Women Battering

A problem requiring medical attention

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Physical violence against women, commonly referred to as woman battering, is a worldwide, pervasive yet invisible problem. It is a phenomenon that cuts across political boundaries, social classes, religious affiliations, racial and ethnic groups. Even though this problem is life threatening, and indeed lives have been lost, it is not perceived by the society as a problem that needs attention in the here and now.

Incidence

It is difficult to ascertain the exact incidence of woman battering because of a lack of accurate statistics. It is estimated that in South Africa, one in six women are battered regularly by their male partners (Sagal & Labe, 1991). Based on the total number of women in the country, this estimate translates to 1 291 694[1]. However, this figure is not reliable. Data available is often obtained from the police and other agencies that are dealing with violence against women. In this way, women who do not seek outside help because of being held captive in their households or because of a lack of services for battered women in their areas are not included.

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Many women are reluctant to report incidents of woman battering. The notion of the family as a private domain and an emphasis on preserving the sanctity of the home are some of the reasons why these women are reluctant to report this crime. For this reason, woman battering remains a crime that is hidden from the public eye.

Public health impact

In a study that was undertaken at Alexandra Health and University Clinic, 389 medical records were analysed to determine the proportion of women identified by health professionals to have sustained injuries caused by battering to determine the nature, extent, and location of their injuries as well as to evaluate the response of the health care system to battered women (Motsei, 1992).

In 17 percent of the cases, the assailants were close to the women

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(11 percent husbands, six percent boyfriends). This figure could be much higher given that in 81 percent of the records, health professionals did not provide information about the assailant. Weapons used to inflict injuries ranging from bare hands, knives, hammers, axes, screwdrivers, bottles, bricks etc. The knife was used in the majority of incidents and was involved in the more serious cases. The areas most commonly injured were the face, head, breasts, abdomen and reproductive organs. Seventeen percent of the women sustained injuries that required hospitalisation while six percent were pregnant at the time of the assault.

Medical intervention

How does one work with a victim of domestic violence, beyond treating the immediate physical injuries? While many battered women often turn to health professionals for help, studies have shown that this problem is poorly detected in medical settings (Morrison, 1988). Spontaneous disclosures of incidents of battering are rare for a variety of reasons: some women may feel ashamed or guilty about their victimisation, others may have received explicit or implicit messages that even if you do tell the health professionals, s/he will do nothing about the situation (Burge, 1989). Very often, the batterer accompanies the woman and stays close at hand, so that he monitors what she says to the health professional. Telling the truth may result in further abuse.

The single most important service that a health professional can give is to ask about the violence. When a health professional initiates the discussion, s/he is communicating to the woman that:

- this problem is not shameful nor irrelevant to talk about;
- s/he understands the woman's discomfort and other reactions to victimisation;
- the situation is not hopeless and can be changed.

Women to blame

Beyond identifying the nature of the problem, health professionals should help the women to understand the dynamics of their relationships and the dangers faced by them and their children. To do this adequately, health professionals should be aware of their own attitudes and stereotypes towards woman battering and the victimisation of women in general. Many health professionals may accept the conventional belief that women are responsible for and/or deserve to be beaten.

Blaming the woman for the violence without taking into account the socio-economic, cultural, religious and other factors that are beyond a woman's control can be emotionally debilitating and disempowering. Even though the practice of victim-blaming has come under attack from a variety of health perspectives, this does not seem to apply to woman battering. Health professionals and society continue to blame the woman. Gender inequalities and power relationships which create this problem are nurtured rather than challenged. Intervention is reduced to offering women a pharmacological or surgical 'fix'. Any victimised person becomes affected and may develop a variety of physical and psychological symptoms. It is therefore important that victimisation should be perceived as a health problem.

Health professionals should remain supportive throughout the woman's crisis, even if the woman choose not to follow 'the doctor's orders' but takes a course of action not prescribed. It is important that health workers are collaborative and supportive rather than prescriptive.❐

FOOTNOTES

1. This figure was calculated by dividing the total number of adult women provided by the Central Statistical Services (1985 figures) with an estimate of one in six.

REFERENCES

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