

THE PUBLIC HEALTH ISSUES OF INTIMATE PARTNER VIOLENCE

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I. Introduction

Violence against women is worldwide problem that cuts through all socio-economic levels, race, religion and creed. It occurs in developing countries as well as industrialized ones. Intimate partner violence (IPV) is a particular form of violence against women. This paper will explore the cyclical nature of IPV, its causes and effects, human rights and legislative and, more importantly, the public health issues behind IPV. The paper will also juxtapose prevalence of IPV domestically as well as internationally. Then recommendations will be given as to how policy makers can create plans to alleviating IPV.

Women can be victims as well as perpetrators of violence in intimate relationships. They can exert acts of violence on their male partners. They may also be violent to female partners in same sex relationships. However the overwhelming numbers of IPV victims worldwide are women. In addition the majority of perpetrators of IPV are men.¹

Intimate partner violence is defined by the World Health Organization (WHO) as “acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various forms of controlling behaviors.”² In a 2003 report by the U.S. Department of Health and Human Services (DHHS 2003 Report) describes IPV as “violence committed by a spouse, or current or former boyfriend or girlfriend.”³ The same report defines violence to be physical, sexual, psychological and emotional.

II. U.S. Statistics

a. Number of victims

According to a 2001 report by Federal Bureau of Investigation about one third of female victims of homicide were killed by their male partners. The 2003 DHHS Report states that in a 12 month period about 1,800,000 women in U.S. will suffer non-fatal victimization by their male intimate partners. Non-fatal victimization means sexual and physical assault and emotional and psychological abuse that did not result in serious injury or homicide.

The same report concluded that about 600,000 of these victims will result in some form of hospital care. About 95,000 will require emergency care. They also researched mental health care accessed by victims of IPV. These victims may access mental health care without reaching out to the police or medical communities. The report estimates 18,500,000 visits for mental health care will occur in a 12 month period regarding issues of violence in the home.

b. Financial costs

The 2003 DHHS Report provides financial costs of IPV. The report measured the costs as direct and indirect. Direct costs are monies spent for health care related services such as emergency department visits, hospitalizations, outpatient health clinic visits, physical therapy and mental health. These also include services by physicians and dentists, paramedic and ambulance transport. Indirect costs stand for value of lost work productivity due absenteeism or unemployment due to IPV.

The average cost of treating an IPV rape victim is about \$516. The annual estimate number of IPV rape victims is 322,230. This means that the cost of treating IPV rape victims is about \$166,270,680. However this cost can be higher. This number assumes that rape occurs only once in a violent relationship. Also there are many IPV rape victims who do not report the incidence.

The average cost of treating IPV victims of physical assault is about \$548 and medical care for injuries is required in about 519,031 cases. This brings an average cost of \$27,964,988. Again this is a conservative number due to underreporting and self-medical care.

For mental health care the costs are difficult to estimate. Mental health care requires numerous visits over an extended period. However, DHHS estimates that an average mental health visit will cost \$78. They also report that in any given year IPV victims will make 18.6 million visits to a mental health care professional. This brings the cost to about \$1.5 billion.

Health care treatment for IPV victims has an estimated annual cost of \$2.2 billion dollars. This number only reflects those victims that seek help. The 2003 DHHS Report that Medicaid pays for about 15% of these costs, private insurance about 50%, and the rest pays out of pocket or from low-income clinics.

III. World wide statistics

a. Number of victims

Aggregate number for victims of IPV world wide is unknown. Just for the mere size of the world population provides great challenges to finding this number. The great discomfort in speaking about intimate partner violence is brings an even

bigger challenge. However the World Health Organization recently published a county study on intimate partner violence. The WHO Multi-Country Study on Women's Health and Domestic Violence against Women provides prevalence reports on 15 countries with different economic standings.⁴

The multi-country study found that between 29%-62% of women surveyed reported sexual and physical abuse by a male intimate partner. The study also found that "the vast majority of women who had ever been physically abused by partners experienced acts of violence more than once, and sometimes frequently."⁵

b. Financial costs

Aggregate financial costs of IPV world wide are unknown. Some countries have begun reporting on the economic impact of intimate partner violence. In a 1999 survey by IndiaSAFE, they concluded that annually some 13% of miss paid work because of injuries from physical assault and another 10% were unable to perform house work.⁶

IV. Consequences of Intimate Partner Violence

The consequences of intimate partner violence are substantial. It affects the physical and mental health of the victim, children in the family, as well as the community at large. Victims of IPV suffer from high levels of physical and mental health disparities when compared to women who are not victimized. This suffering affects their ability to raise children, seek education and economic independence, and participate with the larger community.

a. Impact on physical health

IPV victims can suffer from physical injuries such as bruises, lacerations, abrasions, fractures, and optical damage.⁷ Physical injuries have a great prevalence in abusive relationships. However it is not the most frequent outcome of partner abuse. The more frequent are functional disorders; especially in relationships where abuse is sustained over a long period of time.⁸ They can also suffer from abdominal or thoracic injuries and gastrointestinal disorders. Victims experience long-term chronic pain syndrome, irritable bowel syndrome, consistent fatigue, and overall reduced physical functioning abilities. Studies have shown that functional disorders can be associated with physical and sexual abuse.⁹

b. Impact on sexual and reproductive health

Women who are abused by their male partners face extremely difficult challenges in protecting themselves from unwanted diseases and pregnancies. This is especially true for women in cultures where violence against women is a common practice and polygamy and infidelity are considered part of manhood. In traditional cultures where having a wife, girlfriend, and mistress is common an abused woman will find it difficult to ask her husband to put on a condom. This does not mean that traditional cultures will always abuse their women. However, for abused women they face even more threats of abuse when she asks her male partner to put on a condom. She faces unwarranted scrutiny and blame. According to a Human Rights Watch report on domestic violence in Uganda, the increased number of HIV positive women can be linked their victimization caused by IPV.¹⁰ This is just one of many examples of links between STDs and IPV.

Women in rich nations, such as the U.S., also face difficulties in protecting themselves from STDs if they are in abusive relationships.¹¹ They face coercion and pressure for unsafe sex or direct interference in attempting to use condoms. Like their counterparts in poor countries, women in rich countries experience threats of abuse or actual assault when asking their male partners to put on a condom.

Research has shown that violence during pregnancy increases.¹² Violence during pregnancy results in postponed or no prenatal care, miscarriage, premature or still birth, and fetal injury. For children born from mothers tormented by violence, they suffer from low birth weight. This can result in infant death or arrested physical and mental development.

Abused women suffer from forced and unwanted pregnancy. Their male partners may prohibit them from using contraceptives as a way of control. By bearing more children the women are forced into increased dependence on their abusive male partners. Consequently studies have shown that domestic violence is more prevalent in families with many children.¹³

c. Impact on mental health

The affects of abuse can have a long lasting impact on mental health. Women who are abused experience depression, anxiety, and phobias more so when compared to non-abused women.¹⁴ This prevents them from accessing help, sustaining employment, and overall self-help.

Once a woman leaves an abusive relationship the violence stops. However her mental health problems continue in the form of post-traumatic stress syndrome (PTSD). PTSD is a constant reaction to a cataclysmic experience. Symptoms of

PTSD include “flashbacks and bad dreams, numbness and blunting of emotional responsiveness, detachment from other people, and avoidance of activities and situations that awaken the memory.”¹⁵ People who have PTSD have been subjected to witnessing natural and manmade disaster, war, and torture. For survivors of intimate partner violence, the relationship is akin to war and torture. However, IPV is a very solitary and personal war.

Studies show that female survivors with PTSD report a wide range of physical symptoms such as chronic pain and diseases, bed stays, and somatic symptoms.¹⁶ Some of these can be medically treated but survivors of IPV who have PTSD have a harder time sustaining good physical health. This then affects their ability to work, care for their family and themselves.

d. Impact on children

“Children who live with domestic violence face increased risks: the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents.”¹⁷ They will also face behavioral, cognitive, and long-term problems. For children who witness violence in the home they can suffer from higher levels of aggression and anxiety. Their social behavior and relationships will suffer over extended exposure to violence. The same is true for their cognitive functioning which will stymie their academic performance. Long-term problems include depression and trauma symptoms as adults.

Children are socialized first through their family. They learn to cope with the world through the skills passed on by their parents. Children who witness family

violence are more likely to continue the cycle of violence. They will have difficulties with peaceful conflict resolutions and they may accept rigid gender stereotypes.

V. Why do they stay?

For every romantic and intimate relationship there exists an inexplicable connection between the two people involved. In relationships where abuse is present there is another inexplicable dimension of power and control. This and the cycle of violence can explain some of the reasons why women stay in abusive relationships.

a. Power and control

Many researchers on IPV and gender specialists have explained intimate partner violence by using the Duluth Model of Power and Control.¹⁸ In this model IPV is defined as a pattern of abusive behavior used by the batterer to establish power and control over their romantic/intimate partner. The various types of abusive behavior do not occur in isolation, but simultaneously and over a sustained period of time. As mentioned earlier, these types of abusive behavior are:

- Physical and sexual assault
- Coercion and threats
- Intimidation and isolation
- Emotional and psychological abuse
- Using economic abuse
- Using male privilege
- Minimizing, denying and blaming the abuse

These types of abuse are used together to establish power and control over the victim. The pattern uses of coercion, threats, psychological and emotional abuse are reinforced by physical and sexual violence. This makes up the larger system of abuse. The power and control dimension of an abusive relationship can be thought of as cogs in a wheel.

Figure 1 showcases the power and control wheel. The cogs are the various forms of abuse. The outside wheel is the repeated physical and sexual violence. Therefore the cogs and the wheel work together to reinforce power and control. For example: the cog of emotional abuse includes humiliation, condescending words and behaviors. The cog of male privilege includes, the male dominating the female partner with regards to decisions in the relationship and treating her like a servant instead of a partner. These two cogs are strengthened by the use of physical and sexual violence. As more cogs are added and the violence perpetuates, the wheel becomes more compact and the harder it is to break free.

b. Cycle of violence

Figure 2 illustrates the cycle of violence which is part of the pattern of abuse. This cycle is predictable and contains three phases. Phase one is the honeymoon phase which is during the beginning of the relationship. As in all relationships the honeymoon phase is where both parties are at their best behavior because they are trying to entice the other person. In this phase trust is built. In abusive relationships this phase is stronger and faster. Declarations of love and lifetime commitment are said faster in abusive relationships.

Figure 1. The Power and Control Wheel from the Duluth Model—Domestic Abuse Intervention Project www.duluth-model.org .

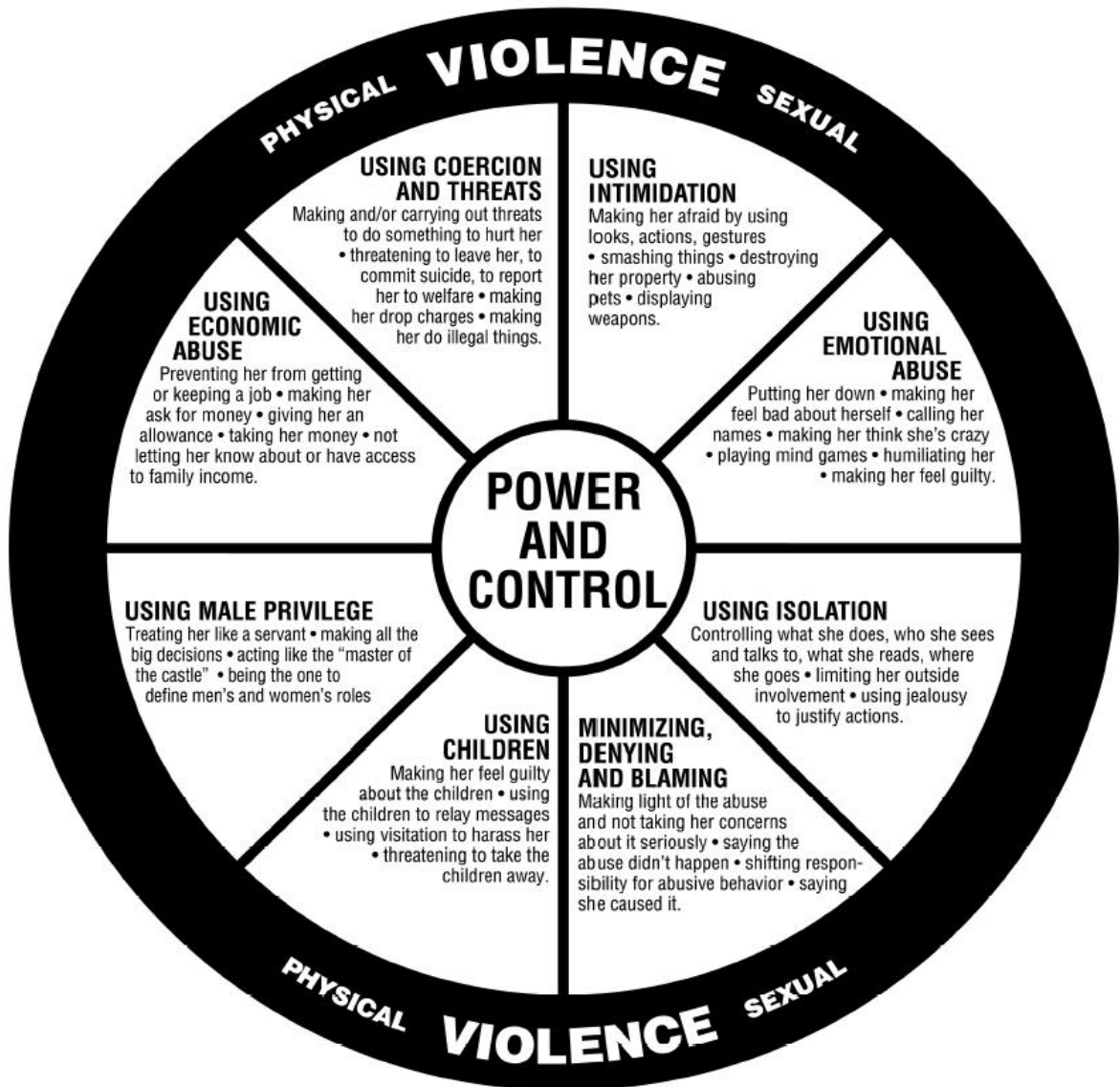
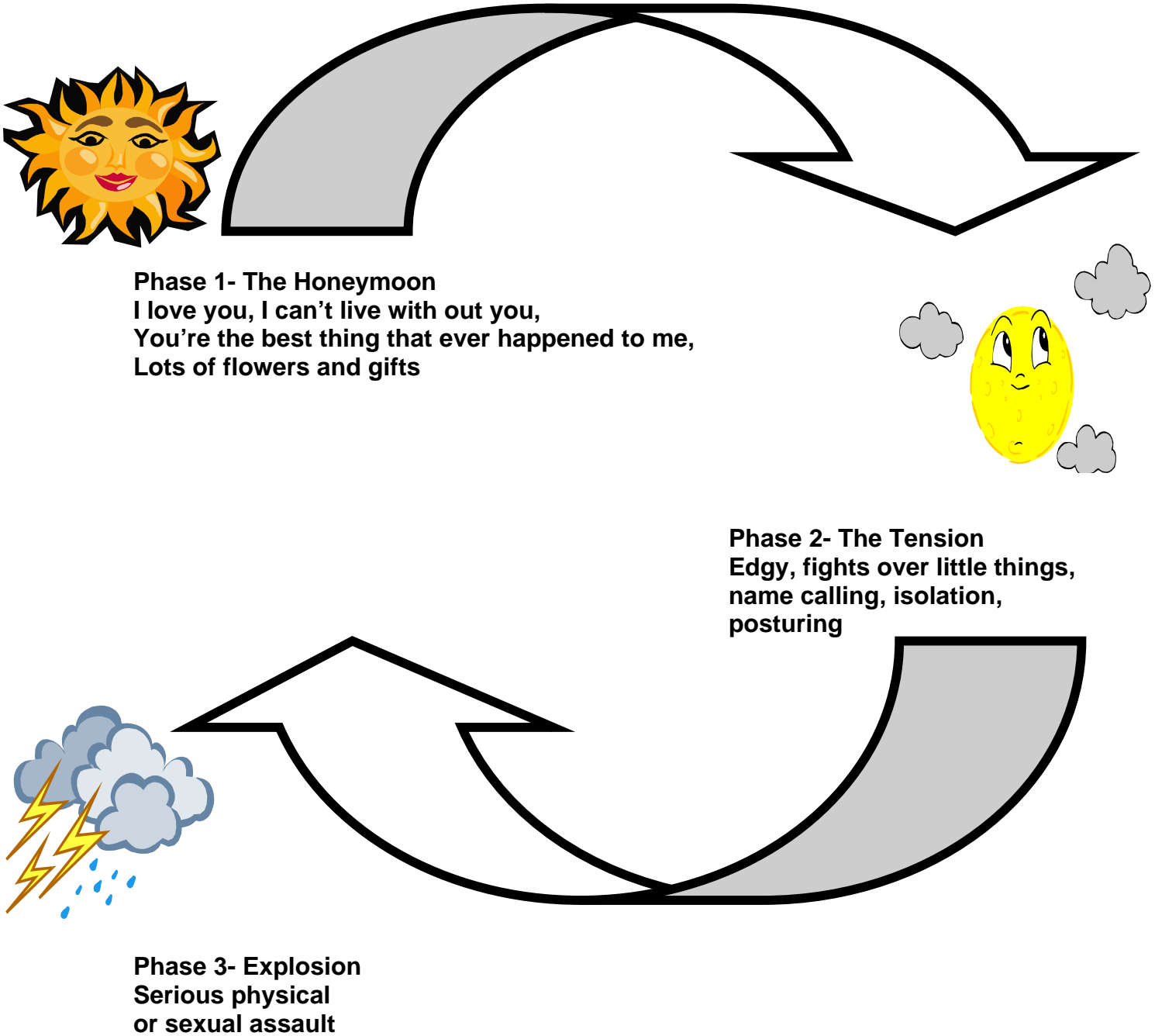


Figure 2-The Cycle of Violence from the Duluth Model- Domestic Abuse Intervention Project.

www.duluth-model.org



Phase two is where the tension begins. The abuser starts to exert his power and control by isolating her from friends and family. In this phase verbal and emotional abuse begins. The abuser is edgy and gets angry quickly at insignificant issues. The victim attempts to appease the abuser and acquiesces to his desires because she trying to return to the first phase.

Phase three is where the battering incident occurs. This can be physical, sexual or both. This is a very fragile phase for both parties. She may be thinking of leaving or looking for the reasons for the assault. The abuser apologizes or blames the female partner for his behavior. He attempts to get her back into the honeymoon phase by buying her gifts and promising never to repeat the incident.

The time segments for these phases can last over unknown amounts. The time between the phases can be short or long. The honeymoon phase can be two months to two years. However once the physical and sexual abuse begins, the time between the phases gets shorter and the abuse becomes more severe. The woman's dependency on her male partner increases over time, especially if there are children in the relationship. She depends on him for economic support and on some level companionship. This makes leaving the relationship more difficult.

c. Other reasons for staying

Economic factors are cited as one of the main reasons for staying in abusive relationships. The women's dependence on her male partner to support the children and/or herself binds her to that relationship. Other factors for staying are: cultural, familial, and continued threats of violence.

In some cultures it is extremely difficult for women to leave a home. She may be seen as abandoning the home and children, dishonoring her husband and her family. This may result in her eventual death. Some women have accepted that violence is part of the relationship and/or her role as the woman. Both the woman and man's family may pressure her into staying. There is still a heavy stigma of divorce which may also prevent her from leaving.

Even if the above reasons did not exist, the woman may still be prevented from leaving because of her partner's threats. Many abusers threaten their partners to control their independent behavior. He may threaten her with the following if she leaves:

- Take the children away
- Stop any form of child support
- Shame her to her family
- He will find her and severely punish her

From a public policy standpoint a critical reason for staying is lack of services and resources for victims. In the WHO report on domestic violence, abused women often left home for one night but would return the next day.¹⁹ They would go to the homes of friends or family. However, they did not have access to legal services and safe houses so that the abuser could not find them. More importantly the report cited that lack of planning, safety, and economic resources forced many women to return to their abusers.

VI. Conclusion and Recommendations

Intimate partner violence does not just affect the women that it victimizes. It also affects children, the community, and society as a whole. Children suffer because of the exposure to violence and its deeply problematic long-term effects. The community suffers because of the costs it bears on helping IPV victims and treating batterers. The society as whole suffers because violence that is perpetuated in the home doesn't just stay there. Those who are victimized and perpetuate violence are part of the global community and their situation spills into the larger society.

A coordinated community response should take place in order to stop the violence. This means that the justice and health care system must be in place in order to provide help for women, children, and the batterers. Education and outreach must be provided to stop the present violence and prevent future assaults.

Health Care System Response

The health care system and its providers can play an important role in detection and prevention of IPV. They can also be the bridge for women to accessing resources and services that can help them escape the violence. Health care providers can detect women victimized by IPV through emergency services, reproductive health services, routine checkups and child wellness checkups. Of course health care detection and prevention will vary depending on each culture. However there are certain foundations that can be used cross culturally.

One of those foundations is the manner in which IPV is brought up during consultations. If a woman was asked point blank, "Are you being abused?" She will most likely say no. This could be for reasons of shame or for simply not knowing

what abuse means. Instead more descriptive questions can be asked. Such as the following:

- Has your partner ever slapped you?
- Has your partner ever kicked you?
- Has your partner ever called you bad names?

These questions can provide clues as to what the relationship is like between the female patient and her batterer. Once the patient begins to disclose of her relationship and IPV is detected, then her safety and confidentiality must be ensured. Above all else she must not be stigmatized for disclosing and experiencing the abuse.

These measures can only be undertaken if health care providers are educated on IPV. Intimate partner violence must be acknowledged as a health care problem and not solely an intra-family one. From the perspective of health care issue, providers would have an easier time providing abused patients on the resources available to them. They can also educate IPV victims on the long-term affects of physical and sexual violence on themselves as well as their children.

Justice System Response

Health care providers that are educated on the effects of intimate partner violence would be weakened if they did not work with local justice systems to help the victims as well as the batterers. "Health providers who see and care for abused women need to coordinate and work with other sectors, particularly the police and social services."²⁰ This will entail the establishment of official referral actions.

The justice system response would be different for each country and culture. Therefore there has to be state commitment to ending intimate partner violence. Once that commitment is made, resources have to be provided, and enforcement mechanisms have to be enacted.

For countries to enact laws prohibiting violence against women, educating health care providers, and providing resources is a time intensive process. However, a more intensive process is that of paradigm shift. People have to revolutionize their views on women and violence. This paradigm shift would be the most difficult undertaking in the road to stopping violence against women. However it is necessary so that individuals can demand of their government and justice system the importance of ending violence against women.

Education and Outreach Process

If nations want to participate in the democratic process and a globalize community they must protect all citizens. Developed countries have laws that prohibit intimate partner violence. These same countries are major donors to developing countries that lack awareness with regards to violence against women. Therefore donor countries can begin to educate developing nations about the ills of violence against women. Donor countries can also demand, as part of the donating agreement, that those nations who do not protect all of their citizens will suffer monetary consequences.

At the individual and community levels, education to stop violence against women must be increased. It is only through this process that people can begin thinking about their own relationships, how violence affects their children, and how it

can bring harm to the community at large. In any part of the world education and outreach against intimate partner violence must be established so that the seeds of change can be planted. With that the next generation can truly work to end violence against women.

¹ World Health Organization, *WHO World Report on Violence and Health*, October 2003.

² Ibid. WHO 2003 report

³ U.S. Department of Health and Human Services Report *Costs of Intimate Partner Violence Against Women in the United States*, March 2003.

⁴ World Health Organization, *WHO Multi-country Study on Women's Health and Violence against Women*, November 2005.

⁵ Ibid. WHO 2005 report

⁶ IndiaSAFE Steering Committee, *IndiaSAFE Final Report*, Washington, DC, International Center for Research on Women, 1999.

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⁸ Ibid. WHO 2003 report

⁹ Leserman, J et al, *Sexual and Physical Abuse History in Gastroenterology Practice: How Types of Abuse Impact Health Status*, *Psychosomatic Medicine*, 1996.

¹⁰ Human Rights Watch, *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*, August 2003.

¹¹ Heise, LL, Ellsberg M, Gottemoeller M, *Ending Violence Against Women*, Johns Hopkins University School of Public Health, Center for Communications Program, 1999.

¹² Ibid. WHO 2003 report

¹³ Tjaden, P & Thoennes N,

¹⁴ Roberts, GL et al, *How Does Domestic Violence Affect Women's Mental Health*, *Women's Health*, 1998.

¹⁵ Emerson, Michel H., Black Robert E., Mills, Anne J., *International Public Health—Diseases, Programs, System and Policies*, Aspen Publication, 2001.

¹⁶ Schnurr, Paula, PhD, *Trauma, PTSD, & Physical Health*, *PTSD Research Quarterly*, Summer 1996.

¹⁷ National Clearing House on Abuse and Neglect Information, *Children and Domestic Violence, A Bulletin for Professionals*, U.S. DHHS 2003.

¹⁸ Duluth Model-Domestic Abuse Intervention Project. Available at www.duluth-model.org.

¹⁹ World Health Organization, *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women*, November 2005.

²⁰ Ibid. WHO 2005 report