicians were more likely to provide referrals for family conflict to unmarried than to married respondents ($\chi^2_1 = 3.86$, $P = .049$) and for respondents with low relationship quality, measured by the Dyadic Consensus scale ($t = 4.12$, $P = .000$). Nonsignificant associations also indicated that physicians were somewhat more likely to refer women ($P = .085$) and younger respondents ($P = .078$) for help with family conflict. Respondents with a history of violence in their relationships were more likely to receive a referral (24%) compared with those who reported no violence (3%) ($\chi^2_1 = 24.96$, $P = .000$). Physicians referred 14 of 50 female victims of violence (28%), 2 of 12 male perpetrators (17%), and 4 of 141 no-violence patients (3%).

Table 4. Advice to Physicians: Assistance

Advice	Recommendation*
Referrals	Refer to therapists
	Severe family problems should be referred to experts on family problems
	Give them a name of a counselor over and over
	Offer alternatives, therapy, or safe place
	Don't do it by yourself; get others to help you and stand behind you
Offer advice	Give advice
	Tell them options
	Don't be afraid to suggest solutions, even if the person acts uninterested
	Ask them to bring God and morality back into their lives
Help	Help them
	Offer help if they can't go to someone else
	Make sure to give them help, and have 1 to 3 follow-ups with the patient
	In mild cases offer help, in severe cases contact police
Support	Provide support
	Offer emotional support, educational information about family problems
	Give support and let the patients know they are not alone
Medicines	Medicate or talk to them
	Dispense medication carefully
	Recommend counselors or medicines

* Includes illustrative, verbatim quotes from patients' open-ended responses.

Patients' Advice to Physicians

Among 253 respondents, 142 (65%) provided open-ended responses to the question: "What advice do you have for doctors who want to help patients with severe family problems?" The qualitative analysis of these responses revealed 3 major themes: (1) communication, (2) assistance, and (3) cautions and encouragement. These themes are described below and are illustrated in Tables 3, 4 and 5.

Communication was a key issue in this study, with particular emphasis on asking and listening. (Table 3). Respondents instructed physicians to ask about family problems and to listen to the stories. Furthermore, they advised specific communication strategies that build good physician-patient relationships. Seventy respondents wrote a comment related to communication.

Within the assistance theme, the most frequent advice from respondents was, "Make referrals." Fifty-five respondents included a comment about referrals. Fifty additional respondents recommended giving advice, help, support, and medications (Table 4).

Finally, respondents provided both cautions and encouragement to physicians (Table 5). Cautions included training concerns, skill levels, and time limitations. Encouragement responses tended to be generic but motivational.

Table 5. Advice to Physicians: Cautions and Encouragement

Advice	Recommendations*
Cautions	Be careful what advice you give
	How would the Dr. know if they should help or if it will just get worse?
	Make sure they have training with human behavior before helping†
	Good luck! It's really tricky to know what people think and feel†
	Most doctors, in my opinion, don't have the time
	You have to be ready to deal with whatever comes up†
Encouragement	Get involved!
	Keep on trying and good luck!
	I think it's very important
	It's fine with me
	I think it's a great idea because …

* Includes illustrative, verbatim quotes from patients' open-ended responses.
† This advice was provided by male perpetrators of partner violence.

Advice From Specific Subgroups

Investigators examined the responses from patients who might be particularly sensitive to questions about family conflict: (1) 6 patients who believed physicians should not ask about family conflict; (2) 11 women who reported being hit by their partner in the past year; and (3) 6 men who reporting hitting their partner in the past year.

Among the 6 who believed physicians should not ask about family conflict, 4 were men, 5 were married, 5 were non-Hispanic white, and 2 were college graduates. Three provided advice for physicians that included recommendations for assistance, communication, and referrals. Two made positive comments: "Sounds like the doctor is interested in us," and "Didn't mind answering the questions."

Among 12 women who had been hit or hurt by their male partners in the past year, all believed physicians should ask about family conflict. Seven provided advice about making referrals, providing information, following up, and getting involved.

Among 5 men who had hit or hurt their female partners in the past year, all believed physicians should ask about family conflict. One advised simply, "Listen." Two commented, "Good luck." Three provided cautionary advice, displayed in Table 5.

DISCUSSION

In this sample of private family medicine patients and their families, nearly all (97%) believed physicians should ask patients about family stress and conflict, and most (94%) thought physicians could be helpful. Even those reporting a history of relationship violence—perpetrators as well as victims—believed physicians should ask. One might expect that perpetrators of violence would find physicians' questioning to be intrusive; in fact, respondents expressed some caution (Table 5), but all agreed that questioning was part of the family physician's job. Among the 6 respondents who thought physicians should never ask about family conflict, 2 provided open-ended responses that implied the opposite: "Good! Sounds like the doctor is interested in us emotionally."

As in previous studies[7,25] these physician volunteers did not universally screen patients for family conflict or violence. Only one third of the respondents remembered ever being asked about family conflict by their physicians. This number is 2 times higher than other reports of violence screening among uninjured patients in primary care settings,[12-14] however, which might suggest these physicians are more comfortable with emotional issues than the average practitioner. Physician screening for family conflict reflected attentiveness to patients' life stresses. Patients with low marital quality or violence in their lives were significantly more likely to be asked about conflict and referred for counseling.

With input from the participating physicians, we elected to use the term *family conflict*, rather than family violence or intimate partner violence, and this choice of terms may have influenced respondents' opinions about the physician's role. Even so, the context of the study probably shaped respondents' working definition of family conflict. The survey packet included many references to family violence: the enrollment script, the referral materials, and the questionnaire itself. The 12 questions addressing physically violent behaviors immediately preceded items about physicians asking about family conflict. Thus investigators intended to lead respondents to consider violent behaviors as part of the package of family conflict. The term *family conflict* has an advantage in its universality. Because nearly everyone has experienced family conflict, the term is less stigmatic, making the job of study enrollment and engagement easier, for both physicians and patients. Further, we believe it provided an opportunity for patients with no violence experiences to contribute their thoughts in a genuine way.

This cross-sectional research design has limitations. One limitation is physician self-selection. The physicians who participated may have patients who intentionally seek health care from someone who is comfortable discussing emotional issues. Thus their approval rating for physician interventions for family conflict would be high. The sample may be further

limited by patient selection bias. Although clinic staff reported compliance with study protocol and documented only 2 refusals, our research team was not available on a daily basis to oversee the procedures. Clinic personnel might have excluded patients who would have strong objections to survey content, which would further inflate the approval rating. A high approval rating, however, is consistent with previous studies of abuse screening, which found 78% to 99% positive attitudes among patient samples.[16,31,32] An additional limitation is self-report. Perhaps patients responded positively to "should doctors ask …?" and "can they be helpful?" in an effort to maintain a positive physician-patient relationship. Investigators attempted to minimize this bias by providing protections for privacy. If a halo effect did occur, it was not reflected in every question. Only 31% responded positively to "Has your doctor ever asked you about family conflict?" Self-report questionnaires have other limitations that are well-documented. Patients tend to underreport health care utilization and victimization experiences when compared with other data collection methods.[36,37]

This study was originally designed to respond to physicians' discomfort with talking to patients about violence. We elicited input from a general patient sample who had varying experiences with violence: no violence, victimization, and perpetration. We learned what patients wanted from their physicians, in patients' own words: ask about family conflict, listen to patients' stories, and provide information and referrals. These are straightforward skills that are well within the domain of family medicine training. Unfortunately, little is known about the effectiveness of these efforts.[38] How helpful is screening and referral in reducing somatic and mental health symptoms in victims of violence? Can family physicians influence perpetrators to stop hurting others? Future research will examine the outcomes of violence prevention efforts in health care settings and inform family physicians' efforts to keep families safe.

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