Breaking the Cycle of Violence: The Role of the Family Practitioner

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Curriculum vitae

Ms Mmatshilo Motsei started her professional career with a few nursing qualifications (at the University of the North) and a BA (Hons) Psychology at UNISA. She has had a wide professional career, starting off as a nurse (Garankuwa Hospital), then a nursing tutor, a research officer (trainee) in the Centre for Health Policy (Wits Medical School) and in 1990 she was involved as a researcher in a project for the study of Violence (Psychology Dept Wits). In 1992 she was the founder and co-ordinator of the Alexandra Domestic Violence Prevention and Training Project, and has published on aspects of woman battering, violence against women and health education. She has been involved in international exchange and training programmes (England, Ireland and Washington DC). Ms Motsei has often been involved in TV and Radio panels on topics of health intervention programmes, violence, gender roles and gender violence.

Summary

Domestic violence has only been recognised as a medical problem since 1985 in the USA, but surveys, as well as a perusal of articles in medical journals in South Africa reveal a total lack of medical concern: women battering is not yet recognised as a medical issue in our country! If GPs only treat the physical injuries, it enables the victim to go back to the destructive environment thus reinforcing the cycle of violence. The GP is ideally situated to notice the first signs of domestic violence and needs to get involved – or to refer to another member of the health team. Referring to a survey where 66 women were positively identified as being battered by their male partners, the GPs never mentioned the cause of the injuries. This article illustrates that domestic violence cuts across all racial, colour and religious barriers and emphasizes that the incidence in RSA is so alarmingly high, that all GPs should get involved; they should be trained at undergraduate level to handle interpersonal violence – it should be incorporated into the core curriculum for undergraduate professionals. The role of the GP could either reinforce the cycle of violence, or help to break it.

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Introduction

Violence against women is a serious, pervasive yet invisible problem that adversely affects women's physical and psychological health. At its most basic, the definition of violence against women includes any act of force or coercion that jeopardizes the life, body, or emotional integrity of women in order to perpetuate or service male power and control.[1] Included in this category would be physical abuse, rape (including marital rape), incest, sexual harassment, female circumcision, dowry murders, trafficking of women, psychological abuse and verbal harassment. A more expansive definition would, however, move beyond the above acts to include forms of institutionalized sexism that compromise the health, integrity and dignity of women. Included here would be neglect of the female child with female infanticide at the extreme end of the continuum, lack of access to safe contraception and abortion, as well as sanctions imposed by institutions such as the police, the clergy and the medical system as a mechanism of behaviour control within a culture that perpetuates female subordination.

Even though violence against women takes many forms, this paper will only focus on physical violence, commonly referred to as woman battering. The paper will largely be based on the research study done at Alexandra Health Clinic. However, a study done at a health centre that serves a population that is predominantly black and poor does not mean that woman battering is common in certain racial and/or class categories. Rather, it is a phenomenon that cuts across racial, ethnic, class, religious and political boundaries.

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Furthermore, the paper will detail the impact of woman battering on women's health and raises questions about the appropriate health care responses.

Woman battering: the cycle of violence

Woman battering is a general term used to describe violence that a husband or a male companion inflicts on his wife or girlfriend. It may also refer to battering of one member of a homosexual couple.[2] Even though the terms "abuse" and "battering" are often used interchangeably, their definitions vary. Battering generally refers to physical violence with or without a weapon while abuse encompasses other acts listed in the earlier definition of violence.

Woman battering is characterized as a vicious cycle. The theory of the cycle of violence is based on a pattern of experiences that Dr Lenore Walker saw emerging as she interviewed battered women in USA. She found that battered women are not constantly being abused nor is the abuse inflicted at random intervals. Instead, the abuse emerged as a pattern of a cycle consisting of three phases.[3]

Woman battering cuts across all racial, ethnic, religious, class and political boundaries.

* The tension building phase characterized by verbal harassment, threats of abuse and minor incidents of battering. Many women in this phase, Lenore Walker reports, become compliant or try to stay out of the abuser's way. This is not because the woman believes that she should be abused; rather, it is beause she believes that "her passivity" will prevent his anger from escalating. During this period, the woman will attempt to lead as normal a life as possible. It is during this time that she is likely to present to her family practitioner with somatic symptoms characteristic of chronic stress.

  Despite her efforts, however, the tension will continue to build and it often reaches a level at which the next phase becomes inevitable.

A culture which perpetuates female subordination.

* The acute battering phase is characterized by a discharge of tension often through physical attacks. These attacks could be triggered by minor incidents such as the abuser having had a bad day at work or the woman not having dinner ready on time. Depending on the extent of the injuries, this is the time when the woman may seek medical help. This is also the time when the police may be called. Many of the women, however, may be held captive and not allowed out of the house.

* In the reconciliatory phase, the abuser becomes apologetic and often swears that the violence will not occur again. Both the abuser and the woman may rationalize what has happened, they may minimize the seriousness of her injuries. At this point, the man genuinely believes that he will never hit her again and the woman also wants to think that the beating will stop. Despite the hope and belief that the abuser will change, the cycle may repeat itself.

Incidence

The extent of woman battering in South Africa remains unknown because of a lack of accurate and reliable statistics. It is estimated that 1 in 6 women are battered regularly by their male partners.[4] Based on the total number of adult women in this country, this estimate translates to 1 291 694.[5]

These statistics are, however, an underestimate because woman battering is a problem that is hidden in the privacy of the home and is infrequently reported to the police. Reasons for not reporting include fear, shame, and feelings of guilt on the part of the woman. Furthermore, the notion of the family as a sacred and private domain contributes to this underreporting. For these reasons, woman battering remains a crime that is pervasive but hidden from the public eye.

The abuser and the battered woman may later on rationalize and minimize the infuries.

Impact on women's physical health

In a study that was undertaken at Alexandra Health Clinic, 389 medical records of women presenting at the

Clinic with a history of assault during October and November 1991 were reviewed. The objectives of the study were to determine the proportion of women identified by health care practitioners as having sustained injuries caused by battering, to determine the nature, location and extent of the injuries as well as to evaluate the health care response to battered women.[6]

Woman battering is hidden in the privacy of the home.

Seventy (18%) of the women had multiple injuries ranging from two to five sites. Sixty one (17%) women sustained serious injuries that required hospitalization. Major reasons for hospitalization were fractures (skull, jaw, forearm, sternum, ribs and nose), deep scalp lacerations, facial lacerations and penetrating chest injuries involving the lungs. In general, the areas most commonly injured were the head, face, breasts, chest, abdomen and reproductive organs. Twenty two (6%) of the women were pregnant during the time of the assault, with most being kicked on their abdomens. The means to afflict the above injuries varied widely and ranged from bare hands to weapons such as knives, hammers, axes, screwdrivers, bottles etc. The knife was used in the majority of the cases and involved in the more serious injuries.

Impact on women's psychological health

If one only looks for physical injury, as was the case in the above study, a vast majority of battered women will be overlooked. Studies done in other countries have revealed that women in abusive relationships tend to develop long-term psychological or somatic symptoms which are a result of living in a state of chronic fear and stress. These reactions include, among others, headaches, chronic fatigue, sleeping and eating disorders, sexual dysfunctions, menstrual problems and other signs of moderate or severe depression.[7] Gayford reported in his study that 18% out of a sample of 100 abused women reported chronic physical illness related to stress. Half of the sample had been diagnosed as clinically depressed, 75% were taking tranquillizers or antidepressants and 53% had attempted suicide at least once.[8] In another study, it was found that one out of four women in abusive relationships attempted suicide, one out of three abused alcohol while one out of ten abused drugs.[9] Too often, it is these symptoms that are treated, leaving the source of the problem ie violence, unexplored.

One in six women in the RSA are battered regulary by their male partners (which means 1 291 694 women).

Health care response

Battered women often visit health care institutions seeking treatment for their injuries. Furthermore, between episodes of violence, the women may present to their family health practitioners with somatic symptoms mentioned above. Even though health workers are often the first point of contact for women who have been battered, studies have shown that battering remains unrecognized and is poorly detected in health care settings.[10,11,12]

Barriers to identification

The American Medical Association has identified the following barriers to accurate detection of battered women:[13]

Patient barriers

Abused women are often reluctant to tell the truth about how they got injured. If they do seek medical attention, they may be ashamed of being beaten or may fear a retaliatory beating from the partner. Very often, the batterer accompanies the woman and stays close at hand so that he monitors what she says. Telling the truth may result in further abuse. Other reasons for not mentioning abuse include: feeling guilty or blaming themselves for the violence; others may have received implicit or explicit messages that even if you do tell the health professionals, they will do nothing about the situation.

Health practitioner barriers

* lack of awareness of the extent and means of identification of the problem.
* believing that violence against women is not a health issue.
* believing that violence and rape of women by a male partner is acceptable and allowed.
* blaming the woman and wondering why she does not leave the battering partner.

* some of the health practitioners may have personally experienced the abuse. This may lead to a repression of feelings and leave them unable to face the pain and the prevalence of abuse.

* not knowing how to intervene.

* concern that addressing the cause of the injury will take a lot of time.

Only since 1985 has domestic violence been regarded as a *medical* issue in the USA – and not yet in the RSA!

Poor detection of battered women in health care settings is further amplified by a number of myths, beliefs and stereotypes surrounding the problem of domestic violence.[14] Social acceptance of these myths hide and prevent any efforts aimed at addressing violence in the lives of women. The following are examples of these myths:

Myth 1: Domestic violence is a private family matter.

No act which can leave a woman permanently injured physically and/or emotionally or result in her death is a family matter. Battering, rape and murder are all criminal acts regardless of the relationship between the people involved.

Myth 2: Domestic violence occurs only in low income families, or within certain racial or ethnic groups.

Domestic violence is a problem that affects all segments of the society. Belief in this inherently racist myth means believing that some racial or cultural groups are by their nature, perhaps even genetically, more aggressive. Professionals can then blame the race, culture or income group for the violence and not hold the dominant patriarchal society accountable.

Myth 3: Battering is caused by alcoholism; only drunk men hit their partners.

Any man has a choice about whether or not to be violent, to what extent, and to whom. Many batterers drink to excuse their violence. Even after alcoholism has been treated, the battering may continue. Some of the men who batter their partners do not drink at all.

Myth 4: Women ask for or provoke the violence.

The abuser may feel legitimate anger toward a family member. However, he chooses violence as a way to express this anger. By believing in this myth, professionals blame the battered woman for her own victimization and this relieves the batterer of responsibility for his violent behaviour. The same professionals may not hold the same views about victimizaton resulting from racism.

Myth 5: Battered women enjoy the battering. If they wanted to, they would seek outside help or leave the abuser.

Battered women are trapped in abusive relationships because of being economically, religiously or culturally constrained. Some are trapped by concern about the future of the children, continued hope for change, low self-esteem and lack of awareness of their rights and options.

Several observers, however, consider medicine to be on the brink of reform. In the past few years, articles on battering have begun to appear in medical journals in countries such as USA and UK. In the USA, domestic violence gained credibility as a medical issue in 1985 during the tenure of Surgeon General Koop, who sponsored a workshop on Violence and Public Health.[15] One of the recommendations of the workshop was that interpersonal violence should be incorporated into the core curriculum for undergraduate and graduate health professionals. Further, they urged that the certifying, licensing and State

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"I do not have the time. I can only treat the injuries" (a GPs words).

Board examinations should include questions on interpersonal violence in order to sensitize health professionals to this problem. Recently, the American Medical Association has produced diagnostic and treatment guidelines on domestic violence. These guidelines are intended to familiarize health care practitioners with the magnitude of the problem, describe how to identify abuse through routine screening as well as provide information on appropriate resources for referral.[16]

Clinicians rarely asked their injured patients any questions indicating suspicion of abuse (Alex survey).

In contrast to the above, a perusal of articles in medical journals in South Africa reveals a lack of research that raises woman battering as a health concern. Health workers require education in recognising and treating victims of battering. Such education will help to break the cycle of violence within the home as well as promote accurate detection, effective treatment and referral to other services that can be of help.

The role of the health care practitioner in breaking the cycle of violence

Detection of woman battering by health workers

In the Alexandra study referred to earlier, the notes indicated that the clinicians rarely asked questions and/or recorded information that would indicate their awareness of the women's risk of abuse. The term abused woman was used once. Sixty six (17%) of the women were positively identified to have been assaulted by their male partners. In 308 (81%) of the records, neither the cause of the injury nor the assailant were recorded.

Any woman seen with a history of injuries, and any woman who is not injured but for whom exists reasons to be suspicious, should be asked if she is experiencing abuse in her life. Direct or indirect questioning may be used by the health care practitioner to confirm his/her suspicions of battering.[17] However, asking "Are you an abused woman?" or "Are you a battered woman?" will rarely get an affirmative response because no person wants to assume the label's negative stigma.

Examples of direct approaches to the problem

* You seem to be frightened of your partner, has he hurt you?
* Did someone hurt you?
* Have there been times during your relationship when you and your partner have had physical fights?
* Are you in a relationship with a person who has hit you?

An indirect approach may use statements like:

* I often see women in my practice who come with injuries like yours. A lot of them are being hurt by someone they are close to. Do you want to talk about what happened to you?
* Many women in our society experience abuse from men in their lives; is anything like this happening to you?

Even if the health practitioner asks directly or indirectly, some women may deny being battered; some may blame themselves for the violence.

If a woman self-identifies or discloses the battering, the practitioner should provide her with extra time whenever possible. As indicated earlier, concern that addressing the cause of the injuries will take a lot of time has been identified as one of the reasons why health practitioners are reluctant to ask. In a meeting with the clinicians at Alexandra Health Clinic, one practitioner mentioned that the reasons they do not ask is "because once you do ask the question, the woman will tell you about her life history of abuse. We are under such pressure, we often do not have time. We are only concerned about treating the injuries."[18] In case the health practitioner is unable to provide the woman with extra time, an appointment should be re-scheduled for a later time or provision should be made for the woman to see someone professional such as a social worker or patient counsellor. Even if the health practitioner will eventually refer the woman for counselling, he/she must name the violence and acknowledge it as serious and life-threatening. The very acknowledgement that domestic violence is going on is a powerful and positive first step.

The GP is ideally situated to notice the first signs of domestic violence.

Appropriate "treatment" for battered women

In the Alexandra Health Clinic study, intervention was aimed primarily at treating the physical injuries and prescribing analgesics and/or antibiotics. In cases where the assailant was recorded to be a woman's partner, there was neither any follow-up or referrals. In the case of repeated visits to the health centre, there was no link in the medical records between one injury to another. While treatment of physical injuries is crucial, it may also constitute a symptomatic intervention that does nothing to address the cause nor prevent subsequent injury. This is clearly illustrated by the following personal account of a battered woman.

> "A few weeks after getting married my husband Joseph started to beat me. The beatings got so bad I ended in hospital. *From that time the hospital staff saw me more than the shopkeeper did.* (emphasis mine) . . . Even when I was pregnant, he beat me. With my second pregnancy my baby stopped growing inside me. I thought I was going to lose it. I left Joseph a few times but I always went back to him, I don't know why . . . I tried to kill myself many times. I drank paraffin, took tablet overdoses, tried to cut myself . . . Because of the beatings, I am blind in one eye. I have stab wounds all over my body. My bowel is not working properly. My face has been damaged and I get headaches all the time . . . I have left him now, this time forever . . . There are many scars I will never be able to get rid of but I know I'll end up in the mortuary if I go back to him again."[19]

Some women blame themselves for the violence.

Similarly, treatment of battered women with medication without addressing the violence compounds health problems in abused women because it enables them to return to a destructive environment thus reinforcing and helping to maintain the cycle. It also provides an opportunity for complications such as drug dependency and suicide.[20]

Given that living in an abusive relationship takes a tremendous toll on a woman's physical and psychological well-being, health care practitioners will interact with an abused woman at some point in the cycle of violence. Using the cycle theory, the health practitioner can help her realize that the violence is likely to occur again, often with serious consequences.[21] Furthermore, the practitioner can help the woman explore options and alternatives open to her. The health practitioner's support and concern for her safety may indicate to her that battering is serious, unacceptable and that she can do something about the situation.

Documentation of clinical findings

Routine screening should be carried out at all entry points of contact between women and health care practitioners, whether at a family practice, emergency room department, primary health care centre, ante-natal or post-natal clinic, psychiatric or family planning service. The family practitioner is especially likely to see manifestations of domestic violence other than physical injuries. While symptomatic treatment is essential, violence must be identified, acknowledged and documented.[21]

Well documented and complete records are essential to alert the health care practitioners once a pattern of battering occurs. Furthermore, the information in the patient's records may be used in future in the case of a legal action. When the bruises and broken bones have healed, this information is all the evidence that remains. The American Medical Association guidelines recommends that records should include:

The responsibility to initiate changes lies with the battered woman.

* description of the abusive event, using the patient's own words whenever possible eg "My husband punched me with a fist" is preferable to "Patient has been abused."
* complete medical and relevant social history.
* detailed description of injuries, where applicable, the location and nature of injuries should be recorded on a body chart.
* results of all laboratory and other diagnostic procedures.
* an opinion on whether the injuries were adequately explained.

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Referral

While most health practitioners would not consider discharging a patient with a life-threatening condition, data from the Alexandra Health Clinic study show that women with injuries that did not require hospitalization were sent home to their violent partners. Referrals to the psychologists followed trauma only when the woman was also raped. Two women with broken teeth were referred to the dentist while 6 of the 22 pregnant women were discharged and requested to come back for ante-natal clinic. In this intance, the health care practitioner fails to realize that despite regular ante-natal check-ups, the violence may result in obstetric complications such as miscarriage or foetal death.[22] Because violence is a critical determinant of the perinatal outcome, its eradication should be a goal of any safe motherhood initiative.

Once battering has been identified and the injuries treated, referral should be made to specially trained staff within the setting or to outside resources. A shortage of community-based services for battered women in this country may however pose problems for health care practitioners. It is therefore crucial that they should be part of, and participate in a campaign to generate these resources.

Conclusion

It is very clear that health care practitioners are best placed to indentify and treat victims of battering. A more responsive intervention should involve routine screening for abuse as well as developing treatment plans and formal protocols for dealing with

such patients. Often, knowledge and acknowledgement of a history of victimization provides a starting point from which to make an appropriate assessment, intervention and referral.

Finally, it is important for the health practitioner to realize that the responsibility to initiate change lies with the woman. The health practitioner can only present intervention options and encourage all steps towards safety, recovery and prevention of further injuries. Eliminating violence and fear for most women is a lengthy process that requires unconditional and nonjudgemental support as well as patience on the part of the health practitioners and other support workers.

Handling interpersonal violence needs to be incorporated into the curriculum of undergraduate and graduate medical professionals.

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References

1. Cited in Heise L. Violence against women: the missing agenda. In: Women's health: A global perspective. Koblinsky M et al (eds) Westview Press, 1992. (forthcoming)
2. Ghent WR, da Sylva NP, Farren E. Family violence: guidelines for recognition and management. Can Med Assoc J 1985; 132: 541-8.
3. Walker, LE. The battered woman. New York: Harper & Row; 1979.
4. Segal T, Labe D. Wife abuse. In: McKendrick, B & Hoffmann, W. People and violence in South Africa: Cape Town; Oxford University Press, 1991.
5. This figure was calculated by dividing the total number of adult women provided by Central Statistical Services, (1985 figure) with an estimate of 1 in 6 women.
6. Motsei, M. Identification of women battering in Health Care settings: the case of Alexandra Health Clinic. Centre for Health Policy, Department of Community Health, University of the Witwatersrand, 1993.
7. Burge, S. Violence against women as a health care issue. Fam Med 1989; 21 (5): 369-73.
8. Gayford JJ. Wife battering: a preliminary survey of 100 cases. Br Med J. 1975; 1: 194-7.
9. Stark E, Flitcraft A, Zuckerman D, Grey A, Robinson J, Frazier W. Wife abuse in the medical setting: An introduction to health personnel. Monograph # 7, Washington D C: Office of Domestic Violence; 1981.
10. Morrison LJ. The battering syndrome: a poor detection in the emergency department. J Emerg Med, 1988; 6: 521-6.
11. Delgaty, K. Battered women: the issues for nursing. Can Nurse, 1985; February: 21-3.
12. Mc Leer SV, Anwar R, Herman S, Maquiling K. Education is not enough: A systems failure in protecting battered women. Ann Emerg Med, 1989; 18 (6): 651-3.
13. American Medical Association, Diagnostic and Treatment Guidelines on Domestic Violence; March 1992.
14. Braham R, Furniss K, Holtz H. Hospital training on Domestic Violence; Jersey Battered Women Service Inc., 1986.
15. op cit ref 9.
16. op cit ref 13.
17. King MC, Ryan J. Abused women: Dispelling myths and encouraging intervention. In: Foley, Hoag, Eliot. Abuse Prevention Program. Empowering Battered Women: Suggestions for health care providers; Boston, Massachusetts, 1991.
18. Personal communication, Clinicians' meeting, Alexandra Health Clinic, 1992.
19. A marriage of blood and beating. Speak Magazine, 1992; September: 26.
20. op cit ref 9.
21. Braham R. The helper's role in breaking the cycle. Disabuse, 1985; 2 (3): 25.
22. Bohn DK. Domestic violence and pregnancy: implications for practice. J Nurse Midwifery, 1990; 35: 86-98.