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Physical violence against women from the perspective of health professionals

ABSTRACT

OBJECTIVE: To comprehend the perception of health professionals regarding physical violence against women by an intimate partner.

METHODOLOGICAL PROCEDURES: This is a qualitative study performed in 2006 on 30 health professionals from three National Health System units in the city of Natal, Northeastern Brazil. Semi-structured interviews were conducted on three thematic topics: ideas associated to physical violence suffered by women; action of the health professional; and the role of health services. The series of interviews included questions on the perception of professionals about gender relations, physical violence, action as a health professional, and the role of health services. Categories were formed from these topics using the thematic content analysis.

RESULTS: Health professionals pointed several factors that influence domestic violence situations, among which are machismo, poor economic conditions, alcoholism, and previous experiences of violence in the family environment. The study group reported they did not feel qualified to discuss the subject with the population and stressed the need that health services promote educational activities with this aim.

CONCLUSIONS: The results suggest the need for systematized and effective actions aimed at humanizing health care for the battered woman.

DESCRIPTORS: Violence against Women, Social Perception. Human Health resources. Health-related Knowledge, Attitudes and Practice. Qualitative Study.

INTRODUCTION

Violence is a multiple determination phenomenon. It is determined by hierarchy of power, conflicts of authority and desire to dominate and annihilate the other. Although violence is not a specific feature of health, it directly impacts on health due to its resulting injuries, traumas and deaths, which can be both physical or emotional, thus representing a major public health problem across society.[10]

The violence phenomenon is a violation to the rights to freedom and to the right of the individual to be the subject of his or her own story. According to Chauí, violence against women results from male domination producing and reproducing, through ideology, a relation that transmutes difference into inequality. There is a general state of subordination whose normative order hierarchizes predetermined social roles and standards of behaviour.[5]

Studying violence against women as a kind of interpersonal violence in spousal relationships means understanding violence as an instrument of power, resulting from inequalities in gender, social class, race/ethnical and generation factors.

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There are two sets of factors considered conditional and precipitation factors of violence. Conditional factors are expressed by the assault perpetrated due to economic unbalance, machismo, institutions that discriminate against women and the effects of education giving privilege to the male gender in detriment of women. In regard to the precipitation elements, we can stress drinking and intake of toxic substances, in addition to stress and fatigue, which can unleash emotional discontrol and cause episodes of violence.[6]

Therefore, women play the social role of 'accomplices' of the violence of which they are victims, although this does not mean they have consciously chosen to do so, and it also contributes to reproducing women's dependence on male domination.[6]

Domestic violence is a serious problem that affects families in a number of different countries across different social classes.[13] Estimates show that 20% to 50% of the women across the world have been victims of physical assaults by their partner at least once in their lives.[15] In Brazil, a study carried out with 322 patients at a health centre (UBS) in the city of São Paulo (Southeastern Brazil) found that 34.1% had been victims of a domestic violence episode at least once in their lives.[15]

In Brazil, as of the 1980s, the problem was given more visibility due to ample debates on gender violence and on the feminist movement, which resulted in raised awareness of society.[3] Consequently, specific services were created aimed at fighting the problem, such services include special police stations for women [*Delegacias de Atendimento à Mulher* - DEAM), shelters and reference centres with providing psychosocial support, which have mainly focused on physical and sexual assault perpetrated against women by their partners or former partners in the domestic environment.[14]

Violence against women has serious consequences in a woman's full personal development and on her health, and it is considered a major public health problem.[4] This kind of violence is mirrored in statistics on the increase of suicide, drug-abuse and drinking, on the incidence of health problems such as cephalgia and gastrointestinal disorders,[15] in addition to all the psychological problems faced by the victim due to her inability of facing the situation she is going through. In regard to reproduction healthcare, violence against women has been associated to unwanted pregnancy, chronic pelvic pain, inflammatory pelvic disease and sexually transmitted disease, including AIDS.[15] Furthermore, it has also been associated to late-onset diseases such as arthritis, high blood pressure and heart conditions.[16]

In face of all of this, it has been noticed that women victims of violence are more likely to seek health services centres, and these play an important role in fighting violence and can play a role in identifying and supporting women before sequelae or more serious incidents take place.[7]

However, a considerable number of cases of assault are not identified, thus making this phenomenon invisible to health services.[14] One of the reasons is the lack of training of health professionals to identify violence in the complaints of women patients. In most cases, health professionals only treat the physical symptoms, thus disregarding psychosocial aspects, in addition to having a strong tendency to medicate.[13]

The relative 'invisibility' is stressed due to the complexity of violence, making intervention more difficult. Therefore, many women do not tell and many health professionals do not ask, many times because of the short period of time available for the appointment. There is also a widespread belief that domestic violence is a private problem and can only be solved in a private context.

From the strategic point of view, health services do not take actions together with psychosocial services in the women's support network, and this results in isolated and ineffective action. Knowing which services are available and referring women to them when necessary is an important step to identifying and fighting the problem.[13]

The objective of the present study was to comprehend the perception of health service professionals on physical violence against women committed by an intimate partner.

METHODOLOGICAL PROCEDURES

This is a qualitative study on a sample made up of 30 health professionals equally distributed in three health units in the city of Natal in the state of Rio Grande do Norte (Northeastern Brazil). Characterization of the sample was performed through a form with information on age, gender, civil status and professional background.

In depth interviews were carried out based on interview guidelines including questions concerning the perception of health professionals in regard to gender relations, physical violence against women, to their role as health service professionals and the role of health services in the face of this phenomenon.

The interviews were conducted simultaneously to the participant observation, between February and August, 2006. Interviews were taped and then fully transcribed.

The data were examined through thematic content analysis.[2] Three central themes, which corresponded to the themes in the interviews, were examined. And based on these themes, the empirical categories were organized.

The study received approval of the Ethics in Research Committee at the *Universidade Federal do Rio Grande do Norte* (#016/06), and participants signed and informed consent statement.

RESULTS

Out of the 30 health professionals interviewed, 28 (93%) were women. The average age was 44.9 years. Concerning professional experience, the average time was 17.8 years. Participants had been working at their respective health unit, in average, 6.7 years.

In regard to occupation, 21% were physicians, 17% nurses and dentists, 13% social workers and community health agents and 10% were psychologists and nursing aid. Concerning social status, 50% were married, 27% single and 23% separated.

Based on the categorization process, we worked on three central themes on violence. There were five categories, 19 subcategories and 150 units of analysis, as illustrated in the Table.

Table. Distribution of categories and subcategories of violence. Natal, Northeastern Brazil, 2006.

Theme and category	Number of units of study
Ideas associated to physical violence against women by their intimate partner	
Causes of physical abuse	
Machismo	20
Financial situation	11
Drinking	8
Family history	3
Actions of healthcare professionals	
Identifying violence	
Symptoms presented	9
Psychological aspects	12
Women do not talk	14
Attitudes of healthcare professionals when faced with a woman victim of violence	
Refer to specialized services	7
Provide support	7
Does not get involved	5
Invite the aggressor for a conversation	3
Role of healthcare services	
Activities of the service	
Educational activities	15
Training professionals	9
Does not know	3
Psychological serves	6
Difficulties faced in service	
Lack of professionals	6
Lack of professional training	7
Work with the aggressor	3
Contact with the support network	11

The main factors health professionals considered to be the major causes of situations of domestic violence were: machismo, economic situation, drinking and history of violence in the family.

Machismo was described as a phenomenon according to which men believe that women have the obligation of serving and being available for them. This idea is reinforced by women themselves and by the current cultural features, as expressed below:

"the man thinks he's superior, that he can do anything he want, right, he wants things his way, to get his way, if he has to hit, he hits". (Nursing aid)

Financial problems were reported to be a potential source of situations of violence.

"I also think abuse is also caused by the poor economical situation of these people". (Physician)

Alcoholism was also stressed as another factor that leads to violence against women. A community health agent also believed that drinking caused physical abuse, whereas, for the psychologist, men do not usually take responsibility for their actions, they justify them by the fact they were not sober, trying to minimize them or even to escape any responsibility, as we can see in:

"alcoholism is an issue that we know that here in the neighbourhood is something that happens very often, and that leads to frequent violence, including because he drinks to be able to be violent". (Nurse)

It was reported that people who experienced domestic violence during childhood tend to reproduce the violent behaviour,[8] by developing violent strategies to solve existing conflicts in their current family, as is illustrated in the following quote:

"in fact, he has seen his father hit his mother, he has seen his mother suffer, and that is how he thinks it should be. He doesn't know any other way of solving conflicts". (Psychologist)

Concerning the work of health professionals, in general, battered women who sought the health service had symptoms. However, they avoided talking the situation they were going through with the health professionals. The feeling of shame was reported to be the reason for not talking about the violence against them, as we can see in:

"they are ashamed to talk about it and they have that distant gaze in their eyes, and we can immediately tell something is wrong". (Dentist)

On the other hand, a good relationship of trust between patient and the professional allowed the latter to express him or herself when he or she suspected there had been violence.

"when I suspect, I simply say that if she needs help, she can count on me. Some of them cry and talk, others just say thank you and don't say a word, and I undertand them". (Physician)

In some cases, health professionals felt powerless in the face of the complexity of the phenomenon, and referred these women to specialized services in the support network for victims of domestic violence.

"what I tell them is to report and look for their rights". *(*Social worker)

Many respondents stated that they should not get involved because there might be a risk of death:

"I didn't do anything because it is dangerous to get involved with the criminals in the neighbourhood, because I come to work here every day. It is better not to get involved". (Physician)

On the other hand, there were professionals who invited the aggressor for a meeting, believing they could contribute to solve the problem:

"I send him a note asking him to come here to the unit. Who knows maybe we can reach an understanding". (Social worker)

Concerning the role played by the health services, many health professionals did not feel prepared to discuss the issue within the health services:

"I think that first professionals have to be prepared, because when we leave medical school we are prepared to work in a clinic, with a patient and air-conditioning. You don't see the patient as a whole, you see the patient in parts". (Physician)

The lack of training of health professionals prevents the issue of violence against women be addressed within the health services.

"we are not trained to deal with these cases. I don't feel I am qualified, because it is a very sensitive situation, many times we end up driving them away, instead of supporting them, and then we are not providing a good service. I think we need training". (Nurse)

Another difficulty reported by the respondents was the high demand in the health services, which results in speedy appointments and treatment focusing on the symptoms presented, thus not addressing the causes in depth. In addition, there is a shortage of professionals to meet the demands of the population who uses the health services; as a result effective services are compromised:

"our staff was reduced, therefore we don't have time to waste talking to the patient; in fact, by doing this we would gain time. But, the truth is we need to act quickly so everyone is treated". (Nurse)

DISCUSSION

Women who experience violence have not only physical, but also psychological and social sequelae. Therefore, providing services to these women requires an interdisciplinary team able to address all the aspects of the lives of these women.

Among the factors responsible for violence against women we find machismo, which has to do with the perception of the differences between men and women as a social and cultural construct, it implies violent and disrespectful behaviour.[12] To the respondents, inequality is obvious in situations in which men have power, thus perpetuating the belief that men are superior and deserve to be respected and obeyed and, when they are not, they feel entitled to abuse women.[16]

In regard to socioeconomic condition, although violence is present across social classes, regardless of the level of schooling and of occupation, it has been observed that the less the social support, the grater the risk of violence, seeing that women tend to submit themselves more frequently to the aggressor as a result of lack of opportunities to fight violence.[16] Women who seek public health services are the ones who have the least external resources to fight the problem, and this fact may justify the perception of health professionals that there is a higher prevalence of violence among the lower social classes. In higher social classes, there is an under-presentation of the data on reported violence due to resources enabling women to hide domestic violence,[1]

Domestic violence is influenced by social factors, such as low schooling rates and unemployment, in addition to habits such as intake of illegal drugs and driking.[8,13] And both alcohol[1] and toxic substances are considered precipitating factors of violent episodes.[16]

In terms of the role played by health professionals in the face of violence, the results of this study show that, on one hand, these professionals find it difficult to identify possible cases of violence and, on the other, women find it difficult to express the violence they experience. All respondents presented the same difficulties concerning identifying, providing service to and referring women in situations of violence to specialized services, which reinforces the idea that, in general, the health professionals do not feel qualified to deal with the problem. Furthermore, there was no distinction in regard to the perception of violence across the different occupations.

It was noticed that there are professionals who invite the aggressor for a conversation, however, it is important to highlight that, most times, this kind of attitude can create even more stress between the couple, due to the fact that men feel exposed and vulnerable in the face of health professionals, and this may unleash situations of conflict and aggression.

Because of the complexity of the problem, we believe that this kind of attitude is not enough to fight the problem adequately, seeing that health professionals limit themselves, in general, to providing practical advice or general formulas, which are not capable of sustaining behavioural changes. This attitude is a result of the existing gaps in the training of health professionals concerning training in interpersonal relations and approaches of ethical and humanistic aspects, which involve their professional practice.

Many professionals believe they should not get involved due to the lack of tools in the health services enabling them to deal with such a complex phenomenon. Another issue is the lack of training during college to deal with the problem, causing uncomfortable professional situations, and, because they do not know what to say, they feel impotent in the face of the complexity of the phenomenon. This happens due to the lack of a common language, in other words, the expectations of the health professional does not always meet the expectations of the patient, who expects comprehensive service, in which not only merely symptomatic issues are addressed. On the other hand, some health professionals limit themselves to addressing strictly organic aspects.[14]

Schraiber et al[14] (2003) approached the following questions: Why don't women tell? And why don't professionals ask? According to the authors, the difficulty lies in the doctor-patient relationship, where women do not feel confident and safe to talk about what they are going through.

Taking this into consideration, professional organizations and international organizations such as the Pan American Health Organization (PAHO) have developed guides for health professionals to enable them to identify, provide support and refer the victims to the appropriate agencies.[16] Interventions such as these must consider that situations of violence cannot be extinguished, in addition the consequences of violence on one's health or psychological suffering resurface constantly and continue to pressure the health services for new interventions.[15]

Sufferings that go without elaboration can be somatized providing grounds for depression or morbidity requiring medical intervention.[14] Adeodato et al (2005)[1] stated that depression, anxiety and phobic symptoms are part of the clinical symptoms found in battered women and that 38% of the women who have experienced situations of violence have thought of suicide. For this reason, these women resort to the health services much more, where some cases are presented in a systematic and repetitive way, in permanent and chronic suffering.[14]

Healthcare services can serve as places where warnings against violence can be identified, thus promoting actions enabling the problem be identified and fought.[13] Establishing rapport with the patient and making the patient feel supported and not judged can be decisive in fighting violence against women. The quality of care is related to a relationship of sympathy, respect and support that healthcare professionals establish with these women in a difficult moment of their lives.[11]

The role of healthcare services in dealing with violence against women includes a wider definition of health, which encompasses understanding and changes of attitudes, beliefs, practices, and this role goes beyond providing diagnoses and treating physical and psychological injuries.[9]

In the present study, because they do not feel prepared, healthcare professionals would like to receive training enabling their intervention to approach women as a whole, thus addressing their physical, psychological and social aspects. Moreover, there is still the need of healthcare professionals overcoming their beliefs and prejudice so they are able to provide better quality healthcare, without being judgmental.[11]

In terms of prevention, healthcare services could develop educational activities. These activities could be carried out at the respective healthcare unit, approaching and discussing the topic with the population. Respondents agreed with this statement, and believe activities of the kind would play a decisive role in fighting violence.

It would be significant that healthcare services promoted these discussions in interdisciplinary teams, in order to go deeper into the topic and to be able to achieve a wider vision of the individual, thus promoting a greater awareness of the health professionals when faced with cases of violence.[11]

In addition, it was observed that healthcare professionals are unaware of existing specialized services providing integral support to women who are victims of violence. This limits women's access to interdisciplinary support which would enable them to think their condition, thus enabling them to become aware of their rights, recover their self esteem and, eventually, put an end to the cycle of violence.

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