THE PHENOMENON OF WOMEN ABUSE: ATTITUDES AND PERCEPTIONS OF HEALTH PROFESSIONALS WORKING IN HEALTH CARE CENTERS IN THE PREFECTURE OF LASITHI,CRETE,GREECE

Androulaki Zacharoula [1], Rovithis Michalis [2], Tsirakos Dimitrios [3], Merkouris Anastasios [4], Zedianakis Zacharias [5], Kakavelakis Kyriakos [6], Androulakis Emmanouil [7], Psarou Maria [8].

1. Associate Professor Department of Nursing, Technological Educational Institution of Crete, Greece
2. Clinical Tutor, Department of Nursing, Technological Educational Institution of Crete, Greece
3. Scientific Fellow, Department of Nursing, Technological Educational Institution of Crete, Greece
4. Associate Professor, Department of Nursing, Technological Educational Institution of Crete, Greece
5. Assistant Professor, Department of Nursing, Technological Educational Institution of Crete, Greece
6. Clinical Fellow, Department of Nursing, Technological Educational Institution of Crete, Greece
7. Postgraduate Student, National Polytechnic School of Athens
8. RN, Nurse, Assistant Tutor, Department of Nursing, Technological Educational Institution of Crete, Greece

Abstract

The purpose of the present study is to evaluate the attitudes and perceptions of healthcare professionals in the prefecture of Lasithi against the phenomenon of abused women, as well as their level of knowledge in identifying and managing the women-victims in a holistic way.

Material Method

A descriptive survey design was employed. Data was collected by using a self – administered questionnaire. The sample consisted of ninety one (91) health professionals (25 physicians and 66 medical nurses) working in pathology, surgery, orthopedic, maternity and emergency units of hospitals in the prefecture of Lasithi. Measures of central tendency and measures of dispersion (average value, standard deviation, range) were implemented for continuous variables, while discrete variables and clustered data were expressed as percentages.

Results

The findings reveal that health professionals believe that the psychological consequences of violence against women affect more the victims themselves (mean 4.64 ± 0.59) and the family as a unit (mean 4.47 ± 0.59). Also, the participants believe that violence against women is always (38.4%) or occasionally (52.5%) manifested in the form of bodily injuries. The participants also reported that in the context of their professional skills they provide to women-victims with medical care (80.5%), nursing care (94.4%), and warm attention (97.8%), in addition to registering the women's bodily injuries (92.1%). Furthermore, they provide psychological support (97.8%), inform the women-victims about their rights (70.1%) and about other services abused women can resort to for help (80.7%).

Conclusions

Health care professionals don't have the required training and skills to cope with and manage aggression against women in a professional manner. To be able to tackle the issue of women abuse physicians and medical nurses need the proper training and screening protocols, in addition to personal sensitization.

Keywords:women abused, violence, aggression, health professionals

ISSN:1108-7366

Corresponding Author
Androulaki Zacharoula
Estavromenos 71004
Heraklion, Crete, Greece.
Tel. 2810-379500

Introduction

Women abuse is a social phenomenon with significant consequences for the victims and one that raises broader psychological, medical, legal, economic and sociological issues. It is the women who are mostly the victims of public and domestic violence in almost all countries of the world and according to international literature the phenomenon of violence against women is increasing (Larkin et al. 1999, Graham 2000, McFarlane et al. 2001, McClennen et al. 2002, Eckert et al. 2002, Pentaraki, 2003, Butterworth 2004). Approximately 1 out of 5 women worldwide have been victims of beating by their intimate partners and 1 out of 3 will be victims to some form of violence in their life time. Violence does not know any bounds, but we should know that it is the weak who suffer (Moreno 2000, Graham 2000, Taket et al. 2003).

The physical and emotional consequences of violence against women are evident and lasting. Even women who choose to live in an abusive relationship suffer long lasting consequences even after their partner has stopped acting violently and, in some cases, these consequences last for a lifetime. (Felitti et al. 1998, Pentaraki 2002). Women who have suffered aggressive behaviour present with pathologies both at physical and mental level, and make more use of medical care services than other women.

Often the women-victims suffer from chronic ailments (headache, abdominal pain). They present with more frequent incidents of depression and anxiety. They have low self-esteem, are more prone to self-immolation and when pregnant they suffer higher rates of complications (Malecha 2003). The physical and psychological symptoms of violence which are evident in the women-victims can also be manifested in children who become eyewitnesses to their mothers' abuse (Jaffe et al. 1990, Graham-Berman & Edleson 2001, Berman et al. 2003).

On the basis of records kept by the Research Center for Gender Equality (KETHI) in Greece, more than 40% women-maltreatment incidents are classified as forms of domestic violence, i.e. aggressive behavior by the intimate partner or husband (Artinopoulou & Farsedakis 2003).

The economic consequences of intimate partner violence (IPV) against women are huge, both for the victims and the national health care systems. The social cost is equally significant.

A report published by the Canadian Ministry of Health estimates that the health care cost from IPV against women in Canada is estimated at more than $1.5 billion annually. This cost includes visits to emergency care units for medical and dental services and long-term hospitalization for psychosomatic support (Health Care Canada 2002). Women who have suffered physical or sexual abuse during their childhood or adult life require more surgical care, make more visits to health care centers and are hospitalized longer than women who have never been victims of aggression (Leserman et al. 1996).

This "hushed" of violence remains a well guarded secret among many women in our days. Although there are some women victims who bear the torment of aggression with extreme courage, yet there is a significant number of other women-victims who seek medical help for bruises or lesions the cause of which is more or less obvious to the trained eyes of physicians (Hoff 1994).

The World Health Organization (WHO) recognized that the management of the victims of violence should be a public health priority for all health care institutions

ISSN:1108-7366

around the world (WHO, 1998).
It has been acknowledged in the international literature the importance of a screening program in health care services for the early diagnosis of violence against women or of women at risk.
This screening program can significantly enhance the proper management of this social phenomenon, reduce its frequency and improve the level of services offered to women in need (Poirier 1997, Department of Health, 2000, Middlesex-London Health Unit 2000, Asher et al. 2001, Punukollu 2003, Family Violence Prevention Fund 2004, Perinatal Partnership Program of Eastern and South Eastern Ontario 2004). The implementation of this kind of program would increase the prospects both for identifying maltreatment cases and improve the designs for intervention (Family Violence Prevention Fund 2004, Perinatal Partnership Program of Eastern and South Eastern Ontario 2004).
This prospect enhances the role of healthcare professionals, e.g. physicians, medical nurses, home care professionals, social workers and psychologists who are called to take up a special role within a concerted and interdisciplinary approach to violence against women. The role of healthcare professionals is very important, particularly if we adopt expert claims that women visiting healthcare units should initially be considered as possible victims of maltreatment (Jones & Bonner 2002). Specifically, medical nurses – health care professionals working in key positions within clinical environments utilize a holistic health promotion framework, incorporating strategies of empowerment and advocacy. This approach is especially important when intervening with abused women (Davidson et al. 2001, Ross 2002, Malecha 2003).
Of course, direct relationship is not the "prerogative" of medical nurses only. The role of other health professionals, e.g. physicians, psychiatrists, is also very important. However, the effective treatment of abused women requires the existence of an integrated program which makes provisions for prevention, assessment (screening) and treatment. This program also requires the collaborative input from health professionals and social workers.
In many cases the design and implementation of such programs in Greece, and in other European countries, is disappointing because health professionals have no knowledge and skills to address the phenomenon in terms of diagnosis and assessment (Caralis and Musialowski 1997, Cole 2000, Gamble 2001).

Methodology

The present study aims to evaluate the attitudes and perceptions of healthcare professionals in the prefecture of Lasithi against the phenomenon of abused women, as well as their level of knowledge in identifying and managing the women-victims in a holistic way.
The sample consisted of ninety one (91) health professionals (25 physicians and 66 medical nurses) working in pathology, surgery, orthopedic, maternity and emergency units of hospitals in the prefecture of Lasithi. Measures of central tendency and measures of dispersion (average value, standard deviation, range) were implemented for continuous variables, while discrete variables and clustered data were expressed as percentages.

Results

The 10% of the participants work in the General Hospital (G.H.) of Ierapetra, 40.0% in the G.H. of Siteia, 39.0% in the G.N. of Agios Nikolaos and 11.0% in primary Healthcare Centers within the prefecture of Lasithi. The age of the participants ranged from 22 to 30 years (36.0%), 31 to 40 years (48.0%), 41 to 50 years (12.0%) and over 50 years (4.0%). In terms of gender, 65.6% were women and 34.4% men. Also, 68.5% were married and 31.5% single. 60.5% of the sample had up to 15 years experience and 39.5% over 15 year.
Furthermore, only eight health professionals (8.9%) had participated in seminars on the subject of abused women which had been included in the curriculum of twelve more participants (14.1%).

ISSN:1108-7366

Based on their responses it was established that the psychological consequences of violence against women affect more the victims themselves (mean 4.64 ± 0.59) and the family as a unit (mean 4.47 ± 0.59). In other words, seven out of ten of health professionals believe that domestic violence drives a mental/emotional blow on women and six out of ten believe that this type of violence affects the entire family.

Also, the participants believe that violence against women is not related to spastic colitis (69.4%), to abdominal pain (51.0%) and to headache (50.5%). On the other hand, they believe that violence is always (38.4%) or occasionally (52.5%) manifested in the form of bodily injuries. Also, the participants associated violence against women with hysteria (45.9%), depression (62.9%) and increased stress (49.5%).

The most frequent question (mean 2.31 ± 0.67) doctors and nurses ask women who come to emergency units to seek treatment for their injuries is whether these women have suffered physical violence. Although 45.5% of participants occasionally ask women to name the perpetrator, 33.7% of the participants are not willing to ask women whether the perpetrator is their husband or intimate partner, and 41.4% of the participants never inquire about the cause of injury.

The participants also reported that in the context of their professional skills they provide to women-victims with medical care (80.5%), nursing care (94.4%), and warm attention (97.8%), in addition to registering the women's bodily injuries (92.1%). Furthermore, they provide psychological support (97.8%), inform the women-victims about their rights (70.1%) and about other services abused women can resort to for help (80.7%).

What is more, the participants in the study reported that that they do refer women victims of domestic violence to the Social Services of their Hospital (96.6%), but they also noted that it is not among their duties and competences to advise the victims to lodge their complaints with the District Attorney (37.6%).

Discussion

The present study concluded that the participating health care professionals believe that the phenomenon of violence undermines the emotional and mental wellbeing of women and their families. This conclusion is corroborated by similar findings reported internationally and in broad terms concurs that domestic violence has a psychopathological impact on the women victims (Gleason 1993, Guthrie et al. 2003).

In Krantz et al (2005) the authors report that health care professionals believe that violence against women affects both the physical and the psychological wellbeing of the victims. The symptoms of violence have a direct biological and emotional/mental impact on these women (Lloyd & Taluc 1999).

Specifically, it has been noticed that abused women are more prone to depression, anxiety, suicidal attempts and have low self-esteem (Malecha 2003).

A large percentage of health care professionals (69.4%) in this study do not associate violence against women with spastic colitis. However, other research studies report that the majority of women victims to sexual abuse also complained about gastro-intestinal symptoms (e.g. indigestion) (67%), inflamed bowel (47%) or both (43%) (Perona et al. 2005).

Other studies have established that women with inflamed bowel often report that they have been victims to physical, sexual or psychological abuse (Salmon et al. 2003, Guthrie et al. 2003).

In the present study the health care professionals find no association between abdominal pain and battered women, in spite of recent research studies which associate abdominal pain with the history of violence in the women victims (Johnson et al. 2004, Hilden et al. 2004, Koloski et al. 2005).

Following research among 239 women who sought help for gastrointestinal problems in primary care units in the USA, the results showed that 66.5% of the women had experienced a form of sexual or physical violence (Leserman et al. 1996).

ISSN:1108-7366

Similarly in this study, the participants believe that there is no link between aggression and chronic headache in the women victims. However, it has been established by numerous research work in this area that battered women are more likely to suffer from chronic headache than other women (Hilden et al. 2004, Leserman 2005).

Also, it has been reported that sexual or physical abuse of women during their childhood results in chronic headache during the victims' adult life (Romans et al. 2002).

Based on the results of this study it is clear that the health care professionals have difficulties in managing women whom they suspect to have suffered physical and/or emotional abuse. In the context of their professional skills, however, the health care professionals in the study provide psychological support to the victims, register their injuries and offer medical and nursing care. Also, they advice the women-victims to seek help in the social services of the State or those of the hospital. However, they believe that it is not their duty to refer these women to the District Attorney for legal assistance. Also, abused women are not likely to complain to the health care professionals that their symptomatology is the result of intimate partner violence (IPA) (Coker et al. 2002). Consequently, it is rather difficult for health care professionals to identify such cases and make interventions in the context of their capacities. It should be noted at this point that the results of the present study underline more the desire of the health care professionals to provide a wide range of ancillary services to women-victims than their level of knowledge on the issue at hand.

This difficulty in asking women about their IPA experience is corroborated by the Registered Nurses Association of Ontario (2005). This Association insists that effective initial approach, evaluation and assessment of IPA cases by health professionals is of outmost significance, but health professionals admit to wrong management and reticence in their handling of such cases (RNAO 2005).

In a study conducted in the USA 109 patients were interviewed, but the cause of injury was identified in only 50 cases. Failure to take a complete history from the patients and failure to note the findings in the medical chart when a complete history was taken were the major reasons for this loss of information (Gamble 2001).

Similarly, research in the UK has established that only few of the healthcare professionals endeavour to establish whether a woman has been the victim of abuse, unless there is visible evidence (Cole 2000). Also, it has been established that women are more willing to talk about their abusive experiences with their physicians, rather than having to fill out a questionnaire (McFarlane 2001)

In a study by Caralis and Musialowski (1997), women known to have been victims of some form of physical abuse were asked to provide their opinion about the reasons physicians often fail to make a successful diagnosis of abuse. The women attributed this failure to the physicians' lack of information on this social phenomenon (63%) and in the tight schedule of the medical and nursing staff (65%). The results of this research underline the need to educate and train medical nurses and physicians in methods to approach and assess abused women who make use of the national health care system three times more than non-abused women (Oklahoma Nurses Association 2005).

To be able to tackle the issue of women abuse physicians and medical nurses need the proper training and screening protocols, in addition to personal sensitization. This is also true for the staff of social agencies which are responsible for dealing with the abusive partner. In addition, the women victims must be properly informed / educated and encouraged to cooperate with women's organizations and other social agencies.

ISSN:1108-7366

Bibiography

1. sher, J., Crespo, E. I., & Sugg, N. K. Detection and treatment of domestic violence. Contemporary Obstetrics & Gynecology; 2001: 46(9), 61-66.
2. Artinopoulou V. and Farsedakis I., Domestic violence against women. First Pan-Hellenic Epidemiological Research: October 2002- April 2003, Athens: Research Center for Gender Equality.2003
3. Berman H., Hardesty J., & Humphreys, J. Children of abused women. In J. Humphreys & J. C. Campbell (Eds.); Family violence and nursing practice. 2003; 150-187. Philadelphia: Lippincott.
4. Butterworth, P. Lone mothers' experience of physical and sexual violence: Association with psychiatric disorders. British Journal of Psychiatry;2004; 184: 21-27.
5. Caralis PV, Musialowski R. Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. Southern Medical Journal 1997; 90:1075-80.
6. Coker, A. L., Bethea, L., Smith, P. H., Fadden, M. K., & Brandt, H. M. Missed opportunities: Intimate partner violence in family practice settings. Preventive Medicine; 2002; 34(4), 445-454.
7. Cole TB. Is domestic violence screening helpful? Journal of the American Medical Association, 2000; 284:551-3.
8. Davidson, L., Grisso, J., Garcia-Moreno, C., Garcia, J., King, V., & Marchant, S. Training programs for healthcare professionals in domestic violence. Journal of Women's Health & Gender-Based Medicine, 2001; 10(10): 953-969.
9. Department of Health. (2000). Domestic violence: a resource manual for health care professionals. Available: http://www.dh.gov.uk/assetRoot/04/06/53/79/04065379.pdf[accessed : 12-04-06].
10. Eckert, L. O., Sugar, N., & Fine, D. Characteristics of sexual assault in women with a major psychiatric diagnosis. American Journal of Obstetrics and Gynecology,2002; 186, 1284-1291.
11. Family Violence Prevention Fund. (2004). National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. Available: http://endabuse.org/programs/display.php3?DocID=206 [accessed : 12-05-06].
12. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V. et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine,1998; 14(4), 245-258.
13. Gamble E., News & Observer, popular government, Spring 2001; 39-43.
14. Gleason WJ. Mental disorders in battered women: an empirical study. Violence & Victims 1993; 8(1): 53-68.
15. Graham, J. An unacceptable risk. The Exceptional Parent, 2000;: 30, 32-34.
16. Graham-Berman, S. A., & Edleson, J. L. (Eds.). Domestic violence in the lives of children: The future of research, intervention and social policy. Washington, DC: American Psychological Association. 2001.
17. Guthrie E, Creed F, Fernandes L, Ratcliffe J, Van Der Jagt J, Martin J, Howlett S, Read N, Barlow J, Thompson D, Tomenson B. Cluster analysis of symptoms and health seeking behaviour differentiates subgroups of patients with severe irritable bowel syndrome.Gut An International Journal of Gastroenterology and Hepatology. 2003 Nov; 52(11):1616-22.
18. Health Care Canada. (2002). Violence against women. Available: http://www.hc-c.gc.ca/english/women/facts_issues/facts_violence.htm[accessed: 21-03-06].
19. Hilden M, Schei B, Swahnberg K, Halmesmaki E, Langhoff-Roos J, Offerdal K, Pikarinen U, Sidenius K, Steingrimsdottir T, Stoum-Hinsverk H, Wijma B. A history of sexual abuse and health: a Nordic multicentre study. British Journal of Obstetrics and Gynaecology; 2004 Oct; 111(10):1121-7.

20. Hoff LA, Rosenbaum L.A victimization assessment tool: instrument development and clinical implications. Journal of Advanced Nursing.1994 Oct; 20(4):637-34.
21. Jaffe PG, Wolfe DA, Wilson SK. Children of battered women. Newbury Park, Calif.: Sage, 1990.
22. Jones, C. & Bonner, M. Screening for domestic violence in an antenatal clinic. Australian Journal of Midwifery: Professional Journal of the Australian College of Midwives Incorporated, 2002; 15, 14-20.
23. John R, Johnson JK, Kukreja S, Found M, Lindow SW. Domestic violence: prevalence and association with gynaecological symptoms. British Journal of Obstetrics and Gynaecology , 2004 Oct; 111(10):1128-32.
24. Koloski NA, Talley NJ, Boyce PM. A history of abuse in community subjects with irritable bowel syndrome and functional dyspepsia: the role of other psychosocial variables. Digestion. 2005; 72(2-3):86-96.
25. Krantz G, Van Phuong T, Larsson V, Thi Bich Thuan N, Ringsberg KC. Intimate Leserman J. Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. Psychosomatic Medicine. 2005 Nov-Dec; 67(6):906-15.
26. Larkin, G. L., Hyman, K. B., Mathias, S. R., D'Amico, F., & MacLeod, B. A. Universal screening for intimate partner violence in the emergency department: Importance of patient and provider factors. Annals of Emergency Medicine,1999; 33(6): 669-675.
27. Leserman, J., Drossman, D. A., Zhiming, L., Toomey, T. C., Nachman, G., & Glogau, L. Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status. Psychosomatic Medicine.1996; 58: 4-15.
28. Leserman J. Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. Psychosomatic Medicine. 2005 Nov-Dec; 67(6):906-15.
29. Lloyd, S. & Taluc, N. The effects of male violence on female employment. Violence Against Women,1999; 5:370-392.
30. Malecha, A. Screening for and treating intimate partner violence in the workplace. The American Association of Occupational Health Nurses Journal.2003; 51(7): 310-316.
31. McClennen, J. C., Summers, A. B., & Daley, J. G. Lesbian partner abuse scale. Research on Social Work Practice, 2002; 12(2): 277-291.
32. McFarlane, J., Hughes, R. B., Nosek, M. A., Groff, J. Y., Swedlend, N., & Dolen Mullen, P. (2001). Abuse assessment screen – disability (AAS-D): Measuring frequency, type and perpetrator of abuse toward women with physical disabilities. Journal of Women's Health & Gender-Based Medicine, 2001; 10(9):861-866.
33. Middlesex-London Health Unit. Task force on the health effects of woman abuse – Final report. London, Ontario: Author.2000.
34. Moreno G., C. Violence against women: international pesrpective.American Journal of Preventive Medicine.2000 Non;19(4);330-3.
35. Oklahoma Nurses Association. Board of Directors; Task Force on intimate partner violence. House of Delegates resolution. Intimate partner violence assessment, intervention and documentation. Okla Nurse. 2005 Dec-2006 Feb; 50(4):7.
36. Pentaraki M., (2003) "Incidence, forms and consequences of violence that suffer the teenager female students of Lyceum in their relationships with the other sex", Unpublished Doctoral thesis, Department of Sociology, Panteios University, Athens.
37. Pentaraki M. (2002) "the invisible side of Relationships among adolescents girls with the other sex: Abuse its extent and preventive measures in: Sexes fall: Texts - Proposals on Sexism and violence, Gkova pub., Athens p. 107-123.

ISSN:1108-7366

38. Perinatal Partnership Program of Eastern and Southeastern Ontario. Women abuse in the perinatal period: Guidelines for care providers. Ottawa: Author. 2004.
39. Perona M, Benasayag R, Perello A, Santos J, Zarate N, Zarate P, Mearin F. Prevalence of functional gastrointestinal disorders in women who report domestic violence to the police. Clinical Gastroenterology and Hepatology. 2005 May; 3(5):436-41.
40. Poirier, L. The importance of screening for domestic violence in all women. The Nurse Practitioner, 1997; 22: 105-122.
41. Punukollu, M. Domestic violence: Screening made practical. The Journal of Family Practice, 2003;52(7): 1-6.
42. Registered Nurses Association of Ontario (RNAO).Woman abuse: screening, Identification and Initial Response. Nursing Best Practice Guidelines Program. March 2005.
43. Romans S, Belaise C, Martin J, Morris E, Raffi A. Childhood abuse and later medical disorders in women. An epidemiological study. Psychotherapy and Psychosomatics. 2002 May-Jun; 71(3):141-50.
44. Ross, M. (2002). Nursing education and violence prevention, detection and intervention.Available:http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/ 2003nursviolence_e.pdf [accessed : 4-05-06].
45. Salmon P, Skaife K, Rhodes J. Abuse, dissociation, and somatization in irritable bowel syndrome: towards an explanatory model. Journal of Behavioral Medicine. 2003 Feb; 26(1):1-18.
46. Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., & Lavis, V., et al. Routinely asking women about domestic violence in health settings. British Medical Journal, 2003; 327(7416): 673-676.
47. World Health Organization. Violence against women information pack: priority health issue. Geneva: WHO; Women's Health and Development Programme,1998

ISSN:1108-7366