Summary

Violence against women is a major problem around the world. There is approximately one in four chance that women will experience intimate partner violence. The consequences of intimate partner violence may be various: immediate and direct (injury or death), direct and long term (chronic illness and disability), indirect (self-perceived health and health activities), or all three. Depression and post-traumatic stress disorder are the most common mental-health consequence of intimate partner violence.

Alcohol consumption presents a significant factor in the development of intimate partner violence. Alcohol use, especially heavy drinking, is one of the individual factors. The aim of this paper is to establish a link between the alcohol consumption and occurrences of intimate partner violence and a portrait of health consequences of intimate partner violence on women. Furthermore, it is meant for the clinicians who deal with alcohol addicts since the treatment program should include the recognition and monitoring of health consequences women suffered by their partners.

Keywords: violence, women, partner, health, alcoholism
INTRODUCTION

The World Health Organization (WHO) defines intimate partner violence (IPV) as “any behavior within an intimate relationship that cause physical, psychological or sexual harm to those in the relationship” [1]. IPV perpetrators seek to maintain control over their partners, not only through episodes of physical violence, but also through psychological and emotional abuse of their partners [2]. The WHO includes the following behaviors into its definition of IPV: Physical aggression, psychological abuse, forced intercourse or sexual compulsion, and various other controlling behaviors [1]. Physical violence presume slapping, hitting, kicking and beating. Sexual violence is forced sexual intercourse and other forms of sexual coercion. Emotional (psychological) abuse, involves insults, belittling, constant humiliation, intimidation, threats of harm, threats to take away the children. Controlling behaviors means isolating a person from her family and friends; following their moves; and restricting financial resources access, education, medical care or employment [1].

Sometimes intimate partner violence is more broadly referred to as family violence, spouse abuse, domestic violence, battering or violence against women.

Still, it is a prevalent problem around the world. There is one in four chance that a woman will experience intimate partner violence. Alcohol use, particularly heavy drinking, is associated with a man’s increased probability of committing violence against his partner [1].

Prevalence of intimate partner violence

It is difficult to establish the prevalence of IPV due to a number of factors that among other include under-reporting, inconsistent definitions used in studies and surveys, and the source of the data (community crime victim survey or clinical and community samples) [3]. The WHO in 48 population based surveys from around the world, reports that between 10 and 69% of women stated that they have been physically abused by an intimate partner at some point in their lives [1]. A survey study in general practice in Australia (2002), discovered that out of 37% of women who reported IPV 1 in 4 (8.6%) reported undergoing physical abuse, 1 in 3 (12.5%) emotional abuse, while 1 in 10 (4%) reported experiencing sexual abuse. However, it is quite common for women, the IPV victims, to experience all three types of abuse during their lifetime. [3]. This fact has been confirmed by a Japanese study that noted that 57% of women who reported the IPV experience had in fact suffered all three types of abuse [4]. In the WHO multi-country study, 23–56% of women who reported ever experiencing physical or sexual IPV had experienced both [5]. A comparative analysis of Demographic and Health Data from 12 Latin American and Caribbean countries found that the vast majority (61–93%) of women who reported physical IPV in the past 12 months also reported facing emotional abuse [6].
lowest prevalence of IPV is found to occur in mid-level socioeconomic and well educated social groups, while it is the highest among poorer women [7]. Better economic and educational grounds might not act as a protective factor for women from being abused, but it certainly influences the escape opportunity or the end to the violence, besides it a factor that makes them less likely to be abused in the first place.[7].

The first Serbian national study in gathering data on IPV was done in 2001 and was organized by Victimology Society of Serbia [8]. This study, which collected data from 700 women in 7 towns and 40 villages, found that 30.6% women had experienced physical violence from a family member. Majority of them (74.8%) had the IPV experience [8]. In the WHO multi-country study, that included data for Serbia, 6.3% of women had experienced sexual violence at least once, 22.8% of women had experienced physical violence at least once, and 3.7% women had experienced physical violence in the past 12 month [5]. According to the last data from 2010, which included part of Serbia (APVojvodina), every second woman had experienced some kind of psychological violence, and every third had experienced physical violence, 9% of women had experienced sexual violence, and 18.6% of women had experience controlling behaviors [9]. The actual family violence against women prevalence rate (during the last 12 months) in Serbia, without Vojvodina, is 37.5%, while overall prevalence (during lifetime) is 54.2%. The most frequent form of violence against women in central Serbia is psychological (31.8% in past 12 months and 48.7% during the lifetime), followed by physical (10.1% and 21.6%) and economical (11.4% and 15.8.6%), while the sexual violence is the least frequent (1.2% and 3.8%) [10].

**Physical violence and women’s health**

The IPV- physical health relationship is complex. The consequences of intimate partner violence may be immediate and direct (injury or death), direct and long term (chronic illness and disability), indirect (self-perceived health and health activities), or all three.

The short-term physical impact of IPV is the most visible and has an important role on women’s health. Direct physical health consequence of IPV is physical injury, with fractures, lacerations, contusions, damage to the face, upper torso, breast and abdomen being the most common [11]. The most common cause of injuries in women is the IPV [12]. The estimate is that even half of women who have suffered the IPV have been physically harmed by it. [13].

Early studies in the United States show that 2.2% of women seek help in the emergency rooms because of acute trauma resulting from intimate partner violence [14]. In two large case-control studies of women in the USA accident and emergency rooms, risk factors for injury by an intimate partner were male rather than female characteristics including histories of arrest, substance abuse, poor education, unemployment and ex-partner status [15, 16]. The most evident and severe health consequence of IPV is homicide, with, for example, IPV accounting for just under half (49%) of the homicides of women in Australia yearly [17]. As per a 1997 study, 40–60% of mur-
ders of women in North America are done by intimate partner [18]. In less-industrialized countries, percentages might be even higher. Mortality rate associated with IPV includes suicide of women in non-industrialized as well as industrialized societies [19].

Some of the long-term physical health sequelae tightly connected to the IPV are traumatic brain injury (TBI), memory loss, seizures, gynecological disorders, adverse pregnancy outcomes, arthritis, sexually-transmitted disease, and chronic pain syndromes [7,20,21,22,23,24]. Women who have experienced the IPV have also reported to have more than average gastrointestinal symptoms (loss of appetite, eating disorders) and diagnosed functional gastrointestinal disorder (chronic irritable bowel syndrome) that are associated with chronic stress. More so, hypertension and chest pain as cardiac symptoms have been self-reported by battered women. The IPV physical health consequences often remain present long after the abuse has ended. These consequences are often manifested as poor health status, poor quality of life, and an increased use of health services [20]. Research suggests that women who experience IPV are at higher risk of TBI and central nervous system (CNS) symptoms. Head injuries are reported as one of the most frequent type of injuries sustained, with up to 36% of victims suffering damage to the head, face or neck [25]. However, not many research relates to the consequences of these injuries and the percentage that result in association with TBI or disability due to post-concussive syndrome [26]. Corrigan et al. conducted a study involving women who registered to hospital emergency rooms due to IPV, and found that out of 51 women sampled, 30% had experienced a loss of consciousness at least once, and 67% reported health problems consistent with a head injury, such as headaches, dizziness, memory loss, and concentration difficulties [26]. According to Campbell & et al.[20] CNS symptoms including fainting, headaches and seizures were more commonly found in women who had experienced the IPV than in those with no IPV experience. The gynecological problems present the most consistent, long lasting, and the most substantial physical health difference between battered and non-battered women as Campbell noted. The most common differential symptoms and conditions are sexually-transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain and urinary tract infection [7]. As mentioned earlier, it is rather common for women suffering the IPV to experience both psychical and sexual abuse. At least 40 – 45% of women who experienced the IPV have suffered both physical and sexual abuse that puts them at even higher risk for health problems than those women who had faced only physical violence[27].

**Pregnancy and IPV**

The prevalence of IPV during pregnancy has been estimated at 1–20% in the general population, however, majority of studies report the prevalence to be between 4 and 8% [28]. Furthermore, adolescent women are at a higher risk of facing IPV during pregnancy than adult women [29]. Curry, Perrin, and
Wall found that 38% of adolescents, compared to 23% of adult women, experience IPV during pregnancy.

Physical violence in pregnancy causes decreased maternal health during pregnancy, also affliction with sexually-transmitted diseases, urinary-tract infections, high blood pressure, and other infections [7, 30]. Hutch-Bocks et al. (2002) found that women who had suffered IPV during pregnancy were more likely to go into a premature labor and remain in hospital after the birth for the reason of health problems. According to them, infants born to women experiencing IPV during pregnancy showed more signs of health problems during the first 2 months postpartum in comparison to infants born to women with no such experience. [30]. Other complications associated with IPV during pregnancy include low birth weight [31], increased risk of antepartum hemorrhage, intrauterine growth restrictions, and perinatal death [32].

**Mental-health effects of IPV**

The most prevalent mental-health sequels of intimate partner violence are depression and post-traumatic stress disorder [7, 20, 33]. It is considered that the IPV could represent a significant depression risk factor IPV. Golding [34] noted that average prevalence of depression among women who had experienced IPV was 47,6%, while Cascardi et al. [33] reported rates between 38 and 83%; rates that significantly exceed depression rates among women in general population. Dienemann et al. [35] states that 63% of women diagnosed with depression, sampled from hospital or community treatment programs, had suffered IPV at some point in their lifetime: 12.2% of women had experienced IPV within the past year, and 6.1% had experienced sexual abuse by an intimate partner in the past year. Depression in women who experienced violence from their partners have also been connected with other life stressors often accompanying domestic violence, such as childhood abuse, daily stressors, number of children, changing residence, forced sex with an intimate partner, marital separations, negative life events, and child behavior problems. Adding to depression, they also suffered more commonly from anxiety, insomnia, and social dysfunction than non-abused women [7]. Average prevalence of PTSD for women with an IPV experience, reported by across studies, was 63,8% compared to 1,3–12,3% in general population [34]. Women experiencing IPV met the PTSD criteria between 31 and 84% [33, 34]. Severity of abuse, previous trauma, and partner domination have been identified as critical precursors of post-traumatic stress disorder emerging from the IPV.

**Alcoholism and IPV**

The most common model used for understanding violence is the ecological model, which suggests that violence is a result of factors acting at four levels: individual, relationship, community and societal. Alcohol and drug abuse belong to a group of individual factors related to a man’s increased probability of committing violence against his partner(s) [1, 36]. Alcohol use, heavy drinking in particular and drinking large amounts per occasion, is associated to man against woman violence [37]. It is suggested by Meta-analyses that alcohol
plays an important contributing role in aggression seen overall [38]; however, the extent to which the role of alcohol in IPV is causal is multilayered and contested [39]. Although the experiments have shown that alcohol increases aggression in both men and women [40], the effect is stronger for men, and drinking by men has been noted to play a more important part in committing the IPV perpetration than has drinking by women [41]. When one of the partners has been drinking, either he or she will not be fully able to address the possible conflict in a constructive manner since the alcohol had affected the cognitive functioning and judgment, the drinking partner may be more likely to lose the focus on giving an appropriate response to a perceived situation, insult or other wrongdoing by a partner and less likely to perceive the situation, insult or apparent wrongdoing from the partners perspective, or to note the situational or environmental factors that may have had the effect on the given situation, therefore the drinking partner might take a highly provocative and aggressive stance and act accordingly without thinking about consequences of such behavior, for men in particular the possible aggressive behaviours by a partner is perceived as threat to masculinity or social identity in general and thus it requires equal answer. [42,43]. Social and cultural perceptions of alcohol can also be influential where the acceptance and tolerance of alcohol-related misbehavior (aggression included), can impact drinkers’ expectations about their behavior when drinking [44]. Meaning that with no regard to the effects, there are people who after drinking intentionally behave aggressively or violently since they believe, or more so expect, to be excused by their partner for such actions due to prior drinking at the time.

In studies of individuals and couples receiving treatment for alcohol or other substance problems, or both, the pre-treatment IPV prevalence has been in the range of approximately 50%–65% [45, 46, 47]. Treatment samples data indicate that male-to-female violence is on a raise on drinking days [48, 49], alcohol use is linked to the likelihood of violent nature conflicts [50], and the probability of male-perpetrated IPV is positively correlated with the seriousness of man’s alcohol problems [51]. Case-control studies of emergency-rooms/trauma centers patients [52, 53, 54] and victims of criminal IPV [55, 56] points to more evidence that male-partner alcohol abuse and heavy drinking represent strong predictors of injuries related to male-perpetrated IPV. According to the analysis based on data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions, a national comorbidity study carried out by the National Institute on Alcohol Abuse and Alcoholism (USA); women who described their partners as having current alcohol problems were at increased risk of numerous health problems. Rates of any or multiple victimizations for those women were just as twice high as for women who had no partner with alcohol problem, thus their rate of various and multiple injuries were more than double. Their rates of any and multiple victimizations were as high as three times as those for women without partner encountering alcohol problems, and their rate of multiple injuries was more than twice as high. Any injury rate was as doubled. Additionally, rates of mood
and anxiety disorders were three and two times as high as for women without partners with alcohol problems. Alcohol problems of a partner were also tied to a higher probability of fair or poor health state, with more past-year stressors, and with a lower mean psychological quality-of-life score. Women with partners suffering from problems with alcohol experienced 46% more negative life events during the past year and their mean psychological and physical quality of life scores were lower by 11% and 5%, respectively than in women whose partners had no alcohol use problems [57].

Even though drinking and IPV can occur independently of each other they are sufficiently inter-related that the World Health Organization gave a proposal for primary interventions which are meant to reduce the harm caused by alcohol that could possibly reduce the IPV occurrence [58]. Since it has been shown that direct interventions addressing violence against women had had a limited effect further investigation on the effects of alcohol on IPV occurrence is needed and of major importance[59]. Recognizing the multi-dimensional and complex nature of IPV, The WHO, identifying that the issue is multi-dimensional and of a complex nature, recommends an ecological framework for violence prevention where the factors influencing the violent behavior act separately and cumulatively at the individual, relationship, community and societal levels [1, 36]. Although the majority of reviews of alcohol interventions have focused primarily on the individual or relationship level [60, 61] (e.g., individual or couple treatment for alcohol dependency), as suggested by this model, alcohol interventions relating to alcohol-related IPV can similarly arise at the community and population level. Community-level interventions are distinguished from population-level interventions in that they pertain to a specific community or area, and are often developed to answer the local needs and problems and involve community members in their development and management [62]. Population or societal-level interventions, on the other hand, are implemented at the broad population level (country, state, region) and may be more likely to involve more formal mechanisms such as taxation, although similar interventions can take place at both community and population levels.

Conclusion

The estimates have it that one in four women are probable to experience one or other type of abuse from an intimate partner during their lifetime. The consequences of abuse can be serious and prolonged. Alcohol abuse is one of the individual factors connected to a man’s increased probability of committing violent acts against his partner. Despite the obvious link between alcohol consumption and IPV and evidence that alcohol abuse contributes to increased risk of violence, there are only a few studies that have clearly pointed to alcohol treatment interventions that could be applied to reduce the male-female violence. Further research should concentrate on defining the appropriate therapeutic treatments and interventions and their application on alcohol addicts who have committed violence against their partners.
ZDRAVLJE ŽENA I NASILJE NAD ŽENAMA ČIJI PARTNERI SU ALKOHOLIČARI

Nataša Dostanić

Specijalna bolnica za bolesti zavisnosti, Beograd, Srbija

Kratak sadržaj

Nasilje nad ženama je značajan problem širom sveta. Svaka četvrta žena može da doživi partnersko nasilje. Posledice partnerskog nasilja mogu biti različite: neposredne i direktna (kao što su povrede ili smrt), dugoročne i direktna (kao što su invalidnost ili hronične bolesti), indirektna (kao što je izmjenjeni doživljaj sopstvenog zdravlja i ponašanja u vezi sa zdravljem) ili se mogu javiti sve tri vrste posledica. Najčešće mentalne posledice partnerskog nasilja su depresija i post-traumatski stresni sindrom. Konzumiranje alkohola, narčito teška pijanostva su povezana sa partnerskim nasiljem muškarca prema ženama. Prekomerno konzumiranje alkohola spada u individualne faktore rizika, koji povećavaju mogućnost javljanja partnerskog nasilja. Cilj ovog rada je da se ustanovi veza između pijenja alkohola i pojave partnerskog nasilja i da se prikazu zdravstvene posledice partnerskog nasilja nad ženama. Ovaj rad je namenjen kliničarima koji rade sa alkoholnim zavisnicima, jer bi program lečenja trebalo da obuhvata i prepoznavanje i praćenje zdravstvenih posledica njihovih partnere.

Ključne reči: nasilje, žene, partner, zdravlje, alkoholizam
References


Nataša Dostanić
Special Hospital for Addiction Diseases
Teodora Drajza 44
Belgrade, Serbia
nakidostanic@gmail.com