Physically abused women's experiences and expectations of medical practitioners

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Abstract

Background: The purpose of this study was to investigate the frequency of physically abused women's medical consultations, the anatomical location of their injuries and the perceived support given by medical practitioners.

Method: The sample consisted of 42 physically abused women who made use of the services of the People Opposing Women Abuse (POWA) Organisation. The group was culturally mixed, with an average age of 35.7. A descriptive *ex post facto* semi-structured questionnaire/interview survey was used.

Results: Of the 31 (73.5%) physically abused respondents who indicated that they had visited a medical practitioner, only seven (23%) visited their general practitioner on more than three occasions. Overall, 13 (42%) respondents were accompanied by someone on these visits. Most of the participants (n=20; 65%) acknowledged to the practitioner that their injuries resulted from gender-based violence, and the same number also identified the abuser. A large majority (n=26; 84%) recommended that medical practitioners consider a more comprehensive approach to their treatment. Suggestions included better medical treatment, emotional support, referral to other health workers, referral regarding legal issues and contacting the abusive partner. Face and neck injuries were mentioned most frequently (n=27; 67.5%). Trunk injuries (n=19; 47.5%) were mostly found on the lower back and thorax. Limb injuries (n=25; 62.5%) were often sustained on the upper limbs. On the lower limbs, the areas above the knee were most frequently injured. Overall, most of the injuries were located in publicly visible areas.

Conclusions: General practitioners are often the first professionals with whom physically abused women come into contact. More effort should be made to inform practitioners of the unique composition and acuteness of these women's needs.

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Introduction

This study explored the expectations, experiences and recommendations of a sample of domestic violence survivors upon presenting their injuries to medical practitioners. The frequency of consultations with medical practitioners was also recorded. In order to ascertain whether patterns of injuries could be discerned, the general physical location of the injuries sustained during domestic violence was also noted. It is argued that this composite information will contribute to the diagnostic indicators used to inform medical practitioners when dealing with cases of chronic domestic violence.

Violence against women and, in particular, intimate partner violence has always been a socio-medical concern. However, up to a decade ago, the prevalence rates of intimate partner violence in South Africa were purely speculative due to the lack of national surveys and reliable statistics.[1] Recent community-based prevalence studies conducted in three South African provinces determined that these women have a 24.6% lifetime likelihood of being exposed to physical violence.[2,3]

Although other types of abuse are also found (e.g. emotional abuse), physical abuse seems to be most prominent and has the widest health implications.[4] Health problems associated with gender-based violence include injuries, HIV, sexually transmitted diseases and mental health problems. Gender-based violence is also a cause of mortality from homicide and suicide in South Africa, with femicide (homicide of women by an intimate partner) as the most serious form of violence against women. A study done in Baltimore showed that femicide victims frequently contacted medical practitioners before they were killed, a factor that presented opportunities to prevent their deaths.[5]

Depending on the seriousness of their injuries, women who have been beaten by their partners are compelled to visit health institutions for treatment. Besides acute injuries, these women

may present with somatic symptoms, such as headaches, backaches, fatigue, abdominal and pelvic pain, recurrent vaginal infections and symptoms of depression.[6] A study conducted in Alexandra township in Johannesburg, South Africa on the location and nature of injuries showed that 18% of cases included multiple injuries (two to five body locations), while a further 17% required hospitalisation for fractures (skull, jaw, limbs, sternum and ribs), deep scalp and facial lacerations and penetrating chest wounds.[1]

As mentioned above, medical practitioners are often the first professionals with whom women traumatised by gender-based violence come into contact, but it seems that they have a poor record of identifying victims of domestic violence.[1] Even the British Medical Association (in a 111-page report) has called on medical practitioners to play a greater role in identifying abuse, helping survivors to disclose the abuse, and to ensure that survivors receive advice and support.[7] In Omaha, it was found that abused women tend to turn to medical practitioners for social and directional support.[8]

However, clinicians often struggle when addressing domestic violence. For example, in 1998 it was found that a sample of South African medical practitioners was of the opinion that the issue was too sensitive, they were too busy, or that it was unnecessary to address abuse.[4] This could be attributed to the fact that clinicians lack the training to deal with the causal context in which violence-based injuries are sustained. A recent local (South African) study reported that only 9.7% of medical practitioners received training in domestic violence.[9] Other reasons stated for the non-involvement of medical practitioners include that they do not know what to say, that it is traumatic for them to listen to their patients describing violence and that they have trouble empathising with the victim's helplessness. As a consequence, the abused women's experiences of isolation and despair are likely to increase due to clinicians treating them for injuries and somatic complaints without exploring the reasons for the injuries. Furthermore, the abusive partner frequently controls the health care attention being received by accompanying the injured partner to the medical practitioner, controlling medical aid and other health benefits and even by controlling dietary requirements.[10]

Motsei[1] argues that the role of health workers should include providing initial and accurate identification of abuse and that they should ask indirect questions in a non-judgmental and supportive manner. Privacy is very important, especially by separating the women from her partner when examining her. This is especially important when women present with multiple injuries or have no history to explain their injuries. Medical practitioners should also keep accurate records and medico-legal reports that include aspects such as the nature and extent of the injuries, the extent to which the injuries are consistent with the assault, a description of the incident by the woman and the treatment given. In addition to treatment, it is suggested that medical practitioners provide referrals and follow-ups and develop closer networks with social services, legal agencies and the police.[1,4,11]

A recently canvassed sample of South African medical practitioners was of the opinion that they empathise adequately with abused patients, but the sample also agreed that they could play a more extended role in prevention and treatment.[9] The respondents in this study treated an average of 11.4 patients with abuse-related injuries a month (sd 13.4). Most of these practices were in predominantly white neighbourhoods. Only 15.1% of the patients disclosed the abuse to the practitioners and in only 12% of the cases did the practitioner raise the issue, even though they suspected abuse in 16.9% of the cases. With the exception of one respondent, all acknowledged that the prevalence and impact of domestic violence was greater than what practitioners generally assume.

Most research into the injuries sustained through physical abuse and the medical practitioners' role in treatment has focused on the medical practitioners' attitudes and roles.[12,1,9] Few studies have focused on the abused women's perspective.[4,13] Yam[14] investigated a group of battered women's experiences in New Jersey and reported that the respondents were of the opinion that emergency staff did not understand the chronic context of the injuries they sustained. Whilst they were satisfied with the treatment of their physical injuries, the causes of the injuries were generally not properly addressed. They had difficulty in disclosing the abuse, mostly due to fear, embarrassment and a lack of resources.

The roles to be played by the health sector in breaking cycles of abuse are increasingly being recognised in South Africa and there appears to be a growing awareness of the need for appropriate interventions, such as documentation, information giving and referrals.[6]

Methods

Counsellors from People Opposing Women Abuse (POWA) surveyed women who contacted them with complaints of physical abuse. The counsellors were instructed in the research objectives and methodology, after which they helped each consenting participant to complete the survey questionnaire. By doubling as fieldworkers for this study, the counsellors were instrumental in obtaining sensitive information, thereby ensuring that the participants interpreted the questions correctly and providing support if required during and after the survey. Also, by making use of counsellors as fieldworkers, a support base was provided, thereby countering possible ethical problems that otherwise could have jeopardised the study. The ethics committees of both POWA and the University of South Africa reviewed and sanctioned the study beforehand.

Sample

All POWA offices and shelters (Berea, Sebokeng, Soweto, Vosloorus, Katlehong) were included in the study.

A sample of convenience consisting of 42 women was recruited during January and February 2003. Women who presented at POWA offices and shelters during this time were invited to take part in the study. A 100% response rate was obtained. Their ages ranged from 23 to 57, with the average age being 35.7 years (sd 7.75). Nearly half of the participants (n=19; 45%) were between 30 and 39 years old. The home languages of the participants in the sample were Sotho (12), Xhosa (10), Zulu (nine), Tswana (six), Pedi (two) and Afrikaans (one) , while two women did not indicate their home language. Whereas the questionnaire was formulated in English, it was in each case administered by a counsellor who was able to speak the mother tongue of the participant in order to help clarify possible misunderstandings.

Measurement

Apart from biographical information, the questionnaire probed the following themes:

- the number of abuse-related visits to medical practitioners;
- the relationship of an accompanying person (if relevant) and whether the accompanying person was present during the examination;
- the nature of treatment and the recommendations made by the medical practitioner ;
- participants' experiences and expectations of the treatment provided; and
- identifying the anatomical location of the injury/injuries sustained. This was done with the use of a body map consisting of an outline of a female figure. Participants were requested to colour the area on the body map where their injuries were located. Two body maps were used to probe two possibly different incidents in each participant's abuse history. The first map was used to explore the occasion when the participant was injured most and sustained the worst injuries. The other body map was used to investigate injuries sustained in the most resent physical abuse incident. In cases in which the latest incident was also the worst incident, only one map was used and only once recorded as the most recent injury. For this reason, the total numbers of worst and most recent injuries do not correspond.

Results

Of all the women who reported that they were physically abused and suffered physical injuries, 73.4% (n=31) sought help from a medical practitioner. More than a quarter of the women in the original sample never visited a medical practitioner, regardless of the extent of their injuries.

Of the 31 women who had been treated by a medical practitioner, 35% (n=11) visited the medical practitioner only once, 30% visited twice, 13% visited three times and 23% visited more than three times.

More than half of the women who had been treated by a medical practitioner (n=18, 58%) reported that they had gone to the medical practitioner on their own, while the rest (n=13, 42%) reported that they were accompanied by another person on at least one occasion. In 31% of the cases, this accompanying person was a neighbour and, in another 31% of cases, it was a family member (e.g. mother, child, sister, sister-in-law). In 23% of the cases the abusive partner accompanied the woman. One woman was accompanied by a friend and another by a police officer. In more than half of the cases (54%) the accompanying person was also present when the woman was examined by the medical practitioner.

In most instances (n=20, 65%), the abuse and perpetrator were reported to the medical practitioner, either by the woman herself or by the accompanying person. Nearly 20% reported the abuse, but attributed the abuse to a person other than the abusive partner to protect the perpetrator. In this sample, only two participants (7%) did not acknowledge the abuse to the practitioner.

Without self-disclosure, a large percentage of the women (n=21, 68%) were of the opinion that the medical practitioner would not have diagnosed the true cause of their injuries. Only seven practitioners (23%) diagnosed the abusive origin of their patients' injuries on their own accord. Two participants lied when asked and one believed that the injuries were not prominently visible and therefore not recognisable as caused by domestic violence.

Only four medical practitioners were perceived to actually address the cause of the abuse. Two contacted the partners of the women, one referred the client to POWA and another encouraged the woman to open a case of assault with the police.

Most women (n=26, 84%) believed that medical practitioners can do more to help women in their situation. One-third of their suggestions dealt with the actual medical treatment they received, placing emphasis on viewing their injuries in a more serious light. Although some (13%) wanted medical practitioners to counsel them on their emotional wellbeing, most women (74%) expected the practitioners to be able to refer them to appropriate resources, such as social workers, psychologists or organisations such as POWA. The majority of women (65%) were of the opinion that medical practitioners could be more aware of the legal aspects of cases of domestic violence. These include administrative issues, such as having more fully and correctly completed forms (e.g. the J88), and helping, referring and encouraging them to open a legal case against the perpetrator. Some women also suggested that the practitioners become more directly involved in their wellbeing as long-term patients by making follow-up calls and offering to contact the abusive partner – especially to explain the extent and danger of the injuries the women had sustained.

Anatomical location of injuries

The results presented in Table I refer to the anatomical classification of the participants' injuries. The analysis was based on the full complement of 42 participants. For the majority of women (n=26, 64%), the most recent time they were injured was also the time they were injured the worst. This appears

Table I: Anatomical location of abused women's injuries

Injury location	Recent injuries		Worst injuries	
	n	%	n	%
Head, face and neck	27	67.5	13	65
Trunk	19	47.5	9	45
Limbs	25	62.5	8	40

Table II: Head and neck injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	%	n	%
Head		9	22.5	10	50
Face		22	55	6	30
	Eye(s)	6	15	4	20
	Nose	2	5	0	0
	Mouth	6	15	2	10
	Ear	2	5	1	5
Neck		3	7.5	3	15

Table III: Trunk injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	%	n	%
Back		12	30	4	20
	Upper	4	10	2	10
	Lower	12	30	3	15
Thorax		8	20	4	20
	Breast(s)	5	12.5	0	0
Abdomen		6	15	6	30
Pelvis		2	5	3	15

Table IV: Limb injuries sustained by a sample of abused women

Injury location		Recent injuries		Worst injuries	
		n	%	n	%
Upper limbs		23	57.5	5	25
Right		12	30	2	10
	Shoulder	6	15	0	0
	Arm	5	12.5	0	0
	Forearm	5	12.5	2	10
	Hand	3	7.5	0	0
Left		18	45	4	20
	Shoulder	4	10	0	0
	Arm	5	12.5	2	10
	Forearm	7	17.5	2	10
	Hand	4	10	1	5
Lower limbs		15	37.5	7	35
Right		10	25	4	20
	Thigh	7	17.5	1	5
	Knee	0	0	2	10
	Leg	5	12.5	1	5
	Foot	1	2.5	0	0
Left		11	27.5	5	25
	Thigh	10	25	3	15
	Knee	1	2.5	1	5
	Leg	3	7.5	1	5
	Foot	0	0	0	0

to indicate that the nature and seriousness of the injuries tend to get worse with each violent incident. Injuries were mostly sustained to the head and neck area. Overall, the reports of injuries were also similar for the time when the participants were injured most and for the most recent time that they were injured. The trunk (including thorax, abdomen and pelvis) was injured in more than 45% of the participants. This percentage remained the same for the most recent as well as for the worst episode of physical abuse reported. Whereas the category of 'most recent injuries' also contained episodes of 'worst injuries', the correspondence between the two overall categories reflect a stable pattern of injuries over time.

Injuries to limbs were also reported frequently. However, the incidence of these differed for the two time periods. It would seem that injuries to limbs were regarded as less serious by the participants, as they reported this with a lower frequency when asked about the most violent injuries.

In order to capture the widest range of responses, both global indications of injury locations as well as more detailed accounts were recorded. For this reason, the reported percentages do not add to 100. For the most recent incidences, injuries to the head and neck area were most frequently found in the face, with the eyes and mouth injured most often (see Table II). Injuries sustained during the worst incidents were found to be located in the head and skull area, rather than in the face.

Injuries to the trunk were located mostly on the lower back and the thorax, especially the breasts (see Table III). When the participants were asked to indicate the location of their injuries during the episode they considered to have been the worst, they indicated injuries sustained to the abdomen as being more serious.

The upper limbs were injured more often than the lower limbs during the most recent incident of abuse (see Table IV). Injuries to the upper limbs were mostly found on the left limb, usually on the arm and forearm. This would indicate defensive injuries when the left arm and forearm are used to shield the face and head from blows or stabs.

There was no preference for the side of injury in the lower limbs. Injuries were located with the same frequency on both the left and right limbs. The thighs were injured most often. The location of injuries for the worst incidents was more or less the same,

except that the upper limbs were indicated less often.

Discussion

Whereas the use of a sample of convenience places some limitations on the external validity of the results, this is counterbalanced by a greatly under-researched and elusive population. Although this sample group can be regarded as representative of abused South African women who have approached nongovernmental organisations for support, the results of this study should be corroborated and refined by follow-up investigations. Nevertheless, it appears that most participants in this study initially contacted medical practitioners for professional care and support. About half of these women also visited the practitioner more than once. When taking into account that the perceived seriousness of their injuries seems to progress over time, it is important that medical practitioners make correct diagnoses as timely as possible.

Most of the participants indicated that they voluntarily disclosed the abusive origin of their injuries, but suggested that their medical practitioners could be more proactive in recording and gaining better insight into the context in which the injuries occurred, as well as suggesting appropriate action in addressing the cause. In addition to short-term emotional support, referral to relevant health professionals and organisations (including legal aid, social services and organisations specifically geared towards helping abused women) was indicated as being needed. As reported by some earlier studies, the women also expected medical practitioners to be more active in networking with the police and in co-ordinating efforts to help stop the violence.[4,6,11] Also consistent with other studies, this sample group emphasised the importance of properly recording the nature of their injuries and the contexts in which they were sustained, as well as of fully completing the relevant documnetation.[6,11,1]

Most women indicated that they were injured in more than one anatomical location per violent incident. Injuries sustained during physical abuse were mostly found in the head and neck area, although injuries to the trunk were also indicated frequently. Injuries to the limbs were more frequent during times when the injuries were not considered serious. The anatomical location of injuries during the most recent incident of physical violence was mostly in the face. Other injuries were located in anatomical sites that would indicate protective actions, especially in guarding the face. The location of injuries sustained during more serious violent incidents was mostly found on the head (skull and face) and the abdomen. As with the present study, multiple injuries (two to five locations on the body) were also reported by other studies and serious injuries were found to be skull fractures, deep scalp and facial lacerations and injuries to the breast and abdomen.[4,1]

Conclusions

Domestic violence appears to be prevalent in South Africa, and medical practitioners are frequently the first professionals to be approached for help. As such, it is important that practitioners be informed of the unique composition and acuteness of these women's needs. Abused women frequently present to medical practitioners in search not only of medical treatment for their physical injuries, but also in an attempt to seek understanding and direction in how to address the cause(s) of their injuries. Given the socio-medical nature of this problem, medical practitioners have a responsibility to gain greater awareness of the plight of physically abused women and how to deal with it effectively.

In order to aid the diagnostic process, an attempt was made to gain systematic information on the anatomical location of injuries most frequently presented by abused women. In this sample, the injuries were mostly directed to the face and involved anatomical areas related to defensive actions in protecting the face.

Whereas the client base of organisations such as POWA is usually from lower socio-economic groups, it should be recognised that physical abuse occurs across all socio-economic levels and is of concern to all general practitioners.

In conclusion, the incidence of gender-based violence and how it is dealt with remains a critical indicator of the regard a society has for its own fabric.

Conflicts of interest

None declared

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