Emergency care provision for, and psychological distress in, survivors of domestic violence

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Abstract

Background

This study aimed (i) to ascertain the number of treatment referrals and information about protection orders given to survivors of domestic violence presenting for emergency trauma care, as reported at the one-month visit, (ii) to obtain a profile of violent incidents and injuries, and (iii) to assess self-esteem and posttraumatic and depressive symptomatology in the aftermath of injury.

Methods

A survey of 62 participants presenting in the acute aftermath of domestic violence (as defined by the Domestic Violence Act of 1998) was conducted over 12 weeks at the Trauma and Resuscitation Unit of a Level One trauma centre in an urban public hospital in South Africa.[1] Following informed consent, face-to-face structured interviews were conducted during admission and a month later. The following instruments were administered at baseline: a Demographic and Injury Questionnaire, the Beck Depression and Rosenberg Self-Esteem Inventories, and the Davidson Trauma Scale. A psychosocial questionnaire was administered at the one-month follow-up.

Results

Fifty-eight per cent of the participants were female and 42% were male. Seventy-four per cent of the perpetrators were male. Ninety-five per cent of the participants said that no health professional had informed them about where or how they could find help. Although all were seriously injured, 76% of the participants said only the researcher had asked about their experience. Sixty-six per cent of the cases of domestic violence were related to intimate partner violence. Overall, subjects displayed high levels of depressive and post-traumatic stress symptomatology that had neither been treated nor adequately referred.

Conclusion

Even though domestic violence poses significant health threats and costs to the health system, it appears to be a neglected area of South African health care. Health professionals should at least be able to identify and intervene within the "open window" period when psychosocial opportunities are pivotal.

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Introduction

Domestic violence is no longer a family or community secret. The World Health Organization recognises it as being of major consequence to women's physical and mental health.2 Despite this recognition, an analysis of the health sector response to domestic violence reveals that most health professionals in South Africa lack skills to deal with domestic violence and therefore tend to hide from the problem.3 The neglected, under-reported and under-documented nature of domestic violence, as well as the perception of this crime as a "family affair" or "justice issue", therefore not needing a health service intervention, is an international phenomenon. Due to the historic absence of attention given to issues relating to gender-based violence in the curricula of health professionals, medical staff may feel they lack the competence, time and resources to deal with this complex issue beyond taking care of the injuries sustained. This endemic limitation of health systems presents a major stumbling block to obtaining accurate epidemiological data. It also masks the recognition of the direct and indirect sequelae on the mental and physical health of survivors of domestic violence.

In 1999, the Domestic Violence Act (DVA) (No. 116 of 1998) was promulgated in an effort to improve legal remedies for individuals experiencing violence in domestic contexts.1 The DVA contains measures to ensure that the justice system takes all forms of domestic violence seriously.4 Significantly, the DVA currently contains no positive legal obligations on the part of healthcare practitioners to assist or provide information to survivors of domestic violence. Advocacy work is currently underway to highlight this issue as an area of the South African health system urgently in need of change.

Revolutionary in its scope and sensitivity, the DVA defines domestic violence as follows: physical, sexual, emotional, verbal, psychological and economic abuse, intimidation, harassment, stalking, damage to property, entrance into the complainant's property without her consent, and any other controlling behaviour which may cause imminent harm to the safety, health or well-being of the complainant.4

The DVA also expands the concept of "domestic relationship" in accordance with people's lived experience: people who are or were married to each other (whether they live together or not), same-sex partners (whether they live together or not), any person who is or was in an engagement, dating or customary relationship, including an actual or perceived romantic relationship, intimate or sexual relationships of any duration, parents of a child, and people who share or recently shared the same residence.

Curnow coined the term "open window phase" for the period immediately after the acute battering episode, when the battered woman is able to see the reality of her victimisation and reach out for help. At this point, she is most receptive to interventions.5 Recognition that emergency departments should implement domestic violence protocols is undercut by the challenges inherent to a trauma (accident and emergency) service designed as generalist, reactive and as a 'quick fix'. This role is diametrically opposed to assuming a proactive, supportive and advisory role devoted to a discrete patient group, as is required in psychosocial care.6 However, researchers now argue that routine inquiry about domestic violence should be incorporated into the health care of women, and that moral, financial and legal imperatives exist.7,8

Although there is little quantitative research measuring the health outcomes of interventions offered in health service settings, there is considerable qualitative evidence to indicate the benefits of routine inquiry. For example, Humphreys et al. reported that women who received an intervention designed to provide them with information on the cycle of violence, a danger assessment, the options available to them, safety planning, and resource referrals in an empowering manner had significantly lower scores for both physical and non-physical abuse at six and 12 months post-intervention than had women who had received no intervention.8

Healthcare professionals are uniquely placed to identify domestic violence and to promote early intervention and appropriate intersectoral referral. It has been suggested that healthcare protocols for the identification, management and referral of domestic violence survivors be developed as a matter of urgency.3

Methods

Participants

Patients presenting to the Trauma and Resuscitation Unit, Tygerberg Hospital, Cape Town between April and June 2003 were screened by six researchers (B CUR IV nursing students), with the cooperation of the surgical trauma team. This study was approved by the Ethics Committee of Stellenbosch University. Written informed consent was obtained from all study participants who met the following inclusion criteria: 18 years of age and older (if legally married, 16 years and older), fluency in English or Afrikaans, treatment seeking following an episode of domestic violence and willingness to give informed consent.

Sixty-two subjects (36 females, 26 males) were recruited over a 12-week period. A convenience sampling strategy was employed with subjects recruited primarily over weekends. The student researchers received training in routine inquiry and the administration of questionnaires. All the questionnaires were formally translated into Afrikaans and back-translated. Participants were assured that their responses would be confidential and anonymous and that refusal to participate would not jeopardise their management. Eligible subjects were interviewed privately during their admission period and again one month later. Face-to-face structured interviews were conducted in either Afrikaans or English. Referral information regarding counselling or legal assistance was supplied in writing to any participant requesting it at the follow-up assessment. Since the aim of this study was to assess what psychosocial care, if any, was offered to domestic violence survivors in a trauma setting, the researchers did not provide routine advice and referral at the initial presentation, as this would have contaminated data collection.

Instruments

A Demographic and Injury Questionnaire based on the internationally recognised "Danger Assessment" screening tool devised by JC Campbell was used.9 The questionnaire includes questions on threat and/or use of weapons, as well as details relating to the physical harm done.

A Psychosocial Questionnaire for the needs of domestic violence survivors in the Western Cape.

The following self-report measures were chosen to assess baseline depression, self-esteem and posttraumatic stress symptoms because they have internationally established psychometric properties:

As a screening tool for depression, the *Beck Depression Inventory* (BDI) has the following recommended cut-off points: 0-9 non-depressed; 10-15 mild depression; 16-23 moderate depression; > 23 severe depression.10

The Rosenberg Self-Esteem Inventory is a widely used measure of self-

esteem. Respondents indicate how they feel on scales of 1 (strongly agree) to 4 (strongly disagree). Scores range from 10 to 40, with higher scores indicating higher self-esteem.11

Items on the *Davidson Trauma Scale* (DTS) measure the 17 posttraumatic stress disorder (PTSD) symptoms in the past month, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Each DTS item is measured on a scale of 0-4, for both severity and frequency, such that the maximum possible score is 136.12,13

For the purposes of this article, only the mental health measures and psychosocial aspects will be addressed.

Results

(i) Demographic characteristics

The demographic variables are presented in Table I. The mean age of the participants was 34.0 8.9 years. The majority were single, relatively uneducated females living below the breadline.

Table I: Sociodemographic characteristics of survivors of domestic violence (N=62)

Variables	N (%)
Gender	
Female	36 (58.1)
Male	26 (41.9)
Ethnicity	
Asian	9 (14.5)
Black	2 (3.2)
Coloured	50 (80.6)
Don't know/refused/missing	1 (1.6)
Education	
No schooling	2 (3.2)
Grade 1 to 8	38 (61.3)
Grade 9 and higher	20 (32.3)
Don't know/refused/missing	2 (3.2)
Marital Status	
Married/ living together	27 (43.5)
Single	28 (46.8)
Divorced	5 (8.1)
Widowed	1 (1.6)
Currently employed	36 (58.1)

(ii) Abuse characteristics

Seventy-three per cent of the participants had been threatened with murder and 79% admitted to having a violently jealous partner (see Table II). The participants displayed a disturbing pattern that is also evident in the international literature: despite indicators of risk (viz. 84% had been assaulted or threatened with a weapon), 45% of the participants said that they felt safe in their current relationship. Moreover, more than 50% reported that the frequency of physical violence had escalated in the past year.

(iii) Psychological responses

Sixty-eight per cent of the participants (n=42) met criteria for PTSD on the DTS, while 45% (n=28) met criteria for depression on the BDI. The mean total score on the BDI was 20.5 14.0 for the sample, just below the accepted cut-off of 21, which denotes clinical depression. The mean total DTS score was 64.0 35.1. This is higher than the recommended cut-off score of 40 for PTSD. The female participants were more symptomatic than the male participants, both in terms of depression and PTSD. Notably, females had significantly higher total BDI scores (mean = 25.6, SD = 12.7) than males had (mean = 135, SD = 12.8, p = .001), and higher total DTS scores (mean = 79.1, SD = 31.7) than males (mean = 43.0, SD = 28.4, p = 0.000). In terms of mean total scores on the Rosenberg Self-Esteem Scale, no significant gender differences were noted (females = 22.3, SD = 4.0; males = 21.4, SD = 4.0; p = .883).

(iv) Psychosocial variables

At one month post-injury, almost all the participants (95%) reported that they had not received treatment referrals from a health professional, had not felt cared for, nor had they been advised about obtaining a protection order. With regard to the perpetrators, 42% were male intimate partners, 24% were female intimate partners, 23% were nuclear family members and 11% were extended family members.

Discussion

The World Health Organization's World Report on Violence and Health shows that intimate partner violence is linked to multiple immediate and long-term health consequences, including depression, posttraumatic stress syndrome, physical disability and death.2 Survivors of domestic violence are also several times more likely to deliberately self-harm or misuse alcohol or drugs than is the norm common causes of attendance at emergency departments.14 Furthermore, male violent and coercive sexual practices impact on women's capacity to protect themselves against STDs and unwanted pregnancy, with the consequent vulnerability to HIV infection. Such abuse impacts on women's parenting abilities, occupational performance and financial status.15 More importantly, in some countries almost 50% of female murder victims were killed by their current or former intimate male partner.2

The first large-scale, community-based prevalence study undertaken in South Africa found that 25% of women were physically abused by current or ex-partners. Significant financial and emotional abuse was also reported, for example the prevalence of a partner having boasted about or brought home girlfriends in the previous year was 7.5%.16 A recent antenatal survey conducted from a random sample of 604 South African women found that 38% had experienced domestic abuse in their lives. Physical abuse (52%) was the most common, and 35% had been abused during the current pregnancy.17

In South Africa, as elsewhere, battering tends to be a hidden phenomenon, remaining undisclosed to relatives, neighbours, clinicians and researchers due to varying cultural constructs about its significance.18 Indeed, a South African study highlighted university students' construction of heterosexual relationships as strongly connected to power, violence and inequality.19 The shared experiences show how violence and male control and coercion over sexuality are an expected and assumed part of 'normal' heterosexual relationships. Challenges to unequal and coercive sexual practices also emerge, emphasising the need for communication, negotiation, equality and women's assertiveness and realisation of their rights.19

The high rate of depression and PTSD in this sample as a whole highlights the need for effective psychosocial interventions during the critical window period. Psychosocial support has also been shown to be crucial to the improved health of traumatised individuals, as a lack of post-trauma social support has consistently been shown to be a predic-

Table II: Abuse characteristics

Injury Questionnaire		N	%
Is there a partner from a previous relationship making you feel unsafe now?	Yes	12	19.4
	No	50	80.6
Do you feel safe in your current relationship?	Yes	28	45.2
	No	32	51.6
	Refused/missing	2	3.2
Have you been hit/punched/kicked in last year?	Yes	43	69.4
	No	19	30.6
Has physical violence increased in frequency in the last year?	Yes	33	53.2
	No	29	46.8
Has a weapon been used or have you been threatened with a weapon?	Yes	52	83.9
	No	10	16.1
Has he or she ever tried to choke you?	Yes	25	40.3
	No	37	59.7
Is there a gun in the house?	Yes	3	4.8
	No	59	95.2
Has he or she ever forced you to have sex when you did not want to?	Yes	11	17.7
	No	41	66.1
	Refused/missing	10	16.1
Do either of you use drugs?	Yes	32	51.6
	No	30	48.4
How regularly does he or she get drunk/stoned?	Never	9	14.5
	Once a month	3	4.8
	Once a week	27	43.5
	Almost every day	22	35.5
Did you or he or she partake of any substances in the 12 hours preceding the incident?	Yes	36	58.1
	No	26	41.9
Has he or she threatened to kill you?	Yes	45	72.6
	No	17	27.4
Does he or she control your activities?	Yes	33	53.2
	No	29	46.8
Have you been hurt by him or her while you were pregnant?	Yes	6	9.7
	No	31	50
	Refused/missing	25	40.3
Is he or she violently jealous of you?	Yes	49	79.0
	No	13	21.0
Have you threatened or tried to commit suicide?	Yes	20	32.3
	No	42	67.7
Has he or she threatened or tried to commit suicide?	Yes	9	14.5
	No	53	85.5
Is he or she violent towards your children?	Yes	22	35.5
	No	34	54.8
	Refused/missing	6	9.7

tor of PTSD and its symptoms.20

Living in poverty is also highly correlated with psychological manifestations of distress.21 Most participants in this study were living below the breadline and, as discussed above, found it impossible to access services. This is clearly evidenced by the fact that no referrals were made by the healthcare staff of the unit to hospital social workers. Furthermore, the limited availability of social workers due to scarce resources did not make routine referral possible. Significantly, it has been suggested that a lack of agency networking presents a major obstacle to the treatment of battered women in South Africa and that work pressure is often used as a defence because any liaison would reveal the shortcomings of the practice.22

Survivors of abuse often report being victimised twice by their abusers, and then by healthcare providers in the facility where they seek help. Inadequate referrals to government and nongovernmental services prevent liaison between healthcare professionals and the legal and crime prevention sectors regarding the implementation of the Domestic Violence Act.4 Only 5% of the sample had received any form of attention to their psychosocial needs, the counselling thereof, advocacy or psycho-education on the DVA. Yet the Western Cape is well resourced with active non-profit and community-based organisations providing services for those affected by domestic violence. This highlights the need for the health professionals to be more responsible about referring patients to the multiple resources available. Such systemic hurdles are internationally recognised and include difficulties

negotiating institutional bureaucracies, the continuing effects of trauma on the survivor's ability to negotiate effectively in the world, and healthcare providers' reactions to, or lack of understanding of, the manifestations of trauma.4, 21

The fact that only 5% of the sample received attention regarding the identification of their psychosocial needs seems to reflect that health professionals experience considerable distress when confronted by issues such as domestic violence.23 Here we are confronted with an ambiguous issue, one we can either respond to or leave alone, and for which our professions seem to have failed to prepare us. Clearly, in the absence of such educational preparation and of policies to support intervention, the response received by a survivor of domestic abuse is based on the idiosyncratic knowledge of the treating health professional.

A lack of feeling cared for emerged clearly in the patients' descriptions of their experiences. Services provided by health professionals that give patients a sense that they are being cared about has been termed 'emotional labour'. This relates to the element of work that is involved in smiling and being courteous and responsive. If emotional labour is unrecognised in healthcare systems, it may be that it does not easily fit the medical model and must seem to be freely given if it is to be of value.24 Further, 'care' and 'emotion' are concepts that have strong cultural associations within the 'private' sphere of love and feelings, rather than the 'public' world of work.

The following limitations of this study are worth noting: First, the small sample size (due to logistical constraints on the researchers to recruit within a restrictive time frame) limits any generalisation of the findings. Second, 62 initial assessments were completed, but only 34% presented for follow-up. The high attrition may be attributed to a lack of finance for transportation and childcare, job demands and language constraints. The trauma staff in the unit pointed out that the low rate of follow-up was normal for their setting.

While the small sample does not allow any generalisation of the findings, the study does offer insight into the efficacy of care provided for traumatised survivors in the acute aftermath of domestic violence at an under-resourced provincial hospital in South Africa. This trauma unit sees in excess of 20 000 patients a year. Most have an Injury Severity Score (ISS) of 15 or higher, with approximately 1 500 patients arriving intubated and sedated. Two to three doctors staff each shift, seeing in excess of 50 patients a shift.

Conclusions

To strengthen advocacy efforts, assist policy makers and direct the format for preventative interventions, it is vital that the health sector takes responsibility for accurately identifying domestic violence, raising awareness, and providing information on appropriate interventions. One of the major obstacles to healthcare workers intervening in domestic violence is the confusion regarding the nature of their professional role in relation to survivors of abuse. Even though domestic violence poses major social and health threats, only the minimum is currently being done to ensure that healthcare professionals receive adequate training. Healthcare providers should at least be able to identify and act within the "open window" period when psychosocial intervention is pivotal.

Existing evidence points to an urgent need for the establishment and implementation of a screening protocol for the management of domestic violence in South Africa. Early identification, comprehensive management, thorough documentation of injuries sustained, and effective referral should be promoted to prevent further injury, ill-health and death.

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