



Recognising and responding to partner abuse: challenging the key facts

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Abstract

Inter-partner violence is a serious public health problem for a minority of the population. Frequently the problem is hidden and goes undetected. Recognising this violence within the primary healthcare setting and responding appropriately are laudable aims, with significant health gains. However it is important that in raising professional and public awareness of the issue, the case is not over-stated. Too often figures such as a NZ\$141 million annual cost of family violence to health are quoted and presented as 'fact' without critical appraisal. Family violence is an emotional topic, and challenge to prevailing viewpoints may be misconstrued as a denial of the problem. These are important issues, and I invite academic debate.

The Ministry of Health has recently released its publication titled *Recognising and responding to partner abuse: a resource for general practice*.¹ This document bears endorsements from the Royal New Zealand College of General Practitioners; Breaking the Cycle of Violence; the New Zealand Medical Association; the New Zealand College of Practice Nurses; Doctors for Sexual Abuse Care; and Accident Compensation Corporation (ACC).

The document follows a 2002 Ministry of Health best practice guideline recommending the annual screening of all female general practice patients sixteen years and over for physical and sexual abuse by their partners.² However routine screening for partner abuse currently does not meet recognised screening criteria.³⁻⁵

The 2002 partner abuse guideline primarily addresses male abuse of female partners. The authors of the current publication are to be commended for recognising that both women and men can be victims of partner abuse. Much of the document is gender neutral, although the advocated 'power/control' model, and recommended actions such as providing a safety plan, address only female victims of male perpetrators.

The need for appropriate detection and intervention in partner abuse is not questioned. However 'partner abuse' has a broad definition and a strong case can be made for GP diagnosis and treatment to focus on the serious end of the spectrum involving significant injury impacting on health.

The Ministry of Health publication in question¹ lists five 'key facts' and promotes the 'power/control' model of family violence. These items raise serious concerns. They are either not evidence-based or are a skewed representation of research findings. The statements suggest an inflated prevalence of partner abuse, and minimise potential objections by patients to routine questioning. This distortion of the scientific evidence reduces the credibility of the publication's recommendations and is a disservice to those requiring active intervention for serious abuse.

The 'key facts' are listed below followed by a critical analysis of their content.

Both women and men experience abuse, however the prevalence is higher for women (Langley et al 1997; Young et al 1997)

The use of the word 'abuse' in this statement is problematic. The publication defines partner abuse as 'the physical, sexual, verbal, and emotional/psychological abuse of current or past intimate partners'. Psychological abuse includes, but is not limited to, 'intimidation harassment, damage to property, threats of physical abuse, sexual abuse, or psychological abuse' and allowing a child to 'see or hear the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship'.

The claim of a higher prevalence in women can be made for 'physical assault' and for 'sexual abuse', but not for physical, verbal, emotional, or psychological abuse. The relative frequencies of men and women verbally or emotionally/psychologically abusing their partners, or exposing a child to such abuse are unknown.

Evidence indicates that men and women physically abuse their partners in similar percentages.⁶ The Dunedin Multidisciplinary Health and Development longitudinal cohort study found that (within partnerships) women actually used more physical violence than men⁷—women reported committing more partner violence than men, and men reported more victimisation than women.⁸

However, far fewer defined this violence as 'assault' causing physical harm, and in those who did, more men than women were named as perpetrators.^{9,10} Indeed, these findings suggest that about four men assault women for every one woman who assaults a man.

Partner homicide is a relatively rare event in New Zealand, with more women than men killed by their partners. A study of New Zealand homicides from 1978 to 1987 found that 82 men and 9 women killed their partners during that decade.¹¹ Another New Zealand study of intentional murders between heterosexual intimates between 1988 to 1995 found 80 male and 22 female offenders.¹² These figures indicate that an average of 11 women and 3 men were murdered by their partners each year.

The majority of women do not object to routine questions about abuse (Ramsay 2002)

While this statement is technically true, over 50% of women have been found to object in some studies. In their systematic review,⁵ Ramsay et al report one study where only 43% of women favoured routine inquiry.¹³ Their review concludes that 'about one-half to three-quarters of women patients in primary care' found domestic violence screening acceptable. This suggests that between 25–50% of women are not comfortable with screening. GPs will be reluctant to screen women patients if 3 or 4 out of every 10 object to being asked.

Over a lifetime, 15–35% of women experience abuse (Young et al 1997)

It is hard to see how these figures are derived from the reference given. The Young et al report on the New Zealand National Survey of Crime Victims 1996 presents the findings of a random sample of 5000 people aged 15 and over.¹⁴

The lifetime prevalence of ever experiencing at least one act of physical or sexual abuse from a partner is reported as 15.3% for women and 7.3% for men. The types of violence include use of force (deliberately kicked, pushed, grabbed, shoved you or hit with something in a way that could hurt you); threats (threatened to kick, push, grab, shove you in a way that actually frightened you); deliberately destroyed or threatened to destroy your belongings in a way that frightened you; made you carry out any sexual activity you did not want to (by holding you down, hurting you or threatening you) or used a weapon (such as a knife or gun).

The prevalence rate for Maori (26.9% of women and 11.9% of men) was much higher than for New Zealand European (14.6% women and 6.8% of men). This may not be a racial and cultural difference, but a reflection of the greater representation of Maori in the lower socioeconomic bracket.

What this report highlights most is the extremely uneven distribution of violent victimisation. Only a very small percentage of the population are victims of significant recurrent violence. The vast majority of people have little exposure to violence or threats, but for a small percentage of the population violent events are nearly commonplace. 'Only 0.5% of the sample (or 6% of those who had been victimised) had been victims of a violent offence 5 or more times, but they accounted for a massive 68% of such offending. Among such victims, the average number of violent and sexual offences was 12.' The report recommends focusing prevention efforts on those small pockets of the population who are particularly at risk of multiple victimisation.

The co-occurrence of partner abuse with child abuse is 30–60% (Ross 1996; Edelson 1999)

The Ross study referenced involved telephone interviews with 6000 American couples in 1985. Of those husbands who were physically violent towards their wives, 22.8% had engaged in physical child abuse.¹⁵ The percentage of violent wives who had engaged in at least one act of physical child abuse was 23.9%. The relationship between marital violence and child abuse had an odds ratio of 1.12 for violent husbands and 1.04 for violent wives. Male children had a higher predicted probability of physical child abuse than female children from both fathers and mothers.

The Edleson reference¹⁶ is a review paper identifying 35 studies that mention an overlap between child maltreatment and adult domestic violence. The search strategy is not outlined and this is not a formal systematic review. In the identified studies, 'the co-occurrence of child maltreatment and adult domestic violence ranged from a low of 6.5% overlap to a high of 97%'. Twelve, or almost half the studies, found the overlap to be in the range of 30% to 60% of families with children'. These were generally populations of either battered women or maltreated children, not epidemiological samples. The sampling approaches of these studies were extremely

diverse and 'probably account for much of the variation in results between studies, making it difficult to draw comparative conclusions'.

In 1994, the annual cost to health was estimated at NZ\$141 million (Snively 1994; Young et al 1997)

A critical analysis of Snively's study indicate severe methodological flaws, including faulty assumptions about prevalence and over-estimates of many of the parameters used in her calculations.⁴

NZ\$141 million is based on an assumed prevalence rate of 14%—that every year 1 in 7 women and 1 in 7 children are victims of family violence requiring medical intervention. The costing assumes that annually, each of these women and children (301,700 people) require two visits to a GP; that half of them also require an accident and emergency consultation; that 12.5% (37,711 people) sustain dental injuries requiring an average of \$200 dental treatment, and that 5.5% (16,895 people) require hospital admission at an average cost of \$17,000 per admission.

These numbers represent huge over-estimates. For example, in the year 2002/2003 there was a total of 6604 ACC dental claims for people suffering dental injuries from being 'struck by a person or animal', of whom just under one-third (2,175) were female. Adjusting for population figures in 1994, this equates to about 6200 cases, of whom 2050 would be female.

Some of these cases would be girls not adult women, and due to causes other than domestic violence (for example, injuries from contact during sport; kicks from horses or other animals; assaults from people other than their partner), therefore less than 2000 women are likely to have suffered dental injury from partner assault in 1994. This figure (2000) is much less than the Snively estimate of 37,711 cases of dental treatment resulting from family violence in that year.¹⁷

Furthermore, it should be noted that the figure of NZ\$141 million was an estimate of combined child and partner abuse, but the Ministry of Health document implies that this is the cost to health of partner abuse alone, effectively doubling the estimated cost of partner abuse.

Power and control wheel

The Ministry of Health book also promotes the use of the 'power and control wheel' devised by the Duluth Domestic Abuse Intervention Project, Minnesota, USA. This tool is not evidence-based. It addresses only male violence towards females. The Duluth 'wheel' is based on the assumption that family violence results from power imbalance between men and women, and that men abuse because they hold the power in our society. However this is not a universally accepted model, and alternatively it can be argued that use of violence is not the act of a powerful man, but rather of one who finds himself relatively powerless.⁶

The desire to do good (reduce and prevent inter-partner violence) does not justify exaggeration or distortion of the evidence to further the cause. The Ministry of Health should disseminate accurate and credible information based on critical appraisal of the research literature.

A particular intervention might seem to be a good idea but if it is based on faulty assumptions, it may be neither effective nor safe. The management of domestic violence requires similar rigorous scientific evaluation as do other areas of clinical intervention.

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