Violence and Abuse Policy Brief

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Scope

Prior to 2008, ALSWH research had documented robust associations between domestic violence and health service use[1], physical health[2] (including reproductive health[3]) and psychological health.[4] Adversity in childhood includes experiencing abuse (including psychological, physical, and sexual abuse) and living with household dysfunction (including exposure to substance abuse, mental illness in the home, having a household member incarcerated, and witnessing domestic violence). These experiences had lifelong health implications for women. In addition, elder abuse was associated with a decline in mental health.[5] This brief includes ALSWH research conducted in the past decade that has examined abuse across the life course and provided sufficient evidence to warrant policy recommendations.

Research Findings

- Women rarely, if ever, disclose abuse when it has not occurred, but they may not disclose abuse when it has occurred if they perceive the costs of doing so outweigh the benefits.[6]
- A history of any type of abuse either in childhood or adulthood was related to the subsequent onset of cardiovascular disease[22] for women born in 1946-51.

Childhood adversity

- 41% of women born 1973-78 reported adversity during childhood. These women had higher GP, allied and specialists healthcare costs (Medicare and out of pocket costs) in adulthood than women who did not experience adversity.[7]
- Bodily pain, poor general health, and depression were associated with childhood sexual abuse. Women who experienced childhood sexual abuse visited their GPs

frequently but were less likely than other women to report satisfaction with their GP services.[8]

Bullying

- Approximately three in four women (72%) in the 1989-95 cohort reported having been bullied. Bullying was associated with adverse health behaviours, poor physical health, psychological distress, suicidal thoughts and self-harm.[9]

Sexual abuse

- Around one in five women born in 1989-95, 9% of women born in 1973-78, and 13% of women born in 1946-51 reported being forced to take part in unwanted sexual activity.[10,11,12]
- Women who experienced forced sex were more likely to have sleeping difficulties and take prescription sleep medication than women who had not experienced forced sex. Experiences of forced sex were also associated with illicit drug use, depression, anxiety, and self-harm.[11]

Domestic violence

- 16% of the 1989-95 cohort, 26% of the 1973-78 cohort, 16% of the 1946-51 cohort and 5% of the 1921-26 cohort reported having been in a violent relationship with a partner or spouse. When domestic violence was measured by asking about abusive acts (such as being hit by their partner), the prevalence was higher.[10,13]
- Women who had experienced domestic violence were less likely to have adequate cervical cancer screening and more likely to have experienced cervical cancer than those who had not experienced domestic violence.[2] Good access to a physician of choice significantly improved cervical cancer screening among women who had experienced domestic violence.[14]
- Women with poorer health were at greater risk of entering into a violent relationship, although their health was better than that of women who had already experienced domestic violence.[13]
- Women who experienced domestic violence had consistently poorer mental health than women who had never experienced domestic violence. For example, 75% of women in the 1989-95 cohort who had experienced domestic violence had felt that life

was not worth living at some point in their lives, compared with 53% of women who had not experienced domestic violence.[15]

- There was a lifetime deficit in mental health associated with domestic violence. This health deficit remained even after the abuse had ceased.[16]
- Women who had experienced domestic violence were more likely to experience menopause at a younger age. They were also more likely to smoke, and the relationship between domestic violence and menopause was mitigated by smoking.[17]
- The association between domestic violence and poor physical health and bodily pain persisted over a 16 year period for women born in 1973-78, 1946-51 and 1921-26.[13]
- Domestic violence in the previous 12 months was associated with domestic relocation among women born in 1973-78.[18]
- For women born in 1946-51, when domestic violence was combined with other stressful activities such as caregiving, health was found to be poorer than when domestic violence was considered alone, suggesting a cumulative health impact.[19]
- Among women born in 1973-78, those who lived in major cities were less likely to experience domestic violence than those living in inner regional and rural areas.[20]

Elder abuse

- Of women aged 70-75 in 1996, 8% reported vulnerability, 6% reported coercion, 18% reported dependence, and 22% reported dejection, the four components of the Vulnerability to Abuse Screening Scale (VASS).[21]
- Women aged 70-75 in 1996 who reported vulnerability or dejection were at greater risk of needing help with daily tasks (due to disability or illness) over the following 12 years than women who did not report these components of the VASS.[21]
- Women aged 70-75 in 1996 who reported coercion or dejection were at a greater risk of dying during the following 12 years than women who did not report these components of the VASS.[21]
- A history of abuse was related to the subsequent onset of cardiovascular disease[22] for women born in 1946-51.

Recommendations

- Results from the ACES and domestic violence research strongly suggest the need for more information about the pathways from early adversity into adult experiences of abuse. A more detailed and nuanced understanding of the mechanisms that lead from childhood adversity to poor health behaviours is needed. The healthcare costs associated with adversity in childhood further support the need for this research.
- Prevention of domestic violence is a priority for improving women's health. However, even if domestic violence ceases, many Australian women will continue to experience health problems associated with past domestic violence. We need to determine how we can implement and augment existing programs using a strengths-based approach.
- Women who have lived with domestic violence have been found to have a consistent risk of income stress. Domestic relocation will contribute to this and warrants further investigation.
- Evidence from ALSWH has suggested a cumulative impact of abuse and stressful events on health over the life course. These preliminary findings have laid the foundation for future research which is urgently needed in order to design effective interventions and to determine the life stage where these are best implemented.
- The higher prevalence of domestic violence in non-metropolitan areas suggests the potential inequity for women living with violent partners in rural Australia, highlighting the need to assess service availability for these women.
- The impact of abuse in childhood is apparent in adulthood. Similarly, abuse experienced in early- and mid-adulthood continues to impact on health as women age. Furthermore, abuse may continue into older age or occur for the first time as women experience decline in physical or mental functioning. There is a need for increased recognition of the very long term impact of adversity in childhood and abuse experienced in adulthood at the population level.

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