

*Women and domestic violence in the professional experience of Italian general practitioners (IGP)^{*1}*

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Summary. A number of studies have investigated the roots of the destructive power acting within the couple (Welzer Lang, 1991; Walker, 1979, 2000). Danis and Lockhart (2003) highlighted how social workers' best practices, are not frequently used, especially in regards to contact with the victims of intimate-partner violence. We investigated how Italian general practitioners (IGPs) deal with this issue within their professional practice. A snowball sample of 268 IGPs was taken, in order to collect their beliefs concerning the victim, the aggressor and the violent couple's relationship. Furthermore the experience in coping with both suspected and actual cases of domestic violence, as well as the GP's needs and expectations was taken in consideration.

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National and international reports are raising the alarm about the violence perpetrated against women by their partners and the inability of social and health services to reduce it (Istat, 2009; Italy, “Dipartimento delle pari opportunità, Presidenza del Consiglio” 2001; WHO 2005; Eures Ansa, 2009; CEDAW: Shadow Report, 30 years of application in Italy, 2011). This is, actually, a phenomenon which most often occurs within the privacy of the home, and engenders victims from every social class and educational background (Istat, 2009).

Several studies have investigated in particular the roots of destructive power acting within the couple and the family. These studies have explored the cyclic dimension of the violent dynamics that characterize the man-woman relationship (Welzer Lang, 1991; Walker, 1979, 2000). In turn, other authors have identified the psychological and physical manifestations used by the victim to ward off their partner’s attacks (Cantin, Rinfret-Raynor, & Fortin, 1994; Baudier, 1997; Souffron, 2000). Also, they have tried to understand what kind of relational structures, mechanisms and symmetrical positions both the victim and the aggressor adopt (Racamier, 1992; Eiguier, 1999; Filippini, 2005; Hirigoyen, 2006, Baldry, 2006; Romito, 2000). In spite of these complexities, the media, however, describe the phenomenon of violence against women only in terms of exceptional cruelty, drawing attention to the number of victims, the aggravating circumstances (only to name a few), instead of taking into account its silent spread and pandemic nature. One might well wonder how the domestic nature of such a widespread phenomenon can be invisible both to the public and to social workers and health workers.

Albeit violence against women is now considered a public health crisis both in Italy and in other Countries, it is still not appropriately recognised, nor properly managed, (Scaricabarozzi, 2011). Notwithstanding the variety of interventions (Olson et al., 2004; Kearns et al., 2008; Stevens, 2002) preventions, education and awareness-raising programmes proposed and implemented by the social and health services of many governments, this issue still remains in large part unresolved (Short, Johnson, Osattin, 1998; Garcia-Moreno et al., 2002; Jewkes, 2002; Weiss, 2000). In this regard, Danis and Lockhart (2003) highlighted how best practices and individual and organisational empowerment strategies adopted by social workers with victims of domestic violence are not very widespread. By contrast, there is now greater pressure inside the health care system to consider violence against women as a very urgent problem (Minsky-Kelly et al., 2005).

In Italy, for instance, the Department for Equal Opportunities (2001) has undertaken research on the functioning of helplines for victims of domestic

violence. Women's associations and social action groups are also promoting awareness and social responsibility with specific regard to this topic: see, for example, the *D.i.Re: Donne in Rete contro la violenza* centres network, set up within the DAFNE-EU project (www.direcontrolaviolenza.it). Reale (2011) has underlined the inability of hospital emergency units to cope with the problem of gender violence, in supporting women who want to file a report against the aggressor. Both Ferrari Bravo (2012) and Di Napoli (2012) have investigated how non-dedicated services act towards women that are victims of family violence. These authors have showed the existence of a lack of intervention protocols shared by social, health and justice services as well as a lack of timely, effective prevention, support, protection and management treatments. There is, actually, a wealth of studies and research projects regarding violent couples, but the relationships between a victim willing to share her story of violence and the network outside the family which she went to for help are still for the most part understudied.

The Family Violence Policy Statement (NASW, 2003) itself, where domestic violence is indeed included, does not provide the social workers with any specific, shared guidelines on how to deal with cases of domestic violence against women.

The necessity for greater support over and above the institutional support given to victims of intimate-partner violence is confirmed by the victims' perception of the service workers. In fact, the latter are described very often as "prohibitive", rather than as supportive figures (Kanuha, 1998); who blame the victim rather than supporting her (Bass, Rice, 1979; Davis, Carlson, 1981); also, they are mainly perceived as more concerned of protecting themselves behind an alleged *neutrality* rather than taking a well-defined, responsible stance against the violent act (Eisikovits & Buchbinder, 1996).

In particular, research highlights a trend among health workers to ignore the violence or, to be more precise, to avoid assuming responsibility towards the victims (Gerbert et al., 2002; Hanvey & Kinnon, 1993; Thurston, Cory, & Scott, 1998). This inability certainly points to an emotional difficulty in dealing with domestic violence.

Moreover, more studies demonstrate that there is an impossibility to diagnose with certainty the physical and psychological abuse in victims of violence and that this is a shared belief among both health workers in general and general practitioners in particular (Abbott et al., 1995; Ferris, 1994).

In this regard, Haj-Yahia and Aynur Uysal (2008) have stimulated the interest of scientific research in pointing out the importance of young physicians' beliefs. The latter can be considered, indeed, as a starting point for identifying and constructing helpful guidelines to give an adequate response to victims of violence.

In Italy, Arcidiacono and Di Napoli (2012) have explored how physicians and parish priests deal with violence against women within either their professional or pastoral practice. The results showed two different stances: parish priests stress the importance to lend an ear to the victim, whereas the physicians seem to be more oriented towards providing information and services in order to give the victim a chance to draw out the violent dynamic all by herself.

Through this evidence, we cannot help to stress the reason for the underlying complaints by women victims of domestic violence is valid along with complaints about the management of this situation by health services that are scant in number and quality (Istat, 2009). On this account, this paper shall investigate how Italian general practitioners (IGPs) deal with this issue within their professional practice.

GPs, commonly known as *family doctors*, offer first-level medical assistance either at their office or through home visits in a given area assigned by the Local Health Service (in Italy, ASL). Therefore they can be considered as the first institutional point of reference for people's psycho-physical wellbeing.

Our contribution intends to stimulate a reflection (Schön, 1993) both on the IGPs' perception and the stance they adopt, towards the management of domestic violence against women.

Research

First and foremost, Italian GPs, according to their specific role, are supposed to be careful and observant figures of the physical and psychological aspects which influence the entire family. Therefore, we focused our attention on the following features, in order to highlight what contributes to the perpetration of silent violence against women within the health care system, that is:

- a) opinions and beliefs concerning the victim, the aggressor and the violent couples relationship;
- b) experiences in dealing with cases of domestic violence in the context of an office environment;
- c) expectations about the collaboration with social and health services; and GP's needs and expectations in coping with both suspect cases of domestic violence and those which they have taken care of already.

Methodology and participants

268 IGPs were contacted by means of snowball sampling, only 205 of them agreed to be interviewed. The group (average age 54.73) includes both men (76%) and women (only 24%), with participants who have been

working in this field from a minimum of 3 to a maximum of 47 years. Less than half participants (109) work in the city of Naples, whereas the others work in the surrounding provinces.

ASL N°1 Centro General Practitioners (Iaccarino & Boschi) collaborated in recruiting the physicians, the latter was involved both in deciding what questions to raise in the interviews as well as discussing the results of the data.

In specific, the physicians underwent an in-depth interview (Arcidiacono, 2012) developed to explore the opinions, beliefs and assistance styles experienced within their professional practice. Clearly, particular attention was given to those aspects which characterize violence against women.

By recalling a case of violence encountered during one's professional life, the interviews also explored both the role effectively played by the doctors and the desired one.

The physicians were interviewed after filling out a self-report questionnaire on the evaluation and management of domestic violence. The latter's results have been described elsewhere (Di Napoli *et al.*, 2012).

The text material has been analysed by means the Grounded Theory (GT) methods. Grounded theory is a qualitative method of research which provides a systematic interpretation of a given phenomenon and of its underlying processes (Corbin, Strauss, 2008). The hallmark of Grounded Theory methods consists, in the first step, in identifying a series of categories characterized by a low degree of abstraction. Subsequently more concepts with a higher degree are constructed in order to get to the core of the phenomenon. "The researcher analyzes data by constant comparison, initially of data with data, progressing to comparisons between their interpretations translated into codes and categories and more data. This constant comparison of analysis to the field, grounds the researcher's final theorizing to the participants' experiences" (Mills, Bonner, Francis, 2006).

Usually, a Grounded Theory analysis starts from a question to which the pre-existent theories have not been able to give a satisfactory answer. This gap in the literature is filled examining a series of processes in a well-defined situation inside a given local context. Therefore, this specific method of research has the purpose of deepening and orientating consequent actions (Charmaz, 2006). Subsequently, the data is processed in order to obtain one or more core categories. Core categories aim to construct a more general theory which highlights the network of relationships and meanings operating within the specific phenomenon. We might say, therefore, that core categories are the backbone of Grounded Theory methods. Indeed, they have the fundamental aim to integrate and bind together all those aspects bearing on the new formulated theory.

In regards to the textual analysis of the interviews, the latter was processed by the Atlas.ti software (Muhr, 1994), one of the best well-known computer-assisted qualitative data analysis systems (CAQDAS).

Results

The first phase of the textual analysis identified 79 codes subsequently assembled into 4 macro-categories, as follows:

- Diagnosis: time as an obstacle in identifying history of violence;
- Isolation and difficulty in dealing with the domestic violence;
- GPs' perception of new contexts and forms of domestic violence;
- The wife/mother generative function in re-launching family bonds

1. Diagnosis: time as an obstacle in identifying history of violence

1.a) Physical symptom as a gateway to history of violence

The majority of physicians interviewed reported they have little or, in some cases, no direct experience of accounts of domestic violence. The interviewees themselves believe that, because of the large number of patients, they don't have enough time to recognize eventual signals and indicators of violence. Indeed, according to the GPs, their privileged position in the observation of family dynamics often loses its merit: this is again due to the large number of patients which frequently reduces the time employed in listening and hosting the victims of violence.

...Nothing in particular. Having never had these kinds of experiences, I could not say (F, age 57, 32 years of service).

...The problem is that, having 1600 patients, (...) there is no evident case (M, age 61, 36 years of service).

According to physician' experiences, rarely do victims of violence spontaneously tell their history, nor explicitly ask for help. Some interviewees told us that they only discovered the incidences of violence only after a deeper investigation of certain unusual physical manifestations. This gave some victims the chance to share and talk about their experience.

...I have been to this patients house. As I spotted some bruises on her body I asked her the causes. She was expecting me to solve the problem from a medical perspective. I asked her instead: "How did you get these bruises?" At that point she took heart and, bursting in tears, told me her husband had beaten her... Then I encouraged her to contact the relevant services. She did, and this case is now completely solved: they got a

divorce and this young woman is now free. What is striking is that she had been victim of this violence, this beating for a long time. Unfortunately, I only came to know about the situation on that particular occasion. Before then she had never given me any clues (F, age 56, 30 years of service).

According to one of the interviewees, symptoms affecting the stomatognathic system, represent one of the possible alarm bells: the stomatognathic system is indeed, considered to be the seat of woman's emotional malaise, certainly for victims of domestic violence as well.

...The reason is that woman's hormonal status is much more absorbent if compared to men's ... while males are reactive when they get pissed off, females absorb instead ... this absorption of all the tensions entails an emotional stress on the stomatognathic system; what does this stomatognathic system has to do with sexual violence? ... during a research, when we asked these women precise questions, ... we noticed how their state of mind was mainly due to domestic violence (M, age 46, 17 years of service)

1. b) GP: a control tower upon patients' families

The physicians interviewed described themselves through the metaphor of the "control tower" upon their patients' families. They especially stress the fact that being considered trustworthy gives them the opportunity to have easy access both to the families and couple's histories.

... A GP is a careful observer. He gets into the home, or better, into the 'bedroom' of every family (F, age 54, 30 years of service)

The interviewees perceive themselves as interlocutors mainly chosen by young victims. Most likely, this happens by virtue of their believed "scientific" outlook, considered lack of prejudice or emotional involvement:

... A GP can often get in touch with young ladies who are frequently ashamed in facing the issue not only with their relatives but even with their priests. Thus, the role of a GP is extremely important in this kind of situations (M, age 59, 35 years of service).

The chance of a global view upon the family dynamics recalls a sense of social responsibility in reporting, even though anonymously, severe cases of violence often hardly discerned within the patchwork of families' life. A complaint would be useful not only to protect women, but also individual families along with the whole community.

However, many interviewees state how the purpose of some colleagues is instead to preserve the family's integrity rather than spur the victim to file a

complaint. Unfortunately, this often accounts for harmful consequences for the victim's life.

... A physician is like the family confessor because he knows their whole history, the whole clinical and psychological aspect of his own patients. Physicians is meant to report, maybe in a confidential way, I mean, surely in a confidential way, then social services are meant to become active (M, age 49, 23 years of service).

... Some physicians do not file a report out of fear, thinking that this could be the best way of saving a family. But we found out that statistically violence escalates and that eventually can lead to feminicide (F, age 54, 21 years of service).

To the difficulty perceived by doctors in reporting cases of violence is added the victim's difficulty, as they do not know whom to report the event. Like the victims, the doctors shared the feeling of an institutional resources and territorial services shortage for taking charge of the victims, and above all for their children.

... I think we would like to do a lot, but we do basically nothing. People who address me ask for advice, but I can see they're confused, and not ready to cope with what they should try to cope with. Victims tend to ask me: "What is going to happen to me after that?" "As I've been telling you this thing, what are they going to do to me?" "And then, what am I supposed to do; should I come to you again?" "I don't know where to go, don't know what to do!" This is, basically, the question (M, age 55, 27 years of service).

Which is why, several physicians are strongly requesting more women's refuges along with any other kind of support which might preserve a woman's dignity.

... A woman who files a complaint for the violent act should be guaranteed that she can bring her children with her. It must be so! So, it's clear that women's refuges are meant to be ready to receive both mothers and their children... Also we are carrying out a fundamental proposal for an economic law which would compensate women for domestic violence; in case of a full-blown history of ill-treatment, of course. These women are supposed to be compensated because that is the right way to give them back their dignity – not just hosting them in a protected facility (F, age 54, 21 years of service).

2. Isolation and difficulty in dealing with domestic violence

2 a) Need to be trained and feeling of powerlessness

A rebutting and disapproving reaction, toward any kind of violence, is a quite common attitude among physicians. The interviewees sense any

limitation of the other's freedom as well as the cowardice of some men who do not recognise their partner's subjectivity acting cruelly against her, as unconceivable and unbearable.

...I think violence must always be condemned, in any case. Not only violence against women, but also domestic violence in general, abuse of power, injustice on the workplace, as well as political, religious and social inequalities which often lead to discrimination (M, age 32, 2 years of service).

The physicians, however, clearly expressed the difficulty felt during their experience listening to the cruelty of the tales of violence. In all the interviews, the GPs denounce a lack of training on the theme of violence. This request stems from the feeling of unease and embarrassment they show in facing and investigating some *veiled* messages which may one think of a situation of violence.

... Maybe we should review some behaviour. Initially you don't think about certain aspects (...).maybe paying more attention to a word. We too should be able to catch any indirect, even tiny signal (M, age 38, 4 years of service).

The GPs feel a deep lack of information about the topic of violence, especially in regards to the couple's relationship. On this account they strongly request training which could satisfy that necessity.

This training could also provide them a chance to overcome the feeling of isolation sensed in facing cases of violence by sharing their experiences with both experts and colleagues.

... I would suggest that the refresher courses for GPs be provided with a specific part on the psychological aspects of the couple, and thus on domestic violence, and thus on violence against women (M, age 54, 24 years of service).

The GPs feel they could offer the victim all the assistance they can, such as a welcoming and emphatic environment able to ease all the pain and suffering the victim brings with her. Which is why, they stress so much on the ability to listen sensitively in order to grasp any possible reference to the violence, especially if expressed in a metaphorical way.

...Victim very rarely reports a clear abuse to a physician, because mainly she tries to make her understandable through metaphors, certainly not lodging a clear complaint (M, age 49, 20 years of service).

3. GPs' perception of new contexts and forms of domestic violence

3 a) Domestic violence contexts

The GPs interviewed believe that violence, physical violence in particular, lurks mainly in those families with low social and cultural conditions, where violent behaviours are often 'normalised' by a cultural system which allows men to have power over women. In such family circumstances, any intervention aimed both to interrupt and prevent the cycle of violence is doomed to fail. Within the couple, this particular social context recognises the man's right to be taken care of, persisting in demanding a disinterested, sacrificial attitude from the woman.

Some physicians even recall how, within small rural areas, the eldest of the family was in charge of initiating the pubescent girl to sexual life. That constitutes a heritage and a background which fosters the perpetuation of domestic violence's histories.

... Especially in rural areas where... as was the custom, the eldest of the family used to have the very first sexual intercourse with the pubescent girl... Thus, it seems to me so clear that, in my professional experience, that 70% of sexual violence cases against women befall within the family (M, age 46, 17 years of service).

Conversely, the GPs highlight how in couples with a medium socio-cultural level the violence is mainly psychological.

In pondering over the reasons behind the silence that conceals numerous cases – which will probably never be reported – the interviewees point to the complicated dynamics between the aggressor and the victim: they indeed hypothesise that the aggressor himself may have been a victim of violence during his childhood.

... Trying to understand the reasons why a certain act has occurred, so it is important trying to understand the history of the two actors involved – both the victim and the perpetrator (M, age 57, 30 years of service).

The GPs also stress on how women can often provoke men's violence, in particular when they elicit a sense of powerlessness, inferiority and/or instability from their partners. Or else when, for professional reasons, they do not perform their 'expected' role of mother and wife. The social climate claims the individual right to adhere to one's group's ethical norms, however – as the physicians themselves agree – within the couple and the family this cultural dimension clashes with the social and cultural determined, deeply-rooted expectations about the role of wife and mother.

... One of my male patients told me that once he had no option but beating his wife. She simply had left him with no other choice: she had exasperated him and put a strain on his nerves (M, age 57, 30 years of service).

... An adult woman – adult means to me over 20, 25 years old – can often be herself cause of her same violence: assuming an excessive childish, playful and eccentric attitude, not appropriate to her age for example. One of these attitudes can be misinterpreted, thus becoming cause for violence (F, age 60, 34 years of service).

... A woman has a fundamental role in the overall balance of the family and for their children's education as well; if a woman decides to undertake a career whatsoever which will keep her busy for longer than is needed to carry out her fundamental duty of "mother-educator-housewife", then she should not start a family at all (M, age 57, 30 years of service).

3 b) Women's violence, a new emergency

The evidence of the Physicians, shows that in many cases of violence they view the women as the aggressor.

According to some of them, as an "answer" to the feminine violence, which mainly manifests itself through exasperating and provoking behaviours, men have no option but to reply with a physical aggression.

...I've seen just one in my entire career. And I'm even divorced. I'd say that there are more women who make violence over men than men over women: that's my opinion. (M, age 56, 25 years of service).

For others, young males are frequently seen as victims of 'bullying' by their female peers who are described as sly and bossy.

... Sometimes we are witnesses of teenage girls who are leaders of a herd, whereas young boys are more ingenuous than the girls; the teenage girl is more...cunning, in my view. Thus, violence is not necessarily against women, but can be toward both sexes (F, age 60, 34 years of service).

4. The woman's generative function in re-launching bonds

The GPs also recognise the woman's crucial role in countering domestic violence. The interviewees seem to spur women to show a female gender image which recovers their value as creator of bonds, rather than perpetuate the stereotype of a woman as a mere sex object.

Women can therefore eradicate or, at least, reduce the violence they have been subjected to by virtue of their psychological features. According to the interviewees, the latter, not only distinguish them from men but make them emotionally more competent.

... I insist – Only a self-reliant woman can get out the circle of violence. It might be too all commonplace, but in my professional experience I always noticed that

women have never realised the powerful weapon they have. If they only got over the stereotype of sex object and stressed their psychological skills which are certainly equal to, if not stronger than, men's (M, age 52, 26 years of service).

According to the physicians, a way towards safeguarding from violence lies in valuing women's procreative function. However, this must be accompanied by better training, coordination of the police forces together with institutional services and local associations' support, all of which are unfortunately not efficient enough in dealing with taking charge of the victims.

5. The harnessed GP

Starting from a careful analysis of the interviews, the most representative categories and theoretical macro-categories revealed the relations among codes, categories, macro-categories, quotations and memos. Indeed a core category, which best expresses IGP's attitude towards domestic violence, has been extracted from data, that is: "IGP –harnessed observer". This category clearly expresses the difficulty the GPs have when they try to face the violence against women. The GP's perceive themselves as careful observers of the families they have taken in charge. Their being 'within' the families puts them in a privileged position compared to other social and health workers who are not directly involved in the family's daily live. The physicians get into the family life's secrets as professional onlookers, reducing in this way the distance between science, knowledge and family wisdom. However, this privileged position is likely to expose them to delicate, problematic family situations which they have no appropriate relational competences to deal with. In regards to violence against women, their observational role seems to lose all its power and accuracy.

In absence of emotional and training resources, the physicians attribute a redeeming power laying in the woman's role of mother and wife which, when invoked, would allow the victim of violence to re-establish the lost family balance. The GPs seem to view the responsibility of family care, socially attributed to the female sex, as an opportunity to transform the violence which women are subjected to into a new, loving and respectful family balance as if by magic.

The claimed lack of time and the necessity to take charge of a great number of patients seems to be an avoidant dimensions which shields them from listening to and getting in touch with cases of domestic violence; perhaps they conceal the physicians' emotional difficulty in getting into the most intimate dimension of the couple relationship.

The procedures knowledge and the network of services available at the local level, responds to the GPs' need to acquire a greater organisational

know-how. At the same time, however, the GPs call for an ad hoc training of the couple dynamics, which may help them to approach the family and the victim of violence's.

Discussion and Conclusions

What do the GPs' words tell us about violence against women? A lack of information on the spread and the causes of this phenomenon among health professionals once again comes to the fore. In fact, stereotypes concerning the cultural poverty of the social groups where violence against women is more common have been often found in many of the interviewees. What aroused considerable attention is the physicians' view of women victims of violence: the triggering event is immediately identified in the stereotype of woman as sex objects. However, they do not point out that the cause of that lies in the value that society attributes to the feminine sex of which men are bearer; to the contrary, they attribute it to the women and their inability to be respected. The GPs believe that the mother and wife role has a protective function from violence, without wondering nor facing the fundamental rights of individuals.

In addition, Tuccillo, Arcidiacono and Di Napoli (2012) highlight the intention of the parish priests to preserve the family bond at any cost, sometimes even at the price of a woman's resignation and acceptance of her partners' requests. On the other hand, even female physicians, likewise country priests, are bearers of the importance and vulnerability of the family bond. Conversely, in this study we showed how a certain background of emotional bonds can lead male physicians not to recognise the women's needs, almost accused of deliberately inciting the violence. Actually, two important factors emerge from the interviews. On one hand, a deep lack of awareness about woman's suffering, on the other hand, the negative effects of conflict on the family bond which lead to an alleged emphasis to the role of wife and mother, to the consequent detriment of respect for the family members' singularity, especially for the woman inasmuch as an individual with her own personal rights.

In terms of organisational tools, the GPs also report a lack of time and institutional support for women victims of violence, however, it would better be underlined the attempt to avoid emotionally intense dynamics. In fact, on one hand, all the interviewees emphasise the importance of their role within the health system as the first observers in identifying pathologies. On the other hand, they state their difficulty in detecting domestic violence. On the whole, they seem unaware of violence's effects on the psycho-physical wellbeing of the individual. Therefore, it would be necessary to work in close collaboration with professionals who are able to 'read' the psychic malaise. In Italy, the proposal to introduce psychologists in local services seems to work in this direction. Finally, a greater integration of the IGPs'

activities should be promoted with those of local services (family counselling centres and social services) and dedicated services (anti-violence support centres and associations).

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