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THE ROLE OF HEALTH SERVICES IN ENCOURAGING DISCLOSURE OF VIOLENCE AGAINST WOMEN

VLOGA ZDRAVSTVENIH USTANOV PRI SPODBUJANJU RAZKRITJA NASILJA NAD ŽENSKAMI

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ABSTRACT

Introduction. The aim of the survey was to assess the differences in disclosure by the type of violence to better plan the role of health services in identifying and disclosing violence.

Methods. A validated, anonymous screening questionnaire (NorAQ) for the identification of female victims of violence was offered to all postpartum women at a single maternity unit over a three-month period in 2014. Response rate was 80% (1018 respondents). Chi square test was used for statistical analysis ($p<0.05$ significant).

Results. There are differences in disclosure by type of violence. Nearly half (41.5%) of violence by health care services was not reported, compared to 33.7% physical, 23.4% psychological, and 32.5% sexual that was reported. The percentage of violence in intimate partnership reported to health care staff is low (9.3% to 20.8%), but almost half of the violence experienced by heath care services (44%) is reported. Intimate partnership violence is more often reported to the physician than to the psychologist or social worker. Violence in health care service is reported also to nurses.

Conclusions. Disclosure enables various institutions to start with the procedures aimed at protecting victims against violence. Health workers should continuously encourage women to speak about violence rather than asking about it only once. It is also important that such inquiries are made on different levels of health care system and by different health care professions, since there are differences to whom women are willing to disclose violence.

Keywords:
disclosure, differences by type of violence, encouraging disclosure of violence in health care

IZVLEČEK

***Uvod**. Namen raziskave je ugotoviti razlike v razkritju nasilja glede na različne vrste nasilja, da bi lahko ustrezneje načrtovali vlogo zdravstvenih institucij v identificiranju in razkrivanju nasilja.*

***Metode**. Na Ginekološki kliniki v Ljubljani smo leta 2014 opravili raziskavo z naslovom Nasilje med nosečnostjo - NANOS. Prevod in priredbo vprašalnika The NorVold Abuse Questionnaire - NorAQ smo na poporodnem oddelku tri mesece v anonimizirani obliki ponujali v izpolnjevanje vsem ženskam po porodu. Vprašalnik je razdeljen v 9 poglavij, ima 101 vprašanje in obsega 11 strani. Odzivnost je bila 80-odstotna (1018 respondentk) Rezultati so bili obdelani s statističnim paketom SPSS (SPSS for Windows version 21, IBM Corp., Armonk, NY, ZDA). Razlike med skupinami so bile testirane, upoštevajoč 95-odstotni interval zaupanja in statistično pomembnost pri $p < 0,05$.*

***Rezultati**. Rezultati kažejo na razlike v razkritju med različnimi vrstami nasilja. Podatki so pokazali, da približno tretjina žensk nikoli ne razkrije nasilja, ki ga doživljajo, in manj kot polovica tistih, ki o tem spregovorijo, razkrije celotno dogajanje. Manj kot polovico nasilja (41,5%) zdravstvenih delavcev respondentke niso prijavile, kar je višji odstotek kot pri drugih vrstah nasilja, kjer niso prijavile 33,7% fizičnega, 23,4% psihičnega in 32,5% spolnega nasilja. Zdravstvenemu osebju razkrije psihično, fizično ali spolno nasilje v intimnih razmerjih od 9,3 do 20,8% anketirank in 44% jih razkrije nasilje zdravstvenega osebja. Najpogosteje nasilje v intimnih razmerjih razkrijejo zdravnikom, psihologom in socialnim delavcem, nasilje zdravstvenih delavcev pa razkrijejo zdravnikom in medicinskim sestram. Najmanj posledic doživljajo zaradi nasilja zdravstvenih delavcev (posledice trpi 16,2%) in največ, če doživijo spolno nasilje (posledice trpi 55,3%). Pri spolnem nasilju tudi največ žensk ne razkrije nasilja, vendar zelo trpijo zaradi posledic (30,3%). Pomoč poišče manj žensk, kot jih trpi posledice nasilje. Pri fizičnem nasilju jih pomoč poišče le 10,9%, pri psihičnem 20,4% in pri spolnem 25%.*

***Zaključek**. Razkritje je ključno dejanje, ki omogoča, da različne institucije lahko sprožijo postopke zaščite žrtve pred nasiljem. Zdravstveni delavci bi morali kontinuirano (in ne le enkrat) spodbujati ženske, da spregovorijo o nasilju. Pomembno je, da o tem sprašujejo in k razkritju spodbujajo različni zdravstveni delavci na različnih ravneh zdravstvenega sistema. Čeprav razkritje v zdravstvu ni pogosto, se ravno zdravstvo srečuje z vsemi ženskami, zato lahko pomembno vpliva na razkritje.*

Ključne besede:
razkritje, razlike glede na vrsto nasilja, spodbujanje razkritja v zdravstvu

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1 INTRODUCTION

Violence against women during pregnancy attracted much professional attention in the past decades and became an important research topic in medicine as well. The reason is primarily the growing awareness of the multiple effects of violence on the physical and mental health of women and children. The World Health Organisation (WHO) studies on intimate partner violence (IPV) indicate that, on the global level, the average incidence of violence during pregnancy is between 4% and 12%. These estimates vary significantly between countries ranging from 1% and 70%. Approximately one third of cases include kicks and punches in the abdomen (1). The consequences of violence during pregnancy can be long-lasting, and can cause a life-long trauma in children. Violence threatens person's physical and mental health and may lead to homicide or suicide. The WHO pointed out that violence may lead to addictive behaviour, which causes additional damage to the child who may suffer the consequences of drug abuse and alcohol consumption (1).

Studies of violence before and during pregnancy most often focus on the prevalence, incidence, consequences and dynamics of violence, with data gathered using both quantitative and qualitative methods. The findings of those studies show that violence during pregnancy has multiple effects on health of the mother and the child, for example, low weight at birth, premature birth, a low gain of weight during pregnancy, kidney infection, antepartum haemorrhage, caesarean section, miscarriage or neo-natal death (2-4). Mental health problems are also frequent, for example, depression, post-traumatic stress disorder, panic disorder, anxiety, as well as abuse of various substances (5, 6). Violence can also cause lack of attachment to the child and lower rates of breastfeeding (1). It can cause physical injuries to fetus, such as bruises, broken bones, and stab wounds, and death in extreme cases (7). Several meta-analyses of existing studies of violence during pregnancy have been conducted (8-10) as well as many national studies. The latter are important because they are conducted in specific socio-cultural environments and structural conditions, so they can offer new insights. In addition, they are an important source of various comparisons and trans-national analysis.

Violence during pregnancy has not been a conspicuous research topic in Slovenia so far. A question referring to it was included in the national survey 'Violence against women in Slovenia' (11). Data showed that 5.5% of women experienced violence during pregnancy. Matko (12) conducted a qualitative study on the sample comprising 13 women who at the time of research, lived in the maternity home or the shelter for women, and who experienced violence during pregnancy. Her results show that 5 (38%) children were born prematurely. This is a much higher proportion of preterm birth compared to approximately 6% of preterm deliveries in the general population in Slovenia (13). More than half of children had health or other problems, such as developmental disorders, hyperactivity, dyslexia, or they needed learning support. Her conclusion is that women experience various kinds of violence during pregnancy. For some of them, physical violence began only during pregnancy and was followed by a ban on breastfeeding or other forms of restricting contact with the new-born. The consequences for women were emotional distress and physical injuries (12).

Violence against women is an important public health problem also because of high expenses of treatment of injuries caused by it. Female victims receive hospital treatment and need medicines more often than women who have no such experience (14). In the opinion of the Institute of Public Health's researchers, violence in Slovenia has not been sufficiently recognized as an important issue in public health, although there is a growing awareness of the problem (15). An important step forward was the adoption of the Rules on procedures for dealing with domestic violence in the implementation of health activities, which sets the professional and ethical standards of work with the victims of violence. The document imposes on health care workers the obligation to report violence, to cooperate within multi-disciplinary teams at centres of social work, and to assess the threat to the victim. The document further specifies that health workers should acquire relevant knowledge and skills through additional training programmes (16).

In 2014, the University Medical Centre Ljubljana, Division of Obstetrics and Gynaecology, Department of Perinatology, conducted the survey 'Violence during pregnancy – NANOS' that sought to establish the incidence of physical, psychological and sexual violence, as well as violence within the health care system before and during pregnancy. In addition, potential influences on the psychological and physical health of mothers and children were also studied. The study is a response to the growing responsibility of health workers to act upon the notice of violence and an important step in understanding the country's specific effects of violence on pregnant women. We used the translated and adapted NorVold Abuse Questionnaire – NorAQ, developed by Swahnberg and Wijma (17), which included questions on violence against women in health-care system due to negative effects that it might have on women and their capability of disclosing violence to health care workers.

In this article, we focus on data about the disclosure of violence and on the role of health care workers in the process of disclosure. The main research question is what are the differences in disclosure concerning the type of

violence and what are the differences in disclosure of violence experienced in intimate partnership or within the health care system. Results are important for future development of health care practices that will encourage women to disclose the violence.

2 METHOD

We conducted an observational cross-sectional study among all women who delivered at our perinatal centre during a three-month period. Quantitative and investigative research method was applied. We used the translated and adapted NorVold Abuse Questionnaire – NorAQ, developed by Swahnberg and Wijma (17). The questionnaire is divided into 9 sections and comprises 101 questions. The main sections include general questions about pregnancy, childbirth and contacts with gynaecologists, health, psychological abuse, abuse perpetrated by health care system, physical abuse, sexual abuse, current partnership, concluding questions, and an addition comprising 9 questions about childbirth. The questionnaire comprised 11 pages of easily comprehensible questions.

The anonymous questionnaire was offered to all postpartum women at a single maternity unit over a three-month period in 2014. Of the total 1272 women, 1018 responded, which amounts to 80% response rate. The questionnaire was available in print and online. Only 7 women chose online version.

The results were processed using the SPSS software (SPSS for Windows version 21, IBM Corp., Armonk, NY, USA). Differences between groups were tested using parametric and non-parametric tests, with confidence interval of 95% and statistical significance at $p<0.05$.

2.1 The Main Characteristics of the Sample

The average age of respondents was 31 years (the youngest one was 18 and the oldest 47); 32.8% of respondents had university education, 31.5% had secondary school education, 1.8% had only elementary school, and 1.6% had a doctoral degree. 52.1% of respondents are cohabitating, 46.5% were married, and 1.2% were single or divorced. As to the ethnic structure, 87% declared themselves as Slovenes, 5% as Serbs, 4.9% as Bosnians, with most of the remaining respondents coming from ex-Yugoslav republics and Eastern European countries. The percentage of employed women in the group was high. Of those, 72.3% said they were employed, 5.4% said that they were on a maternity leave, and 5.9% said that they were on a longer sick leave. Other respondents were either students or unemployed. Most women (85%) support their families along with their partners; 11% of respondents said that their partner was the only breadwinner in the family, and 2.4% said that they earned livelihood alone. As many as 33% said that they had no job guaranteed after the end of the maternity leave. Mobbing at a workplace was experienced by 10.4% of respondents. Sixty percent of respondents lived in their own dwellings, 22.1% in a rented accommodation, and 17.8% with their relatives or friends. One person lived in a maternity home. Approximately one quarter (25.9%) of respondents came from the rural area. Pregnancy was unplanned or undesired for 0.3% of respondents, while 25.9% of them did not plan it, but assessed it as desired. The sex of the child was deemed irrelevant by 69.2% of respondents, while 12.4% wished for a boy, and 18.4% for a girl. In the opinion of 67.9% of respondents, gender was irrelevant for their partners; 17.5% of partners wanted a boy, and 14.6% wanted a girl. One fourth of respondents had a miscarriage before current pregnancy, and 15% terminated pregnancy. One fourth already had a gynaecological surgery. Approximately one tenth of respondents assessed their health during pregnancy as poor; 24% visited a physician more than ten times during pregnancy, 38.2% up to three times, and 15.5% were hospitalised. Psychiatric help was sought by 3.4% of respondents during pregnancy. Approximately 15% experienced anxiety, and 11% were depressed.

Data point to some trends that are mirroring the societal change. More women live in co-habitation, the extent of employed is high, a vast majority is sharing the financial support of the family, although 11% is economically depended on their partners. Their future employment status is insecure, which reflects the precariousness of current employment patterns. For the tenth of them the workplace is a source of violence as they are experiencing mobbing. The ethnic structure of the sample reflects the ethnic structure of the Slovene society. For most couples, the gender of a child does not matter, but there are some differences between those that preferred a daughter or a son. Women whished more to have a daughter and men whished more to have a son. The health of women is an issue to be further explored. 15% of women who experienced anxiety and 11% who were depressed are relatively high percentages. A quarter of women also visited physician more than 10 times during pregnancy. Partly their psychological and physical condition can be explained with the age, but more in-depth research is needed.

2.2 Data on Violence Experienced in Different Life Periods

We sought to establish the presence of four types of violence, i.e. psychological, physical and sexual violence, as well as violence perpetrated by health care system. Table 1 shows the incidence of individual types of violence, enabling us to establish the scope of the phenomenon. Some women experienced violence as children and as adults, and some experienced several types of

violence simultaneously. Violence during pregnancy was experienced by 9.2% of respondents, most frequently by health care system. While most of the IPV is gender-specific, meaning that most of the perpetrators are men, violence in health care is performed by both genders.
Comparing to the national prevalence study on violence against women (11), our survey shows a slightly higher extent of physical violence (23% in national survey), significantly less psychological violence (49.9% in national survey), and a slightly higher extent of sexual violence (6.5%), which is the consequence of different methodology and age limits. The national study was asking for violence experienced after 15 years of age. The comparison is also difficult to make because some women experience more than one kind of violence at the same time, which is pointed out in the European survey on violence against women (18).

3 RESULTS

In Table 2, we compare data on disclosure of any kind of violence. Approximately one third of respondents reported violence they experienced, but not all types of violence were reported at equal rate. Violence perpetrated by health care system was the least reported, in contrast to psychological violence, which was most frequently disclosed. Approximately half of respondents who reported every instance of violence most frequently reported violence experienced by health care system.

There are differences regarding which health worker they choose to disclose a specific type of violence. Table 3 shows that while violence perpetrated by health workers is most often disclosed to the physician or the nurse at the primary level, other types of violence are more often reported to a psychologist, physician on a secondary or tertiary level, or a social worker, but not to a nurse.

Table 1. Incidence of individual types of violence in various periods of life.

Period of life	Physical violence	Psychological violence	Sexual violence	Violence by health care system	Any type of violence
Before the age of 18	22.4	14.8	6.1	2.7	31.2
In adulthood	9.5	14.1	2.0	10.1	19.1
During pregnancy	1.0	3.2	0.0	5.8	9.2
Whenever	29.2	26.1	7.6	16.1	46.9

Table 2. Disclosure to anyone.

% of disclosure	Physical violence	Psychological violence	Sexual violence	Violence by health care system
No	33.7	23.4	32.5	41.5
Yes, partly	21.8	29.4	26.0	10.2
Yes, everything	44.4	47.2	41.6	48.3

Table 3. Reporting violence to health care staff.

% of disclosure	Physical violence (N=13)	Psychological violence (N=21)	Sexual violence (N=7)	Violence by health care system (N=29)
Physician	46.2	28.6	42.9	65.5
Nurse	/	4.8	/	27.6
Psychologist	38.5	57.1	42.9	3.4
Social worker	15.4	9.5	14.7	3.4

Table 4. Disclosing violence to a health worker.

% of disclosure	Physical violence	Psychological violence	Sexual violence	Violence by health care system
No	90.7	79.2	80.4	56.0
Yes, he already knew	2.3	2.8	3.9	8.3
Yes, when he asked about it	2.9	7.3	9.8	10.7
Yes, I told it of my own will	4.1	10.7	5.9	25.0

Table 5. Seeking help after experiencing violence.

% of seeking help	Physical violence (N=256)	Psychological violence (N=225)	Sexual violence (N=76)	Violence by health care system (N=148)
No, since it did not cause much suffering	70.7	55.6	44.7	83.8
No, although I suffered a lot	18.4	24.0	30.3	11.5
Yes, I sought help	10.9	20.4	25.0	4.7

Table 4 shows that women speak about violence if asked about it by a physician. They more often report psychological violence, unlike about physical violence, which is rarely reported.

The research shows differences in the extent of the severity of various types of violence (Table 5). Violence committed by health workers causes least consequences, and sexual violence caused severe consequences for more than half of women who experienced it. A significant proportion of women (32.5%) do not disclose sexual violence, but the suffering caused by it is severe. Some women who experienced violence did not ask for help: one tenth of those who experienced physical violence, one fifth of those who were psychologically abused, and one third of those who were sexually abused.

4 DISCUSSION

Disclosure is an essential step that enables various institutions to start with the procedures aimed at protecting victims against violence. However, many obstacles prevent victims from disclosing violence. Distrust, shame and fear affect women's attitude towards various public services, and few women are willing to speak about violence. Women who have experienced violence seek health care due to physical injuries, but often they do not disclose the associated abuse or violence. 'A health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. […] Health professionals can provide assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care; or gathering forensic evidence, particularly in cases of sexual violence' (19). Research findings show the tendency to downplay violence as a problem issue. It has been shown that most victims presenting for social and health care are not asked about violence and do not receive attention or intervention (30).

Our research data show that approximately one third of women never disclose violence they experienced, while less than half of those who do report violence are willing to tell everything. 9.3% (counted together all 'yes' answers in Table 4), and 20.8% of respondents disclosed psychological, physical, or sexual violence in intimate relationships to health workers, while 44% disclosed violence perpetrated by health workers. Data points to a difference between IPV and institutional violence. Different research shows that women often tolerate violence in intimate partnership, fail to recognise it, find it difficult to resist, and even more difficult to leave such a relationship, because they frequently believe that the perpetrator loves them and that he will change (20). They seek reasons for violence in the problems of their partners, they tend to minimise the problem, and attribute it to their own behaviour (provoking the partner, refusing sex). Other reasons of staying in violent relationship include fear of retribution, a lack of alternative means of economic support, concern for the children, emotional dependence, a lack of support from family and friends, and an abiding hope that the partner will change (14).

Reasons for disclosing the institutional violence differ from IPV. The primary common feature of each type of violence is a wish to gain power and control, regardless of whether it is committed in IPV or elsewhere. It is a means taken by the perpetrator to acquire power over other members of a society and subordinate them (21). It should be noted,

however, that abuse in healthcare is defined by patients' subjective experiences of encounters with the health care system, characterized by devoid of care, where patients suffer and feel they lose their value as human beings (22). Violence in health care is performed by men and women alike, and research shows that the most common forms of violence against women are neglect, verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation, then physical violence, including denial of pain-relief when technically indicated, and sexual violence, which is similar to the forms of violence that occur in IPV (23). The main difference between IPV and institutional violence that leads to a higher percentage of reported violence perpetrated by medical staff in our survey is a lack of emotional attachment and, consequently, a lack of tolerance to such practices. The percentage of women in our survey that did not disclose violence committed by medical staff is the highest, which is a paradoxical situation that needs to be further examined, because it points to the specific relationship between a patient and a physician. Power relations and hierarchical structures are significant for medical institutions, not just between physicians and patients, but also between different medical professions. Patients often subordinate to physicians because of the awareness of hierarchal positions (24). Such patients internalize social hierarchy and subordinated positions, and develop fear of disclosure. Others do not have such fear; they understand mechanisms within power relations and are, accordingly, capable of resistance. They have trust in medical knowledge, expect professional attitude based on mutual respect, and respect for dignity even if the situation involves uneven power relations (23). They refuse to accept inappropriate institutional conduct regardless of their own position in the social hierarchy. They do not defy the social prestige associated with medical profession, but are convinced that prestige does not imply superiority over patients (24).

Our research pointed to the difference between the disclosure of the IPV and of the violence within the health system, which is important when planning measures to prevent violence within health institutions. While physical and sexual violence in intimate partnerships is disclosed primarily to psychologists, physicians or social workers, violence perpetrated by medical staff is mainly disclosed to physicians and nurses. One of the reasons is that violence committed by health workers (excluding severe sexual or physical violence) does not cause as much suffering as violence in intimate partnership, so it is not reported to psychologists and social workers. Another reason is that in the case of violence perpetrated by health workers, the complaint procedure is better defined, which makes it easier for them to speak out. It is also important to stress that in our survey, physicians perpetrated the largest part of violence within the health system, so the victims speak about it to other health workers. This information is important in planning the ways to encourage disclosure of violence. Nonetheless, in the case of violence in health institutions, it is important to establish as independent as possible complaint procedures, and to ensure that IPV is reported in a personal contact with a physician. A nurse cannot pose questions about violence as part of routine inquiries before the patient encounters the physician. Much time and more visits are needed so that women can speak out, and in order to bring them to voice their problems, health workers' attitude must be respectful, so that women are encouraged to disclose violence. They will not speak out unless they believe that it is safe to disclose violence.

5 CONCLUSION

Institutional violence undermines public good (25) that should provide every person with dignity and respect. Health care institutions (as much as educational, social, cultural and other) are responsible to treat people equally regardless of their personal circumstances, and to broaden their choices for dignified life. They should understand power relations that are incorporated in medical system as much as in the relationship between a patient and a physician. 'However, addressing the problem of violence by health workers is necessary to support the efforts of dedicated staff who are committed to improving clinical practice' (23). It is important to sensitize health care providers and encourage routine screening for abuse, as well as to draw up protocols for proper management of abuse (28, 29).

To maximize efficiency when identifying the victims of violence, health workers should persistently encourage women to speak about potential violence rather than asking about it only once. There are tools available to screen women for IPV during obstetric care (26) that can be adopted to Slovene situation. It is also important that such inquiries are made on different levels and not only in primary health institutions (27, 31). The WHO emphasises that it is the public health institutions that encounter almost all victims of violence, so their staff needs to be highly trained to recognize violence and effectively handle it. Accordingly, they should establish cooperation with other institutions trained to handle violence, which will enable them to avoid excessive burden that could reduce the likelihood of dealing suitably with the problem. It is important to sensitize health care providers and encourage routine screening for abuse, as well as to draw up protocols for proper management of abuse. Confronting deep-rooted beliefs and attitudes is also important. Research suggests that making procedural changes in patient care has the greatest effect on the behaviour of health care providers (14).

CONFLICTS OF INTEREST

The authors declare that no conflicts of interest exist.

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ETHICAL APPROVAL

Ethical approval was received by the National Medical Ethics Committee (no. 64/11/13).

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