AN EXPLORATION OF WOMEN'S ATTITUDES TOWARDS ROUTINE SCREENING FOR DOMESTIC VIOLENCE IN A HEALTH-CARE SETTING

by

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ABSTRACT

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South Africa has the highest statistics for violence against women in the world. The focus of this study was on domestic violence, or violence against women by their intimate partners. The World Health Organisation has declared domestic violence a public health emergency. Routine screening would improve the capacity of the health care sector to address domestic violence, through direct assistance or referral. The purpose of this research was to explore women's attitudes towards routine screening for domestic violence by health professionals, such as general practitioners and nurses, in a health-care setting. The main objective was to explore women's views on the acceptability and relevance of routine enquiry for domestic violence. A secondary aim was to explore women's perceptions around disclosure of personal information to health professionals. The rationale for this study was that the implementation of routine screening in South Africa is contingent on it being accepted by the general population of women. This was an exploratory study, which aimed to identify issues and concerns women may have with regard to routine screening for abuse. The study was located within a feminist standpoint framework that recognizes the social and political context of abuse. In addition, the implementation of routine screening was conceptualised within the South African context with its legacy of apartheid and unequal distribution of

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resources that have resulted in an overburdened health care system currently under reconstruction. A qualitative research design and methodology was employed, utilizing a short demographic questionnaire together with a vignette and an in-depth, semi-structured interview. Nine interviews were held with women from the Cape Town area. Interviews were recorded, transcribed verbatim, and thematic analysis of data was carried out. Identified themes revealed the following findings:

1) Participants regarded routine screening as relevant and necessary for South African women. Predominant reasons given were: to address the high levels of woman abuse in this country, to help women leave abusive relationships, and to educate women about abuse.
2) Disclosure to health professionals was seen to be difficult; particularly in the light of uncaring and patriarchal attitudes that invalidate women's experiences, negative experiences of the impact of apartheid structures, women's own feelings of shame, and fear of reprisal from partners.
3) Routine screening was regarded as acceptable if carried out with sensitivity, respect and empathy, in a non-judgmental, confidential and safe environment. A general perception was that there is a need – in South African hospitals and clinics – for more humane health professionals who have specific knowledge of domestic violence. Furthermore, participants indicated a strong preference for female health professionals dealing with domestic violence.

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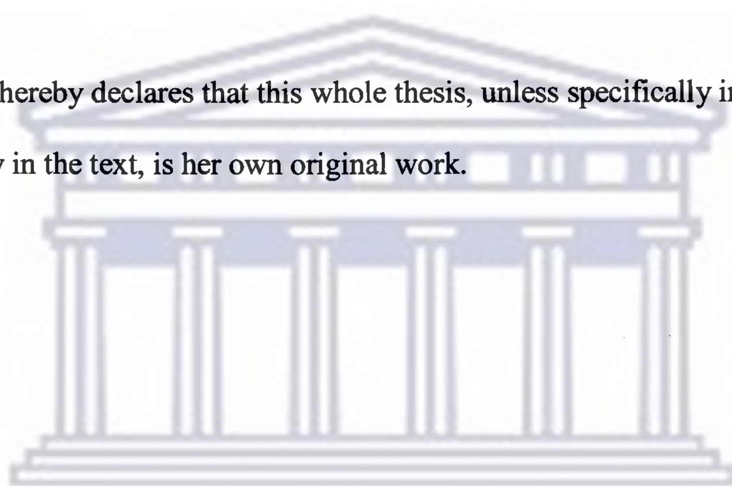
DECLARATION



The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.

Signed: Tamara Gersohn

Dated: 31 March 2004

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This thesis is dedicated to my two amazing children, Daniel and Kayla, whose boundless love, humour and patience sustained me throughout the past couple of months. Thank you to both of you for putting up with your mom who was "always on the computer."

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CHAPTER 1

INTRODUCTION

"Recognizing November 25 as International Day for the elimination of Violence Against Women, Amnesty International declared violence against women to be today's 'most pervasive human rights challenge.' Stressing that such violence spans cultural and religious boundaries and political, social, and economic status, AI cites numerous examples from around the world: worldwide, 120 million women are subjected to brutal circumcision every year; in the United States, over 700,000 women are raped annually; in Bangladesh, 50 percent of all murders are of women by their partners; in South Africa, 147 women are raped every day..." (Gajewski, 2004, p. 46).

Physical and sexual violence by an intimate partner affects between 20-50% of women in most populations globally (Jewkes, 2002). Furthermore, 75% of battered women suffer repeated abuse (Asher, Crespo & Sugg, 2001).

South African women are more likely to be murdered, raped or abused than women anywhere else in the democratic world, including the rest of Africa (Mama, 2000). The incidence of domestic violence in South Africa has reached alarming levels (Shaik & Park, 1998). Statistics on domestic violence are notoriously difficult to obtain, as police statistics only reflect reported crimes such as assault, rape or malicious damage to property. There are many actions that constitute domestic violence that are not defined as crimes, such as forced isolation, verbal abuse, stalking and economic abuse (Dissel & Ngubeni, 2003). Having said that, studies reveal that about 25% of South African women are in violent relationships, and one woman is murdered by her partner every six days (Mama, 2000; Shaik & Park, 1998; Vetten, 1996). Community based studies

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have found that up to a quarter of women report having been abused in their lifetimes by a current or previous partner, and that almost half are affected by economic or emotional abuse (Jewkes, Penn-Kekana, Levin, Ratsaka & Schreiber, 1999).

For the purpose of this study the terms domestic violence, violence against women, gender-based violence and woman abuse will be used interchangeably to refer to violence perpetrated by husbands and current or previous male partners against their female partners in their homes. The abuse may be actual or threatened, physical, verbal, sexual, emotional, or economic.

Domestic violence has a severe impact on the physical and mental health of the women experiencing it (Jewkes, 2002). Violence against women is therefore a significant public health issue (Taft, Hegarty & Flood, 2001). The World Health Organisation defines violence (including violence against women) as a public health emergency, and highlights the role of public health professionals in understanding and responding to violence (Grange, 2002).

Support systems to assist and protect victims of domestic violence are few and inadequately funded (Artz, 1998). Research has shown that most women who experience domestic violence are more likely to visit a clinic or hospital for health problems related to violence, than any other service ("International award", 2000). However, studies show that health care professionals rarely

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identify victims of abuse (Mmatshilo Motsei, 1992). Health care professionals are not asking women about violence, and therefore women whose health problems arise from abuse are not receiving the health care they need (Gerbert, Caspers, Milliken, Berlin, Bronstone & Moe, 2000). In South Africa, this inattention has become the norm, particularly as health care institutions currently have no policy guidelines for dealing with female victims of abuse (Mmatshilo Motsei, 1992).

The early detection of abuse will improve the capacity of the health care sector to address domestic violence, through direct assistance and referral, and act as an agent of change in improving the status of women (Gerbert *et al.*, 2000). Early detection of domestic violence requires unselective, routine screening of all patients, in the form of questionnaires, observation and sensitive questioning (Asher *et al.*, 2001).

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The purpose of this study is to explore women's attitudes towards routine screening for domestic violence in a health-care setting. The main objective is to explore women's views on the acceptability and relevance of routine enquiry for domestic violence, by health professionals such as general practitioners and nurses. Specifically, the study will attempt to elicit whether women find it necessary and acceptable to be asked, on a routine visit to a day hospital, clinic or private medical practice, questions about the presence or absence of domestic violence in their relationships with their intimate partners. A secondary aim is

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to explore women's perceptions and experiences around disclosure of personal information to the medical profession. In this regard, women will be asked whether or not they feel comfortable disclosing personal information to health professionals, and to whom in particular they feel comfortable disclosing information.

The rationale for this study is that implementation of routine screening in South Africa is both necessary for the improvement of women's health, and contingent on it being accepted by the general population of women. Furthermore there is a need for research on the acceptability, to South African women, of routine screening (Jewkes, 2002). As will be discussed in chapter 2, limited studies show acceptability of routine screening in other countries. However, one cannot assume generalisation of these findings to the unique South African context, hence the need to explore the feelings of women around routine screening in this context.

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This study is located within a feminist theoretical framework. Feminist theorising is useful for explaining the gender inequities and patriarchal structures, inherent in society, which facilitate and maintain domestic violence. Specifically, a feminist standpoint perspective (Harding, 1987) is used. This perspective aims to understand women's lives by means of a feminist exploration of women's experiences of oppression. Furthermore, it emphasizes the role of research in bringing about social change. Hence feminist research

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proposes research *for* as opposed to research merely *about* women (Olesen, 2000).

A qualitative research design was chosen in order to enable in-depth examination of a small group of South African women, such that each participant represented a unique case study, referred to by Stake (1994) as the collective case approach. In this way individual meanings as well as common themes of women's lives, specific to living within the South African context, were elicited. This may not otherwise have been achieved in a quantitative study, where the detail and richness of each participant's response is lost (Johnson, 1999). Furthermore, according to Miles and Huberman (1994), the collection of qualitative data has often been advocated as the best strategy for exploring a new area (such as routine screening). Feminist research gives authority to women's voices in the research process, and proposes research that benefits women and contributes to social change ("Designing a Feminist", 2000).

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The research methods included nine semi-structured informal interviews, which were transcribed and analysed using thematic analysis. A vignette - or hypothetical scenario - was drawn up, and questions were posed around it. A vignette was used in order to reduce the invasive and threatening aspect of asking questions about abuse.

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In summary, this is an exploratory study, which aims to identify issues and concerns women may have with regard to routine screening, as well as to make a contribution towards understanding women's needs with regard to the detection and prevention of abuse in this country. It is proposed that further research in this area could inform the development of health care policy regarding the detection and prevention of domestic violence in South Africa. This relates specifically to the education and training of health care professionals, and the implementation of screening protocols within the healthcare system.

Chapter 2 proceeds with a literature review on the issue of woman abuse and routine screening. Chapter 3 presents the research design and the methodology employed in gathering and analysing data. Chapter 4 constitutes the analysis of the results and in Chapter 5, the researcher concludes with a discussion of the limitations of this study, as well as recommendations for future research.

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CHAPTER 2

LITERATURE REVIEW

2.1 Defining domestic violence

The South African Domestic Violence Act (Act 116 of 1998) affords women legal protection from domestic violence. The Act describes a broad range of behaviours that constitute domestic violence, including, physical, sexual, verbal, emotional and psychological abuse, stalking, intimidation, harassment, malicious damage to property, unauthorized access to property, as well as other types of controlling behaviours that may cause harm to the safety, health or well being of a complainant. The notion of 'domestic relationship' is also extended to provide protection to married couples, same-sex couples, couples who are or were dating, couples engaged or in customary relationships, as well as any person in an intimate relationship, parents of a child, and people who do or have recently shared a residence (Dissel & Ngubeni, 2003).

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Domestic violence frequently occurs as an ongoing pattern of abuse, rather than one-off incidents, most of which are not reported to the police owing to women's feelings of shame, fear of retaliation by partners, fear of intimidation by police, and fear of not being believed (De Sousa, 1991; Dissel & Ngubeni, 2003). It was widely believed that domestic violence occurred only in already stigmatised sections of society, such as people from socio-economically disadvantaged backgrounds, and the mentally ill. However, research to date

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Within this context, violence against women and children has emerged as one of the serious challenges threatening to undermine women's health and enjoyment of their rights in a democratic South Africa.

Definitions of health should however take cognisance of context. From a feminist and contextual perspective, health is a relative construct (Lee, 1998). From this perspective, ideas about what constitutes health or dysfunction only exist relative to a set of socially sanctioned norms or conventions held by the observer. That is, something is only normal or abnormal because individuals, and society, believe it to be so. For instance, wife and child battering are considered normal practice in many cultures (Becvar & Becvar 1996). Health or dysfunction can therefore be seen as metaphors communicating a message about the context in which they have meaning and make sense. In this light, the problem of domestic violence, if not seen within the light of sanctioned and dysfunctional power differentials that exist between men and women in society, may instead be attributed to innate psychological characteristics of men and women.

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2.4 The health consequences of violence against women

The impact of domestic violence on health has been well established (Jewkes, 2002). Domestic violence causes physical injury, is associated with a range of mental and physical health problems, and is a leading cause of death in women from injuries and suicide (Jewkes, 2002). The consequences of sexual assault

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include physical injury, pregnancy, sexually transmitted diseases and HIV transmission. The link between HIV/AIDS and gender violence is a significant one, seeing that 4.5 million South Africans were living with HIV in the year 2000, most of them being women (Human Rights Watch, 1995).

Research on woman abuse shows some common patterns of social and mental health impairment. Victims suffering from the long-term effects of abuse are characterized by low self-esteem, instability in their intimate relationships, anxiety, depression, suicide attempts, substance abuse, psychosomatic complaints, and poor functioning in work situations (Bowen, Strauss, Sedlak, Hotaling & Sugarman; Browne & Finkelhor; Martin, Beezley, Conway & Kempe cited in Finkelhor, 1988). Research suggests that abused women endure enormous psychological suffering, many being severely depressed or anxious, with others displaying symptoms of post-traumatic stress disorder. These women may be chronically fatigued, unable to sleep; they may have nightmares or eating disorders, use alcohol to numb the pain, or become socially isolated and withdrawn (WHO, 2004).

However, the physical and psychosocial harm to women, as well as the enormous monetary cost to health care, are not the worst aspects of domestic violence. In the long run, it takes place in families and is intergenerationally transmitted. Children are often the victims of abuse, in families where abuse between parents takes place (Hirschhorn, 2001). Children who witness domestic

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violence frequently suffer from the same symptoms as children who have been physically or sexually abused themselves. Furthermore, girls who witness violence against their mothers are more likely to accept violence as a normal part of marriage, while boys who have witnessed the same violence are more likely to be violent to their partners as adults (WHO, 2004). Preliminary research, from the Centre for the Study of Violence and Reconciliation, found that in 68% of cases of intimate femicide (women killed by their intimate partners) there are witnesses, 14% of whom are the couple's children ("Preventing intimate femicide", 2003).

2.5 Theoretical frameworks for understanding the abuse of women

Traditionally, theoretical explanations of woman abuse fall into three broad categories, namely, psychological, sociological and feminist perspectives (Chornesky, 2000). In general, however, there is no agreement in the literature on a definitive explanation for woman abuse, and interventions appear to vary, depending on individual practitioners' conceptualisations of the problem. Many propose the use of multiple theoretical perspectives, or an integrated understanding of a complex problem (Chornesky, 2000).

For the purposes of this study, however, a feminist perspective will be adopted. Feminists have criticized theoretical explanations of woman abuse that (explicitly or implicitly) attribute blame to the victims, and deny a consideration of the socio-political and economic conditions that contribute to family

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dysfunction. Feminist epistemology moves away from traditional, positivistic and reductionistic ways of knowing, to more holistic, contextual and ethical ways. In a sense this mirrors the relatively recent paradigm shift from Cartesian-Newtonian lineal thinking (believed to be the received view in society) to an ecological worldview (Becvar & Becvar, 1996; Capra, 1988). Here the focus is on the contexts of women's lives and how they are constructed in social organization and relationships. Consequently, from a feminist perspective, domestic violence is not just an individual problem, but also a social and political one.

2.6 Feminisms

Feminist scholars argue that domestic violence has its roots in gender, power and the interaction between the two, and represents men's active attempts to maintain dominance and control over women (Anderson, 1997). Feminists drawing on sociological theory maintain that economic and social problems such as poverty, unemployment, HIV and racism are inextricably linked to violence in our society. Hence, when addressing violence one has to address these fundamental societal issues as well (Mercy, Rosenberg, Powell, Broome & Roper, 1993). Thus feminists acknowledge the impact of a woman's political and cultural context on her life and, more specifically, on her health (Northrup, 1995).

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2.6.1 Feminist standpoint theory

Feminist scholarship is a diverse and complex enterprise where no single voice can claim a dominant position. Instead within the framework of feminism there are multiple voices and theories (Olesen, 2000). Varying epistemologies and methodologies have evolved, consistent with feminist ideals. Feminist epistemologies, such as feminist empiricism, standpoint theory, and postmodernism recognize women's lived experiences as legitimate sources of knowledge; while feminist methodologies capture women's voices in an attempt to eradicate sexist bias in research (Campbell & Wasco, 2000; Olesen, 2000).

This study is specifically located within the framework of feminist standpoint theory, introduced earlier. This presents a feminist approach to epistemology, which postulates a disparity between women's consciousness and experience, and the social order (or the received view in society). Traditional research has seen the conceptualisation of women's experiences within dominant male conceptual schemas or discourses (Harding, 1986, 1987). From the perspective of feminist standpoint theory this necessitates critical research from the standpoint (or perspective) of women, such that social structures that oppress and marginalize women (like androcentrism and racism), become visible. According to Harding (1991) such research leads to less distorted claims that are more representative of women. Standpoint theorists have difficulty maintaining a postmodernist's respect for multiple perspectives. Agreeing with postmodernists that the unique perspectives of "oppressors" and "oppressed"

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are equally valid, may present a problem in terms of affecting social change (Latting, 1995). Regarding domestic violence as but another viewpoint in the multiverse of realties, may normalize a potentially dangerous situation, and relieve health professionals of their social responsibility to the powerless members of a family (usually women and children) (Becvar & Becvar, 1996; Hansen & Goldenberg, 1993).

Standpoint theorists have been criticized for proposing a universal female truth, however this has been contested by writers who focus on multiple standpoints that reveal the complexities of race, gender, class, sexual orientation and religion in women's lives (Enns, 1997; Olesen, 2000). The concept of a universalised woman has disappeared in standpoint thinking, giving way to a situated woman with experience and knowledge specific to her context. Hence the view is that knowledge claims are socially located, and that some social locations are better starting points for seeking knowledge (Olesen, 2000). Feminist standpoint theorists maintain that, relative to other strands of feminism, this approach conceptualises political change and activism more richly than most, by insisting that feminist theorising is grounded in political activism and political struggle for social change (Harding, 1987, 1991; Olesen, 2000). As a result of worldwide feminist activism, abused women now have greater access to resources than in the past. For this reason, a basic tenet of this study is that research oriented towards political change is important for women.

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2.6.2 Patriarchy in South Africa

The feminist perspective places the blame for violence against women squarely on the male perpetrators, and on unequal power relationships that characterize our patriarchal society (Becvar & Becvar, 1996). It maintains that abusive relationships continue because women typically lack the economic and political power to extricate themselves or obtain legal redress. Domestic violence occurs within the privacy and supposed safety of the home. The historical emphasis on the sanctity of the family stems from biblical times (Chornesky, 2000). This has resulted in the tendency to trivialize violence in the home as a legitimate and private occurrence, and the underestimation of the seriousness and severity of spousal abuse. In the past it was expected that women who were victims of domestic violence should keep the experience to themselves. Feminists maintain, however, that women need to raise awareness and speak out about domestic violence, because the personal is also political (Chornesky, 2000). The physical and mental abuse of women is a crime, yet is often dismissed as a domestic, personal or family matter by police and neighbours (De Sousa, 1991).

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A feminist standpoint approach maintains that women's experiences are programmed by a male-dominant worldview, or social culture, which socializes women to defer to men and the demands of the family. Thus domestic violence can be seen as a response to a social system that condones it. Change then becomes necessary at the broader socio-political level, since patriarchy is an

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attitude that has infiltrated all systems, not only the family system (Harway & Hansen, 1993).

Within the context of the patriarchal organisation of most societies worldwide today, gender inequality is still the norm and patriarchy has created a one-down position in terms of female status. Patriarchal practices within institutions in society have created a gender imbalance and removed power from the hands of women (Barnett & La Violette, 1993). In South Africa, the impact of apartheid on women has been especially harmful. Political oppression, coupled with traditional gender roles, has further undermined women's ability to exercise control over their environment. Furthermore, during times of political conflict violence against women escalates (Pauw & Brener, 1997).

Within the South African context, the concept of patriarchy is a highly complex one, where the predominantly male worldview is historically linked to race and a white male worldview. The issue of patriarchy is a matter of historical and political dominance by white men; a view not so easily attributed to men of colour (Stanfield II, 1994). Instead the concept of complex and multiple patriarchies has been used to more appropriately describe women's experiences, where male domination within the family may have a different form to male domination in the workplace or within religious structures.

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According to Mama (2000), gender-based violence in South Africa is not taken seriously or contested effectively by members of society. South African society is extremely tolerant of gender-based violence, which is downplayed by implicit patriarchal assumptions. Predominantly patriarchal discourse in the media currently limits women from being more accurately represented in South Africa. According to the Media Monitoring Project (1998), the challenge for South African media is to move gender from its marginalized position, to becoming a fundamental human right, as race has become.

Tolerance towards gender-based violence is also evident in the trivialization of incest in the South African courts. In addition, legal protections are largely ineffective in preventing violence and protecting women in South Africa (Mama, 2000). In South Africa the revised domestic violence act, mentioned previously, promotes social change by providing more effective protective legislation for women and children. However, implementation of the act is fraught with difficulties. According to Artz (2001), attitudes and belief systems do not change overnight, and ongoing education is therefore necessary at all levels of society.

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2.6.3 The importance of context

As discussed, a feminist epistemology provides a useful way of conceptualising woman abuse within the broader context of South African society. From a feminist perspective, gender is a power relation not unlike class and race.

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Gender is located within a particular socio-political context. Within the South African context women have a history of oppression based on gender and racial inequality. However, women experience their oppression differently depending on their position in society, their culture and background. In the same way women experiencing abuse do not represent a homogeneous group. Their experiences and needs are different, although there are also common experiences of gender for all women, such as the reality and fear of rape and violence. (Shefer, 1997).

In this country, feminism differs from its so-called western counterpart originating in America and Europe, owing to South Africa's particular political history. That is, many South Africa women are still feeling the effects of the apartheid regime, during which they were triply discriminated against owing to race and class as well as gender. The manner in which gender identity and power are constructed in post-apartheid South Africa has been the subject of gender research, which aims to understand violence against women (Shefer, 1997). In examining political influences on gender, researchers have also explored the crisis of masculinity, in terms of the long-term effects on men of apartheid brutality, the state's encroachment on patriarchal authority in families, and massive unemployment of black men (Ratele & Duncan, 2003; Vogelman & Eagle, 1991).

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According to feminist researchers and authors, the challenge for feminism on the African continent lies in how to combine the past and current tensions between so-called Western and African feminisms into an all-embracing feminist response. By all-embracing is not meant homogeneous. According to Msimang (2002), within the context of Africa, it is more appropriate to speak of feminisms, as the diversity of social realities in Africa makes it impossible to assume homogeneity in African feminist thought. There are common denominators, however, regardless of context. According to Mama, African feminists struggle for the same things as their Western counterparts in the USA and Europe, namely, respect, dignity, equality, and lives free of violence. Furthermore, she notes that Western feminists have incorporated the more complex theorising of African-based feminists, with regard to the significance of class, race and culture in structuring gender relations (Salo, 2001).

2.7 The health care sector's response to domestic violence

South Africa's health care system also cannot be seen in isolation from other aspects of society, especially its social, political and economic organization. The health care system is based on the same assumptions, values and worldview of the larger society. According to Helman (1990), gender divisions within the medical profession still persist, despite major social changes in this century. Although the majority of health care professionals (such as nurses and midwives) are female, male physicians still hold the higher paid and higher prestige jobs (Helman, 1990). The medical profession to some extent reflects

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the patriarchal bias in society as a whole. For example, the paternal role of the physician may encourage and perpetuate sexist attitudes and patriarchal patterns of power in medicine, with respect to women patients (Capra, 1988). It is consequently important to examine patriarchal assumptions, within the health care context, that may contribute towards a tolerance of domestic violence and an undermining of abused women's experiences.

Until recently a white male dominated medical profession exerted control over all aspects of medical practice in South Africa. Women in medicine have been disadvantaged in this country, as a result of both patriarchy within the medical fraternity and racism. For many years nursing and teaching were the only professions open to black women. As a society in transition post apartheid, there has been much change, with many feminist demands being met, and women medical students are now the norm. However, fewer than 30% of currently registered doctors are women (Wynchank, 1996). Research shows that the need for women doctors is now being recognized in many countries, including South Africa. Specifically, there is a great need for black women doctors in this country, in order to lessen transcultural communication barriers (Wynchank, 1996). Studies show that women doctors in a clinical setting show clear differences in the way they treat patients. Women doctors spend more time talking with patients, and employ more patient-centred strategies than their male counterparts (Sanders, Barnes, Du Plessis, Muller, & Mostert; Tait & Platt cited in Wynchank, 1996).

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Political oppression has undermined the effectiveness of the health care system owing to gross inequalities in racially divided health care departments and services (Pauw & Brener, 1997). With regard to health care for women, it has been and still is primarily white doctors that treat the country's black majority of women; while women in the rural areas have little access to health care, where currently there is only one doctor for every 4000 to 5000 patients ("Miracle health train", 2004).

Over the past few years, the health sector has undergone rapid change to make it more equitable, and to create greater access to primary health care. According to Human Rights Watch (1997), the restructuring of South Africa's health care system must take cognisance of domestic violence. They call on the government to intensify its efforts to improve the state's response to woman abuse, paying particular attention to the medico-legal system, which despite recent efforts at reform, still continues to fail women. Women attempting to report abuse and rape are still being traumatized further by the treatment they receive by district surgeons and other doctors. The enormous gap between rape and the arrest and conviction of rapists in this country, led to medical professionals in the Western Cape introducing a rape protocol for medical practitioners in 1998. The aim was to improve clinical care and the gathering of forensic evidence. According to Prof. Denny (senior specialist at Groote Schuur Hospital), without forensic evidence a woman will lose the case, hence the necessity for establishing multi-purpose rape centres to provide medical

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attention by staff trained in gathering forensic evidence (as cited in Cullinan, 2002).

According to Jewkes (2002), gender and health issues, as well as domestic violence, feature little in undergraduate and postgraduate medical training programs and textbooks in South Africa. Jewkes maintains that medical graduates can only adjust their clinical practice accordingly, if they are equipped with an understanding of the impact of gender inequality on health, and an understanding of the dynamics of domestic violence.

2.8 Routine screening

Standardizing the detection, assessment and treatment of abused women in the health care system, whether in rural communities or metropolitan areas, is regarded as an important step towards eliminating the cycle of domestic violence (Carlson & McNutt, 1984). Furthermore, the enquiry about domestic violence has the positive effect of uncovering a hidden stigma, even if no action follows from it (Jewkes, 2002).

2.8.1 Establishing a need for routine screening

Research has shown that women who experience domestic violence are more likely to visit a health worker with health problems related to abuse, than any other service. There is thus a need for a collective effort to improve the

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response of the South African health sector to gender-based violence (Jewkes, 2002).

Routine screening may help reduce the incidence of domestic violence. After the American Medical Association and the American College of Obstetricians and Gynaecologists recommended that physicians screen female patients for abuse, violence against women by their partners decreased by 21% between 1993 and 1998 (Association of Operating Room Nurses, Inc., 2001). It seems, however, that the jury is still out with regard to the effectiveness and hence the necessity of routine screening for all women in health care settings. The effectiveness of routine screening for domestic violence has not been directly assessed (Nelson, Nygren, McInerney & Klein, 2004). British researchers maintain that as pregnant women are at higher risk than other women, this could support a case for selective screening in antenatal clinics (Richardson, Coid, Petruckevitch, Wai, Moorey & Feder, 2002).

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The positive effects of routine screening for abuse are: the uncovering and reframing of a hidden problem, validation of the woman's self-worth, drawing up of safety plans to protect women in crisis, as well as referrals to social and legal agencies or social workers and psychologists. In addition, studies found that breaking through denial was a way of planting seeds for change. Documenting abuse (by written reports and photographs) provided a way of recording abuse in the event of legal action being taken. Providing information

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about domestic violence, hot lines and shelters assisted women in obtaining help in a crisis and changing the way they perceive their situation (Gerbert *et al.*, 2000; Thornton, Garner, Swenson-Britt & Brackley, 2002).

2.8.2 Research on the acceptability of routine screening to women

According to Jewkes (2002), there is a need for much more research on, amongst other things, the acceptability to women of routine screening in clinical practice. A review of the literature reveals that there are limited data about how women feel about such screening (Webster, Stratigos & Grimes, 2001). Research from the United States shows that most women welcome inquiries about domestic violence, but doctors and nurses rarely ask about it (Jewkes, 2002). Studies conducted in America reported that women felt comfortable being asked questions from the Woman Abuse Screening Tool (WAST) by family physicians, one study reporting that 91% of patients felt comfortable or very comfortable (Brown, Lent, Schmidt & Sas, 2000; Brown, 2001). Studies conducted in Britain found that routine enquiry for domestic violence is acceptable to women, if conducted in a confidential and empathic manner by health professionals (Bacchu, Mezey & Bewley, 2002; Bradley, Smith, Long & O'Dowd, 2002). At least 20% of women in another British study objected to screening for domestic violence, and the researchers saw this as an unconvincing case for screening (Richardson *et al.*, 2002). An Australian study found that women in Queensland found screening for domestic violence acceptable and,

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where health providers are suitably educated, it should be included when taking a routine health history (Webster *et al.*, 2001).

2.8.3 Routine screening protocols

According to a review of research in the area, protocols for routine screening are already in use in the United States and, to a very limited extent, in Israel and England. These involve standardized instruments or questionnaires, toolkits including educational manuals and cards for recording information, questions about abuse included in history- taking interviews, posters displayed in women's restrooms or examination rooms, as well as safety planning and referrals (Association of Operating Room Nurses, 2001; Davidson, Grisso, Garcia-Moreno, Garcia, King & Marchant, 2001; Grynbaum, Biderman, Levy & Petasne-Weinstock, 2001). Several instruments have been developed in the United States to increase physicians' ability to detect violence. Two of these are the Woman Abuse Screening Tool or WAST (an eight-item questionnaire), and the Abuse Risk Inventory (Fogarty & Brown, 2002). The WAST was found to be a reliable and valid measure of abuse when used in the family practice setting, and patients were comfortable with it being used (Brown, 2001).

2.8.4 Barriers to routine screening

Relatively simple, inexpensive changes at the doctor's office could help uncover and treat more cases of abuse (Henderson, 2000). However, studies indicate that many doctors are reluctant to screen for a condition that they cannot treat (Cole,

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1999). Researches have found that doctors' fear of offending patients, a sense of futility and their lack of training and time all contribute to barriers to action in domestic violence cases (Henderson, 2000). Other barriers are doctors' discomfort with domestic violence and perceived victim responsibility (Larkin, Rolniak, Hyman, MacLeod & Savage, 2000). Barriers encountered by emergency department nursing staff included lack of information about domestic violence issues, lack of training, as well as personal perceptions and feelings about domestic violence (Davis & Harsh, 2001). Doctors' underlying patriarchal assumptions were also found to act as barriers to screening, which calls for a need for doctors to question assumptions about the right of men to control women (Candib, 2000). The avoidance of victim-blaming treatment from health care personnel will prevent secondary victimization of abused women (Campbell, Wasco, Ahrens, Sefl & Barnes, 2001).

Institutional barriers to screening include a lack of privacy in health care settings, and documentation systems that put women further at risk through the lack of confidentiality (Cole, 1999). Other institutional barriers to implementing domestic violence protocols include under-funding, staffing shortages, and the lack of education on the topic (Runy, 2001). Studies found a substantial increase in routine enquiry into abuse, by doctors, when they received skills training around abuse, and when disciplinary action interventions were implemented in hospitals (Henderson, 2000; Larkin *et al.*, 2000).

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A major barrier to the detection of abuse is women's reluctance to disclose domestic violence to health care professionals. Women's reticence to disclose information is linked to internal perceptions, that is, women regard the abuse as a personal problem (Hegarty & Taft, 2001). In addition, other factors which limit disclosure include women's fear of reprisal from the perpetrator, fear of police involvement, concerns about confidentiality and the negative perceptions of health care personnel (no time, lack of interest and judgmental attitudes) (Rodriguez, Sheldon, Bauer & Perez-Stable, 2001). Women's fear of reprisal constitutes a realistic and significant barrier to disclosure, particularly in the light of evidence that encouraging women to leave an abusive relationship may be lethal advice. After an abused partner leaves her husband, the probability of homicide, suicide or both increases significantly for up to two years (Hirschhorn, 2001).

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2.9 Conclusion

From a feminist standpoint perspective, it becomes apparent that domestic violence in this country is inextricably related to and maintained by inequitable power structures, that are gender-based, and which define our political, economic, and socio-cultural life. Successful interventions are dependent on political commitment to improving women's health. Routine screening for domestic violence in the health care sector may contribute towards breaking the silence and the cycle of violence towards women. From a feminist perspective, it is important to ascertain women's attitudes towards such an intervention.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

In selecting an appropriate methodology from which to give women equality and voice in the research process, feminist principles were adopted. Emerging from the trend in feminist critique of the research process is the realization of a need to study women in terms of their own experiences. Such an approach would empower women and demonstrate their strengths and positive contributions, rather than regarding them as victims (Harding, 1987; Pilcher & Coffey, 1996). This seems particularly relevant given that this study contains the premise that woman patients are disempowered by a patriarchal health care system that in effect silences them. Furthermore, a feminist approach to research involves advocacy, and is used to improve the conditions and status of women. Research should therefore focus on questions directed towards the development of effective interventions for women, as well as societal-level transformations (McHugh, 1993). In accordance with this definition, this study can be seen as an attempt to look at an effective systemic intervention for women, from the perspective of women themselves.

3.2 Feminist qualitative research

In the light of the above, research was conducted within a qualitative paradigm. With research conducted within the positivistic paradigm, the emphasis is on defining variables and framing a hypothesis before data are collected. In

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contrast, the qualitative researcher begins with defining very general concepts, which change as the research progresses. A feminist approach to qualitative research is about levelling the power imbalance between researched and researcher. This can be regarded as an idealized position as we are reminded that in reality the researcher, by virtue of the fact that she interprets and writes up the account, remains in the more powerful position (Letherby, 2002). However, feminist research is also about allowing participants to participate in the research process, to be heard and listened to fully, to speak in their own voice, and to be listened to by someone who understands and who can fully represent that voice (Harding, 1991). The issue of representation will be discussed in a later section. Data analysis is an ongoing recursive process of continuous analysis, not possible in a quantitative study. As the researcher is in the field collecting data, it is impossible not to start thinking about what is being heard and seen (Pope, Ziebland & Mays, 2000). This allows interpretation of data to begin at the data collection phase, and continue in a dialogue between participant and researcher. Hence, the researcher can go back to participants and clarify unclear information, or pursue a different avenue of inquiry.

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3.2.1 Standpoint theory

Feminist standpoint research places women at the centre of inquiry, erasing the boundaries between researcher and participant. In the light of this, researchers regard the qualitative in-depth study of women useful for clarifying women's perspectives and realities, particularly in health care settings. Feminist

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qualitative research in health care settings, which promotes policy formation and social change, has become increasingly important (Pope *et al.*, 2000).

With reference to the researcher, feminist standpoint theory argues that men's dominating position in social life results in partial understandings, whereas women's subjugated position provides the possibility of more complete understandings (Harding, 1986). However, within the arena of feminist research a primary critique has been levelled at the predominance of white women researching black women uncritically (De la Rey *et al.*, 1997). Harding (1987) further maintains that it is the nature of the research and the way it is done, rather than the identity of the researcher, which sets it apart as feminist.

Regardless of what method is used, three principles are essential in guiding feminist research ("Designing a Feminist", 2000):

1. Grounding research in women's experiences by giving authority to the voices of women.
2. Undertaking research that benefits women's lives, for example, that works towards ending violence against women and children.
3. Designing research that is attentive to power relations between the researcher and participants, and that does not exploit women. This would entail engaging participants in a meaningful way in the research process, establishing a relationship of trust, and being ready to deal with the consequences of participants' disclosing information of a sensitive nature.

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3.3 A description of the participants

According to Miles and Huberman (1994) qualitative samples tend to be purposive rather than random, as with a small number of participants, random sampling can lead to a biased sample. For the purpose of this study snowball sampling was used to recruit nine English-speaking women, between the ages of 18 and 55, living in the Cape Town area. Thus participants were recruited via referrals from participants and others known to the researcher.

Qualitative studies are seldom large enough to generalize findings (Miles & Huberman, 1994). While it was not intended to present this study as representative of all South African women, there was a limited attempt to include women from a variety of backgrounds (Table 1). From a feminist research perspective, it is important to discover and understand women's diversity as well as features of commonality. As previously discussed, women's life experiences are not universal, and differ according to race, class, religion, age, ability, ethnicity and sexual orientation. However, feminist researchers point out that there is no distinctive and unique feminist methodology that will unequivocally ensure against bias on the basis of gender, race, class, or other characteristics ("Designing a Feminist", 2000).

An attempt was made to represent the voices of both abused and non-abused women (Table 2). From a review of the literature it appears that of the studies similar to the current one, those employing quantitative methods do not

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distinguish between abused and non-abused women as a sampling criteria (Bradley *et al.*, 2001; Richardson *et al.*, 2002; Webster *et al.*, 2001). In contrast, a qualitative study - with similar objectives to the current study - included both abused and non-abused women in the sample (Bacchu *et al.*, 2002). It follows that a small study such as this one necessitates purposeful sampling for abuse, whereas larger randomly chosen samples do not. Consequently, to ensure that abused women's voices were represented, the researcher purposefully recruited two participants with known current or previous experience of an abusive intimate relationship. In retrospect however, this appears to have been an unnecessary step, as the eventual sample comprised 6 abused and 3 non-abused women. While no attempt was made to generalize this study to the broader population, it was evident that partner abuse was a pervasive theme in participants' lives. That is, most women in the sample were either currently or previously in an intimate relationship that they considered to be abusive.

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Table 1

Demographic details of participants

Name	Age	Education/ Occupation	Number of Children
Priscilla	44	Matric. Domestic worker	2
Zureida	45	Office Administrator	1
Cheryl	24	Grade 10. Hairdresser assistant	0
Michaela	42	Physiotherapist	2
Theresa	33	Bank Clerk	0
Candice	37	Property administrator	1
Thandi	26	Secretary	0
Anna	31	Psychotherapist	0
Lilly (pilot)	44	Home-made arts & craft business	2

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Table 2

Intimate relationship details of participants

Name	Current relationship	Current abuse	Type of abuse	Previous abusive relationships	Type of abuse
Priscilla	None.	No	_	Boyfriend	Physical, verbal
Zureida	None. Divorced twice.	No	_	Husband	Verbal
Cheryl	Boyfriend	Yes	Physical, emotional	Boyfriends	Physical, sexual, verbal
Michaela	Married	No	_	Boyfriend	Emotional
Theresa	None	No	_	Boyfriend	Physical, sexual, emotional, verbal, economic
Candice	None. Divorced.	No	_	Husband	Physical, emotional, verbal
Thandi	Boyfriend	No	_	No	_
Anna	Married	No	_	No	_
Lilly (pilot)	Married	No	_	No	_

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3.4 Data collection tools

Each participant completed a biographical questionnaire (Appendix A), and voluntarily signed to give informed consent (Appendix B). The participant was then presented with a vignette to read (Appendix C). A vignette is a narrative description of a series of events, so created to represent the core research issues under investigation (Miles & Huberman, 1994). In the current study the vignette was drawn up by the researcher, and used as a tool to rapidly engage participants. To facilitate the emergence of personalized and autobiographical data, an in-depth, semi-structured interview, comprised of open-ended questions, was conducted with each participant (Appendix D). The open-ended questions were initially related to the vignette, so as to provide distance from the participant's own experiences and emotions, such that the interview process was an unobtrusive and unthreatening one. As rapport was established in the interview, questions became more personal. The major purpose of a qualitative in-depth interview is to learn to see the world from the participants' own frame of reference. In this type of interview, the interviewer strives to understand the meaning underlying people's experiences (Ely, 1991). Open-ended questions allow for further questions to arise from data elicited from the interview. It also allows for a flexible interview structure in which the participant guides the researcher (Ely, 1991).

An initial pilot interview was conducted at the home of a participant, Lilly, such that collaboration between the researcher and Lilly resulted in changes being

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made to the interview format. According to Ussher (1999) the feminist researcher strives to create collaborative and non-exploitative relationships with participants. In incorporating Lilly's perspective, the researcher gained valuable insight with regard to the impact of the interview. While not generalizing Lilly's perception to the other participants, this process nonetheless was helpful in guiding the researcher, confirming some ideas and discounting others. For example, the research topic was introduced by means of a vignette depicting a woman in a domestic violence situation. Lilly stated that she found a vignette to be a non-intrusive way of initiating an interview, as it directed attention away from the participant, particularly given the sensitive nature of abuse. Furthermore, it was Lilly's suggestion that the biographical questionnaire (with its questions around abuse in relationships) be administered at the end of the interview, after a relationship of trust had developed between participant and researcher. The pilot interview was included in the data collection, as Lilly's voice was seen to be no less valid than the other eight participants recruited for this study.

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3.5 Setting

All participants were from the Cape Town area. They were interviewed in a private setting of their choice, and at a time of their choice. Two participants were interviewed at their place of work; another two participants were interviewed in their homes, while five participants asked to be interviewed at the researcher's home.

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3.6 Reflexivity

Feminists have challenged conventional approaches to research, such as preserving the distance between the researcher and the passive subject. Qualitative researchers use themselves as research instruments, attending as much to their own cultural assumptions, and how they intertwine with those being researched, as to the data. In seeking to gain insight into the respondents' social worlds, the researcher is then expected to be flexible and reflexive (Letherby, 2002).

Reflexivity is defined as the manner in which the researcher influences the participants (Johnson, 1999). It is regarded as being critical to feminist research owing to feminist's concerns about the way research has been and is carried out, without questioning certain assumptions that researchers bring to a study. Feminists argue that a researcher is part of the social world she or he studies. Hence reflexive analysis involves the researcher analysing her own experience, and acknowledging that she is part of the social context under investigation. In this way, the participants' reality is seen as a subjective construction of the researcher, rather than as objective truth. Letherby (2002) describes a tension between accountability (the researcher examining her own role in interpretation such that interpretation is constructed inside her head, as it were) and representation (research which represents universal truths and material reality). She argues for a methodological position between the two, which does not

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negate the existence of objective truths, but acknowledges that judgements about them are always relative to the context in which such knowledge is produced.

3.7 Representation and validity

In order to examine her influence on the research process, the researcher kept a journal documenting her own involvement. Apart from transparency, such documentation has the added purpose of lending validity to the study, as an attempt is made to articulate methodology and process (Miles & Huberman, 1994).

In quantitative methodology the relationship between an object and its representation is dealt with by means of concepts such as validity, reliability and generalisability. It has been argued that these are not appropriate for evaluating research in the qualitative paradigm. An alternative paradigm, used to guide this study, proposes use of the concepts credibility, dependability and transferability to evaluate the 'trustworthiness' (Lincoln & Guba; Robson cited in Johnson, 1999), or good practice, of a study. Transferability refers to external validity or the extent to which findings can be generalized. Johnson (1999) maintains that the transferability of a study to wider settings can only be judged if the specifics of situations and settings are made known. This means linking the experiences of the women in this study to theory and other related studies, which the researcher has attempted to do. Dependability, linked to reliability in quantitative studies, is not the same as being able to replicate studies, as it is

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argued that different researchers would produce different, but equally valid work. However, a qualitative researcher can achieve a degree of dependability through a systematic and clearly documented approach to data collection and analysis. The final concept, as discussed by Johnson, is credibility, which is linked to the internal validity of quantitative studies. To achieve this, the researcher received feedback from her research supervisor, a colleague, as well as participants, which informed the development of the study. The appropriateness of using a rater to review qualitative data has been contested in the literature. Reasons given are that different researchers are bound to offer differing accounts based on their own worldviews, and it raises ethical concerns around confidentiality (Pope *et al.*, 2000; Olesen, 2000). Pope *et al.* (2000) suggest that involving another researcher in data analysis, to make sure that consistent themes are found, may be appropriate in certain settings where researcher bias is highly likely. This researcher did not see the need for it, however, in the current study. Reflexivity, as already mentioned, is another way of increasing a study's trustworthiness (Johnson, 1999).

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Although standpoint theory maintains that women are better located to represent the voices of female participants, current research is questioning whether the 'insider' researcher necessarily provides 'insider' knowledge. While not claiming to fully and completely accurately represent participants, this study takes the position that sufficient reflexivity can evoke resources within the researcher, which can be used to guide her work (Olesen, 2000). The next

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section will explore some of the ways in which the researcher attempted to reduce what Johnson (1999) refers to as the 'horror' of reflexivity, namely the gap between objects of study and their representation. For the purpose of easier reading, the first person will be used.

3.8 The researcher's voice

As a woman with experience of being both a medical patient and a health care professional, I found myself very much a part of the medical and social context under investigation. In relation to my understanding of woman abuse in South Africa, I have gained valuable insight having worked as a counsellor within the context of a non-governmental organization for abused women. From the perspective of this 'insider' experience, I felt readily able to empathize with participants' feelings, and to collude with their negative perceptions of various contexts, such as the medical context. Furthermore, feminist-based training in abuse counselling and legal issues provided knowledge and insight into the dynamics of domestic violence in South Africa. For example, I experienced first hand the frustration of attempting to elicit help for abused women, from support structures in the community that were either lacking or overburdened. From the perspective of the health sector, having worked in state hospitals in Cape Town, I have gained insight into the difficulties experienced by health care professionals in providing ideal service, under conditions that are frequently less than ideal (involving staff shortages, lack of resources, and hospitals grappling with the legacy of apartheid).

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It was throughout an emotional journey for me as I recognized my own voice in participants' narratives. I could relate to the stories of courage and competence juxtaposed with feelings of alienation and 'otherness' relative to medical contexts and perceived masculine norms. As a South African woman committed to social change in this country, I was emotionally invested in this study. It is hoped that this bias contributed positively towards my attempt to undertake research that is *for* as opposed to merely *about* women.

Commenting on the participants' perspectives on the participant-researcher relationship, feedback from participants was varied, but generally interviews appeared to elicit emotional responses, and some cathartic ones. Several participants experienced the research process as deeply meaningful for a variety of reasons; providing a space to express feelings, gaining insight through disclosure, finding closure through discussion, and so on. Some participants volunteered that they felt comfortable being interviewed, and linked this to the fact that I was a woman. A few participants revealed information they had never revealed to anyone before, while others revealed information they had only previously revealed to one or two others. These revelations were mainly in relation to experiences of abuse, as well uncomfortable or humiliating encounters with health professionals. The reconstruction (in story telling) of painful past experiences frequently occurred within the context of powerful emotions (such as anger, fear and grief) evoked in both participant and researcher. A couple of participants described how reading the transcripts of

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their interviews had evoked strong emotional reactions, one participant stating that she had cried for hours afterwards. Some women felt that reading the telling of their stories had a more powerful impact on them, than when they narrated them in the interviews. Several participants said that they appreciated the opportunity to be involved in the research process, and reported feeling a sense of satisfaction and validation that their voices, experiences, and opinions were being heard and valued.

The narratives of a couple of women, depicting both partner abuse and the systemic abuses of racist social structures, compelled me to examine my own position as a white researcher in post apartheid South Africa. I was painfully aware that certain experiences contained in black women's narratives could only be accessed in my imagination. I wondered whether – as researcher and participants - we were more divided by our oppressive history or united by our shared gender-defined experiences. These issues were not discussed in the interviews, and perhaps they should not have been avoided. Ultimately, however, it was my perception (and my hope) that the ongoing struggle for a non-violent, equitable and healthy South Africa was what united researcher and participant, irrespective of our background.

On an emotional level, it was at times overwhelming being immersed in participants' painful narratives of abuse. Often during the data analysis I felt the need to temporarily step back from the project, in order to create some distance

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between myself and participants' voices, owing to the intensity of women's lived pain. I realized that the more I engaged with the research process, the more complex my understanding of the women's voices I was claiming to represent became; which in turn shed more light on my own inner processes. This led to me becoming acutely cognizant of some of the current debates within the feminist arena, specifically in relation to scientific objectivity and the researcher/participant divide. I experienced the complexity inherent in embracing the emerging feminist view that research investigates, rather than ignores, the relationship between researcher and participant. As Weston so aptly explains: "A single body cannot bridge that mythical divide between insider and outsider, researcher and researched. I am neither, in any simple way, and yet I am both." (cited in Olesen, 2000, p. 227).

3.9 Ethical considerations

In accordance with ethical research, the purpose and nature of the study was explained to participants. Participation was hence voluntary, informed and confidential. Interviews were also conducted in private, in settings chosen by the participants. Each interview was conducted with respect for the sensitive nature of the topic and the possibility of eliciting painful emotional reactions related to traumatic situations. Each participant was given time to work through her experience at her own pace until she felt ready to end the interview. From the outset, participants were made aware that the researcher was not acting in a capacity of psychotherapist. Social support service referrals, such as

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counselling, were offered at the conclusion of each interview, but all participants declined the offer.

The researcher attempted to be transparent and ethical (in accordance with feminist principles) in providing participants with the opportunity to view transcripts of the interview, as explained. In addition, participants were told that recorded material belongs to them, and that audiotapes may be erased or returned to them, if they so request. Typed transcripts were given to each participant, to ascertain whether they had anything to add and whether their voices were represented accurately. At this stage, as throughout the research process, participants were given the opportunity to withdraw from the study if they so wished. In the final stage, research findings were fed back to participants telephonically, or at a prearranged meeting. The attitude of the researcher was at all times one of appreciation and respect. This recursive interaction, between researcher and participant, created a collaborative and trusting relationship such that women hopefully experienced themselves as equal and empowered participants in the research process.

An ethical dilemma arose for the researcher when an interview evoked the wrath of a participant's physically abusive boyfriend. The researcher was confronted with the dilemma of not knowing to what extent, if at all, to intervene to assist the participant, and was extremely concerned about her well-being. The boundary between the roles of researcher and health professional became

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unclear. After consultation with colleagues, it was decided that the ethical and caring response was to telephone the participant to enquire about her well-being, and to again offer referral to social support services for assistance and counselling. The participant appreciated the call, but declined the offer. This was a sobering reminder to the researcher of how research can impact on participants' lives in ways that are often unanticipated and, in some instances, negative. The researcher is never a neutral observer and influences what is being observed by virtue of her presence. Feminist and ethical research practice holds us accountable, as researchers, to our participants' health and well-being, and our primary concern should be that we do no harm (Becvar & Becvar, 1996).

3.10 The procedure

Each participant signed a consent form requesting permission and ensuring confidentiality. Participants were informed that participation was voluntary and that they had the right to terminate the interview at any stage. A short questionnaire was administered in order to obtain biographical data, in addition to enquiring whether women have been or are currently in abusive relationships with their intimate partners. This was administered at the end of the interview, as discussed. In-depth, semi-structured interviews were conducted comprising a series of open-ended questions. The questions merely acted as a guide in facilitating the exploration of women's perceptions and attitudes of routine enquiry into domestic violence by health professionals.

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Reflective and clarifying communication techniques were employed to obtain a rich narrative description of women's experiences. The interview was conducted in a relaxed conversational style, with the researcher maintaining transparency about her thoughts and goals at all times. In this way rapport was established. According to Fontana and Frey (1994), establishing rapport is crucial in facilitating understanding of the participant's world. All interviews were audio taped and transcribed verbatim with pseudonym insertion. Participants were given the option of feedback if they so desired. All participants chose to receive feedback, which entailed providing each with a transcript of the interview for her perusal and comment. Adjustments were made to the transcripts accordingly. In accordance with an ethical feminist approach, participants were thus empowered to take responsibility for their own stories, making sure that their voices were heard accurately. The interviews were conducted in the same two-month period by the researcher, who was an intern clinical psychologist at the time.

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3.11 Data analysis

Interviews were recorded, transcribed verbatim and the resulting texts analysed using thematic analysis. Cross-case analysis refers to data coming from multiple sources or participants (such as in this study). A frequently used approach to analysing this type of data is finding themes (or recurring patterns) that cut across cases. In qualitative research analytic categories, or common themes, are linked to describing and explaining social phenomena (Pope *et al.*, 2000). Miles

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and Huberman (1994) refer to the focus on themes, as a variable-oriented strategy for doing cross-case analysis.

According to Ely (1991), to analyse text qualitatively is to tease out what the researcher considers essential meaning in the raw data, and to reorganize and combine themes, which speak to the heart of research questions. In eliciting themes the researcher paid close attention to statements of meaning that ran through most of the pertinent data, as well as statements that, although not pervasive, nonetheless carried heavy emotional or factual impact (Ely, 1991). A tension exists in reconciling each individual participant's uniqueness with the need to understand general processes across cases. In order not to misrepresent voices by averaging results across cases, the researcher attempted to preserve the uniqueness of individual narratives, while also making comparisons (Miles & Huberman, 1994).

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The data analysis in this study involved using a technique called Narrative Summaries (Miller cited in Way, 1997). This technique entails condensing the stories told by each participant into brief summaries, while listening closely to the voices of participants, and paying attention to the relational aspects of research. The feminist method of research draws attention to the relationship between speaker and listener, and thus to the fact that patterns do not exist out there as it were, but are jointly constructed within the context of a relationship between the researcher and the researched. Thus in this study, data analysis was

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a continuous process in that there was an ongoing dialogue between the researcher and participants. Participants were questioned about ambivalent or incomplete responses, and asked for feedback throughout the process. In this way it was hoped to capture women's voices in such a way as to empower them, and give authority to their voices in the research process itself ("Designing a Feminist", 2000). Analytic categories, or themes, were identified across and within these narrative summaries. Each theme was then looked for in the interview transcripts, by means of highlighting supporting chunks of information (in passages, sentences or words).

3.12 Conclusion

As standpoint theory is concerned about understanding the world through participants' eyes (Harding, 1991), the question of voice - and how to make women's multiple voices heard without distorting them - becomes critical. Feminist researchers place the emphasis on context and on the discovery of socially constructed - rather than absolute - truths. The aim, as argued by Alway (1995, p. 225), is "to try to produce less false, less partial and less perverse representations without making any claims about what is absolutely and always true." Thus in analysing the following texts, this study tried to work towards an understanding (less partial, although not portrayed as the absolute truth) of encounters with participants. This understanding was located within a feminist standpoint theoretical framework, and filtered through the lens of the personal worldview of the researcher.

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CHAPTER 4

RESULTS: PRESENTATION AND DISCUSSION

4.1 Introduction

While the study yielded many interesting results regarding the emotional impact of abuse on women, in addition to women's experiences and perceptions around abuse, the focus of this paper was on women's perceptions in relation to routine screening for abuse. In this section the researcher has attempted to classify and interpret analytical themes and substantiate these with quotations, which will appear in italics.

4.2 Common themes

Themes depicted common patterns of experience, feelings, attitudes and opinions, as previously discussed. Where significantly different voices were heard, it was noted as a contrasting opinion, or negative evidence. After close examination, three central analytical categories emerged:

(1) Participants' express concerns about disclosure to health professionals;

(2) Participants' are in favour of routine screening; and

(3) Participants' define conditions of acceptability of routine screening.

These categories emerged deductively and were linked to the research questions. In a deductive strategy to thematic analysis, the researcher starts off with some orienting constructs, the research questions in this case. According to Miles and

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Huberman (1994), deduction and induction are not mutually exclusive research procedures. With an inductive strategy, the researcher discovers recurrent themes and relations, clustering them together to form causal networks. Hence, relevant and predominant themes, or subcategories, were further identified inductively, and classified within the three central categories, as follows.

4.2.1 PARTICIPANTS EXPRESS CONCERNS AROUND DISCLOSURE

In this section, five common themes emerged (inverted commas denote participants' own words):

a) "Disclosure is difficult",

b) The medical context: shared stories of mistrust,

c) The wise woman healer,

d) "Black women really suffer",

e) "Things are better now, a bit."

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4.2.1. (a) "Disclosure is difficult"

Lilly was the only participant who said she had never disclosed personal information to medical professionals: *"I haven't really had to. I'm very boring."* Lilly then elaborated that she felt uncomfortable talking to male doctors, and in the event of needing to talk about personal matters, would prefer speaking to a female. This sentiment was generally shared, and women repeatedly emphasized the link between gender and disclosure, as will be illustrated.

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A predominant theme emerged that personal disclosure to medical professionals is difficult:

Candice: *"Certain information is not easy to say."*

Cheryl: *"I don't trust anybody enough to speak to."*

Theresa: *"It's not so easy to go for professional help. I couldn't talk to doctors, because obviously they wouldn't understand."*

Participants' reasons for discomfort with disclosure were related to 1) health professionals' patriarchal and uncaring attitudes, 2) women's feelings of shame, and 3) fear of the consequences of disclosure. These reasons will be briefly illustrated.

1) With regard to medical professionals' attitudes, some comments were the following:

Michaela: *"I find I omit certain information because I fear they'll see me as a typical neurotic female."*

Cheryl: *"...sometimes a person doesn't trust doctors because you don't know where it's going to run to at the end of the day. Tomorrow you come and visit them again, and they look at you and think, 'ah, she was the one that was abused the other day, you remember?' And then you come back when you get abused again on the same spot, same spot, and eventually at the end the doctors won't help you anymore, because they know you."*

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Lilly: *"Hospital staff are too busy, they don't care, they couldn't be bothered."*

As mentioned earlier, studies have found that doctors' underlying patriarchal assumptions and victim-blaming attitudes can act as barriers to screening in that women are reluctant to disclose personal information (Campbell *et al.*, 2001; Candib, 2000). Health professionals' attitudes will be further explored in the subsequent section, under the heading 'medical context: shared stories of mistrust.'

2) An idea frequently voiced by participants, was that feelings of embarrassment and shame accompany disclosure about abuse:

According to Anna: *"It's hard to imagine because I've never been abused myself. But I'd imagine that I'd be feeling ashamed and guilty. This would be related to not being the perfect wife, I did something wrong, haven't been able to fulfil my husband's needs, not fulfilling the expected mother/wife role. It's difficult to understand why women react like that."*

Theresa also acknowledged that: *"When I was abused I never went to a doctor. Also because I was proud and thought people would think badly of me, and I was ashamed."*

Studies have reported women's reluctance to disclose to be a major barrier to screening, as previously discussed. Fogarty and Brown (2002) maintain that barriers perceived by both physicians and patients in addressing domestic

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violence are considerable. Physicians have cited patient evasiveness and failure to disclose information as a barrier to intervention (Gerbert *et al.*, 2000). Participants in this study relate that feelings of shame and guilt are barriers to disclosure. One can speculate that these internal or emotional barriers are closely related to the perceived stigma and negative attitudes associated with domestic violence. Theresa illustrates this in the victim-blaming attitudes of her family: *"My family, they could see what was happening around me and I could see it, but instead of talking to me and being more constructive, they blamed me: 'You're stupid, why do you keep on going back.' Instead of understanding what I'm going through."*

3) Finally, and not least significantly, participants' expressed concerns about the consequences of disclosure. This included the possibility of partners being arrested, as well as reprisal from partners in the event of them finding out about the disclosure:

Priscilla: *"You try but when they ask you questions, you lie. You try and protect him, at all times. Whenever you are in this situation, especially when you love the person, you always think that tomorrow he's going to change. And then when you talk to the doctor, 'no...maybe next time if he does it I'll leave him.' But you're still waiting for another blow...."*

Cheryl: *"You can't say anything, because you're too afraid that you will be slapped or hit around or things like that. My boss used to see it and she was scared for my life. When I was pushed down from the stairs, my boss took me to*

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the hospital. And I was with the doctor and he was very kind, and he asked me, 'please don't be shy, just tell me what happened because it's not a thing that somebody stabbed you, you must have been pushed from somewhere', because the inside of my back and things are damaged. Then I said to him, 'no I just hurt myself by accident'..."

As previously noted, women's fear of reprisal is a realistic one as research has found that women are more likely to be murdered by an abusive intimate partner after they leave the relationship, than at any other time (Hirschhorn, 2001). Physician surveys carried out by Rodriguez, Bauer, McLoughlin and Grumbach (1999) indicated that physicians identified fear of partner retaliation as a barrier to disclosure in 82% of patients.

4.2.1 (b) The medical context: shared stories of mistrust

Participant's perceptions of patient-doctor relationships appeared to have evolved through their experiences. From the interviews, detailed narratives emerged - which I have referred to as *shared stories of mistrust* - illustrating negative encounters with medical professionals. These encounters strongly influenced participants' decisions about choice of health professionals, and decisions about to whom they would disclose personal information. This has significant implications within the context of woman abuse and disclosure to health professionals.

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Candice and Cheryl related recurrent encounters in which they felt sexualised within the medical context:

Candice said: "*Males are more driven by other things...that's how they make me feel. And with the male gynaecologist, I just noticed something and I thought, my word, you're supposed to be a professional person, and I couldn't wait to get out of there, I was terrified. They didn't look at a person sitting there with a problem. They saw a woman maybe with big breasts, or I'm friendly or something like that. Because of them, I've never been for a gynaecological check-up ever again, and it's been three years and I haven't been back to a therapist ever again.*"

Cheryl said: "*What's the use you're going to a male, a man doctor; look at the things that he can do to you. I mean, you lie there, and you ... okay you get nice men, nice doctors that's very nice and things like that, and you get this one that's sick ... sick. Doctors that don't actually examine you for what you have to be examined, but they examine you for something else ... that's why I don't trust men doctors so much.*"

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Cheryl and Priscilla explain their difficulty with trusting medical doctors, after seeking help for abuse by their partners. Cheryl said: "*Sometimes you need someone to talk to, you can't talk to your mom. You tell your doctor and ask for advice and help and he just says he doesn't know where you should go. He's supposed to know. When I was younger I had a doctor that didn't understand how I felt or what I was trying to tell him, he didn't understand I needed to be*

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referred for help. I was too scared to tell him about the abuse. He wasn't a man of words, just examined me physically. There was just one doctor, the first one I trusted, but she was a woman."

Similarly Priscilla relates her experiences of recurrent visits to a hospital after being severely beaten by her partner: *"You don't at all feel comfortable. You try but always whenever they ask questions, you lie. 'What happened to you?' You might just say, 'no, I bumped myself against the wall' whereas you've been hit on the face, so you don't feel comfortable at all. You don't trust these people. You trust.... the fact is that the main person that you trust is the person that hit you."*

It has been well documented in the literature that patients have particular expectations of doctors, and that these expectations are often not met (Corbet-Owen, 1999). In this study, most participants clearly stated their disappointment with how they were treated by medical professionals. According to Rothman and Caschetta (1995), in medicine there is no specialty devoted to the study of men, comparable to the specialties of obstetrics and gynaecology, which are devoted to the study of women and their reproductive functions. They speculate that it may be because general medicine is already oriented towards men and the male body, while women are treated as different cases. Feminists express concern for a medical context in which the feminine is marginalized as a matter of course, and in which women are virtually unable to be represented except in

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relation to a masculine norm (Beasley, 1999). According to Michael Foucault, power can be easily abused by medical professionals who are unaware of medical discourses which ascribe an expert role to them by virtue of knowledge; knowledge that a patient does not possess and which therefore places her in a one down position relative to the medical professional. The way health professionals treat patients is closely related to the ongoing power relationships in society (Knudson-Martin, 1996). Thus health professionals have to be aware of powerful patriarchal discourses in medicine that may marginalize female patients.

Theresa, Michaela and Candice relate their experiences of a patriarchal medical context that invalidates and pathologizes women's experience:

Theresa: *" I had five weeks of intense therapy after the abuse. I felt I couldn't go anywhere ... I tried to commit suicide ... I couldn't open up to everyone. I needed one specific person I could trust and open up to, and trust they'd help me through it and make me stronger. I couldn't talk to doctors. The abuse impacts on your nervous system and eventually your whole body just collapses, and doctors will just put it down to depression or something. My therapists were female, and the psychiatrist running the place was male ... and I couldn't speak to him."*

Michaela: *"Male doctors in particular are quick to classify women, put them into certain compartments, not take them seriously enough, not validate their problems. Male doctors say you need a holiday or you have some psychological*

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flaw. The more complex your problem, the less they respect you. They like your problem to be linear; as soon as you bring in a whole embroidery of stories they start shutting down and think you're another neurotic woman. If you get complex then they patronize you, here's another neurotic woman with emotional stuff, not a happy marriage, husband needs more sex, etcetera. I've heard the same thing often from other women who have not been taken seriously."

Studies indicate that doctors prescribe psychotropic medication roughly twice as often as they do for men, thereby promoting drugs as a solution for women's life stresses and role conflicts (Helman, 1990). According to Helman (1990), advertisements for psychotropic drugs show images of women that outnumber men by 15 to one. Hence medicine proposes the medicalization of social problems like abuse, whereby women are offered drugs rather than being assisted in changing the situation itself.

As Candice reports: *"My house doctor is male, a good doctor, but he says every problem is stress and prescribes anti-depressants or tranquillisers."*

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Participants distinguished between the physical and the emotional needs of vulnerable women in need of help. They all felt that medical professionals were capable of dealing with physical injury, but not with the emotional aspects of women's lives:

Lilly: *"Hospitals must find out how a woman got her injuries, and then send her to a social worker or for therapy. But I know how hospitals work. Nurses*

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are not interested or trained to do that. They should treat the mental side, ...but they will just treat the injury."

Anna: *"My G.P.'s a male and I don't have a problem speaking to him about an organic problem like a common cold. If it were personal relationship kinds of stuff I would definitely feel more comfortable disclosing to a female. There are male counsellors and doctors who would be just as empathic as females, but due to my experience, I think females can associate more easily with Mary's kind of scenario, which is a violation of one's sexuality."*

These ideas had significant implications for women's perceptions of what routine screening should entail. An important theme was the separation of women's physical and emotional needs in terms of health professionals who are only skilled to deal with either one or the other. In effect, participants were describing their dissatisfaction with the received modernistic worldview of medicine and society, referred to earlier, characterised by reductionism and mind-body dichotomies (Becvar & Becvar, 1996). Also reflected here is a need for the previously discussed feminist way of knowing (or epistemology), where the focus is on understanding women in more holistic and contextual ways (Becvar & Becvar, 1996). This raises the question of whether, or to what extent, current western medical practice serves the interests of women. Michaela alluded to this when she pointed out: *" With complimentary therapists the difference between men and women is not large, the difference becomes blurry;*

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because I've found a lot of male complimentary therapists very caring and wonderful. In traditional medicine there's a big difference between men and women, in that women are much more sensitive, more empathic, much more in touch with your emotional being, and men are much more patronizing, and disrespectful of you as a woman".

In a South African study by Corbet-Owen (1999) South African female participants had similar views and felt that hospitals and health professionals should provide for more than just women's physical needs. Woodtli (2001) recommends that health professionals apply a health promotion framework, in order to encourage attitudes of care that are holistic and ecological.

In this section participants' narratives delineated a medical context that neither supports nor validates women's disclosure around abuse. In a qualitative study by Gerbert, Abercrombie, Caspers, Love & Bronstone (1999), 25 domestic violence survivors found that validation from a health professional was essential, in that it facilitated disclosure, provided comfort and assisted them to leave a dangerous situation. Validation referred to acknowledgment of the abuse, and confirmation of the patient's worth. Similarly, participants of this study felt that a lack of validation by health professionals made disclosure difficult.

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4.2.1 (c) The wise woman healer

As discussed, the power and authority inherent in the role of the medial professional has a clear impact on the way in which women process their experiences of abuse in the medical context. Furthermore, in the case of male doctors and female patients, these relationships reflect not only medical discourses, but gender discourses as well. As previously discussed, the majority of doctors in this county are male (Wynchank, 1996), which has significant implications for women disclosing about abuse in a medical context. Studies show that women doctors spend more time talking with patients, and employ more patient-centred strategies than their male counterparts (Sanders *et al.*, 1990; Tait & Platt cited in Wynchank, 1996). Similarly, participants in this study perceived differences in the way they were treated by male and female clinicians, with the result that a predominant theme to emerge from this study was participants' preference for being seen by female medical professionals:

Zureida explained: *"I will got to a male doctor if I know that doctor and I've been to that doctor and I know that doctor relates well. Then I haven't got a problem with that. But most of the time, I feel I'd rather go to a female doctor."*

Candice said: *"From my experience I've learned if I need help I'll seek a woman, because you'll get much further; men don't take the same interest."*

Similarly, Theresa said: *"All my doctors are women."*

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Participants' narratives delineated an archetype referred to here as the wise woman healer. The Concise Oxford Dictionary defines archetype as a recurrent symbol or motif (Sykes, 1989). It is in their stories of being listened to and cared for by female and male health professionals, that participants' gender-specific beliefs and attitudes emerged. It is not within the scope of this study to fully explore these beliefs about male and female medical professionals, however two assumptions are briefly illustrated here:

1) A predominant theme was that participants felt that women are better at healing other women owing to their holistic and empathic attitudes:

Michaela: *"Women are innately probably far better healers generally, more people oriented. Male doctors can often add to the shame by the way that they question you and I'd be very hesitant, and fear their attitude. Let's say it was sexual abuse, and I'm admitting to it, I'd also be anxious about how the male doctor would be perceiving me. His comments might be prejudiced, so I might then avoid divulging information out of fear of what he might say. Even if it's not real, it might be just perceived ...a perceived idea that's how they would respond to me, and then that would definitely prevent me from being truthful."*

Lilly: *"In my experience female professionals are more empathic and more caring...[a female] seems to get down to the nitty gritty, past just the basic medical side of things. They're interested in everything else about you, who you are, where you come from... and for a lot of men it's not important in their lives.*

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Men aren't interested in exploring feelings, knowing more about you, what you care about, what you don't like, chit chats."

Candice: *"When I went to a female GP she took the time and effort to understand. A male thinks I'm a woman with PMS and moods. When you go to a female doctor she sees a person."*

2) A second theme to emerge was the assumption that female professionals have a better understanding of female patients, owing to their similar and shared experiences of being women in the world:

Anna: *"It does make a difference if you're the same gender. Generally a females has had similar experiences and can understand better."*

Candice: *"A female doctor would have understood why big breasts are a problem."*

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Zureida: *"A lot of men and women are different, because they think differently as well. For an abused woman, ... like Mary, she'd feel more comfortable talking to another woman, because a man is the abuser. She may feel ashamed and scared to talk to another man. A man's attitude to the abuse also may be different, he may not understand, a man may blame her, or judge her. Females relate better to each other, especially in abusive situations, because a lot of women have been through abuse themselves".*

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In a study by Richardson *et al.* (2002), 42% of women reported that they would find it easier to discuss domestic violence issues with a female doctor, and 3% with a male doctor. The implications for clinical practice, especially within the South African context, is that there is a great need for more female medical professionals, particularly black female doctors, as discussed earlier (Wynchank, 1996).

Linked to the theme of the wise woman healer, was the idea expressed by several participants that older, more mature health professionals are more likely to have had similar experiences to their patients. As remarked by Cheryl: *"A lot of young doctors and young nurses are coming now, and you speak to them and they don't know how to answer your questions, they don't know what to say to you ... it's just like a story to them ... they don't understand what you are trying to say."*

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Postmodern feminists warn against sanctifying a universal feminine identity shared by all women, or as in this study, all female doctors. However other postmodern feminists are more ambivalent, according to Beasley, and argue that the use of a group identity in relation to women is strategically necessary, as resistance to power cannot occur "from some theoretically pure position outside of the current conditions of power including the organisation of categories around sexual identity" (Beasley, 1999, p. 88). From the perspective of feminist standpoint research, knowledge claims are grounded in women's experiences.

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Participants in this study appear to support a premise of standpoint theory, namely that there is a lack of fit between their experiences, as women, and dominant conceptual schemas (such as the medical model) which have a male bias (Harding, 1990). Hence expressed here was a preference for female doctors who may be more holistic and empathic in their approach, owing to their shared experiences as women living in a patriarchal society that tolerates a high incidence of woman abuse.

Only one participant had no gender preference in relation to disclosure. According to Thandi: *"It doesn't matter if it is a man or a woman; if someone is interested I can talk to her or him."* It is interesting to note that, unlike other participants, Thandi has had no prior history of abuse nor negative encounters with the medical profession. This reflects, as previously discussed, how women's perceptions are inextricably related to the specific contexts of their lives. This will be further illustrated in the next section.

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4.2.1 (d) "Black women really suffer"

In an interview with Salo, Amina Mama indicates the importance of class, race and culture in configuring gender relationships. According to Mama, different women are oppressed differently, depending on the context of their lives. In this study, participants related narratives of suffering owing to cultural-specific attitudes that sanction woman abuse (Salo, 2001).

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Thandi discussed the way in which woman abuse is sanctioned in her culture: *"Black women, they are the one's who have a problem, because if your husband or your boyfriend hits you, you can't tell anyone ... If you go to your in-laws or your mother, they will say, 'go to your husband and talk to him.' They say, 'marriage is like that.' They put those thoughts in your mind, like, as a black person you have to work hard; marriage is like that and a man should hit you, or it's the way of like showing that he is the head of the family so he can do whatever he likes to do. And I think they [women] don't get any chance to talk about what's going on in their homes. Even the elders will tell you that is the way marriage should be: He is your husband, you should respect him; he should show you respect by hitting you with a sambok or whatever. But you end up not respecting that man. You're just scared of your husband ... I think black women are the one's who have suffered."*

Candice discussed the way in which mothers raise their sons and daughters, and how it creates a culture that sanctions male authority: "*The roles have changed so much. When my mom grew up there were different values and then those came on to us. You must be the good housewife; you must keep the house clean. What's wrong with the man doing it? What's wrong with him babysitting and you going out somewhere? There's nothing wrong with it, but we were taught that it's not supposed to be like that. I've learned on my own that it can't work like that, because the woman will get burnt out. So men used to get the credit or get what they wanted because they're a man and men have authority. Because*

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even their mothers still do it today, when they walk into the house: "Oh, would you like a cup of tea?' Not, 'Mom can I make you a cup of tea.' A lot of women, like me and my sister, we're quite happy with our set-up at home. Why must I change that and become a man's slave again, or become abused? I'm very terrified of commitment again."

It is Cheryl's belief that violence towards women is more prevalent in her culture than in others: *"I'm a coloured girl and I just think, you know, for a coloured person to be abused, it's like every day. It happens, they've seen it every day and it's fine. But if you look at a white person, you don't see a woman getting physically abused in front of her children or anything like that. But, like, in our culture, there you see it; your mother has been hit in front of you, daddy doesn't worry, he doesn't care, nothing at all."*

From these narratives it appears that not only is the influence of contextual factors (such as history, race and culture) highly significant with regard to women's attitudes, but also the form that context takes in women's lives is so varied and multifaceted that it does not seem possible to implement generic forms of screening imported from other countries. The implication here appears to be that before any form of routine screening is implemented, researchers investigate thoroughly the details of implementation in terms of what women in this country would regard as acceptable practice.

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4.2.1 (e) "Things are better now, a bit"

Theresa related how attitudes towards woman abuse have changed over time: *"I was raped, and I blame myself for not going to report this person. I was eighteen, I was very young, and in those days – I'm talking about fifteen/twenty years ago – the woman was the one that was always to blame. Not going to report it, I felt that I was letting myself down. But it's much more in the open now and I think society turns more to the woman than it used to do before."*

Participants related narratives depicting painful past experiences of political oppression. Abused women living in South Africa, under the apartheid regime, were triply discriminated against on the basis of gender, class and race. Priscilla, a black participant, recalls: *"If you went to the police station to report your case, no-one would even bother, they ignored you!"*

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Health professionals' own experiences of political oppression may have influenced the manner in which they treated abused women. As previously discussed, apartheid severely restricted the professions open to women. To illustrate, Priscilla described how black women's lack of career opportunities resulted in people going into professions, such as nursing, that did not interest them. She recounted being laughed at by nursing staff at Khayelitsha Day Hospital, after being severely beaten by her partner: *"The female staff, the nurses, they liked to make fun of people whenever they come into the hospital ... For them it was not a profession they went into to heal people. But for them it*

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was just a job, because there was only that profession for black people. You could either be a nurse or you could be a teacher. There were no other courses they could do. So you choose to be a nurse ... then there are things you are going to come across. They were not skilled, that's what I can say."

A study by Woodtli (2001) found that nurses' attitudes significantly influence the way in which they interact and intervene with women and families involved in domestic violence. It was suggested that domestic violence is of special concern to nurses, as they are often the first health professionals to interact with battered women.

Priscilla's perception, however, is that the situation is changing with regard to health professionals' attitudes, as well as support systems now available for abused women: *"The hospitals today are different than in the past. Patients now have rights and if a nurse speaks badly there'll be consequences. In those days you'd get your medicine and then get out. If I were abused now, it'd be very easy for me to get out of the relationship. Because now there are so many facilities, opportunities for people to cry out and be heard by the people. I would use the hospitals now if I was abused, because there are now social workers there, and counsellors, and everything is there now in the hospital."*

Similarly, Cheryl and Thandi commented on how the situation has improved, to some extent, for women of colour. Cheryl recounted: *"There was no way out,*

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no doors open; now doors are open, things have changed a little bit, but not much. There's so much abuse, I feel sick when I hear of children being abused."

Thandi said: *"I think now they [black women] are starting to talk about it. They must, they must do something about it ... I see there's a change happening, I'm not sure about in the rural areas and so on, but people are starting to see what's what, the difference between showing respect and abusing your wife. But it's slow ... slow change ... but it is going to change, I hope."*

Candice: *"...I do feel that in the society we're living in all the time that women are abused more than ever and they try and hide it because they feel that there isn't help ... I also think that women do speak up more than before, but I feel a lot don't speak up because they don't have the strength to do it. And also the people that have always been there are men. They're the ones that's always there, but now there are more women to help women so these things are coming out more in the open, I feel."*

Much has been written about the link between high levels of political violence and violence against women. South Africa is a country living in the aftermath of terrible violence, where victims and perpetrators are still living together in the same society. According to Samuel (2001), South Africa urgently needs to bridge the gap between policies and laws, and their implementation. Thus in

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theory women's positions in society have been greatly improved, with commendable legislation such as the Equality Clause (guaranteeing equal treatment for all South African), but in reality, this is not the case. Samuel maintains that unequal power relations in South African society still persist, such that the majority of women still bear the main burden of increasing unemployment, abject poverty, and lack of delivery in health and welfare.

4.2.2 PARTICIPANTS ARE IN FAVOUR OF ROUTINE SCREENING

In spite of the negativity expressed by most participants in relation to contact with the health care system, participants expressed overwhelming support for the implementation of routine screening. The predominant reasons participants gave will be outlined and illustrated below.

1) A predominant opinion was that the high level of abuse in South Africa makes it necessary for women's voices to be heard, in order to stop the cycle of abuse:

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Theresa explained: *"It's not about women becoming powerful. I think I'm a powerful person in my own right ... it's just a matter of being heard by society, and to put a stop to what's going on in this country. I think I've reached a stage where keeping quiet about what's happened to me in my life, is not going to benefit me. So I've learned I can speak, and I couldn't for 13 years. You become so used to keeping quiet, and I've learned to overcome all of that. In*

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South Africa I think there's a level of abuse that is very high. If I had not dealt with the issues that I have, I would treat my child that way, and it's going to come out in that person. If it's a boy, he's going to treat a woman that way. It's a snowball effect, so if it doesn't get stopped at one level, it's going to carry on."

2) A predominant feeling was that routine screening, if carried out with sensitivity, could help women leave abusive relationships:

Lilly: *"I think everybody wants to be helped to get out [of the relationship], but you've got to get to them. Because maybe Mary's scared for her life, that if somebody starts helping her, or interfering, that her husband or boyfriend will come chasing after her. So you actually need someone with a lot of insight, in a hospital, to go up to people - not just a nurse with a list going tick, tick, tick."*

Theresa: *"Maybe it [routine screening] would have made me feel a little bit better about myself, not feeling that I'm not worthy of anybody. Maybe understanding why I felt the way I did, it would have helped me as a person ... maybe I would have left a long time ago."*

3) Routine screening was seen to have an educational role, creating awareness about woman abuse:

Anna: "*Yes it's important because it [routine screening] creates an awareness of the problem; instead of being shoved under the carpet, people will become*

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more aware of abuse and more aware of their rights, that abuse is something that is illegal."

4) Most participants felt that the state is accountable for preventing women abuse in this country, and that hospitals have a significant role to play in informing women of their options and rights:

Thandi: *"It's important because some women don't know their rights, and they think they deserve to be abused, and that's not true. Doctors and social workers and nurses are there for that. If you've broken something, you have to go to a doctor; maybe he or she is the first person you talk to. So she or he can give you advice, refer you where to go and what to do. You're in a state, you're scared, and maybe haven't even told a friend. You go to a doctor, and so it's important that the doctor ask what happened to you. Even if the woman lies, the doctor can say, if your boyfriend hurt you, you can go to a social worker. People often don't want to go to the police station, because there are lots of people there and you can't really explain yourself, and also some policemen are very rude. So with doctors and social workers, it's a good place to start."*

Cheryl: *"I would like the government to give us a nice community in South Africa, and say to us: 'this is for women that get abused, to speak out and say what they want to say.' Let's stand up and say that we don't want men to hit us or put us down."*

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4) Participants also felt that women themselves should take responsibility for making their voices heard, thereby helping to stop abuse:

Priscilla: *"If Mary could tell the story to the hospital staff, that's the main thing. She must open up and tell the people what went on. Women are human beings. They mustn't allow that to happen to them; even if you've got nothing and you depend on the relationship, I mean try and talk, say something to anybody, cry to the next person. Women mustn't keep quiet. They must talk about these things. They must cry out to be heard by the people. They must scream very loud to be heard."*

Although Lilly felt that routine screening was important, she was concerned that it may be offensive to women if managed insensitively. She therefore concluded that only high-risk cases (such as women with physical signs of abuse) should be screened. As noted, a case has been made for selective screening as a more acceptable option, owing to studies that reveal that a significant minority of women – in some studies 20% - object to universal screening (Richardson *et al.*, 2002).

The participants of this study emphasized the powerful role that doctor's and other health professionals have to play in implementing routine screening successfully. If this is true, it is imperative to determine how these professionals can play a positive role in providing abused women with the opportunity to be

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heard and appropriately assisted in the health care system. It is this question that the researcher attempts to answer in the following sections.

4.2.3 PARTICIPANTS DEFINE CONDITIONS OF ACCEPTABILITY OF ROUTINE SCREENING

The participants of this study regarded routine screening as relevant (as illustrated in the previous section), and acceptable. However, it was made clear that routine screening was acceptable to them only under certain specific and essential conditions. Participants' ideas, regarding these necessary conditions, appeared to be closely related to their personal experiences as patients in health care settings. Despite differences in participants' backgrounds, and participants' differing experiences of health care in this country, they all identified desirable conditions of remarkable similarity. This suggests that women as a gender have similar experiences and needs in relation to health care. A recurrent theme, as has already been illustrated, is the need for deconstructing powerful medical discourses in society, which too often negatively affect female patients.

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A prominent feeling amongst participants was that, although routine screening for woman abuse is important for South Africa, its successful implementation is not guaranteed. According to Candice, if routine screening is not carried out sensitively then: *"there's a good chance that women won't tell the truth."* Similarly, Lilly felt that universal screening, if not carried out sensitively, may be perceived as offensive, and suggested instead selective screening which

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targeted vulnerable women that health professionals suspected of having been abused. As Lilly said: *"If routine screening is going to help people then it should be done, but it must be done very carefully, without offending people. There's a good chance routine screening won't work if it's not handled correctly".*

Thus, successful routine screening was seen to be contingent on the manner in which it is carried out in the health care system. Participants were very clear about the circumstances they perceived to be necessary for facilitating successful routine screening. This will be discussed in the following sections.

4.2.3.1 Health professionals – gender, attitudes, confidentiality, knowledge and training

4.2.3.1 (a) Gender

Participants felt that health care professionals had a responsibility to implement routine screening in a careful and sensitive manner. Specifically, there was a preference for female health professionals, because of the sensitive nature of abuse, as discussed previously and again illustrated here:

Anna: *"I would feel more comfortable disclosing to another woman, for Mary and myself. I'm not saying that men are not good counsellors or debriefers, but with extreme trauma a woman may be better."*

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Michaela: *"I'd prefer a female person to deal with me. If I was visiting a female doctor I'd be comfortable talking to her, but if I'm visiting a male doctor, I'd prefer not to discuss the questionnaire with him, but then be contacted or referred to a female."*

With regard to the type of health professional, a couple of participants felt that mental health professionals were more qualified to administer routine screening, as illustrated by Michaela's statement:
"*I would like to speak to a mental health professional if it's about mental health issues, especially if I was Mary."*

However, the majority of participants did not mind what type of health professional conducted the routine screening, whether they are doctors, social workers or nurses.

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4.2.3.1 (b) Attitudes

As with gender, participants had remarkably similar ideas about the manner in which routine screening should be done. The attitude of the health professional conducting the screening was spoken about at length in the interviews. The need for professionals to utilize communication and microcounselling skills was also emphasized. Candice explained the delicate nature of the interaction between patient and health professional: "*It would be hard to talk about abuse because it is very traumatic so you'd need a special kind of person that would be*

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able to help Mary to open up and talk about it – not anybody would get that right, because first of all an abused woman is embarrassed about it. She doesn't want people to know, because she feels that she's doing something wrong."

A predominant theme was that in order to be successful, routine screening must be carried out with a manner or an attitude that conveys empathy, respect, and care:

Zureida: *"It's important that it's done with a caring attitude ..."*

Lilly: *"They must be interested in you, show some form of intelligence, and do what they do for your benefit, not to skinner about you. They must be empathic, not just tick questions off a list. They must care; they must talk to you like a friend."*

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Another theme to emerge was participants' feeling that health professionals should be non-judgemental. This was discussed in relation to disempowering patriarchal attitudes held by medical professionals. Patriarchal attitudes were discussed and illustrated in the previous section on disclosure, and are therefore only mentioned here. The attitude of non-judgement was also discussed within the context of harmful attitudes which blame women for their abuse, as explained by Theresa: "*The more women see that they are not being blamed for their abuse then the more they will disclose, and it'll have a snowball effect."*

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Participants felt that health professionals should ask questions about abuse in a sensitive way, such that women felt comfortable, heard, and able to trust the professional:

Cheryl: *"So I would just love people - like especially for the youngsters today - if they want somebody to speak to, speak to somebody who can understand, that understands you, somebody that you think you can trust. I would love somebody to trust."*

A predominant theme was that health professionals, who question women about abuse, should be genuine and express genuine interest:

Candice: *"The person must be really genuine, and take a genuine interest in you. And it must be confidential – you don't want the next person to know. So she must be female, compassionate, mature; must want to help you, be there for you, must be on your side, and must take you seriously."*

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Thandi: *"Body language must show that the person's interested in you, they must listen and not judge you. They must sympathise with you, show interest so that you can keep on talking about whatever troubles you."*

The attitudes described by participants are similar to the attitudes of a counsellor working from the perspective of person-centred therapy (Rogers, 1986). The American psychologist, Carl Rogers, originated a counselling approach in which the relationship between client and counsellor is of paramount importance. He

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described an attitudinal orientation which is useful in all human relationships, and which consists of three dimensions, namely, empathy, genuineness, and unconditional positive regard. The last is a fundamental attitude by which the counsellor deeply values the humanity of the client, and it manifests in the counsellor's consistent acceptance of and enduring warmth towards the client (Mearns & Thorne, 1999). According to Rogers, these attitudes and skills can be learned, and they allow the health professional to enter into the perceptual frame of reference of a client, such that a relationship of trust can develop. The implication here for health professionals is that basic microcounselling skills such as these are essential, can be easily learned, and should be incorporated into professional training programs. A study by Hegarty and Taft (2001) showed that a general practitioner's good communication skills facilitated disclosure about abuse.

4.2.3.1 (c) Confidentiality

The storage and dissemination of personal information was an extremely important issue for all participants. A predominant theme was that strict confidentiality and anonymity were essential for routine screening to succeed. Furthermore, participants said that women should be informed in advance of the consequences of giving out personal information, that is, they needed to know what was going to be done with the information. Linked to this was a primary concern that women should feel safe enough to disclose information about abuse.

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Theresa explained: *"In your instance, you understand the kinds of things that you go through, but not necessarily nurses, because you don't know if you can trust them with that information, or whether they're going to tell everybody about it. I suppose if there's a certain level of confidence, then you'll disclose that information, but not to just anybody. Confidentiality is very important."*

It can be speculated that underpinning participants' insistence on confidentiality is the issue of empowerment. That is, participants' voiced an important need to feel safe from their abusing partners, and in control of their right to choose whether or not they divulge personal information and to whom. This is understandable when one considers the context of disempowering experiences of abuse, lack of trust in participants' relationships with medical professionals, as well as the realistic danger of reprisal by abusive partners. To illustrate, Candice supports routine screening, but discusses her own fear of what a breech in confidentiality might entail: *"As long as you know it's confidential, because if you're abused and your partner finds out you've told, he'll hurt you even more. That information must go to a certain person who takes full responsibility for it, not just be in an open folder."*

It was evident that participants grappled with the complexity of how to conduct routine screening for woman abuse in a way that would not be offensive or invasive to women, nor compromise their safety. Although it is beyond the scope of this study to explore an acceptable protocol for routine screening, it is

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interesting to note some of the suggestions made by participants, and the concerns highlighted:

Michaela preferred filling out a written questionnaire, rather than risk the discomfort of initial disclosure to a health professional: *"I wouldn't mind filling in a questionnaire. So it [routine screening] must be written, I must know who's going to read it, someone specialised in abuse, and it must be kept in the strictest confidence. It must be reviewed by an empathic mental health professional, and should I choose to divulge any information, if I'm contacted it should be done in a very discreet way ... So there would be two issues: that it would be totally confidential - that nothing will be done without my consent, having received this information; and the second thing is that I can choose who I want to discuss it with."*

Cheryl on the other hand, preferred routine screening by oral disclosure, as in her opinion documentation - whether written or computerized - was open to exploitation: *"I'd throw it away; I would not fill it in because I don't know to which person it's all going, understand? I'm your patient, but that paper can travel the whole world for all I know. That paper's going to lay there, any person is going to see that this is Cheryl Smith; she's an abused woman. The person at reception, wherever it goes, on computer or whatever, they are looking through the files, and that's not a confidential thing."*

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One of the most important outcomes of this study, from the perspective of the researcher, was the awareness of the complexities involved in creating routine screening protocols. The participants grappled with the specifics of day-to-day screening protocols, and what they would like to see. Furthermore, participants' needs appeared to be intricately related to the context of their lives. Hence (as illustrated) Cheryl, who has a history of physically abusive relationships, would not fill in a questionnaire for fear that breech of confidentiality might evoke reprisal from her partner. On the other hand Michaela, a participant who has experienced an emotionally abusive relationship, would prefer to fill out a questionnaire, as she is more averse to the discomfort of disclosure to health professionals.

4.2.3.1 (d) Knowledge and Training

Knowledge and training, or lack of it, was a recurrent theme of concern. Several participants mentioned that health professionals, particularly doctors, should have specific knowledgeable about abuse, and receive ongoing training in dealing with abuse.

According to Cheryl, medical professionals lack of knowledge and experience with abuse left her feeling unsupported and not knowing where to turn for help. She described what abused women need from health professionals: "*People that know what they are dealing with. People that aren't going to sit and cry with you or ask you a lot of stupid questions ... that know how to speak to you, that*

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know how to answer your questions, that will open a door for you and say: 'okay, from here onwards you go there.' That will help you further and show you the steps to take from here."

Similarly, Thandi said: *"They must give you options. Tell you what your rights are, show you that there are people to help you, the police, nurse, social worker; that you're not alone and you can get help to stop this abuse."*

In discussing professional training, Michaela said: *"I think doctors need to be educated because from my understanding, they have very little training in psychology during their medical training. If doctors were trained, they'd have a lot more insight into abuse and violation and how to deal with it more effectively, not necessarily to counsel. I wouldn't expect my doctor to counsel me, but just to ask relevant questions because I'm assuming that the doctor's role then would be to know where to refer me; not to have to deal with the problem themselves. The doctor must be able to basically come to some sort of decision about where it would be appropriate for me to go. But they need the training to deal with it sensitively, that's essential really."*

The importance of adequate training cannot be underestimated, particularly as studies have found a substantial increase in routine enquiry into abuse, by doctors, when they received skills training and education around abuse, and

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were trained to ask direct questions about partner abuse (Henderson, 2000; Larkin et al., 2000; Weiss, Kripke, Coons & O'Brien, 2000).

4.2.3.2 Health care settings - structural difficulties in hospitals and clinics

A predominant theme was participants' negative attitudes towards state-owned health care settings such as hospitals and clinics. Participants were generally of the opinion that routine screening would be seriously compromised by structural difficulties in the hospital system. Specifically, these were lack of confidentiality, lack of privacy, no follow-up, and lack of time owing to work overload and staff shortages. In addition, and perhaps most crucial with regard to routine screening protocols, participants felt that referral by medical professionals to support structures for abused women, was either lacking or inadequate. Research shows that support structures for abused women in South Africa are seriously lacking, which would create a problem for medical professionals who want to refer women (Artz, 1998).

Cheryl makes a very relevant point with regard to the needs of abused women, and the ability of hospitals to meet those needs: *"Abuse happens mainly at night. It would be better if there were social workers on duty at night, because that's when women need them. But you don't get them working often at night. So it's fine to have routine screening, but women mostly go to the hospitals at night, like with Mary, and I'd like to see social workers and counsellors available at night, people that I can talk to when I need it most so I don't have to*

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wait until morning. All the resources should be open 24 hours. Police are not 24 hrs on duty. Often they don't come and then somebody could have killed you already. It's one thing referring people, but there must be people to refer them to who are there 24 hrs."

Theresa maintained that private practice settings are more private and personal relative to hospital settings: "*Maybe I'd feel more comfortable with it [routine screening] in private practice, because of the one-on-one thing. It depends on the environment. It's more private at a G.P., and more confidential. There's no privacy at a clinic especially when answering a questionnaire. Privacy and confidentiality are very important."*

A predominant theme was that in a state hospital setting medical professionals are short of time. As Lilly said: *"In this country.... well.... you put your form in 11 languages and take your chances. I think you will probably land up with an optional extra form, and just hope you don't end up with some administrator barking it at the people. In this country where there's not enough health care, where there isn't enough time, it's not a perfect world."*

Thandi had a similar opinion: *"I went to a male private doctor and he made me feel comfortable to talk about anything. Doctors in the hospitals are very busy I think. They don't have time."*

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Zureida suggested a way of dealing with the problem of time and staff shortages. She proposed a telephone abuse line, as a form of routine screening in busy hospitals. In this way patients can telephone the hospital and be assisted directly or appropriately referred: "*When they [women] go to the hospital, then it might take too long...the whole process. Sometimes you sit there half a day maybe, whereas you could have 'phoned the hospital, and asked them if they can direct you to one of the outlets, give you the number and you phone them, it's much quicker. That person might be in such a state.... that they need help immediately. I've been to day hospitals.... and you sit there almost forever...for hours, waiting for somebody to see you.*"

According to a disturbing article by Sookha (2004), hundreds of community members recently shared their experiences of healthcare in South Africa, and many spoke of the long wait before being attended, stating that many people have died waiting.

To summarize this section, participants' views were that routine screening is acceptable to women under certain conditions. These conditions pertained to the manner in which health professionals conducted screening, and to structural factors in health care settings. Specifically, in relation to dealing with abused women, participants' expressed a preference for female health professionals. Furthermore, health professionals' attitudes were seen to be a highly significant factor in relation to abused women feeling comfortable enough to disclose

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information about their abuse. It was felt that women felt most comfortable with health professionals whose attitudes conveyed empathy, respect, genuine interest and care, as well as non-judgment. Participants' also felt that confidentiality and anonymity were essential, as for women to disclose they needed to feel safe. Furthermore, participants' expressed the need for health professionals who had specific knowledge of domestic violence, and received ongoing training in this area.

With regard to structural conditions in public hospitals and clinics, participants were concerned about perceived difficulties or barriers to screening. Specifically, these were the lack of confidentiality and privacy, time and staff shortages, long waits before being attended to, the lack of follow-up and appropriate referral, and the lack of 24 hour services for abused women. The general opinion was that private health care settings were more private, confidential and personal.

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Although there is limited research on the acceptability to women of routine screening in clinical practice (Jewkes, 2002), a review of the research (reflected in chapter 2) reveals close correlation with findings from this study. To illustrate further, in a qualitative study in London, ten women (abused and non-abused) regarded routine screening for domestic violence in maternity settings as acceptable to women if conducted in a safe, confidential environment by a trained health professional that is empathic and non-judgmental. Furthermore,

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the effectiveness of routine enquiry was seen to be influenced by factors such as lack of time, confidentiality, training and availability of resources (Bacchu *et al.*, 2002).

Brown *et al.* (2000) reviewed several studies of abused women in health care settings, and found that women want to be asked about abuse by their physicians, but in a manner that is caring, respectful and supportive. It was also found that when women feel understood, listened to, and validated by their doctors they are more inclined to discuss their abuse (Gerbert, Johnston, Caspers, Bleecker, Woods & Rosenbaum; McCauley, Yurk, Jenckes & Ford; Hamberger, Ambuel, Marbella & Donze; Hamberger, Johansson & Lindgren cited in Brown *et al.*, 2000).

4.3 Central findings

The participants of this study regarded routine screening as relevant and essential for South African women. Predominant reasons given were: the responsibility of government to address domestic violence and inform women of their rights; the need to break the silence and put an end to high levels of abuse; abused women's need for validation from health professionals who could assist them in leaving abusive relationships; and lastly the need for public awareness and education around domestic violence. Furthermore, the opinion was that women themselves are as accountable for addressing the issue of domestic violence by speaking out about abuse. One participant felt that universal

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screening, if conducted insensitively, may offend women. She suggested instead the selective screening of vulnerable women, for example female patients with physical signs of abuse.

Disclosure to health professionals was seen to be difficult, particularly in the light of patriarchal attitudes that alienate and pathologize women. Women also found disclosure difficult owing to their own feelings of shame, guilt and embarrassment, as well as the fear of the consequences of disclosure, such as reprisal from partners. Mistrust of the medical context was a pervasive theme, and inextricably related to the sociocultural contexts of participants' lives, such as past experiences of racism, and victim-blaming attitudes. Participants reflected on the role of culture in constructing ideas about woman abuse. The perception of black participants was that black abused women in this country have especially suffered, owing to apartheid, racist and patriarchal attitudes, as well as economic dependence on partners. Furthermore, it was felt that health professionals own experiences of political oppression impacted on their attitudes towards abused women. This situation, however, was seen to have improved somewhat owing to the availability of resources that were not previously available.

Routine screening was regarded as acceptable to participants, if carried out with sensitivity, respect and empathy, in a non-judgemental, confidential and safe environment. Participants expressed the need to feel validated and be taken

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seriously by health professionals. The general opinion was that for routine screening to be implemented successfully in this country, there is a need for better trained, more knowledgeable, and more humane health care workers in South African hospitals and clinics. Specifically, there was a strong preference for female health professionals dealing with domestic violence. The belief was expressed that female health professionals may more readily understand abused female patients owing to their similar experiences of the world. In addition, the general perception was that female health professionals, more so than male health professionals, convey attitudes that are holistic and empathic.

Furthermore, participants felt that although the health care system is under resourced and under funded, it should nonetheless make privacy and confidentiality a priority. Lastly, it was felt that revising structural conditions in hospitals would make health care more accessible to women. Ideas were expressed in relation to the necessity of the health care sector offering a broader range of services, such as 24-hour care and telephonic assistance, that are based on the realities of abused women's lives. Cheryl also made the important point that there is no point in implementing routine screening protocols without a solid referral network in place that is available 24 hours.

The prevailing feeling was that health care institutions and health professionals do not appear to know what women want or need, in relation to care. It is interesting to note that the priorities outlined by participants are in line with

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contemporary women's health advocates, who emphasize a worldwide need for better health care for women, and access to a wider range of services in the health care system (Rothman & Caschetta, 1995).

An unexpected outcome (from the researcher's perspective) was the frequently expressed conviction that routine screening would fail in this country, if not managed correctly. The researcher had not even begun to think in terms of the logistics of implementation, or the possibility of failure. Participants, more so than the researcher, were acutely aware that the implementation of routine screening did by no means guarantee that women would be helped in the long term.

To conclude this chapter, a brief summary of the central findings is delineated:

1) It was found that participants regarded routine screening as relevant and necessary for South African women. Predominant reasons given were: to end the cycle of abuse, to validate women's experiences and assist them to leave abusive relationships, as well as to educate people about woman abuse.
2) Disclosure to health professionals was seen to be difficult, particularly in the light of negative experiences of the medical context. These were found to be patriarchal and uncaring attitudes that invalidate women's experiences, the devastating impact of apartheid structures on black abused women, health professionals own experiences of political oppression, women's feelings of shame and guilt, as well as fear of reprisal from partners.

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3) Routine screening for domestic violence was regarded as acceptable, if carried out with sensitivity, respect and empathy, in a non-judgmental, confidential and safe environment. One participant suggested selective screening of vulnerable women, in order not to offend women with insensitive questioning. A general perception was that there is a need – in South African hospitals and clinics – for more humane health care workers who have specific knowledge of domestic violence. Furthermore, participants indicated a strong preference for female health professionals dealing with domestic violence.
4) Participant's expressed the view that the successful implementation of routine screening in this country was contingent on careful planning and sensitive management.

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CHAPTER 5

LIMITATIONS OF THE STUDY AND RECOMMENDATIONS FOR FUTURE RESEARCH

5.1 Limitations of the study

Although this study delineates some of the ways in which health care in this country can help to provide a context within which women can process the experience of abuse, it has very specific limitations and raises many new questions. The voices of certain groups such as women with lesbian partners, women known to have HIV/AIDS, disabled women, and women living in rural areas were not represented here. In addition, participant's attitudes were strongly influenced by factors linked to the unique socio-cultural and historical context of South Africa. These are factors such as race, age, religion, culture, health status and poverty. This suggests that women, far from being a universal and homogeneous group, have needs that reflect multiple interacting dimensions, unique to the South African context. Although an exploration of all these dimensions was outside the scope of this study, it has also been questioned to what extent the standpoint researcher is able to understand women's fragmented identities. Standpoint theory critics have further questioned the extent to which women's experiences can be equated with knowledge, without detailed interpretations of how these experiences have been constructed (Olesen, 2000). Although some of the contexts in which women's experiences are

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differentially constructed were explored, a richer and more detailed understanding of how such constructions are formed was not attempted here. Notwithstanding these limitations, it is hoped that this study highlighted the complexity of women's lives and of implementing programs to screen women for domestic violence in this country.

According to Olesen (2000), within the context of feminist research knowledge production is an ongoing, dynamic process. In this light, the researcher is aware that the knowledge gained here is only partial knowledge; being constructed in interaction between the researcher and participants, at a particular point in time, it can provide but a transitory platform for action and reform, as the contexts of women's lives continually change and give way to new ideas.

5.2 Recommendations for future research

As South Africa is only ten years post apartheid, there is still an obvious need for research on the effects of apartheid on the status of women. As elaborated by some participants, and reflected in the literature discussed, it appears that social structures (such as racism, androcentrism, and oppressive family structures) effectively silenced, and still do marginalize, women with regard to abuse. Politically motivated research attempts to make visible these oppressive structures, where gender inequality and domestic violence are the socially sanctioned norm.

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As discussed earlier, children are also the victims in families where women are abused. Consequently, routine screening for women benefits families and therefore society in general. As Samuel (2001) states, even in times of severe resource limitations, the vulnerable members of society must be protected. Future studies could identify these vulnerable populations, thereby perhaps supporting a case for selective rather than universal screening, which targets high risk groups like pregnant women, or women with children who are also being abused.

With specific reference to this study, nine South African women regarded the implementation of routine screening for woman abuse as important for this country. However, the general consensus was that routine screening would only succeed under certain necessary and essential conditions, as described. Those conditions need to be further explored, for the purpose of establishing screening interventions that are meaningful to women, and that are effective. Specifically this would entail, as previously discussed, the manner in which confidential information is elicited and recorded, as well as the creation of standardized protocols that would best serve the needs of South African women, such as, the drawing up of safety plans, recording abuse, educating women about their legal rights, providing shelter and creating referral networks. As routine enquiry into domestic violence is different to other screening programs, it should primarily be looked at as a way of empowering women, and providing them with a voice in order to unveil and reframe a hidden stigma (Bradley *et al.*, 2002).

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As delineated by this study, future research necessitates the undertaking of research on a broader, national level that can contribute towards policy-making decisions in this country. Specifically, large-scale quantitative research is necessary in order to sample women's opinions around the acceptability and significance of routine screening for domestic violence (Jewkes, 2002). Large-scale studies could also further illuminate what women currently experience in the health care system with regard to inquiry about abuse, and what they perceive their needs to be. Large-scale quantitative research in England, America and Australia - sampling a range of health care settings - has measured the prevalence of domestic violence among women attending health care services, and examined the effectiveness of screening tools, the association between the experience of domestic violence and demographic factors, the frequency of inquiry about domestic violence by health professionals, and explored barriers to screening (Bradley *et al.*, 2002; Brown *et al.*, 2000; Brown, 2001; Davidson *et al.*, 2001; Rodriguez *et al.*, 2001; Webster *et al.*, 2001).

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Although participants were enthusiastic about the implementation of routine screening protocols, they were not convinced of its success. Hence what emerged from this study is that we need to look beyond screening, as ultimately screening alone is not enough to change the status of abused women in this country. This view is supported by Jewkes (2002), who acknowledges the importance of training programs on domestic violence for health professionals. These programs often fail to achieve the desired effect in clinical practice.

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Jewkes states that training programs are often too short, neglect the personal experiences of domestic violence of staff that may influence their attitudes towards patients, and fail to provide an adequate understanding of this complex problem within a broader gender context. Hence future studies need to rigorously evaluate training programs for health professionals, that teach communication skills, and that provide education around gender issues and the detection and treatment of women affected by domestic violence. (Davidson *et al.*, 2001). What emerged from this study is that easily learned micro counselling and communication skills (as delineated by Rogers, 1986) are essential requirements for health professionals. An understanding of the law in relation to domestic violence is also essential (Weiss, 2000). Training programs need to help both male and female health professionals clarify their values, in order to see how their gender and their experiences affect how they do their work (Candib, 2000). Furthermore, Cole (1999) sees a need for longitudinal outcome data to help persuade health professionals of the benefits of routine screening, and break down a significant barrier to screening.

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Studies show that even when health facilities have screening protocols, doctors are still resistant to implementing them (Brown *et al.*, 2000). According to Candib (2000), battering is a problem most clinicians do not seem to want to identify. She speculates whether this is not because domestic violence issues challenge closely held assumptions that health professionals (as well as patients) have about men and women, and identifies a need to know more about these

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factors in ourselves. Consequently, in addition to implementing screening protocols and making clinical practice more responsive to gender issues, it remains essential for us as a society to work on changing our patriarchal assumptions and ideas about violence at the level of families, schools, the community, as well as the individual patient. According to Candib (2000), a primary prevention approach is thus essential, as are long-term studies of the impact of violence prevention interventions in health care settings. As standpoint theory reminds us, and as was evident in this study, the insider knowledge of women with experience of domestic violence can be a valuable resource in the designing of such interventions.

5.3 Conclusion

It would seem that this study illuminated more questions than answers. From the perspective of feminist standpoint research, however, it is significant that the questions were those that participants themselves were concerned with finding the answers to. Primarily, these were questions related to participants' grappling with what routine screening would exactly entail, as screening was seen to be an intervention that would require careful planning, a real understanding of women's needs in post-apartheid South Africa, and sensitive management.

According to Goldblatt and Meintjies (1998), reparation and reconstruction in post apartheid South Africa needs more attention, and involves helping women deal with their past experiences of gender violence. Women's present and

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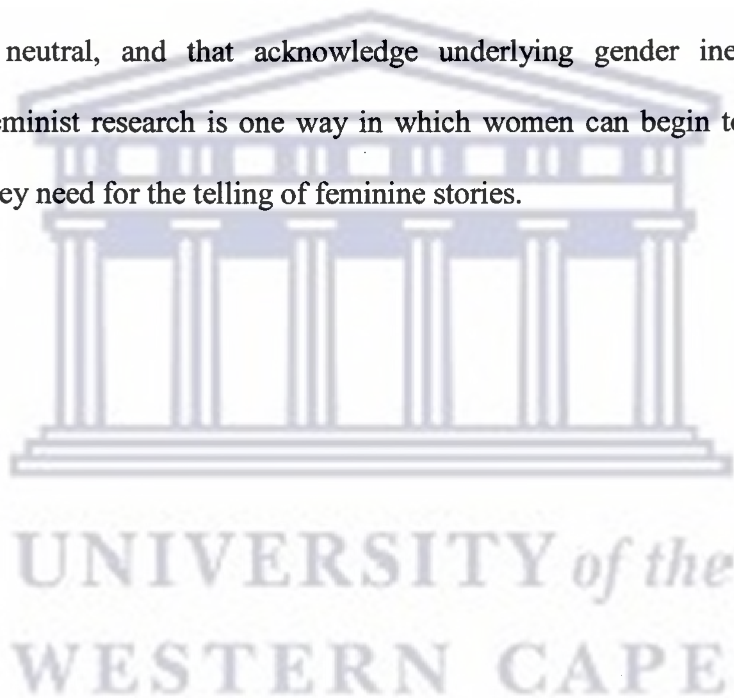
future experiences are intrinsically linked to our past, as participants in this study have told us, and creating a space for women's voices to be heard in South Africa is therefore essential in terms of rebuilding and healing our society. According to Samuel (2001) women's inclusion in the transformation process in this country is about recognising women's ability to accurately identify priorities for the well being of their communities and themselves. In this way women's health in South Africa will be fostered by policies that are gender sensitive rather than neutral, and that acknowledge underlying gender inequalities. Hopefully feminist research is one way in which women can begin to reclaim the spaces they need for the telling of feminine stories.



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Appendix A

CONFIDENTIAL BIOGRAPHICAL QUESTIONNAIRE

Name: ....

Age: ....

Level of education/Occupation: ....

Children: ....

Intimate partner information (tick and underline where relevant):

I have a male/female partner (married/unmarried)   I am not in a relationship

Address: ....

Telephone: ....(h)........................(w).............................(c)

Are you currently in an abusive relationship with your husband/boyfriend/partner?

(Tick where relevant):

Yes   No

If you answered yes, what type of abuse is involved? (Tick where relevant):

Physical   Sexual   Emotional   Verbal   Economic

Have you previously been in an abusive relationship with your

husband/boyfriend/partner? (Tick where relevant):

Yes   No

If you answered yes, what type of abuse was involved? (Tick where relevant):

Physical   Sexual   Emotional   Verbal   Economic

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Appendix C

VIGNETTE:

MARY'S STORY

Mary left home late one night. It was dark outside. It hurt to walk upright because of the pain in her chest. Mary wondered about the way she looked. There was dried blood in her hair and she was sure that her swollen wrist was broken. But the neighbours were asleep, and so was Frank. She'd waited many hours just to make sure. Mary tried to make sense of things. But she kept on thinking the same thoughts, over and over again. Where to go, what to do... She didn't want anybody to know. She was ashamed enough as it is. If she left Frank, he'd be sure to find her and kill her and the baby growing inside of her. That's what he'd told her. And she wasn't sure whether she could manage without him. She could never leave. Mary felt trapped. A silent scream of desperation was building up inside of her as she nervously made her way to Tygerberg hospital's emergency entrance. She would have to be quick, before Frank discovered she had left.

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Appendix D

INTERVIEW SCHEDULE

1. Can you tell me about your thoughts and feelings while reading this story?

2. What role do you think the hospital could have played in helping Mary?

3. If you were in Mary's position would you feel comfortable talking about the abuse? Please explain your answer.

4. What has been your experience with medical professionals such as doctors and nurses, when disclosing information about yourself?

5. To whom would you feel more comfortable disclosing personal information and why?
(Relate question especially to gender and type of health professional).

6. Please discuss whether or not you would find it acceptable to be asked questions about your relationship with your partner, on a routine visit to your doctor/nurse/other health professional, at a private practice, clinic or hospital.

7. *(Explain the concept of routine screening).* Please discuss your opinion of routine screening for domestic violence, and whether or not you think it's important for South African women.

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Appendix E

LETTER TO PARTICIPANT

3 February 2004

Dear *(Participant's Name)*

I have enclosed a copy of the interview, which you kindly agreed to do for my research project. This copy is for you to keep.

As discussed initially, this information is yours, and you are welcome to change your mind at any time about participating in the project. The entire interview will not be used, only general ideas which all the women participants have in common, and here and there a particularly interesting or useful idea.

To keep the interview completely anonymous and confidential, I have changed your name. If you would prefer me to use another name of your choice, please let me know.

I will telephone you in the next few days to see if you are happy with what was said, and if there are any further comments. Please feel free to write points down, and I can collect it from you.

Your contribution has been very valuable and many thanks once again.

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Kind regards

Tamara Gersohn

Tel: 5518600

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