



## **Domestic Violence and Women's Physical Health <sup>\*</sup>**

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### **Introduction**

This paper reviews the research which identifies the short- and longer-term impacts of domestic violence on women's physical health<sup>#</sup> and explores some of the implications of these findings for health and domestic violence service providers. Although injuries arising from physical violence are the most obvious health impact of domestic violence, in fact intimate partner abuse is associated with much more complex physical health impacts, many of them long-term, even when the woman is no longer in an abusive relationship.

### **The immediate physical consequences of domestic violence**

According to Guth and Pachter (2000), intimate partner abuse by a current or former partner is the most common cause of injury to women, comprising 21 per cent of traumatic injuries. They identify the following patterns of injury associated with domestic violence:

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<sup>#</sup> Readers interested in the impact of domestic violence on women's mental health are referred to Clearinghouse Issues Paper #8: *Promoting Women's Mental Health: The Challenge of Intimate/Domestic Violence Against Women*, written by Angela Taft (2003).

*Injuries range from cuts, bruises, and black eyes to miscarriage, bony injuries, splenic and liver trauma, partial loss of hearing or vision, and scars from burn or knife wounds. Injuries to the breast, chest and abdomen are more common in battered women, as are the presence of multiple old and current injuries. Defensive injuries are common. For example, fractures, dislocations, and contusions of the wrist and lower arms result from attempts to fend off blows to the chest or face. (Guth & Pachter 2000, p. 135)*

In a community sample of women who had experienced assault by a partner in the previous six months, Sutherland, Bybee and Sullivan (2002) found that, on average, women sustained three different types of injuries. Ninety two per cent of the women reported cuts, scrapes and bruises; 11 per cent broken bones and fractures; and 3 per cent gunshot or knife wounds

Domestic violence is associated with increased use of Emergency Departments and outpatient services (Roberts et al. 1997). It is estimated that more than 35 per cent of all Emergency Department visits by women are the result of domestic violence (Guth & Pachter 2000). However, only between 25 and 50 per cent of these visits are a result of acute injury. Women who have experienced domestic violence also present to Emergency Departments with somatic complaints (e.g. headaches), obstetric complications and mental health issues such as depression and substance abuse (Guth & Pachter 2000).

## **The longer-term health consequences of domestic violence**

*There is mounting evidence that domestic violence (DV) has long-term negative consequences for survivors, even after the abuse has ended. This can translate into lower health status, lower quality of life, and higher utilization of health services. (Campbell et al. 2002, p. 1157)*

In comparison with non-abused women, abused women have a 50-70 per cent increase in gynaecological, central nervous system (CNS) and chronic stress-related problems (Campbell et al. 2002). These health impacts are most likely to be reported by women who have experienced physical and sexual abuse within their intimate relationships. Chronic stress-related problems include functional gastrointestinal disorders, appetite loss and viral infections such as colds and flu (Campbell et al. 2002). Central nervous system problems include headaches, back pain, fainting or seizures (Campbell et al. 2002). Gynaecological problems include sexually transmitted diseases, fibroids, pelvic pain, vaginal bleeding or infection and urinary tract infections. Plichta and Abraham (1996) found that domestic violence tripled the odds of receiving a diagnosis of a gynaecologic problem. An association has been found between domestic violence and HIV (Fischback & Herbert 1997; Molina & Basinait-Smith 1998; Maman et al. 2002). This association has been linked to women in violent relationships being forced to engage in sexual intercourse and being unable to negotiate condom-use for fear of further abuse (Campbell et al. 2002; Maman et al. 2002).

Physical impacts have been found to be 'dose-dependent' (Coker et al. 2000, p.1020). This means that the length of the relationship as well as the severity of the abuse and the frequency of incidents play a role in determining the extent of the injury and/or illness resulting from violence (Sutherland et al. 2002).

In an exploratory study, Coker et al. (2000) found that women who have been in an abusive relationship for a long period of time, who had injuries associated with physical violence and who had a high frequency and severity of physical and/or sexual abuse, may have an increased risk of developing cervical neoplasia. Cervical neoplasia is associated with a history of having had a sexually transmitted infection (STI). This study also found that women experiencing physical and/or sexual violence without an STI were still at an increased risk of developing cervical neoplasia in comparison with non-abused women. This study's findings, which the author cautions should be seen as exploratory and hypothesis-generating in nature, support research which suggests a stress-

response theory of abuse. Women in abusive relationships suffer from fear and stress which may result in long-term health problems and may reduce women's immunity to illness overall (Coker et al. 2000; Campbell et al. 2002; Sutherland et al. 2002).

In addition to specific associations between domestic violence and longer-term illnesses, there is evidence that abused women remain less healthy over time (Campbell et al 2002). International research finds that 'female victims of physical and/or sexual abuse have a significantly higher rate of common health problems, even after abuse ends, compared to women who have never been abused' (Campbell et al. 2002, p. 1162).

In Australia, the longitudinal Women's Health Australia (WHA) study, commissioned by the Commonwealth Department of Human Services to investigate the health and well-being of Australian women, provides the opportunity for population based national research (Parker & Lee 2002). Violence against women is one of five key themes in this study. Forty thousand women were recruited in three cohorts, 18 to 23 years of age, 45 to 50 years of age, and 70 to 75 years of age. Parker and Lee (2002a; 2002b) have reported the results of a study for which participants in the mid-aged cohort were selected on the basis of their response to a WHA survey question about experiences of abuse in adulthood or childhood. Thirty five per cent of women answered that they had experienced physical, mental, emotional, sexual abuse or violence. Self-report questionnaires were then used to gather data on the nature of women's experiences of abuse, their help-seeking, subjective health status, psychological wellbeing and depression.

The majority of women reporting abuse had experienced more than one type of abuse and multiple acts over time. Fifty per cent of women reported abuse in childhood; 37 per cent during adolescence; and 73 per cent had experienced abuse by a partner or ex partner. With respect to their health, the study found that:

*...the experience of abuse significantly affected the general health and wellbeing of mid-aged women. Overall, the participants had poorer physical and mental health than non-abused women of a similar age, and a substantial number were psychologically distressed and depressed.*  
(Parker & Lee 2002a, pp. 145-146)

Using this data, Parker and Lee (2002b, p. 989) assessed 'the extent to which the overall characteristics of abuse and help-seeking behaviours contribute to deficits in physical and emotional health in abused mid-aged women.' They found that the majority of variance on a number of measures of health and wellbeing was not explicable by characteristics of the abuse or by aspects of help-seeking. They conclude about these unexpected findings that: '...the results imply that a history of abuse is only one aspect of a woman's life that will impact on her well-being and that even the most extreme experiences of violence are not total determinants of general physical and emotional functioning.' (Parker & Lee 2002b, p. 996) These results are informing the ongoing research in this project which will involve asking women about the ways in which they dealt with the abuse and the factors which were helpful and unhelpful in this respect.

## **Domestic violence and homicide**

*Intimate partner homicide is the most serious form of domestic violence...*  
(Carcach & James 1998, p. 5)

Women in abusive relationships are at an increased risk of being killed by a current or ex-partner (Mouzos 1999; Guth & Pachter 2000; Mouzos 2001). The National Homicide Monitoring Program (Mouzos 1999) found that nearly three in five of all female deaths in Australia, where the woman is over fifteen, occur between intimate partners. Although the low reporting rates of domestic violence make it difficult to accurately identify the proportion of intimate partner homicides where there is evidence of prior domestic violence, Mouzos (2000) argues that, 'Contrary to media portrayals of intimate homicide that it is a sudden

spontaneous act of extreme violence, research indicates that a majority of incidents occur in the context of a previous, usually escalating, history of abuse surrounding domestic violence.’ Data from the National Homicide Monitoring Program indicates that in the period 1996/97 to 1998/99, in 30 per cent of intimate partner homicides, there was documented evidence of a prior history of domestic violence.

According to Guth and Pachter (2000), between 30 and 50 per cent of women murdered in the United States are killed by a partner or ex partner. They cite a study of female homicides in one American state which found that the perpetrator was an intimate partner in 46 per cent of cases and that more than one third of the murdered women had evidence of prior trauma on autopsy or had previously reported injuries from domestic violence partners to police. Websdale (2000) makes the point that the availability of emergency medical services may be a factor determining whether or not a situation ends as a homicide or is recorded as an aggravated assault.

Indigenous Australians experience higher rates of homicide than non Indigenous Australians (Mouzos 2001). Memmott et al. (2001) point out that the way in which deaths are recorded can obscure the role of domestic violence in Indigenous women’s deaths arising from long-term, severe relationship violence:

*In many of these cases the immediate cause of death may be attributed to other factors, for example, renal or liver failure, but this obscures a history of long-term violent abuse culminating in death from multiple causes. Bolger (1991: 69) details one such case of a woman who was assaulted and violently abused, often in conjunction with alcohol use, over a period of at least five years, during which she was hospitalised seven times, the last being when she died. Her cause of death included renal failure and hepatitis but no physical or other violence was listed. (Memmott et al. 2001, p. 39)*

## **Domestic violence and pregnancy**

A Brisbane study of antenatal patients found that 18.3 per cent of women were abused for the first time during a current or a previous pregnancy (Taft 2001). Women exposed to abuse during pregnancy had an increased risk of miscarriage and abortion when compared with non-abused women, as found in a study conducted at the Royal Women's Hospital, Brisbane (Webster et al. 1996). This study also found that the proportion of women having had multiple miscarriages increased with the severity of abuse. This is consistent with the idea that physical impacts are dose-dependent and increase with severe and frequent abuse. The Brisbane study also linked smoking with abuse, identifying it as a negative coping behaviour that jeopardised the health of the unborn child. Lastly, a poor obstetric or medical history combined with admissions to hospital during pregnancy for conditions which are unrelated to pregnancy, were found as possible indicators of domestic violence (Webster et al. 1996).

One study that focused on abdominal trauma during pregnancy found an incidence of domestic violence of 20 per cent (Pak et al. 1998). Causes of trauma were car accidents, falls and direct assaults (including domestic violence). Women experiencing domestic abuse were more likely to have peri partum complications in comparison with women who experienced other forms abdominal trauma. Peri partum complications include premature preterm rupture of membranes, preterm labour, abruption placentae and uterine contractions. This study also found that 75 per cent of the women in the study who were hospitalised twice during the same pregnancy reported domestic abuse as the cause of the trauma (Pak et al. 1998).

Other possible risks that pregnant women experiencing violence may face include preterm labour, foetal-maternal haemorrhage, uterine rupture and stillbirth (Pearlman et al., 1990; Rose et al. 1995). Studies have produced contradictory findings regarding the association between abuse and low birth weight. However, a meta-analysis of studies conducted in the United States,

Australia and Norway, found a significant association found between abuse and low birth weight (Murphy et al. 2001).

## **Systemic Responses to Domestic Violence**

The physical and mental health impacts of domestic violence result in increased use of health services by abused women (Campbell et al. 2002). Because of this, the health-care sector has the potential to reach many women living with domestic violence and to play a key role in a co-ordinated community response to domestic violence.

There is evidence from survivors of abuse that an appropriate response from a health service provider can be empowering and validating and hence important in assisting women to deal with the abuse which they are experiencing (Gerbert 1999). For women who had helpful encounters with health-care providers, the common theme that emerged was the importance of a non-judgemental, sympathetic and caring health-care provider. Health-care providers, who paid attention to possible risk factors, listened for hints, documented injuries and questioned clients in a sensitive manner, validated women's experiences. Validation, for many women in this study, represented a turning point where women realised that what they were experiencing was abuse and it was wrong. Validation also involved the realisation that it wasn't their fault and feelings of relief.

However, although domestic violence is associated with a range of adverse health impacts, it is often not identified by health service providers, for several reasons. As Campbell et al. (2002, p. 1157) point out:

*There is no agreement on the constellation of signs, symptoms, and illnesses that a primary care physician should recognize as associated with a current or prior history of DV.*

Further, although abused women use health services at a higher rate than non-abused women, they do not seek medical attention only for abuse-related

injuries, but also for health problems which appear unrelated to the abuse (Sutherland et al. 2002; Rhodes & Levinson 2003). Because of the difficulties in identifying abused women within health services, and the importance of identification to early intervention, the practice of routinely enquiring of all women about domestic violence, has been widely advocated.

Campbell et al. (2002) argue, based on their findings that abused women have increased risk of gynaecological, central nervous system and stress-related health problems, even after the abuse has ended, that women be screened for domestic violence, including specific inquiry about sexual abuse. Thus, screening is not only useful in identifying women who require assistance for current abuse. It can also alert the health care provider to the need to thoroughly assess women's physical and mental health and to provide treatment which can overcome the longer-term health impacts of domestic violence:

*Physicians are becoming more aware of the immediate health problems associated with abuse and need to expand this awareness to those that persist or develop over time or that occur after the women has left the abusive relationship. Many women may not associate these problems with previous abuse and, therefore, may not disclose abuse. This information may be vital in creating an effective treatment plan. (Campbell et al. 2002, p. 1162)*

Screening usually takes the form of three or four questions being asked of women presenting to the Emergency Department, antenatal clinic or other health service. Evaluation of the Queensland Domestic Violence Initiative, which aims to incorporate screening for domestic violence into routine history taking in antenatal, outpatient gynaecology and emergency services, found that that 97% of surveyed women supported screening (Queensland Health 2001)

Screening is not without its criticisms. An Emergency Department of a Sydney hospital encountered several problems with the piloting of routine screening. The staff reported that there was a lack of time to ask questions; lack of privacy and

confidentiality for patients; no after-hours social worker for referrals; and that the staff believed that the questions were inappropriate (Ramsden & Bonner 2002). This study also reported problems with staff attendance at training, which in conjunction with the above problems, resulted in only 10 per cent of patients being screened. However, the pilot program, which identified 14.6 per cent of screened women as having been subjected to domestic violence, raised staff awareness of domestic violence as an issue for their service (Ramsden & Bonner 2002). Subsequently, an alternative case-finding model for identifying victims of domestic violence in an Emergency Department has been developed. Screening conducted in antenatal clinics was more successful in research studies and viewed as the 'right place' (Stenson et al. 2001, p.9) for screening due to the calm environment and often a trusting relationship with the midwife.

A Queensland study reported that women felt screening for violence is demonstrative to women that health-care professionals are concerned about them (Webster et al. 2000). Despite this, not all women will disclose previous or current abuse. However, it is important for women to know that when they are ready they will be listened to and assisted (Webster et al. 2001). Poor responses from health-care providers including an inability to provide useful information or unsympathetic responses may reduce the likelihood of further disclosure (Webster et al. 2001). A key theme in screening studies is the emphasis on adequate training for health-care professionals and access to useful resources and referrals to respond appropriately. Screening is one response that raises awareness amongst health services and attempts to improve communication between key sectors and women experiencing domestic violence (Robinson 1999).

Understanding the physical health impacts of domestic violence is also relevant to workers in the domestic violence field, who can encourage women to participate in preventive health measures, such as screening for cervical and breast cancer, and who can support them in obtaining health care to address both the short- and long-term health impacts of domestic violence.

## Conclusion

Domestic violence does not only result in immediate, short-term injuries. The detrimental effects of violence can occur even after the abuse has ended (Campbell et al. 2002). Short- and long-term physical health consequences of intimate partner violence place the health-care system in an appropriate and pivotal position to respond to women experiencing violence. Ramsden and Bonner (2002 p. 37) stated that ‘...health services can no longer ignore that domestic violence is a major health concern for women in NSW’. Screening studies have shown the need for health-care professionals to be trained adequately to be able to respond appropriately to women experiencing domestic violence. Health-care professionals that are able to validate, support and refer women in a non-judgemental and caring fashion, play a large role in validating and empowering women (Gerbert 1999). They can also ensure that the health impacts of domestic violence are thoroughly assessed and that appropriate treatment is offered to women.

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