Patients presenting with fresh trauma after interpersonal violence

Part II. Assault history

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Background. Patients presenting with fresh trauma are frequently victims of interpersonal violence. Nevertheless, few South African studies have documented the history surrounding such assaults and their management.

Methods. Patients presenting with fresh trauma to the Trauma Unit of Tygerberg Hospital were selected in order to provide a representative sample. Where patients were victims of interpersonal violence, a history of the current and previous assault(s) was taken.

Results. Victims of interpersonal violence often reported that they had been involved in such violence on previous occasions. Nevertheless, these patients had rarely received management from psychosocial services. Patients with a previous history of having been assaulted had a number of distinct characteristics, including female gender and increased substance use.

Conclusions. Trauma has justifiably been described as a recurrent disease. There is an urgent need for effective psychosocial services for victims of interpersonal violence; ideally, this would prevent future multiple hospital admissions.

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While substance abuse appears to play an important role in the precipitation of interpersonal violence, many additional psychological and sociological factors may also contribute to this extensive problem. The study of patients presenting with fresh trauma after interpersonal violence provides an opportunity to investigate some of these factors. Nevertheless, previous studies of fresh trauma in the South African setting have only rarely explored psychosocial variables.

We were particularly interested in obtaining a history of previous assaults and their management. It has been argued that trauma is a recurrent disease, and in the South African setting there is some evidence that this dictum holds true. This study aimed to collect data on circumstances surrounding the current assault and prior assaults from patients presenting with fresh trauma after interpersonal violence.

Methods

Recruitment of patients presenting with fresh trauma is described in detail in the first paper of this series. All subjects who gave a history of interpersonal violence were questioned by the research nurses in order to obtain information about circumstances surrounding the current assault and about past history of assaults and their management.

Results

Demographics of the sample. The sample of patients with fresh trauma after interpersonal violence comprised 113 people (84 men (74.3%), 29 women (25.7%). This indicates that over a 28-day period, the Tygerberg Hospital Trauma Unit manages approximately 2 260 adults presenting after interpersonal violence.

Mean age of these subjects was 31.5 ± 9.1 years. Racial groups included coloureds (99 (88.4%), blacks (12 (10.7%)) and whites (1 (0.9%)). Subjects were categorised as employed (59 (52.2%)) or unemployed (54 (47.8%)). Mean number of years of education was 7.5 ± 3.3.

Details of alcohol and substance abuse levels in these patients are described in Part I. It is notable that there was a significant positive association between number of months unemployed and blood alcohol levels (r = 0.29, P = 0.04).

Description of the assault. In patients presenting with fresh trauma after interpersonal violence, assault was typically with a sharp object (74 (65.5%)), a blunt object (24 (21.2%)) or fists/feet (15 (13.3%)). The scene of the trauma was either in the home (56 (50.5%)) or outside the home (55 (49.5%)).

Assault was by one (60 (56.6%)), two (13 (12.3%)) or more people, typically male (91 (80.5%)) or male and female (10 (8.8%)). Assault was by friends or acquaintances (29 (25.6%)), relatives or lovers (25 (22.2%)) and gang members (22 (19.5%)). The arguments leading up to an assault had focused on money (22 (19.5%)), love/infidelity (12 (10.6%)) and substance abuse (11 (9.7%)). Subjects frequently stated that the assailant had used alcohol (52 (46.0%)) or other substances (19 (16.8%)).

Many patients presenting with trauma after interpersonal violence (48 (42.2%)) had been transported to the hospital by ambulance. On clinical assessment, specialist care was required in 29 (27.1%) patients and a tertiary institute was needed for 16 (14.8%) of these subjects. Indeed, 14 (13.2%) of these patients went to theatre and 23 (20.9%) were admitted to hospital. The estimated degree of disability was assessed to be either moderate or severe in 30 (27.9%).

Past history of assault. In some cases (22 (20.2%)), subjects had previously suffered assault by the same assailant(s). Furthermore, such assaults had sometimes (17
(15.6%) take place on more than one previous occasion.

In addition, many victims of assault (63 (55.8%)) had previously been assaulted by a different assailant. Such assaults had been by one (27 (42.9%)), two (10 (15.9%)) or more people, most of whom were male (56 (68.9%)); these included friends and acquaintances (39 (37.0%)), relatives or lovers (8 (12.7%)) and gang members (18 (28.6%)), and had taken place on one (28 (60.9%)) or more occasions.

Previous assaults had often led to police (23 (35.9%)) or medical (41 (64.1%)) involvement, but never to psychosocial intervention. Furthermore, a court order had been applied for or obtained by only 4 subjects.

Conversely, some victims of assault (27 (23.9%)) had previously assaulted someone else. Such assaults had been on one (9 (34.6%)), two (5 (19.2%)) or more people, usually men (20 (74.1%)), including friends and acquaintances (10 (37.0%)), relatives or lovers (4 (14.8%)), and gang members (5 (18.5%)), and had taken place on one (7 (53.8%)) or more occasions. Often these assaults had led to police (13 (48.1%)) or medical involvement (8 (29.6%), but never to psychosocial intervention.

Prior history of interpersonal violence. A number of differences were found between subjects with and without a previous history of having been assaulted by the current assailant(s). In particular, patients with such a history were more often female (13/22 (59.1%) than those without such a history (14/87 (16.1%) (χ² = 17.4; P < 0.0001).

Alcohol presence (according to history, breath levels and blood concentrations) was more frequent in trauma victims with such a previous assault history than in trauma victims without such a history, but these differences did not reach statistical significance. Presence of other substances was, however, significantly more frequent in trauma victims with such a previous history of assault (8/8 (100%) than in those without such a history (17/32 (53.1%) (χ² = 6.0; P = 0.01). In particular, the frequency of positive cannabinoid levels in patients with such a previous history of assault (8/8 (100%)) compared with patients without such a history (22/32 (68.8%)) tended towards significance (χ² = 3.3; P = 0.07).

The scene of interpersonal violence was the home in 16/22 (72.8%) of those with such a previous assault history and in only 39/85 (45.9%) without such a history (χ² = 5.0; P = 0.02). An ambulance was used to transport 15/21 (71.4%) of those patients with such a previous history to hospital, but only 32/79 (40.5%) of those without (χ² = 6.4; P = 0.01). Estimated degree of disability was assessed to be moderate or severe in 2/21 (9.5%) with such a previous history and 27/86 (31.4%) without (χ² = 4.1; P = 0.04).

Similarly, expected time away from work/out of action was more than a week in 2/21 (9.5%) with such a previous history of assault and 26/84 (30.9%) without (χ² = 3.9; P = 0.05).

Conclusion

The main findings of this study were: (i) that interpersonal violence may result in significant traumatic injuries; (ii) that victims of interpersonal violence have frequently been involved in interpersonal violence in the past; (iii) that victims of interpersonal violence have rarely received psychosocial services in the past; and (iv) that victims previously assaulted by the current assailant(s) had a number of distinct characteristics, including increased likelihood of being female and increased substance use.

While it should be emphasised that our findings may not be generalisable to trauma units in other geographical areas or to types of interpersonal violence that do not result in fresh trauma, the data here are consistent with previous research in other parts of the world. While it is extremely important not to 'blame the victim', it is also essential to recognise that trauma, particularly after interpersonal violence, is a recurrent phenomenon. Women in particular seem to be at risk for repeated admissions for trauma after interpersonal violence meted out at home by relatives or lovers.

Even in developed countries, it has only recently been recognised that psychiatric and psychosocial services may be useful for trauma patients. Even so, the finding that none of the subjects in our sample, including those with multiple admissions for trauma inflicted by relatives or lovers and those with high levels of alcohol and other substances, had received such services is remarkable. Similarly, the finding that only a small minority of subjects had applied for or obtained court orders of protection is notable.

There is a range of effective methods for reducing both interpersonal violence and other causes of trauma. Education of our communities about the role of various risk factors in interpersonal violence may be particularly useful. For example, research in South Africa comparing imaginary constructions with forensic reconstructions of fatal violence has shown that lay-persons underestimate the possibility that victims will know the perpetrator and that the violence will take place in the home. In addition, a broad sociopolitical perspective is needed if problems such as the link between substance abuse and unemployment, shown here and elsewhere, are to be addressed adequately.

Finally, from our perspective, a singularly important consideration is the provision of psychiatric and psychosocial services for individual patients at the point of presentation in the trauma unit. Given the high costs of medical care for patients who present repeatedly after interpersonal violence, each admission may be seen as an opportunity for timely assessment and intervention. Many patients presenting with trauma may have histories of childhood abuse, of post-traumatic stress disorder, of alcohol or substance abuse. Assessment for these problems and referral for treatment would be ideal. Research on how best to evaluate and treat such patients in the South African setting is needed.

REFERENCES


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