ORIGINAL ARTICLE

Medical attention for domestic violence in a regional hospital: sociodemographic characteristics of the victims and aggressors

ENRIQUE FERNÁNDEZ-ROMERO, RAFAEL ESPINO PÉREZ, MANUEL AGUILERA PEÑA, MARÍA DOLORES PABLO VÁZQUEZ, CARLOS JAVIER GALÁN DOVAL, JOSÉ MANUEL RECIO RAMÍREZ

Emergency Department of the Line of Critical Processes and Emergencies of the Hospital de Montilla (Córdoba), Spain. Empresa Pública Hospital Alto Guadalquivir, Consejería de Salud de la Junta de Andalucía.

CORRESPONDENCE:
Enrique Fernández Romero
Servicio de Urgencias
Hospital de Montilla
Carretera Montoro-Puente
Genil, Km 65.350
14550 Montilla - Córdoba, Spain
E-mail: efernandezr@ephag.es;
efrzuheros@hotmail.com

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Aim: The primary objective of the study was to assess the sociodemographic characteristics of victims and aggressors, the type of abuse and the defining circumstances of mistreatment in domestic violence cases attended in the Emergency Department a county hospital. The second aim was to determine gender-related differences between the victim and aggressor.
Methods: Prospective, observational study of domestic violence victims who presented at the hospital in the period from March 15, 2003 to March 14, 2004. While being atended every patient completed a sociodemographic questionnaire and a medical-legal and clinical performance evaluation form. Statistical analysis of differential variables based an the gender of the victim and aggressor was performed.
Results: A total of 58 persons were included, 43 (74%) reporting couple-related violence (39 against women), 2 (3%) ill-treatment to the elderly and 5 (9%) mistreatment of minors under 18 years of age. The mean age of the subjects was 35 ± 14 years, 82.6% were female, predominantly married (48%), with low education (67%) and poor economic status. The aggressor was most frequently a 39-12 year old male (90%), who was the partner of the victim (74%) with a prolonged relationship (60%, > 6 years). The most frequent aggression was isolated physical injury (55%), previous aggressions had occurred in 65% and associated death threats in 36%. The aggressor more often had a more stable job (41%) than to the victim (19%; $p < 0.05$). Primary or lower education was more common (78%) in male aggressors compared to female agressors (32%; $p < 0.05$).
Conclusions: Violence against the women within the couple is the most frequent form of mistreatment. Commonly the aggressor is a middle-aged man, who had been cohabiting for a long time with the victim. The prevalence of continued mistreatment in the present study was very high. [Emergencias 2008;20:164-172]

Key words: Domestic violence. Gender violence. Hospital emergency. Intimate companion violence. Child mistreatment. Ill-treatment of the elder.

Introduction

Domestic violence represents one of the great conflicts of cohabitation of our society and is considered a healthcare problem with both a serious and complex solution. In our country there are no large clinical studies on the prevalence of domestic violence. In the United States the prevalence in clinical statistics is high: 15%-30% of the women attended in the emergency departments (EDs)[1,2] and 12%-13% of those who visit the department of family assistance[3,4] have reported to have received physical abuse or threats from their partners within the last year. In a study developed in Spain by the Instituto de la Mujer (Institute of the Woman) in the general population in 1999, 10.1% of the women over the age of 18 years recognised having felt mistreated within the family nucleus at some time in their life. In the same study, 4.2% of the women studied recognised having been mistreated in the last 12 months and in 52% of the cases the aggressor was their partner[5].

The number of deaths secondary to mistreatment increases in our country every year with the

death of one woman as a victim of this type of abuse every four days in Spain (www.redfeminista.org, 2003)[6], and these values are rising yearly, despite the recent changes in legislation[6,7]. According to the monographic report on violence elaborated for Spain by the Ombudsman in 1998[8], more than 90% of the deaths by homicide in women were attributable to their partner.

We understand mistreatment within the setting of domestic violence to be any act committed within the family by one of its members against the life, body, psychological integrity of freedom of any of its members, especially aggressive behaviour against women and minors (Martín Inglesias, 1989)[9]. These acts also include those produced after the rupture of a family relationship or cohabitation, as well as sexual assault. Within the type of violence in the family setting, the most frequent is abuse towards the wife[10].

Perhaps what makes domestic violence in all of its forms (sexual assault and mistreatment of the wife, children or the elderly) such a peculiar and terrible phenomenon is that it takes place within the family nucleus, a closed circle, representing a special sentimental proximity between intervening subjects. This conditions a relationship of dependence and possession of the victim and aggressor with different degrees of tolerance according to the different people involved, the society of origin and different times of life[11], and a possibility of a fatal end with no previous signs of alarm, even to people close to them.

Within the general healthcare setting the prevalence varies greatly from 20% to 55%[12-17]. The emergency services and measures are some of the healthcare bodies which most often attend episodes of mistreatment. In a study by Lejoyeux et al.[13] in Belgium, the presence of mistreatment was detected in 18% of the population attending an ED for another reason. The study concluded that the patients attended in the ED should be considered, in general, as a group of risk of domestic violence.

We believe that training aimed towards the detection of signs of mistreatment would be the best ally at the time of dealing with this socio-political-healthcare problem. In the daily attendance of patients a high index of suspicion may allow knowledge of occult situations of mistreatment to be established. Adequate action by healthcare professionals would allow a potentially dangerous situation and the possibility of severe injury to be avoided[18-22]. The same integral law on gender violence dictates that "with the framework of the Interterritorial Council of the National Healthcare System, the healthcare administrations will promote and launch actions by healthcare professional for the early detection of gender violence and will propose the measures they deem necessary with the aim of optimising the contribution of the healthcare sector in the fight against this type of violence"[23].

The first step to search for solutions to a problem undoubtedly consists in a good description of the same. With this objective the present epidemiological study was developed. The aim of the study was to determine the exact number of victims of domestic violence attended in our hospital as well as the sociodemographic and relationship characteristics which define both the victim and the aggressor, the type of mistreatment attended, the circumstances surrounding the assault, and the needs for medical assistance. A secondary objective was to study the possible differences in the characteristics which define mistreatment based on who inflicts it (man or woman) and who it is inflicted upon (man or woman).

Methods

A transversal, observational, descriptive study was carried out including all the cases of victims of domestic violence attended in the ED of the Hospital Alto Guadalquivir de Andújar (Jaén), Spain from March 15, 2003 to March 14, 2004.

The study population was estimated to be around 80,200 inhabitants, corresponding to the hospital reference area, being a predominantly rural population grouped in nuclei of between 3,000 to 36,000 inhabitants. A percentage of greater than 90% pertain to the basic regions of Andújar, Arjona and part of that of Porcuna. In addition, a large part of the emergencies from the bordering populations of Bailén, La Carolina, Villa del Río and Montoro are attended.

The inclusion criteria were patients attended in the hospital for having been mistreated or sexually assaulted (all the cases legally considered as mistreatment by a judge) as well as those who were otherwise attended and in whom this was suspected and no notification had been made.

In all the cases studied a survey was made using a specific form containing the sociodemographic variables reported by the victim (sex, age, education, work status, cohabitation with minors, personal income, marital status, victim-assailant relationship, and time since the initiation of this relationship) and the aggressor (sex, age, education, work status), data related to the mistreatment and the type of aggression requiring consultation (type of aggression, existence of the threat

of death, witnesses to the assault, coexistence of aggression to third parties, previous assaults, time since first assault, use of substance abuse, type of toxic used and the use of objects to carry out the assault) and clinical data related to the episode and the diagnostic-therapeutic approaches undertaken (origin of the consultation, injuries found, prognosis of the injuries, emotional status, need for medication, need for admission). The sociodemographic data of both the victim and the assailant were exclusively obtained by the testimony of the victim and were filed without personal data. The examination and description of the lesions were made following the published recommendations[17,24].

A descriptive study of all the variables was performed (means, proportions and study of distribution of frequencies). Some variables (those related to age and time) were grouped into intervals for better evaluation.

Since the sample was limited, conversion of the variables studied was carried out in dichotomy and thus, the previously existing variables were unified into two categories. A comparison of proportions was then performed (Fisher exact test, because of the presence of boxes with a very low number of cases) based on the gender of the victim and the aggressor.

Results

The results are shown in tables 1-4 which refer to the different groups of variables: sociodemograhic variables of the victim (Table 1) and aggressor (Table 2), data related to the mistreatment and the assault for which the consultation was made (Table 3) and clinical data related to the episode and the diagnostic-therapeutic approach followed (Table 4).

During the study period 58 cases of victims of domestic violence were attended (all the cases attended were included in the study), 8 men and 50 women, with a mean age of 35 ± 14 years and 62.1% of the cases (36 cases) were grouped between 18 and 44 years of age.

Among the patients included 43 were cases of violence by a partner, with 39 being violence against the female partner and in 4 cases the victim was a man (of these, in one case the aggressor was also male). In the 5 cases of infant mistreatment, the aggressors were the parents and in the 2 victims over the age of 60 years (excluding those considered as gender violence) the aggressors were the sons.

Table 1. Distribution of the frequencies of the variables related to the victim

Variables	Frequency	(%)
Victim gender		
Male	8	(13.8)
Female	50	(86.2)
Age of the Victim		
Less than 28 years	5	(8.6)
From 18 to 29 years	16	(27.6)
From 30 to 44 years	20	(34.5)
From 43 to 59 years	9	(15.5)
From 60 to 74 years	6	(10.3)
Over 75 years	1	(1.7)
Not identified	1	(1.7)
Level of education of the victim		
Illiterate	7	(12.1)
Reads and writes	12	(20.7)
Primary school	20	(34.5)
Secondary school	10	(17.2)
University	4	(6.9)
Not identified	5	(8.6)
Profession of the victim		
Housewife	14	(24.1)
No work sought	8	(13.8)
Long-term unemployment	7	(12.1)
Pensioner	2	(3.4)
Student	2	(3.4)
Part-time work	9	(15.5)
Full time work	9	(15.5)
Business person	1	(1.7)
Not identified	6	(10.3)
Personal income of victim		
No	35	(60.3)
Yes	23	(39.7)
Cohabitation with minors		
No	47	(81.0)
Yes	11	(19.0)
Marital status of victim		
Married	26	(44.8)
Common-law marriage	5	(8.6)
Separated	6	(10.3)
Single	19	(32.8)
Not identified	2	(3.4)
Aggressor-victim relationship		
Partner	26	(44.8)
In-law	3	(5.2)
Brother	3	(5.2)
Son/daughter	2	(3.4)
Father/mother	7	(12.1)
Common-law partner/fiance	17	(29.3)
Time of victim-aggressor relationship		
Less than 1 year	5	(8.6)
From 1 to 2 years	5	(8.6)
From 3 to 5 years	4	(6.9)
More than 6 years	35	(60.3)
Not identified	9	(15.5)

The data not included in the form are shown in the table under the heading "Not identified". The variable "Personal income of victim" refers not only to income from work but also from pensions (widowhood or any other type), income from disability pension.

The level of education of the victims was of "primary school" or less in 67.3% (39) of the cases. The victim did not have paid work outside the home in 80.8% (42) of the cases which responded (52 cases), although up to 40% of the victims attended received some type of personal income. The most frequent marital situation among the

Table 2. Distribution of frequencies of the variables related to the aggressor

Variables	Frequency	(%)
Gender of aggressor		
Male	52	(89.7)
Female	6	(10.3)
Age of aggressor		
From 18 to 29 years	10	(17.2)
From 30 to 44 years	23	(39.7)
From 45 to 59 years	11	(19.0)
From 60 to 74 years	5	(8.6)
Not identified	9	(15.5)
Level of education of aggressor		
Illiterate	3	(5.2)
Reads and writes	15	(25.9)
Primary school	25	(43.1)
Secondary school	7	(12.1)
University	1	(1.7)
Not identified	7	(12.1)
Profession of aggressor		
Business person	2	(3.4)
Full time work	13	(22.4)
Free-lance work	6	(10.3)
Student	1	(1.7)
No work sought	1	(1.7)
Occasional work	8	(13.8)
Long term unemployment	11	(19)
Pensioner	8	(13.8)
Not identified	8	(13.8)

victims was that of married (26 cases, 44.8%). Nineteen percent had children within the family nucleus. In 44.8% (26 cases) the aggressor was the partner, followed by common law partner or fiancé (29.3%). Of these relationships, 60.3% (71, 41% of the 49 victims responding to this question) were of more than 6 years. The relationship was one of less than one year in only 5 cases. The remaining details of the victim are depicted in Table 1.

In 89.7% of the assaults reported during the one-year study period, the aggressor was a male, with a woman causing the mistreatment on only 6 occasions. The mean age was of 39±12 years, with no case of an aggressor being a minor or over the age of 75 years. The level of education was similar to that of the victims with 74.2% having a "primary school" education or less. It was found that 58% of the aggressors, of whom data related to the professional situation were available, had a regular income. The remaining details of the aggressors may be consulted in Table 2. When the aggressor was a man, the predominating type of mistreatment was violence against the wife within the couple setting (76% of the cases) (Figure 1). The aggressor more often had stable employment (41%) than the victim (19%; $p < 0.05$).

The most frequent type of assault for which our victims consulted was isolated physical aggression (55.2%) followed by joint physical and psychological aggression (32.8%). In 35 cases (60.3%) there were witnesses to the aggression and in 9 (15.5%) persons other the victim attended were assaulted. In at least 22.4% of the cases the aggressor was under the effect of some toxic substance, the most frequent being alcohol (present in 15.5% of the aggressions). In 11 of the cases reported (19%), objects were used to assault the victim. The aggressor made death threats during the assault in 21 of the episodes (36.2%). At the time of receiving medical assistance, the victim reported having been assaulted on other occasions in 65.5% (38) of the cases. Only 26.3% of the victims with a history of mistreatment had made previous contact with some level of social assistance to report their problem.

In 53.4% (34 cases) the victims attended the ED on their own volition while 32.8% (19 cases) were accompanied by the police. The most frequent types of lesion diagnosed were contusions (41.4%) and bruises (13%). Only 5.2% of the con-

Table 3. Distribution of frequencies of the variables related to mistreatment

Variables	Frequency	(%)
Type of assault/mistreatment		
Psychological aggression (PA)	4	(6.9)
Physical aggression (PhA)	32	(55.2)
PhA and PA	19	(32.8)
PhA , PA and sexual assault	3	(5.2)
Existence of witnesses to mistreatment		
No	23	(39.7)
Yes	35	(60.3)
Third party aggression		
No	49	(84.5)
Yes	9	(15.5)
Use of toxic substances during aggression		
No	45	(77.6)
Yes	13	(22.4)
Type of toxic substance consumed		
Alcohol	9	(15.5)
Illegal drugs	4	(6.9)
None and not known	45	(75.9)
Not identified	1	(1.7)
Use of objects for aggression		
No	47	(81.0)
Yes	11	(19.0)
Death threat made		
No	37	(63.8)
Yes	21	(36.2)
Previous aggressions		
No	20	(34.5)
Yes	38	(65.5)
Previous reports of maltreatment		
No	48	(82.8)
Yes	10	(17.2)
Time since first aggression		
First aggression	20	(34.5)
<1 year	12	(20.4)
1-2 years	7	(12.1)
3-5 years	7	(12.1)
More than 6 years	12	(20.7)

Previous reports of mistreatment refer to having filed police, judicial or medical-legal charges for a situation of mistreatment.

Table 4. Description of the results of the variables related to the clinical situation and the healthcare assistance received

Variables	Frequency	(%)
Origin of referral		
Primary care	5	(8.6)
Another hospital	1	(1.7)
Police	19	(32.8)
Personal decision	31	(53.4)
Not identified	2	(3.4)
Type of lesions found		
Scrapes	24	(41.4)
Erosiones	9	(15.5)
Fracture	1	(1.7)
Bruises	13	(22.4)
HIC	3	(5.2)
No apparent lesion	4	(6.9)
Not identified	4	(6.9)
Prognosis of lesions		
Severe	3	(5.2)
Mild	55	(94.8)
Emotional state of victim		
Terrified	2	(3.4)
Continuous crying	11	(19.0)
Anxious	7	(12.1)
Nervous	21	(36.2)
Calm	15	(25.9)
Not identified	2	(3.4)
Need for medication during assistance		
No	29	(50.0)
Yes	29	(50.0)
Need for admission		
No	56	(96.6)
Yes	2	(3.4)

sultations were considered to be of severe prognosis. From an emotional point of view, the victims attended by the ED were most frequently (criterion of attending physician) "nervous" (36.2%) followed by "calm" (25.9%) and "continuously crying" (19%). Fifty percent of the victims attended required medication in the ED and only 2 were admitted to hospital (Table 4).

On comparing possible differential characteristics according to the gender of the aggressor, a statistically significant proportion of males was found to more frequently have a primary school or lower education ($p = 0.03$; Table 5). On the other hand, no differential characteristics were observed with respect to the gender of the person assaulted (victim; Table 6).

Discussion

During the year of data collection 58 victims were attended, representing an incidence of 69 cases/100,000 inhabitants/year. This figure is considered to be high, despite being only slightly higher to that reported in the province of Jaén (63/100,000 inhabitants/year; data collected by the Provincial Delegation in Jaén of the Ministry of Health of the Autonomous Region of Andalusia) since episodes of mistreatment in the area are attended at all the points of primary healthcare assistance as well as in our hospital.

The victim of domestic violence attended in our hospital was most frequently a middle-aged woman from 18 to 44 years of age with a low cul-

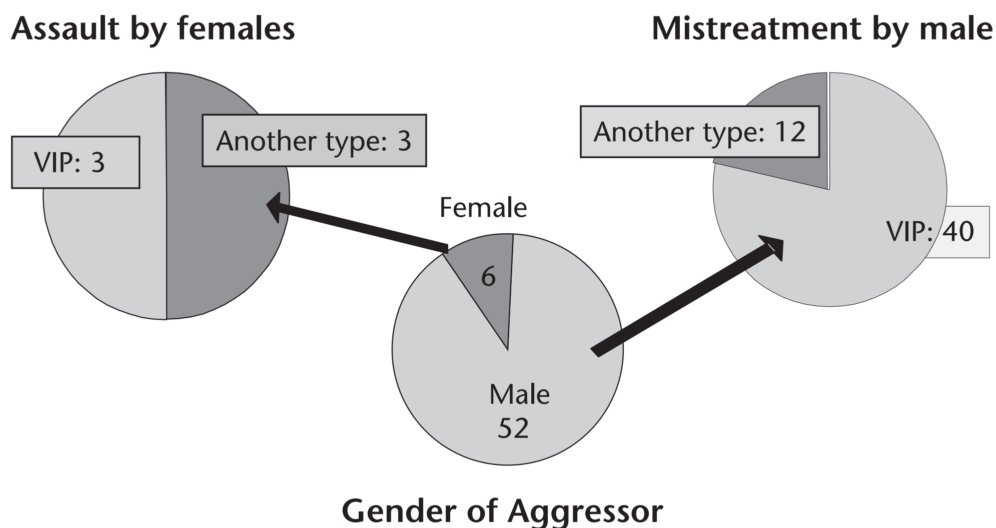

Figure 1. Violence within the couple (violence by intimate partner) based on the gender of the aggressor. When the aggressor to the person assisted was a male, in 77% of the cases he was the partner of victim, while in the episodes of domestic violence in which the aggressor was female, only half of the cases were carried out by an intimate partner ($p = 0.17$). VIP: violence by intimate partner. Another type: type of domestic violence other than VIP.

Table 5. Comparison of different variables (prior to dichotomy transformation) according to the gender of the aggressor

	Total (n = 58) n/responders (%)	Males (n = 52) n (%)	Female (n = 6) n (%)	*p*
Age under 45 years	33/49 (67)	29 (65)	4 (80)	1
Primary education or less	43/58 (74)	41 (78)	2 (33)	0.03
Stable employment	21/51 (41)	20 (43)	1 (20)	0.34
Violence against partner	43/58 (74)	40 (77)	3 (50)	0.17
Physical aggression	54/58 (93)	48 (92)	6 (100)	1
Existence of witnesses	35/58 (77)	41 (78)	4 (66)	0.6
Aggression to third parties	9/58 (15)	9 (17)	0 (0)	0.57
Consumption of toxic substances	13/58 (22)	13 (25)	0 (0)	0.32
Use of objects for assault	11/58 (19)	11 (21)	0 (0)	0.58
Death threats	21/58 (36)	18 (34)	3 (50)	0.65
Previous assaults	38/58 (65)	34 (65)	4 (66)	1
Previous reports of mistreatment	10/58 (17)	10 (19)	0 (0)	0.57
First assault	20/58 (34)	18 (34)	2 (33)	1
Own decision to attend the ED	31/58 (53)	26 (50)	5 (83)	0.26
Severe prognosis of lesions	3/58 (5)	3 (5)	0 (0)	1

tural level and scarce personal economic resources. The victims were, in most cases, married and were mainly mistreated by their partner with whom they had cohabited for more than 6 years. This study did not include variables related to pathologic antecedents or pathology associated with the victims, which may have provided relevant information at the time of suspecting mistreatment[25].

The existence of aggressions by an ex-partner, included within the definition of domestic violence was highly infrequent in the present study. Since the study population was predominantly rural, the percentage of marriage separation may have been scarce. This may also be the reason for the low number of consultations for mistreatment during the first year of relationship when it is known that domestic violence, especially in couples, initiates at the beginning of the relationship[9]. The apparent acceptance of situations of initial violence may be explained by cultural conditioning and recognition of social habits and educational roles learned by the victims in childhood.

The aggressor in this study was, almost exclusively, a middle-aged male with a low level of education and with a better professional situation than that of the victim. In contrast to the victims, only 26% of the aggressors did not have any income, demonstrating that the aggressors were the source of income in the family nucleus. We believe that, apart from other educational and social factors, this economic dependence of the victims is one of the factors influencing the high tolerance observed on the part of the victim towards a relationship with a high content of violence.

Despite the scarce number of episodes of aggression by women attended, there was a clear difference with respect to that by men: violence against partners did not predominate in relation to other types of domestic violence (50%) versus the clear predominance of violence against partners in

Table 6. Comparison of the different variables (prior to dichotomy transformation) according to the gender of the victim

	Total (n = 58) n/responders (%)	Males (n = 8) n (%)	Female (n = 50) n (%)	*p*
Age under 45 years	41/57 (71)	4 (50)	37 (75)	0.2
Primary education or less	39/53 (73)	5 (71)	34 (73)	1
Stable employment	10/52 (19)	1 (14)	9 (20)	1
Marital status: married	26/56 (46)	3 (47)	23 (47)	0.71
Violence against partner	43/58 (74)	4 (50)	39 (78)	0.18
Length of relation with aggressor > 5 years	35/49 (71)	4 (66)	31 (72)	1
Personal income	23/58 (39)	3 (37)	20 (40)	1
Physical aggression	54/58 (93)	8 (100)	46 (92)	1
Existence of witnesses	35/58 (60)	5 (62)	30 (60)	1
Aggression to third parties	9/58 (15)	1 (12)	8 (16)	1
Consumption of toxic substances	13/58 (22)	2 (25)	11 (22)	1
Use of objects for assault	11/58 (19)	2 (25)	9 (18)	0.63
Death threats	21/58 (36)	3 (37)	18 (36)	1
Previous assaults	38/58 (65)	5 (62)	33 (66)	1
Previous reports of mistreatment	10/58 (17)	0 (0)	10 (20)	0.32
First assault	20/58 (34)	3 (37)	17 (34)	1
Own decision to attend the ED	31/56 (55)	6 (75)	25 (50)	0.26
Severe prognosis of lesions	3/58 (5)	0 (0)	3 (6)	1

aggressions by men (83%). Thus, gender violence predominated in the cases of violence within the family studied.

With regard to the type of mistreatment, a high percentage of consultations for physical aggression, alone or in combination with another category, were observed. Although it has been widely described in the literature that psychological mistreatment is much more frequent than physical mistreatment[9,26,27], in the present study less than half of the victims believed to have been maltreated in this way. The degree of adaptation of the victims to this situation seems to be very high, and it is very probable that on responding to the questions by the physician, the victim obviated a continued situation of psychological maltreatment either due to unawareness or most probably because they considered "this type of relationship" as normal. What does seem to be logical is that the greater the intensity of the mistreatment, and particularly the addition of a more physical component of abuse, the greater the possibility that the victim will request help and come to the hospital when an increase in the level of violence is apparent.

On the other hand, this study demonstrates that the most frequent method of domestic violence was continued mistreatment. Up to 65% of the victims attended had been maltreated on previous occasions, and even one quarter of the cases had previously been attended in the ED. In the case of minors it is obvious that consultation to the ED did not occur in the first episodes, except for severe injuries. In gender violence, continued mistreatment is justified, as previously observed, by social and cultural and economic dependence. Together with the type of aggression received (as explained above), some of the data that may provide a subjective view of an increase in the intensity of the abuse on the part of the victim and which justifies the demand for healthcare or police support are the use of objects for aggression (despite not necessarily implying greater bodily injury), the coexistence of aggression to other members of the family or the verbalisation of death threats.

Lastly, of the descriptive data, the scarce incidence of the consumption of toxic substances among the aggressors in the episodes attended was of note, although the number of cases with no response to this question or with a non conclusive answer was high.

On statistical analysis of the data, only one variable showed statistically significant differences. The scarce relevance of these results may be explained by the low number of cases studied, and especially due to the low percentage of female aggressors and male victims.

Nonetheless, significant differences were found in the variable "education" (primary school or less versus secondary school or higher) based on aggressor gender. A lower level of education was found in male aggressors (73% with primary studies or less versus 33%; $p = 0.03$). This may correspond to the most frequent type of domestic violence in each gender, with violence against the partner being much more frequent in male (77%) than in female aggressors (50%), although the differences were not significant (Figure 1). The lowest "p" value was observed in violence against the partner versus other types of domestic violence, without achieving statistical significance in either the gender of the victim (0.18) or the aggressor (0.17).

After revision and initial evaluation, the present study remains ongoing, with the collection of more cases and other more ambitious studies with a greater capacity of intervention and the implication of other healthcare, social and judicial bodies which will allow a better approach to the situation of mistreatment in our society. This line of investigation is always incomplete and has infinite possibilities of action. It should not be forgotten that despite being an eminently medical work, this is one of the most dramatic social problems of our times. Therefore, the ultimate aim of the study was to obtain more in depth knowledge of this problem to prevent, detect and better treat the victims of domestic violence in our work setting.

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Violencia doméstica atendida en urgencias de un hospital comarcal: características sociodemográficas de víctima y agresor

Fernández-Romero E, Espino Pérez R, Aguilera Peña M, Pablo Vázquez MD, Galán Doval CJ, Recio Ramírez JM

Objetivos: Conocer las características sociodemográficas de víctimas y agresores, tipo de maltrato y las circunstancias que lo definen, en los casos de violencia doméstica atendidos en el servicio de urgencias de un hospital comarcal. Como segundo objetivo se investigará si existieron rasgos diferenciales, tanto en la víctima como en el agresor, en función del género.
Métodos: Estudio prospectivo, observacional, de las víctimas de violencia doméstica atendidas del 15 de marzo de 2003 al 14 de marzo de 2004. Durante la atención se cumplimenta un cuestionario sociodemográfico y un formulario médico-legal y de actuación clínica. Se realizó el estudio estadístico de las variables diferenciadas en función del género de víctima y agresor.
Resultados: Se recogieron 58 casos, 43 (74%) de violencia dentro de la pareja (39 contra mujeres), 2 (3%) de malos tratos al anciano y 5 (9%) de maltrato a menores de 18 años. Las víctimas tienen una edad media de 35 ± 14, y el 82,6% son mujeres, y principalmente casadas (48%), con nivel de estudios bajo (67%) y escaso poder económico autónomo. El agresor es más frecuentemente hombre (90%) de 39±12 años de edad, pareja de la víctima (74%) con la que ha mantenido relaciones prolongadas (60% más de 6 años). La agresión más frecuente es la física aislada (55%), existen agresiones previas en el 65% y amenaza de muerte asociada en el 36%. El agresor tiene trabajo estable (41%) con mayor frecuencia que el agredido (19%; $p < 0,05$). Con mayor frecuencia el hombre agresor tiene estudios primarios o inferiores (78%) que la mujer agresora (32%; $p < 0,05$).
Conclusiones: La violencia contra la mujer dentro de la pareja es la forma más frecuente de maltrato. El agresor es más frecuentemente hombre, de edad media y conviviente durante largo tiempo con la víctima. El maltrato continuado tiene una alta prevalencia en el estudio. [Emergencias 2008;20:164-172]

Palabras clave: Violencia doméstica. Violencia de género. Urgencias hospitalarias. Violencia por compañero íntimo. Maltrato infantil. Maltrato al anciano.