



Responding to partner abuse: understanding its consequences, and recognising the global and historical context

Dr Felicity Goodyear-Smith's article *Recognising and responding to partner abuse: challenging the key facts* (N Z Med J. 2004 Sep 24;117(1202). URL: <http://www.nzma.org.nz/journal/117-1202/1074>) is presented in this issue of the *Journal* as a critique of the facts in the recent Ministry of Health (MOH) publication *Recognising and responding to partner abuse, a resource for general practitioners*.

Goodyear-Smith's article recommends a more restrictive strategy for the identification and response to partner abuse than is recommended by the MOH document. This more restrictive approach is not consistent with a broader understanding of the literature. As such, it has the potential to skew our interpretation of research findings in a way that will not constructively advance our responses to this critical public health issue.

One of the overall problems in Goodyear-Smith's article is its assertion that the only consequences of partner abuse to be concerned about are physical injuries, and that prevention efforts should primarily be directed at the small proportion of victims who are likely to be at highest risk of re-assault (as this has the greatest potential to reduce the overall number of assaults).

While it is undoubtedly important to provide high levels of assistance to this multiply abused group (assuming we have the skills to identify them in advance, which is doubtful at present), efforts to prevent these individuals from being further assaulted limits us to achieving only a small part of the reduction in violence, and its attendant health burden, that could be possible. Focusing exclusively on this group would rule out the possibility for GPs to play a role in secondary prevention of abuse, by intervening before violence is entrenched. It also runs counter to strong current evidence that relatively less severe physical violence and non-physical abuse have serious health implications that are not restricted to injuries.

A recent comprehensive review drawing on the strongest studies currently available notes that partner abuse can have a wide range of long-term physical health effects (eg, chronic pain, gastrointestinal and cardiac symptoms, sexually transmitted diseases, vaginal bleeding and infection, chronic pelvic pain, and urinary tract infections), and mental health effects (eg, depression, post-traumatic stress disorder, alcohol and drug abuse).¹

Understanding the wide-ranging consequences of partner violence is important, because unless GPs and other healthcare providers know about (and consider) the possible role of partner abuse in a present illness, they risk compromising the efficacy of any treatment plans they develop. A strategy that focuses only on the more severe instances of physical violence also does nothing to decrease the lifetime prevalence of partner abuse in the general population.

In addition to clouding the link between violence and multiple health effects, Goodyear-Smith seeks to challenge the acceptability of questioning about partner violence for the majority of patients. She does this by stating that a minority of women may not feel comfortable with being asked about abuse, and that GPs risk causing offence by asking about violence. However, by failing to explore why some women report feeling uncomfortable with disclosing abuse, the author does practitioners a disservice.

To undertake adequate healthcare assessments, practitioners often need to ask about topics that some people may feel uncomfortable about. As with many other areas of healthcare inquiry, the method of inquiry (eg, respectful communication, privacy, safety, and a plan for effective response²) is central to reducing discomfort. The author's presentation of the information on acceptability without discussing the importance of the context of questioning, obscures the fact that, when questioned appropriately, the majority of women are not offended by being asked about partner abuse.³ Not presenting the contextual information also misses an important opportunity for education.

Goodyear-Smith also questions the quality of the literature related to the economic cost of partner abuse and the overlap between child and partner abuse. While some of the criticisms raised have merit, they are presented without heed to the historical context. One of the problems that has inhibited evidence-based policy and practice recommendations in this field is that, while activists have been aware that partner abuse is a problem requiring serious attention for over 30 years, practitioners and researchers have been slower to produce the evidence needed to contribute to the solution. A recent comprehensive review of healthcare response to family violence carried out by the Institute of Medicine in the USA concluded that chronic neglect was the best way to describe the current lack of evidence-based knowledge about key questions in this important field.⁴

Goodyear-Smith states that the Snively report overestimates the economic costs of family violence. However, it is more likely that it underestimates costs. When the work was carried out in 1994, it utilised the best available information relating to prevalence and health consequences. Subsequent work has identified health costings associated with partner abuse that were not included (eg, gynaecological problems), that may be underestimated (eg, treatment for mental health effects), and that indicate that the prevalence rate of partner abuse is substantively higher (ie, Snively calculated estimates based on 14% lifetime prevalence, current lifetime estimates from the 2001 NZNCVS are 27%⁵). The World Health Organization (WHO) and the United States' Centers for Disease Control and Prevention (CDC) have also recently released reports on the economic costs of violence that suggest that partner abuse, along with other forms of violence, places a significant drain on the world's economy.^{6,7}

Similarly, the author criticises use of the Edleson reference related to the overlap between child and partner abuse, on the basis that it was not a systematic review. What is not said, however, is that one of the factors limiting the Edleson review was the extreme dearth of studies that have explored the co-occurrence of partner abuse and child abuse. Given the ethical and practical difficulties of undertaking research in this area, at present the Edleson review constitutes the best available evidence we have on this topic, and would seem to be a stronger basis for drawing conclusions than assertions based on no evidence.

The author also challenges the notion that women are more likely to be the victims of partner abuse than men, yet much of the data presented in the article actually supports the veracity of this statement, as does data from the NZNCVS (24.6% of women reported lifetime prevalence of partner abuse, compared with 18.2% of men⁵). Practitioners should also be aware that the consequences of men's violence against women is often more severe, with greater likelihood of both physical injury and death, and greater likelihood of engendering fear. Readers wishing to unpack the critique further are referred to a recent comprehensive review.⁸

Understanding the global context of our response to partner abuse is also important. The guidelines presented in the Ministry of Health document are consistent with best practice suggested by major institutions in countries with values similar to New Zealand (eg, the American Medical Association,⁹ and the UK Department of Health.¹⁰), and the importance of partner abuse as a population health issue is recognised by the WHO¹¹ and the CDC.¹² The more limited approach to assessment and response advocated by this paper is less consistent with international best practice.

If we in New Zealand are to join the rest of the world community in seeking to address this far-too common problem that places a serious drain on the health of the nation, we have to commit to developing a more refined understanding of the depth and breadth of the problem and mount a better response to it. To do this, however, we must work from a framework that recognises that all violence is potentially harmful, and strive to increase our understanding of ways that violence can be prevented. Goodyear-Smith's article, while reminding us not to let emotion cloud our science, may act to impede the development of a serious response to the whole of this serious problem.

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