How doctors should react to domestic violence

A palpable alarm echoed throughout Hong Kong when two young children were chopped to death and another critically wounded by their father before he hanged himself on 20 January 2002. Domestic violence in the form of homicide, suicide, spouse battering, and child abuse are among the most common social and mental health problems worldwide.[1] Such incidents are but the tip of an invisible iceberg of less severe domestic violence, suicide attempts, and emotional distress. The latter, recent research confirms, clusters with psychopathology, which may in turn fuel domestic violence. In a meta-analysis conducted, the prevalence of mental health problems among battered women was 63.8% in 11 studies of post-traumatic stress disorder (PTSD)—a psychophysiologically distressing anxiety disorder that follows exposure to a major traumatic stressor—47.6% in 18 studies of depression, 17.9% in 13 studies of suicidal behaviour, 18.5% in 10 studies of alcohol abuse, and 8.9% in four studies of drug abuse.[2] Homicide, followed by suicide and parasuicide, seems particularly common in Asian societies where the restrictive welfare system and moral values pertaining to filial piety and intra-familial dependency contribute to distressed individuals' decision to die in tandem with their family members. Historical accounts bear witness to this long-standing pattern in Chinese communal life.[3]

Domestic violence is multifactorial in origin. Although robust community-based incidence rates are lacking, the aftermath of the Asian economic depression has noticeably exacerbated the problem in Hong Kong.[4] There is increasing public recognition that emotional well-being is an essential constituent of a person's health. This perspective is, to borrow our own jargon, 'evidence-based'. Negative mood states such as anger, shame, and depression fuel impulsive aggression that can turn 'outward' to become brutality, and/or 'inward' to cause suicide. Like emotional illnesses, aggression is linked with external stressors as well as central serotonergic dysfunction.[5] Studies have demonstrated that some 90% of suicides are caused by treatable emotional illnesses, predominantly depression.[6] As a group of world experts has concluded: "Suicide is a preventable mode of death. Some, perhaps a great deal, of suicide behavior can be prevented through the provision of broad-based supportive and rehabilitative services to persons at risk and other affected persons".[7]

Domestic violence, including suicide, is not caused by a momentary impulse. Often it is both preceded and followed by emotional distress,[6] the reduction of which may prevent serious violence from occurring.[2] Unlike severe mental disorders, emotional illnesses such as anxiety and depression are common worldwide, with about 15% of those who are severely depressed eventually killing themselves.[1,8] The World Health Report points out that one in four people will experience mental health problems at some point in their lives, but the magnitude of the burden is not matched by the size and effectiveness of the response.[9] Apart from limited access to psychiatric services, two entrenched myths deter emotionally distressed individuals from seeking professional help. One is that people who seek such help are crazy, dangerous, and to be avoided. The effect of this stigma is real, with mental health service users widely discriminated against at work, in interpersonal relationships, and even by health care professionals.[10] The other myth is that mental health problems are 'all in the mind' of inherently weak individuals or transitory responses to unfortunate circumstances. This perception is hardly evidence-based. Advances in neuropharmacology have amply demonstrated that emotional illnesses have no fewer biological substrates than chronic physical diseases. They are just as, and often more, likely to respond to medical therapy. Full restoration of psychosocial function and long-term wellness are common.[11]

Doctors can play an important role in the treatment and prevention of suicide and other forms of domestic violence. A heightened level of awareness and a vigorous endeavour to network and refer patients is fundamental. Emotional illnesses such as depression and PTSD usually present with physical idioms of distress. Depressed patients spontaneously complain to doctors of somatic symptoms such as insomnia, headache, chest discomfort, and/or fatigue.[8] Likewise, although patients with PTSD suffer intense fear, helplessness, anger, and intrusive recollections of the traumatic events that brought about their illness, musculoskeletal and neurological symptoms such as headache and respiratory discomfort are common presenting symptoms.[12] In children too, depression and PTSD may simply present as somatic symptoms, disorganised behaviour, agitation, or deterioration in school work. Consequently, unless doctors ask the right questions in the right manner, they will not elicit psychological symptoms and causes. Intervention will cease at the stage of symptomatic treatment, typically tranquillisers and analgesics. Contrary to popular belief, individuals with emotional illnesses readily reveal suicidal symptoms upon being questioned. Tellingly, over 50% of those committing suicide have seen a general practitioner or medical specialist within the month before their death.[13]

In more severe cases of spouse or child abuse, doctors should watch for signs of unconventional fractures and bruises during physical examination. They must also perform a psychosocial evaluation. Because of the fear of retribution and/or financial insecurity, victims are often not ready to 'break the silence'. They may be reluctant to disclose the real cause of injuries, or to leave their violent partners for a new 'normal' life. Depending on the individual situation, doctors should involve other disciplines such as social workers, clinical psychologists, teachers, lawyers,

and/or the police in evaluation and management. A cautious balance between intervention and the protection of patients' well-being and future safety is essential.[14]

On a preventive level, doctors can also help patients with emotional distress. The timely prescription of a mood-modulating agent and stress management techniques may reduce subjective distress and hopelessness, thereby preventing violent events from occurring. Where necessary, an urgent referral to a psychiatric clinic can be made. Public psychiatric clinics now operate a triage system that grants priority to such patients. To enhance professional communication in the interest of the patient, it is useful to make a personal phone call to the psychiatrist in charge. If a patient declines to visit a psychiatric clinic, referral to a physician or other health professional in the primary care setting who can offer effective pharmacotherapy or quality psychotherapy for emotional illness is a helpful alternative. Unlike the older generation of antidepressants that are lethal in overdose and prescribed in subtherapeutic doses, the new generation of mood modulators such as the selective serotonin reuptake inhibitors (SSRIs) are now safely used by general practitioners worldwide.[15,16] These are effective not only in depression but also a broad spectrum of other emotional illnesses. For example, they are valuable for controlling the intrusive, avoidance, and hyperarousal symptoms of PTSD,[17] which is exceptionally common among victims of domestic violence.[2] Compared to the benzodiazepines, they have a later onset of action of 1 to 2 weeks but can bring about clinical remission rather than a partial symptomatic response. The risk of inducing dependence, tolerance, and behavioural dysfunction is also much lower. Even in the West, the rate of detection of domestic violence by doctors is often low. This is especially true of older and male doctors. However, focused training may enhance doctors' and nurses' ability to identify and record the psychosocial aspects of domestic violence and to refer the victims to the appropriate services.[18,19] Since most emotionally distressed individuals approach primary care practitioners first, the need for training that allows the treatment of emotional illnesses to be integrated into primary care can hardly be overemphasised.[9]

Domestic violence is a clinical as well as a public health problem of widespread consequence and does not belong to the domain of mental health professionals alone. At the clinical level, more doctors can identify and treat victims of domestic violence and help prevent tragic outcomes from occurring. At the public health level, are doctors ready to become leaders in the multidisciplinary approach to domestic violence and other problems of emotional health in Hong Kong? At present, one person dies from suicide every 10 hours, but the public health response of the medical profession has been very limited. Social workers have made a much louder voice after publicised incidents of suicide and domestic violence. They have acquired new government funding for crisis intervention programmes, even though the evidence for using a social work approach to effectively reduce domestic violence is unclear.

Traditionally, medicine in Hong Kong has favoured the development of high-tech specialist care rather than primary care and public health remedies. To engage domestic violence is to require ourselves, as a profession, to rethink what health and medicine should encompass in 21st century Hong Kong.

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