Australian Longitudinal Study on Women's Health
Report to the Office of the Status of Women

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"Stay strong, and never accept it as a way of life."
Australian Women's Experiences of Abuse and Life After Abuse

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Executive Summary

The prevalence of abuse and violence against women in Australian society, and the negative impact on women's health and well-being is well established. The Australian Longitudinal Study on Women's Health continues to play a vital role in documenting the extent and consequences of this major social problem. While the need for education and prevention continues to be evident, this report focuses on the health of women who are abused and on strategies and resources that these women have used to recover from abuse and move on.

The first section of this report documents the health and well-being of the 35% of middle-aged women who have experienced any form of abuse. By comparison with women who report no history of abuse, these women are clearly disadvantaged in multiple domains.

A comparison of the two groups of women (abused and non-abused) demonstrated significant health disadvantages. Women with any history of abuse were higher users of all categories of health services. They also had higher rates of surgery, particularly for gynaecological and digestive problems, and were more likely to have been diagnosed with a range of serious medical conditions. Most notably, they were more than twice as likely as non-abused women to have received a psychiatric diagnosis, and twice as likely to use medication to help them sleep, for depression, and for nerves.

A higher percentage of abused women were smokers, and they were less likely to be partnered. Women with a history of abuse also had more difficulty in managing on their income, and were more likely not to have finished high school. Even after taking these social differences into account, there were still significant health differences.

Women from rural and remote areas who experience domestic abuse experienced particular problems in dealing with the abuse. For these women, help-seeking was inhibited by isolation, by a lack of knowledge of what services were available, and by long distances.

Medicare unit records (from those who consented to linkage) confirmed the women's reports. Women who had been abused were significantly higher users of services, including GPs, psychiatrists and other specialists, and incurred greater Medicare costs, but their out-of-pocket costs were no higher than others in the same age group.

Women's own voices were used to explore ways in which women have managed to overcome violent and abusive situations. Qualititative analysis showed that women had used many positive strategies to cope with abuse and with adjusting to life after abuse. Women spoke movingly of drawing on inner strength to face the challenges posed by abusive situations with determination and persistence. They stressed the importance of taking control and recognizing their own values and desires, in order to build independence and positive relationships.

The women stressed the importance of speaking out, and of seeking support both from family and friends and from counselors and formal support systems. The majority stressed the importance of removing themselves from the abusive situation, and finding new goals and challenges, including social activities, further education, paid employment and a career path.

Women who had experienced abuse also commented on what advice they would give to others who faced similar situations. The overwhelming advice was to leave the situation as quickly as possible, and to resist the temptation to return. Support from professional and informal sources was also considered critical, and women stressed the importance of being prepared, knowing what resources were available, and knowing where to go. They were clear on the importance of feeling positive and strong. Once a woman had left, they advocated acting to develop self-confidence and strength, while taking practical steps to start a new life.

Women also advised on what services would have been helpful to them. Raising awareness, through educational programs, the media, and advertising campaigns, was seen as vital. Counselling services, community programs, and support services were also high on the agenda, although respondents emphasized that these must be safe, confidential and practical. There was a strong emphasis on practical assistance. Some recommended more refuges and safe accommodation, while others recommended greater levels of legal aid, financial support, assistance in education, job skills and job seeking, and practical help to re-establish their lives elsewhere.

The report emphasises both the health and emotional burden carried by women who have been abused, and the enormous emotional strength these women have drawn upon to rebuild their lives. Their recommendations balance a need for psychological support with a clear preference for practical help to enable them to lead independent, happy and productive lives. The focus on coping with the aftermath of abuse in no way reduces the importance of prevention and of community education, but provides a valuable complement.

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Section 1: Health and Lifestyle Differences Between Abused and Non-abused Women

When looking at abuse of women, there is tendency to focus on the direct short-term trauma, and on the characteristics of the abuse situation, prevalence, and the direct and immediate consequences for women's well-being. Such research is extremely important in documenting the extent of the problem and in raising awareness of the need for intervention.

However, the evidence that levels of abuse against women continue to be unacceptably high in Australia is now well established. Two further challenges are addressed in this report. The first is to gain a much more complete picture by broadening this focus to include the wider social context; to look at these women's lives outside of the abusive situation, as well as the less obvious, more long term implications for their health and health behaviours. The second is to go beyond the notion that women can only ever be passive victims of abuse, to look at stories of coping and survivorhood. If we can understand how some women have managed to overcome violent and abusive situations and regain their equilibrium, we will be better positioned to provide help to the many other women who continue to find themselves in such situations.

With the first of these questions in mind, we used the data provided by the Australian Longitudinal Study of Women's Health (ALSWH), and compared women who have been abused with those who have not, on a number of sociodemographic and health-related characteristics (see Appendix 1 for a full list of the variables tested and the results). In this instance, we were interested in middle-aged women (aged 45 to 50 years when the study began in 1996, and 47 to 52 when these data were collected), who had completed the first two waves of the study, as they had provided a wealth of relevant details about their lives.

The ALSWH, funded since 1996 by the Australian Department of Health and Ageing, surveys a representative sample of over 40,000 Australian women in three discrete age groups. Surveys are used to collect information on physical and emotional health, use of health services, health behaviours, demographics, social circumstances, time use and major life events. Violence and abuse has been an important theme since the project began. As well as survey data, the participants are invited to consent to access to their Medicare unit records, which enables administrative information on health service use to be assessed as well.

Women's experiences of abuse were identified through one item in the ALSWH Survey 2 for Mid-Age women (1998). This asked women to indicate whether they had ever experienced any form of physical, mental, emotional or sexual abuse or violence, either as a child, in an adult relationship, or at any other time[1]. Thirty-five percent of

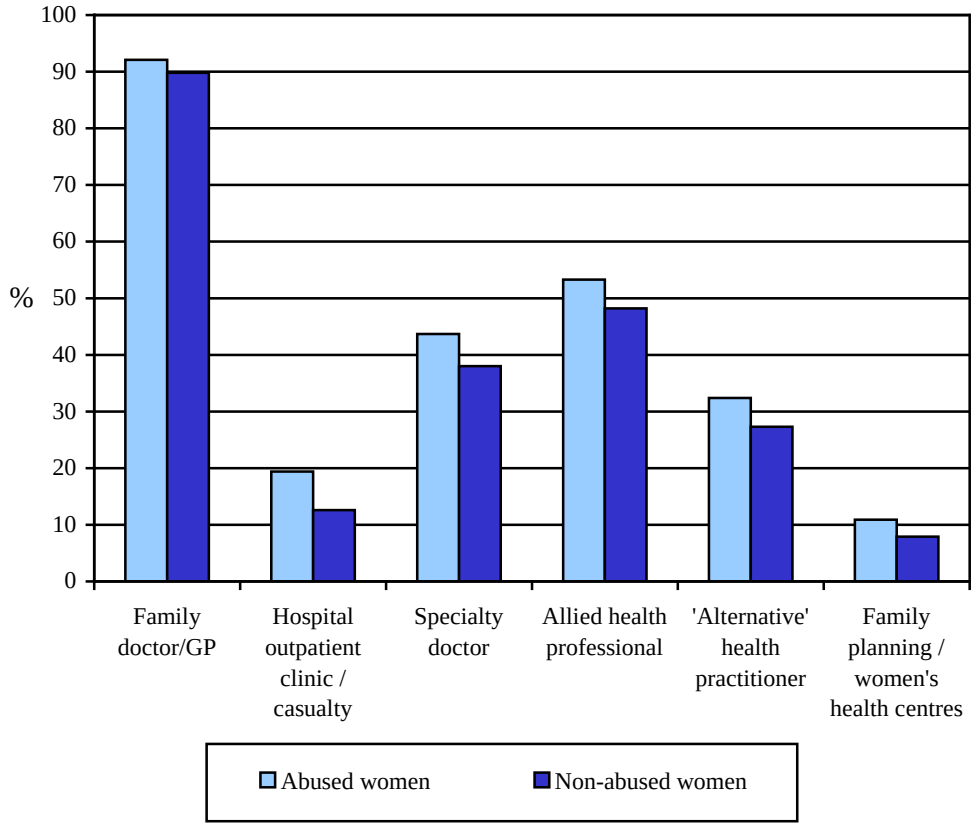
[1] Women also had the option of marking "do not want to answer" and were reminded that they could leave the question blank if they preferred; they were also provided with a number of referrals in case the question triggered a need to seek help.

women indicated that they had a history of abuse, while 58% reported that they had never experienced abuse.

It should be noted that this analysis uses the most comprehensive definition of abuse – of any kind, at any time, and by any person – and thus the "abused" group identified is a large one. More specific questions, clearly, define a smaller proportion of the sample. For example, 15.4% of the Mid-Age women reported having ever lived in a violent relationship. The larger sample discussed includes these women, together with others who had experienced abuse as children, from strangers, in work relationships, or elsewhere.

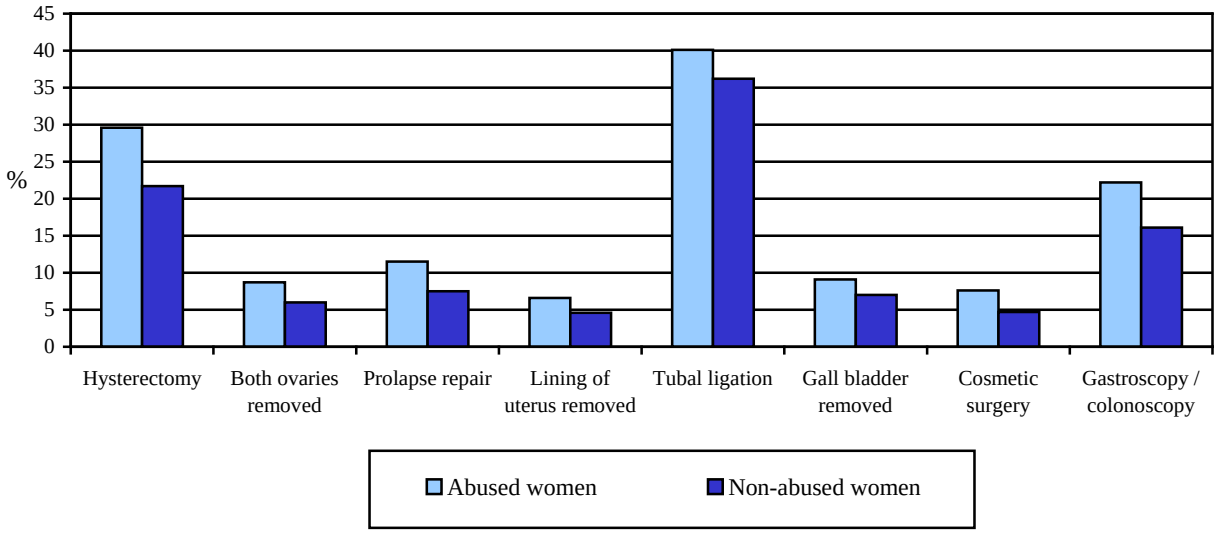
A comparison of the two groups of women (abused and non-abused) revealed a number of significant differences in their lives. Women with any history of abuse were higher users of health services; they more frequently visited GPs, hospital outpatients services, medical specialists, allied health, and alternative practitioners, and were more likely to have visited family planning or women's health centres (see Figure 1).

Figure 1. Use of health services in the past 12 months, self-report.



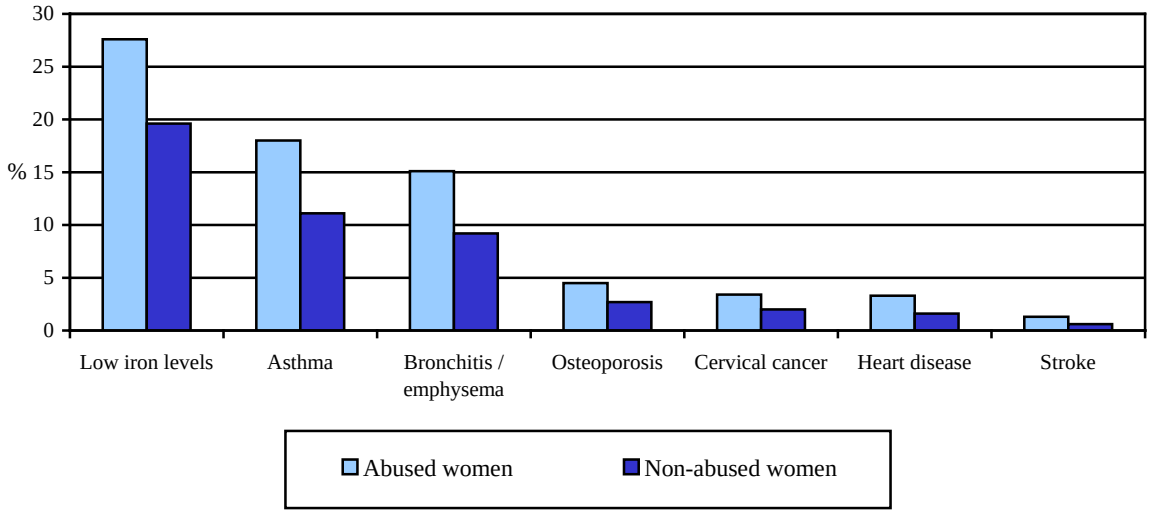
Women with a history of abuse were also more likely to have undergone surgical procedures, including hysterectomy, removal of both ovaries, uterus lining, and gall bladder; hysterectomy; prolapse repair; tubal ligation; cosmetic surgery; and gastroscopy or colonoscopy (see Figure 2).

Figure 2. Surgical procedures, self-report.



Abused women were more frequently diagnosed with a range of serious medical conditions, including heart disease, stroke, bronchitis or emphysema, osteoporosis and certain types of cancer, as well as less serious conditions such as asthma and low iron levels (see Figure 3).

Figure 3. Diagnosed medical conditions.



Most notably, they were more than twice as likely as non-abused women to have received a diagnosis of depression, anxiety or other major psychiatric disorder (see Figure 4); not surprisingly, abused women were also around twice as likely to be taking medication to help them sleep, for depression, and for nerves (see Figure 5).

Figure 4. Diagnosed psychiatric conditions.

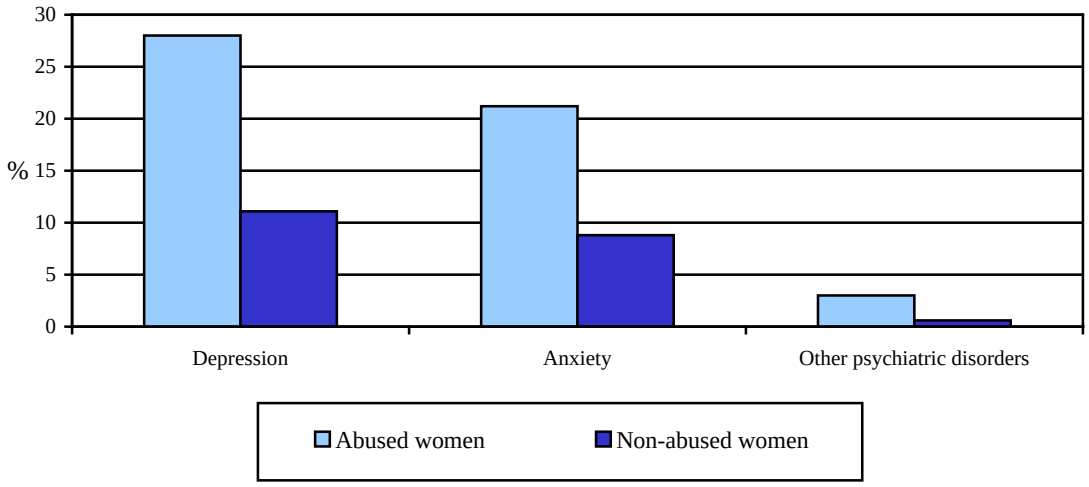
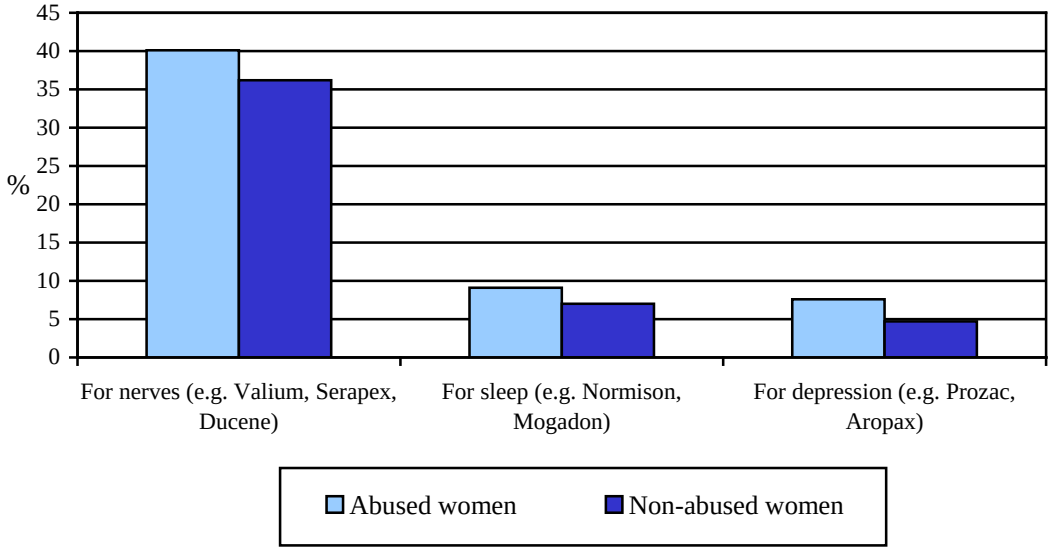


Figure 5. Prescription medications.



A higher percentage of abused women were smokers, either in the past or currently, and abused women were less likely to be married or in de facto relationships (see Figure 6), and more than twice as likely to be divorced or separated (see Figure 7). Women with a history of abuse also had more difficulty in managing on their income[2], and were more likely not to have finished high school.

Figure 6. History of smoking.

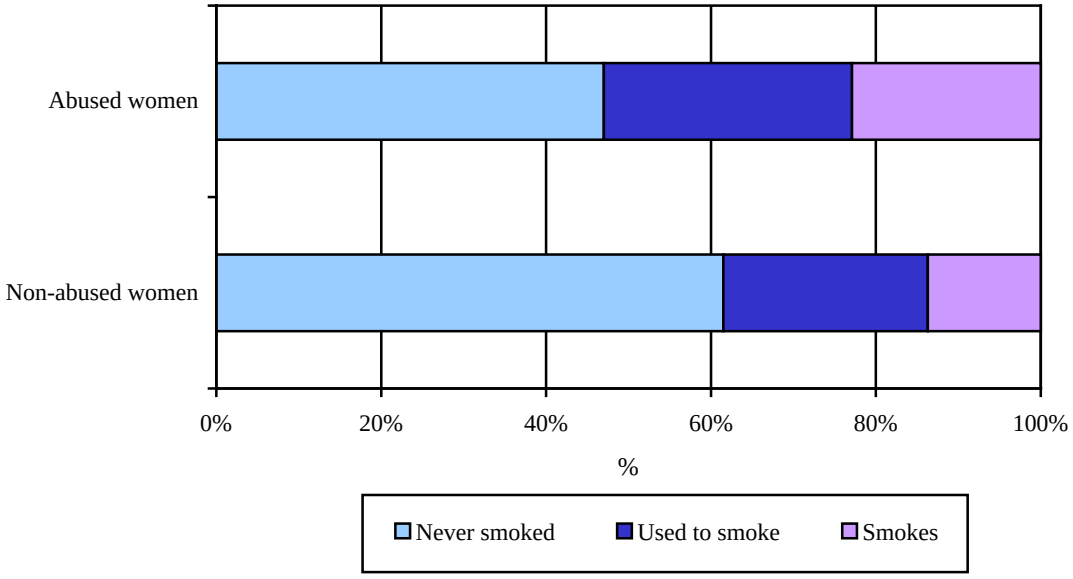
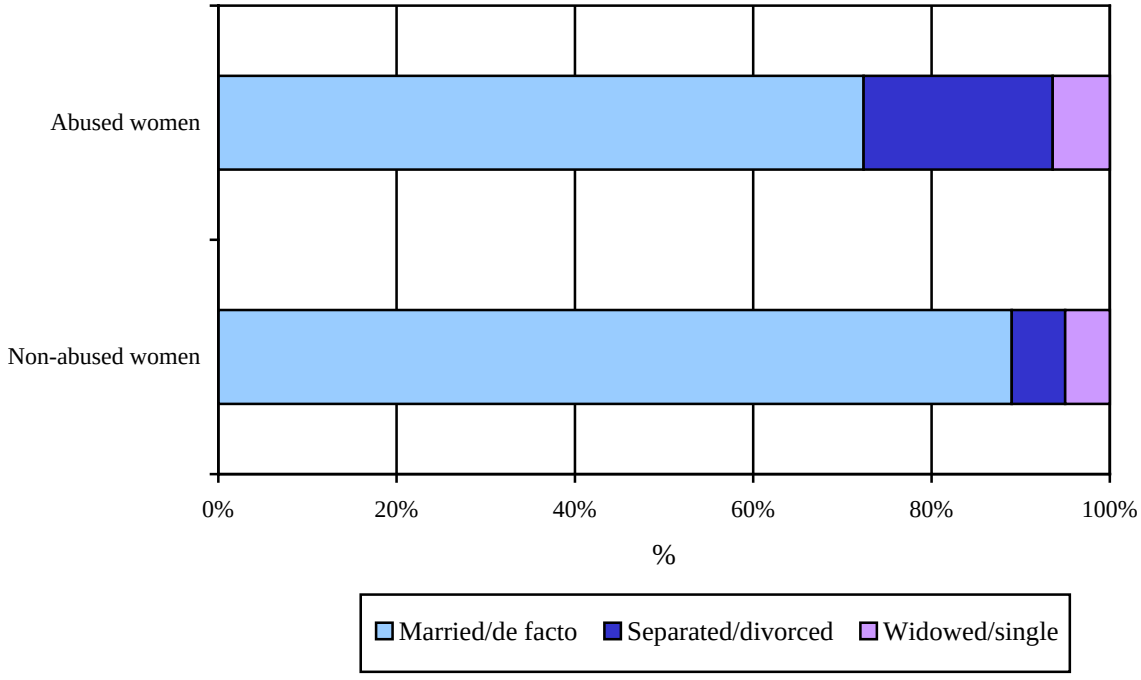


Figure 7. Marital status



[2] Responses to the item, "How do you manage on the income you have available?" were used as a proxy for income, because of high levels of missing data on direct questions about finances.

Further analysis was conducted to adjust for the effects of demographic differences – it is widely known established that women of lower socio-economic status are in poorer health than those of higher socio-economic status, regardless of abuse experiences. Even after adjustment, there were still significant differences in use of health services and medications, surgical procedures, medical problems, and psychiatric diagnoses.

A mediation analysis showed that the relationship between domestic violence and poorer physical health was partially affected by stress, number of major life events, education, difficulty managing on income, and smoking. In other words, the physical health disadvantage for abused women was strongest among those who were also suffering from stress, experiencing life disruptions, and who had low levels of education and difficulties with income, and who smoked. A similar analysis looking at mental health showed that the psychological disadvantage for abused women was strongest for those suffering stress, high life disruption, and low levels of social support.

A separate study found that women from rural and remote areas who experience domestic abuse experience particular problems in dealing with the abuse. They tend to be more isolated than urban women; they face an increased risk of being threatened with a firearm, and in some cases abusive partners are able to restrict their ability to seek help by restricting access to telephones or transport. For these women, help-seeking is inhibited by isolation, by a lack of knowledge of what services are available, and long distances to access help providers. Many women also report fears about confidentiality; in rural areas, the people available to provide support often have existing social or family relationships with the victim, the perpetrator, or both; conversely, people from outside the area appear not to understand the particular problems arising in isolated communities.

Overall, the survey data paint a picture of women who report abuse as having higher levels of illness, both physical and psychiatric, being higher users of health services and of medications, and as being less likely to be in supportive partnered relationships.

One problem with the interpretation of self-report data is that of response bias. If women who have experienced abuse are more likely to be depressed, they may also be more likely to respond negatively to a range of other questions. While the findings summarized above deal mainly with objective information such as major diagnoses and surgery, the possibility of bias cannot be discounted.

For this reason, in the second part of this report we explore differences between the same two groups of women, but in this case the data are derived from Medicare unit records and not from the women's own reports.

Section 2: Health Service Use: Differences Between Abused and Non-abused Women

All women participating in the Australian Longitudinal Study on Women's Health were invited to consent to the researchers having access to their Medicare unit records. Privacy legislation means that we could only access records for women who actively consented by signing a separate consent form and returning it to us. Seventy percent of women in the Mid-age cohort consented to this request. This consent rate was no different for those who told us they had been abused and those who told us they had not. Although we do know that those who consented to access tended to have better education and higher socio-economic status than those who did not, this effect was the same for abused and non-abused women.

Thus, while there were biases in who chose to consent to linkage, these biases did not appear to be related to their experience of abuse. It must also be noted that Medicare records do not include all health service use. In particular, they do not include hospital services for public patients, which are covered by the States, or private services where no rebate is claimed[3]. In this report, we analyse out-of-hospital services only. While this only provides part of the picture, GP visits are generally the first port of call for entry into hospitals and other higher-level care, so the data should provide an accurate picture over overall use.

Analysis was carried out on year-long data for each of 1998, 1999 and 2000. Since the results were much the same in each year, we present the 1998 data only here[4]. A full set of analyses appears in Appendix 2.

The Medicare data confirmed the women's reports. Women who had been abused were significantly higher users of GP services (see Figure 8). In a separate analysis, we looked only at the top 5% of attenders in the entire sample; these "frequent attenders" were women saw GPs at least once a month on average, and in some cases several times a week. Of these, 57% had reported abuse. This compares with 36% of the rest of the sample. Thus, while one middle-aged woman in three has experienced abuse, over half of the middle-aged women who make very frequent GP visits have experienced abuse.

The Medicare data also showed that women who had been abused were significantly more likely to have seen a psychiatrist over the course of the year, but were not significantly more likely to have seen any other medical specialist (see Figure 9). While Medicare unit records do not record the reasons for visits, or any diagnoses, treatments or prescriptions that arise, the higher use of services is consistent with the women's self-reports of higher levels of illness.

[3] This latter category is, however, very small.
[4] The pattern of results is the same in each year for all six of the variables described in this section.

Figure 8. GP visits during 1998, Medicare data.

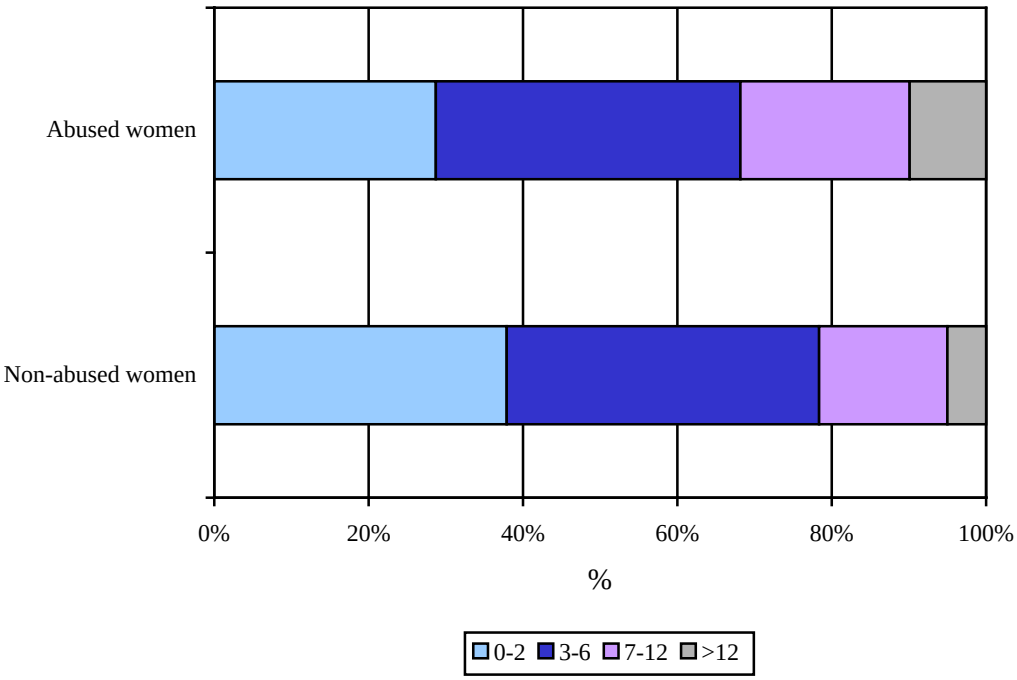
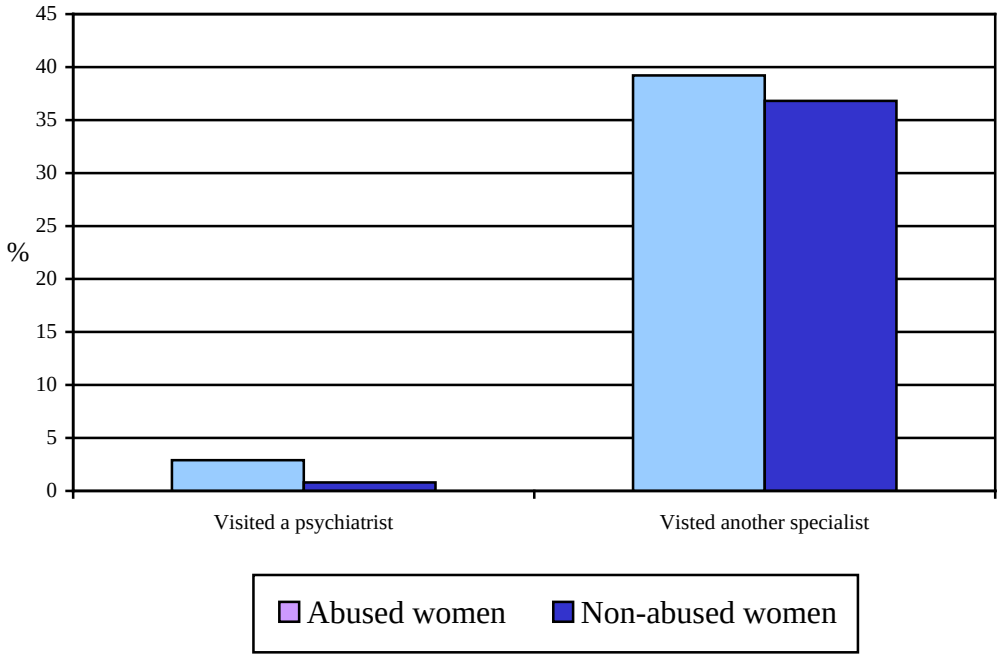


Figure 9. Psychiatrist and other-specialist visits during 1998, Medicare data.

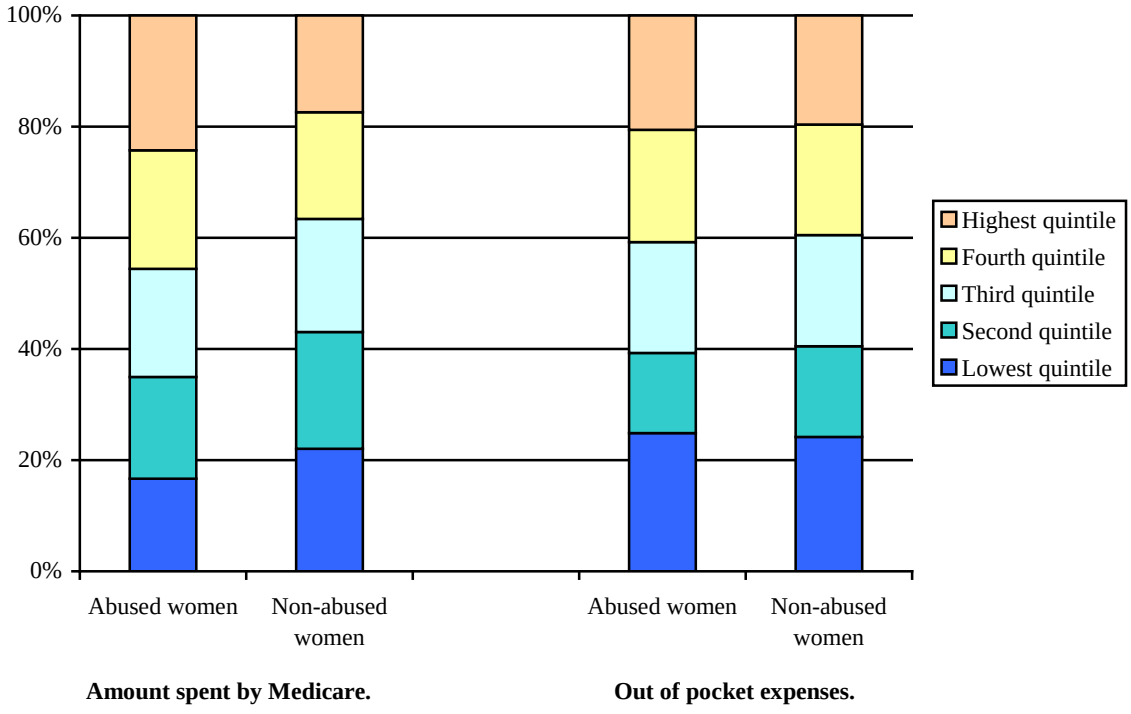


Medicare unit records include the amount paid for the service and the amount of the Medicare rebate. Thus it is possible to calculate how much was paid by Medicare for each woman over the course of the year, and also what additional costs there were – out-of-pocket costs which were presumably met by the woman using the service. Rather than dealing with absolute amounts, we divided the entire sample of women into five equal cost bands and then examined what percentage of abused women fell into each of these bands. Clearly, if costs were not related to abuse, we would expect 20% of women in each band.

Figure 10 shows that, for Medicare payments, the highest bands had a higher proportion of abused women and the lowest bands a lower proportion. For example, 24% of the abused women and 17% of the non-abused women fell into the highest band, while 17% of the abused women and 22% of the non-abused women fell into the lowest band.

Figure 10 also shows the figures for out-of-pocket costs. As 23% all women had no out-of-pocket costs, the lowest category (consisting of all those with no out-of-pocket costs) is in fact slightly more than 20% for both abused and non-abused women. In this case, there are no significant differences between women who have and have not been abused. Thus, although abused women are using health services more often and incurring greater Medicare expenses, they are not having to pay any more personally than are women who have not been abused. This may be because some of the women are reaching the Safety Net, and may also be related to a higher number having Health Care Cards, but it suggests that when women are able to access high levels of service, they do so without high financial cost at a personal level.

Figure 10. Proportion of women in each quintile of amount spent by Medicare, and out of pocket expenses, for services out of hospital during 1998.



Section 3: Women's Experiences of Abuse

So far, this report has demonstrated that women who have experienced abuse have higher levels of physical and psychiatric illness, higher use of health service, and poorer socioeconomic circumstances than other women. This finding is consistent with other research, both in Australia and internationally. However, it fails to address the question of how we may best respond to these findings, and how best to help women come through abuse and make a good recovery. The next section of this report uses the words of abused women themselves to examine the process of survival and recovery, and to make recommendations for service provision. While obviously in an ideal world there would be no abuse, and efforts to prevent its occurrence continue to be of vital importance, it is also important to listen to the stories of women who have survived such experiences, in order to provide the most appropriate services.

In 2000, a small sample of 143 women who had reported experiencing abuse in the context of an adult relationship answered open-ended questions about their experiences. While that survey covered many topics, this report will focus on their responses in three main areas: how they coped, what advice they would give to other abused women, and what services they think would have helped.

How did you cope?

We used responses to two different questions to explore how women coped with the aftermath of abuse. The first question concerned ways of coping that they had personally found useful, and the second related to changes they had made to their priorities in life. Several different ways of coping with abuse were outlined, with an overall emphasis on self-empowerment, seeking support, and a determination to make life better for themselves.

<u>Inner strength</u>

Inner strength was a common theme for many women; they spoke of facing the challenges posed by abusive situations with determination and persistence:

> *Stay strong, and never accept it (the abuse) as a way of life.*
>
> *Obviously leaving the relationship and being determined not to let past experiences affect my life after leaving that relationship.*

Others told of confronting their emotions honestly: "*Have a good cry, talk to myself a lot and work*".

Women also described active measures they had taken to bolster the psychological resources they had available to them. Thus women spoke of working to rebuild their self-confidence through self-affirmation: "*Just keep telling myself that I am a good person*" or through new challenges*: "Work. Got a job this helped self esteem"*.

Others gained strength and healing from meditation, spiritual beliefs and a healthy lifestyle: "*Having faith in a higher power and an inner knowledge that I will be okay and not react to situations"*.

Some even viewed the abuse itself as a challenge leading to personal development: "*I have learnt to be more tolerant and not criticise as quickly as I did*".

Other respondents felt that their experiences had encouraged them to place more importance on empathy and sensitivity:

> *My life philosophies have altered – I now have great compassion for the underdog.*
>
> *I am sad for me that I had to experience it to become the person I have – but then on the other hand, would I have become that loving caring compassionate person that I am if I hadn't.*

Taking control and valuing what is personally important

The theme of inner strength carried over into changes women had made to their priorities in life. Many abused women spoke of valuing themselves, their own well-being and happiness more highly, of retaking control of their lives, and not accepting the status quo. For example:

> *I think it has made me a stronger person – not happy to accept things that are not ok. I am very happy with my life now and I think it makes me appreciate more the life I now lead and the happiness in my life.*
>
> *My priority is to look after my own well-being and to be not frightened or intimidated by a person or situation that I am not comfortable with.*
>
> *I have started to consider myself and my feelings. I used to put myself last. I am important and I deserve to be treated with respect.*

Women spoke of seeking independence; of living their own lives and doing what they needed to be happy and feel safe:

> *I now value my independence and prefer to spend more time alone. My aim in life is to find tranquillity and a serene environment*

At the same time, many were placing a new emphasis on the importance of positive relationships with loved ones:

> *The importance of spending as much time with people who love me and see me for who and what I am – my children, their partners, my granddaughter, loving them and laughing with them*

as well as enjoying life to the full:

> *A huge appreciation of life on a daily basis because I always wake up happy or enjoy my life.*
>
> *Value my life – accept help if and when you need it – know yourself, where you want to be and how you are going to get there. One step at a time. You can do anything if you really want to.*
>
> *Life's too short. Enjoy or try to – every minute… Stand up for yourself and believe in yourself.*

Speaking out and seeking support

Another common theme running through women's coping strategies was the issue of speaking out: being open about what had occurred, and seeking support if necessary. As one woman said, it helped to: "*Talk with friends, family, counsellors, bring it out in the open if possible*".

For some this involved formal services: "*Alanon and gamanon – people talking about how they coped*" while others spoke of the benefits of seeking out people who understood first hand: "*Talking to people in the same situations and giving each other support*". Several women believed that loved ones were the best people to turn to: "*Having a great long time friend who was always there to lend an ear*". For one woman, it was enough to express herself on paper: she wrote that she found it useful to keep a journal: "*Writing about it helps to clarify it. I don't have it all in my head"*.

Removing themselves from bad situations

In terms of more action-based coping strategies, there was a strong pattern of removing themselves from danger. Many women found the best way to cope with abusive situations was to leave them. For instance:

> *With the arguments – I found I could somehow shut that away from me, knowing it would end eventually. But when the pushing and shoving started I just grabbed the car keys and ran.*
>
> *Since there was no obvious "trigger" the only solution I had was to leave and while reflecting on the situation, I decided I am a worthy person, full of love – others like me – and I live my life responsibly.*

Distractions and new goals

A large number of women reported using a range of activities as distractions from their abusive situations. The most common were work and family activities, but other women involved themselves in hobbies, undertook further education, or joined sporting or community organizations. These activities served not only to distract them from the problems associated with the abuse, but in many cases removed them from potentially abusive situations:

When I was a younger person I had pets which helped and also I used to go to my room and paint or sketch. These days if I feel any pressure I tend to retreat or steer clear of people or situations which are intrusive or borderline abusive.

These outside interests also boosted abused women's inner strength, through self-improvement and the development of more extensive social networks, and by giving added meaning to their lives:

I went back to university to requalify for a teaching job

I got busy taking the children to sports meetings, sport training, took up sport myself and joined a badminton club and waited until I was ready to do something about my marriage.

I have joined clubs and community groups in order to make friends and to contribute to society.

In particular, prioritizing further education and a better career-path boosted women's confidence and gave them a greater sense of power and independence:

Yes, I am me. It has taken me a long while to realise that I am a worthwhile person. I have gone to TAFE and have got a diploma in intellectual disabilities. I have a good career now and am earning money. I support my husband who does not work. I am independent. I have learnt that everyone's life is important and matters. My priorities are that I need to be independent. I will never be anyone's doormat again.

Other "distracting" activities included taking time out, keeping busy, and having friends:

Women friends are the thing; and, actually, long-term male friends too. Being single for a long time I concentrated on maintaining friendships and it pays off.

Overall, women used a wide range of active strategies to cope. These included self-exploration and discovery, seeking help from others, and finding new challenges and meanings in life. The courage that these women showed in taking these steps is remarkable, but understanding the value of these strategies provides directions for the provision of support.

What advice would you give to others?

As women with insight into the victim's point of view and with the benefits of hindsight, the respondents were asked what advice they would give to other women who

experienced abuse. They were asked specifically for advice to women who remained in abusive situations; to those who were contemplating leaving; and to women who were recently independent of an abusive situation. However, there were also a wide range of suggestions, again showing a strong emphasis on self-empowerment, doing what is right for themselves, and the importance of support.

Abused women who remain

Almost half of the participants who responded to this question urged the women to leave:

> *Leave and don't blame yourself for being abused. Abusers have to blame someone for their actions so they always blame the one they abuse.*
>
> *Get out as soon as possible and don't go back.*

Many others advocated zero tolerance for abuse. Amongst the women who didn't advise necessarily leaving the abuser, most advised other constructive action. For instance, careful evaluation of the situation was suggested, as well as doing what is right for themselves:

> *Depending on the reasons for the above – become informed, talk about it with others who understand, through a support group. Do whatever feels right for you. Trust your gut feeling*.
>
> *Just try to make sure it's what you, not what other people want you to do*

Other respondents recommended thinking of ways to change the situation. One woman remarked, "*If it's alcohol-related – get the partner to help. It may work (if he has a lot of other good points). Work it out together. Write how you feel in a letter & give it to your partner when he is not abusive. Worked for me*".

Many women urged victims still in abusive situations to become strong within themselves. Some examples of their admonitions included:

> *Leave. Life is too short and there is so much more out there to enjoy. You must value yourself as a person and look after number 1 first.*
>
> *Become motivated, independent, financially secure, raise/hold self confidence and self esteem at all times*

Social support from professional and informal sources was also considered critical:

> *Get counselling assistance to get clearer about what is happening to them and the factors that are causing them to be in that situation, ie insight, clarity and determine options.*

Get out of it and get help immediately from others you trust and who believe it has happened.

Establish friendship outside the abusive situation. Attend groups/courses etc at community health centres, e.g. personal development, assertiveness, growth groups.

Similarly, a few women recommended developing outside interests as a way of developing a different perspective on the situation: "*Ask themselves if they are not worthy of better treatment. I would advise them to go out – join more creative groups – it gives you another perspective*"

There were also suggestions that a better life was waiting, "*Think deeply about the gift of life and ask yourself why you are throwing it away"* and that it was important that they not blame themselves, "*Remember it is not your fault, it's happening to you*".

Abused Women Contemplating Leaving

Again, the most frequently proffered suggestion was to leave the abusive situation. Responses ranged from, "*Go as fast as you can*", to, "*I know it can be hard, and that so many people stay because they are afraid of being alone, but do it. Leave*", to the more negative "*By this time no advice taken in. You are a complete screwball to stay*". Several respondents warned of the importance of evaluating the situation and planning ahead:

Find a safe place to move to. Take AVO if really necessary. Write a journal, spend time with nature, while still in the relation be very aware and don't push buttons and make it worse.

Try to be strong. Think about what is the best way to tackle it to protect you and your children from further harm. Get a job. Earn money to support you and your children.

Make sure you have a support set up – friends, family, money, place to live, plans for the future.

One woman recommended *not* leaving but getting the abuser to go: "*Stay put, have him kicked out, don't give up your home and possessions, you won't get them back. I've been told this by separated friends.*"

Once more, advice was given to seek support from formal and informal sources:

Get support to help you leave: friends, counselling, telephone helpline.

Have faith in yourself and your decision. Know that there is help 'out there' for you, and people who have been in your position, then moved on!

Participants were clear on the importance of feeling positive and strong. One woman declared: "*Make up your mind, remain steadfast and get moving*." Others indicated the value of being independent, while one respondent observed, "*Most people don't change unless they want to. No-one deserves to be abused*."

Women Recently Independent of Abusive Situations

Again, similar themes were evident in women's advice to those who had recently left an abusive situation: much of the advice centred around being strong and in control, taking care of themselves, and seeking the support that they need. For instance:

> *Remember you are a worthwhile person and now you can begin to take control.*
>
> *To meditate, feel deeply, breath love from the universe, get counselling, journal, spend time in nature, dance, eat well, love yourself first, forgive and grieve.*
>
> *Need love, lots of friends – give themselves lots of time – and do not rush into another relationship – grow up first!*

However, the fact of having taken action and left their abusers also stimulated words of approval, affirmation and reassurance. Typical comments included:

> *You have done the right thing and you can congratulate yourself because it would have been the first thing you have done for yourself in a long time.*
>
> *You have already shown that you have enormous courage and strength. This will be the start of a better and more fulfilling life for you. A year from now, you will be a different, happier person.*
>
> *Now is the beginning of the rest of your life. You deserve some happiness. Congratulations. You are a strong woman.*

On the other hand, there was concern that women who leave might return to the abusive situation. One woman urged, "*Even though you know you have to get out it can still be traumatic. Don't be talked into going back. Every time they try to get you back write a list of the reasons you left. You'll soon find out any temptation will go*". Women were also advised to create a new future and new directions in life for themselves: "*Look forward, not back. Learn from past experiences and don't let yourself dwell on it*", and to "*Seek, expect, and create positive situations in your life*".

Other suggestions included being careful of rushing in to new relationships, accepting challenges, enjoying life one day at a time, remaining busy, and being realistic:

Be careful of the pitfalls of reaching out for another relationship, for the sake of the comfort zone. Learn to live with yourself before branching out to share with another partner.

The adjustment period is difficult but having one's own life to value is most important.

Life goes on, you have to deal with it, don't sweep it under the carpet

The women's advice to others is of particular interest. Asking people what advice they would give others often provides a forum for them to describe what worked best for them, or what they wished they had been able to do themselves. The emphasis on leaving and not looking back, on seeking support and outside interests, and on seeking self-affirmation and inner strength is an indication of how important these are in women's positive survival of abuse.

What services would have helped?

We also took up the opportunity to gain an insight into current prevention and intervention policies and services, from the abused woman's point of view. Thus, the women who responded to the survey were asked whether they thought that there were any changes to government, charity or other support services that would be useful in the long term, to women who remain in abusive situations; to women were thinking of leaving the abusive relationship; and to women who had just left an abusive situation. The women provided a variety of recommendations, with an emphasis on counselling, community education and awareness campaigns, and providing the aid and protection to allow women to rebuild their lives.

<u>When Women Remain in Abusive Situations</u>

A number of respondents expressed a range of personal opinions not directly related to the question, such as, "*I have no respect for women who stay in an abusive situation*". Some others believed that no-one could help: "*If someone wants to remain in such a situation, I don't think anyone can really help*". While understandable coming from women who had themselves undergone the difficult journey of leaving an abusive situation, these are not particularly helpful in terms of developing appropriate services.

The strategy most frequently reported by the remaining participants was raising awareness, through educational programs, the media, and advertising campaigns:

Educate young women to recognise abuse and get out of abusive situations.

More media campaigns to encourage women to reach out for help and counselling to make the break from abuse.

> *More advertising about the help available. Advertising at places that women go (shops etc).*

Counselling services, community programs, and support services were also high on the women's agenda, although respondents were explicit that the services should be appropriate: "*Whatever system of services available. Must be offering confidentiality, safety and non-judgemental teaching programmes for the victim, and be willing to address legally the perpetrators of abuse*", and from one woman, "*…When I needed a mental health team, I found them more terrifying and useless than the disintegrative episode!!!*". Some women recommended more "safe house" accommodation, whilst others felt it was important to educate the abuser and change community attitudes. Examples of other suggestions included:

> *Make the courts and any legal system more protective towards the victim and harder on the abuser.*

> *Take the perpetrator away – don't expect the mother to leave the home.*

> *I feel that the support social security give women with children is great; but women on their own could do with more financial support.*

Some innovative ideas included formal monitoring of the situation and home visits, for example, "*Counselling with practitioners who go into the home and help rather than having to go somewhere*".

<u>When Women are Thinking of Leaving Abusive Situations</u>

Responses to this item demonstrated wide variability in women's perceptions. A number of respondents felt there were already sufficient support services and resources; others called for an increase in general support, while one woman questioned whether abused women have the psychological resources to seek help at all: "*The abused person (woman) would possibly have been aware (or made aware) of help services – but does one have the confidence, knowledge, understanding, and self-esteem to seek help?*"

Amongst women who outlined specific strategies for change, counselling assistance was a high priority, particularly if the help offered was supportive and regularly available. Again, there were warnings about potential problems with professional support:

> *Women in need of help don't need to be misunderstood by other women who lack empathy or don't accept the differentness of human beings. Textbook learning almost becomes a bizarre nightmare when you're desperate for help and you get textbook learning thrown at you. I am one woman who would never ask for help from a government or institution because of my experience.*

Many women believed there should be more information and more practical options, including alternative accommodation:

> *More refuges and support services – more safe houses. Support services that offer practical help – money, shelter, job if possible (if the person is not minding small children), help in relocating, better police protection.*
>
> *Give information on alternatives. Help them to look at the situation objectively.*

Women also remarked on the need for financial support, and for cost-free services, as many abused women seem unable to take anything with them when they leave and may have dependent children with them.

When Women have Left Abusive Situations

When discussing support for women who have left abusive situations, counselling was once again seen as important. There were also several suggestions for some form of mentoring, such as, "*Support from carers who have been in the same situation to help people to see a bright purposeful future*".

Other women emphasised practical assistance for daily living, such as legal aid, help with accommodation and employment, and financial assistance:

> *More help with childcare, accommodation, but most important, finding a job. Maybe even moving interstate to start again.*
>
> *There must be funding for on-going support and financial aid, also counselling. Phone calls and visits from supportive people. Training for independence.*
>
> *Follow through, encouragement, financial help if necessary. Moral support and training for employment if necessary.*
>
> *Governments need to remember that we are all one spirit and one family. If the children are happy, the nation will prosper and grow – give heaps more financial support and community homes to the growing number of single parent families – it is so hard for most of us to cope.*

Other women indicated the value of being informed: "*Debrief them (eg what happened here). Give information on what to do now. Inform them of what would happen next and plan their moves.*"

Participants also advocated that the government invoke specific policies for protection purposes, and for increased funding for support programs. As one woman explained, "*These women hopefully would be given the opportunity by the government to restart their lives, free from abuse and fear. And be given a chance at living a full and*

happy life by being heard and understood, and most of all, there should be some sort of policy for abused women".

These suggestions, with their emphasis on practical support and assistance to deal with the trauma and to develop a new life (through support with finances, employment, and further education) indicate a strong commitment among the women who responded to surviving and recovering from abuse. These women do not see themselves solely as victims, or as people who have been irreparably damaged by their experiences, but as women who intend to rebuild their lives and who deserve practical support while they do it.

Section 4: Conclusion

The information presented in this report confirms the seriousness of abuse as an issue in the lives of Australian women. The report documents the health and well-being of the 35% of middle-aged women who have experienced any form of abuse. By comparison with women who report no history of abuse, these women are disadvantaged in multiple domains.

These women experience significant health disadvantages. They are higher users of health services, and are more likely to have had a range of surgical procedures, receive a range of major physical and psychiatric diagnoses, and to be users of psychotropic medication. They also report a range of social disadvantages, and women in rural areas experience particular difficulties in seeking help.

Women's own voices are used to examine ways in which women have managed to overcome violent and abusive situations and regain their equilibrium. The women speak movingly of their own journeys and of using positive strategies to cope with abuse and with life after abuse. They stress the importance of taking control and recognizing their own values and desires, in order to build independence and positive relationships.

The women stress the importance of speaking out, telling their stories, and seeking support both from family and friends and from counselors and formal support systems. The majority stress the importance of removing themselves from the abusive situation, and finding new goals and challenges, including social activities, further education, paid employment and a career path.

Advice to others in similar situations was dominated by encouragement to leave the situation as quickly as possible, and to resist the temptation to return. Social support from professional and informal sources was also considered critical, and women stressed the importance of being prepared, knowing what resources were available, and knowing where to go. Participants were clear on the importance of feeling positive and strong. Once a woman had left, they advocated working on self-confidence and strength, while taking practical steps to start a new life.

Women also advised on what services would have been helpful to them. They women provided a variety of recommendations, with an emphasis on counselling, community education and awareness campaigns, and providing the aid, protection and practical support to allow women to rebuild their lives.

Raising awareness, through educational programs, the media, and advertising campaigns, was seen as vital. Counselling services, community programs, and support services were also high on the agenda, although respondents emphasized that these must be safe, confidential and practical. There was an emphasis on practical assistance, including more refuges and safe accommodation, greater levels of legal aid, financial support, assistance in education, job skills and job seeking, and practical help to re-establish their lives elsewhere.

Section 5: Publications and Presentations Relevant to Abuse Against Women

Young M, Byles J & Dobson A. The effectiveness of legal protection in the prevention of domestic violence in the lives of young Australian women. *Trends and Issues in Crime and Criminal Justice,* No. 148, March 2000. pp. 1-6. Canberra: Australian Institute of Criminology, 2000.

Domestic violence is a criminal issue of public concern. The first large national survey of women and violence found that 23 per cent of women who had ever been married, or lived in a defacto relationship, experienced violence by their partner and that 3 per cent of women currently in a relationship had experienced violence by their partner in the last 12 months (Australian Bureau of Statistics (ABS), 1996). International studies have shown that for young women, the risk of violence by a partner is 3-4 times higher than the risk for women overall (ABS 1996, Rodgers 1994, Mirrlees-Black 1995, Bachman and Saltzman 1995). The limited data on violence by boyfriends, a situation in which young women are likely to be disproportionately represented, show that injury by boyfriends is relatively high: 56 per cent of women assaulted by a boyfriend were injured in the last incidents, compared to 31 per cent of women assaulted by married or defacto partners (ABS 1996).

This report describes a large national study of young women who experienced physical violence by a partner. In particular, it examines the effectiveness of legal protection in preventing repeated violence and compares outcomes after legal intervention from the police or the courts, or both. It is an observational study of the "natural history" of partner violence against young women in the community, rather than an experiment to test intervention strategies to prevent recurring violence, or police responses, as in the mandatory arrest experiments in the USA. As such, it reports the outcomes for women who used strategies other than legal intervention, as well as those who sought legal intervention in response to violence.

Parker, G & Lee, C. Violence and Abuse: An assessment of mid-aged Australian women's experiences. *Australian Psychologist,* 2002; 37(2): 142-148.

Little systematic research has been conducted in Australia to develop a picture of women's experiences of violence and abuse across their lifetimes. The present study was designed to address this deficiency by assessing the prevalence of different types of abuse, the situations in which they occur, how women have coped, and the effect of abusive encounters on general health and wellbeing. Using self-report questionnaires, data were obtained from 1,159 women aged 48 to 53, previously recruited in the Women's Health Australia longitudinal project. Measures included descriptors of the abuse and help-seeking behaviours, and measures of general wellbeing and depression. The most frequently reported forms of abuse were emotional, physical and sexual. These overwhelmingly occurred in the home, and across all life stages, but mostly in adulthood, and most commonly on an occasional or weekly basis. Perpetrators were usually persons known to the victim. Most abusive

encounters were not recent but, when experienced, had persisted over time and had negatively affected mental and physical health. The majority of women had discussed their circumstances with close relatives, friends, or professional persons. One-third of respondents had reported abusive episodes to the police, and almost half of these had found it helpful to do so. The data show that abuse is a fact of life for many Australian women and demonstrate a continuing need for appropriate prevention and intervention strategies.

Parker G & Lee C. Predictors of physical and emotional health in a sample of abused Australian women. *Journal of Interpersonal Violence,* 2002; 17(9): 987-1001.

This study investigated the extent to which aspects of abuse and of help seeking were associated with physical and emotional health. A total of 1,168 women aged 48 to 53, identified from the mid-age cohort of the Women's Health Australia longitudinal project as having experienced abuse, completed self-report questionnaires. Descriptors of the abuse and of help seeking were used in an attempt to predict scores on the SF-36 physical and mental health summary measures, GHQ-12, and the CES-D depression scale. Although relationships were apparent in the data, all predictors together accounted for less than 25% of the variance in outcome measures, indicating that a history of abuse is only one aspect of a woman's life that impacts on her general well-being. Future investigations would benefit from a focus on personal coping characteristics that are predictive of positive outcomes in identifying strategies that help women survive abuse experiences.

Loxton D, Hussain R & Schofield M. Women's experiences of domestic abuse in rural and remote Australia. *Proceedings from the 7th National Rural Health Conference,* 1-4 March 2003, Hobart, Tasmania, Australia. Refereed Infront Outback paper.

OBJECTIVE: This qualitative interview study was conducted with the primary aim of elaborating on the impact of domestic abuse on health, and the psychosocial factors that had acted to improve or further damage health. For the purposes of this paper, issues that were raised by women that related to their place of residence were examined, and major themes that pertained to living in rural and remote regions were identified.

METHOD: Potential informants had indicated on previous WHA surveys that they had left a violent relationship, and that they were willing to participate in a telephone interview. Of the 38 women contacted, 26 completed interviews that were transcribed, and 17 of these women had lived in a rural or remote region for at least a proportion of the time that they were living in an abusive relationship.

RESULTS: This study found that women from rural and remote areas who experience domestic abuse tend to be isolated, and face an increased risk of being threatened with a firearm. Help seeking was inhibited by isolation, lack of knowledge of local services, distance to help providers, fears about confidentiality, social relationships between the perpetrator and the help providers, poor rapport with doctors who were not known, previous adverse responses, and a fear of not being believed. Help seeking was enhanced when help

providers could engender trust, which included assurances of confidentiality, a non-judgmental attitude, and being a 'stranger' to the area. No women in this study reported that their confidentiality was breached to the local community by a health worker. Where contact with the police and court system occurred, the community became aware of the abusive situation leaving women to contend with community gossip which they found distressing. Although the short-term consequences of leaving an abusive relationship were stressful, the long-term outcomes were more positive.

IMPLICATIONS: It is the recommendation of this paper that the feasibility of providing domestic abuse counselling services by people who do not live in the towns that they service be investigated.

Loxton D, Schofield M, Hussain R & Mishra G. History of domestic violence and physical health in mid-life: Women's Health Australia. Submitted to *British Journal of Health Psychology*.

OBJECTIVES: To examine the associations between domestic violence and physical symptoms and illnesses using a large representative sample of Australian mid-aged women.

DESIGN: Cross-sectional survey.

METHODS: Of the 28,000 women who were randomly selected from the general population, 14,100 women, aged 45-50 years, responded to health and lifestyle surveys as part of the first survey of the Australian Longitudinal Study on Women's Health.

RESULTS: In univariate analyses, physical symptoms and illnesses, menopause, health behaviours and demographic factors were associated with domestic violence. At the multivariate level, a number of physical health conditions (allergies/breathing problems, pain/fatigue, bowel problems, vaginal discharge, eyesight and hearing problems, low iron, asthma, bronchitis/emphysema, cervical cancer) were associated with a history of domestic violence after adjustment for demographic, health behaviour characteristics and menopause status.

CONCLUSIONS: The results highlight the importance of health professionals undertaking a full social history from women.

Loxton D, Schofield M & Hussain R. History of domestic violence and health service use among mid-aged Australian women. Submitted to *Australian & New Zealand Journal of Public Health*.

OBJECTIVES: To examine associations between history of domestic violence and health service use among mid-aged Australian women, adjusting for physical and psychological health status and demographic factors.

METHODS: Population-based cross-sectional postal survey (1996) of the Australian Longitudinal Study on Women's Health, known as Women's Health Australia. Of 28,000 women randomly selected, 14,100 (53.5%), aged 45-50 years participated. Participants adequately represented the population of Australian mid-aged women. Logistic regressions were used to assess associations between domestic violence and health service use.

RESULTS: After adjusting for demographic variables, multivariate analysis revealed associations between domestic violence and three or more consultations with a family doctor (OR = 2.07, 95% CI = 1.68, 2.55), hospital doctor (OR = 1.77, 95% CI = 1.44, 2.17), or specialist doctor (OR = 1.54, 95% CI = 1.35, 1.75), or being hospitalised (OR = 1.36, 95% CI = 1.20, 1.54). After adjusting for demographic variables and physical and psychological health status, these associations were attenuated: three or more consultations with family doctor (OR = 1.36, 95% CI = 1.09, 1.70), hospital doctor (OR = 1.16, 95% CI = 0.92, 1.45), or specialist doctor (OR = 1.14, 95% CI = 0.98, 1.32), and being hospitalised (OR = 1.10, 95% CI = 0.96, 1.26).

CONCLUSIONS: Physical and psychological health status accounted for the associations between domestic violence and higher health service use, with the exception of general practitioner consultations, which remained associated with domestic violence.

IMPLICATIONS: Physical health status only partially explains the increased health service use associated with domestic violence, while both physical and psychological health status explained higher usage of specialist and hospital services. It seems likely that women who have experienced domestic violence may be seeking consultations from family doctors for reasons additional to health status.

Loxton D, Schofield M & Hussain R. Psychological health in mid-life among women who have ever lived with a violent partner or spouse. Submitted to *Journal of Interpersonal Violence*.

This study examined the psychological health correlates of domestic violence in a large random sample of mid-aged Australian women (N = 11 310; 47-52 years). Logistic regression analyses were used to investigate the associations between a history of domestic violence and past, recent and current depression, anxiety, and psychological wellbeing, after adjusting for demographic variables (marital status, income management, area of residence). Results indicated that ever having experienced a diagnosis of depression, anxiety, or an 'other' psychiatric disorder; recent symptoms of depression and anxiety; the use of psychoactive medication for depression or anxiety in the four weeks prior to the survey; and current depression were related to increased odds of having experienced domestic violence. In addition, current psychological wellbeing had an inverse association with a history of domestic violence: as psychological wellbeing decreased, the odds of having ever experienced domestic violence increased. Taken together the results indicted that a history of domestic violence is associated with decreased psychological wellbeing in mid-aged Australian women.

Taft A, Watson L & Lee C. Violence against young Australian women and associated reproductive health outcomes: A cross sectional analysis. Submitted to *Medical Journal of Australia.*

OBJECTIVE: This study aimed to investigate the associations between violence and younger women's reproductive health using the Survey 1 (1996) data of the Younger cohort of the Australian Longitudinal Study of Women's Health (ALSWH).

METHODS: Multinomial regression, using composite variables for both violence and reproductive outcomes, adjusting for socio-economic variables and weighted for RRMA.

RESULTS: 24% of 14,784 women aged 18 to 23 years reported any violence. 12.6% reported non-partner violence in the previous year. Of the 11.2% who reported ever having had a violent relationship with a partner, 43% (4.8% overall) also reported violence in the past year. Compared with women reporting no violence, women with recent non-partner violence (rrr=1.36, $p<0.001$); ever partner violence (rrr=2.55, $p<0.001$) or partner and recent violence (rrr=3.96, $p<0.001$) were significantly more likely to have had one or more pregnancies. Of those women who had a pregnancy (2561), having had a miscarriage or termination was associated with all categories of violence. Recent non-partner violence was associated with an increased rate of one or more miscarriages (rrr=2.00, $p<0.001$), terminations (rrr=2.44, $p<0.001$) or both (rrr=3.31, $p=0.01$), compared with women who have had a live birth and no losses. Stronger associations existed for women reporting partner and recent violence, for miscarriage; whether alone (rrr=2.85, $p<0.001$); with termination (rrr=4.60, $p<0.001$); or with both birth and termination (rrr=4.12, $p<0.001$).

CONCLUSIONS AND IMPLICATIONS: Violence among young women of childbearing age is a factor for which doctors need to be vigilant, well-trained and supported to identify and manage effectively.

Parker G & Lee C. Relationships among abuse characteristics, ways of coping, and abused women's psychological health: A path model. Submitted to *Health Psychology*.

This study examined the relationships among characteristics of abuse experience, ways of coping, and psychological health, for 143 women who had experienced abuse in adult relationships. Measures included the Revised Ways of Coping Checklist, Antonovsky's Sense of Coherence scale, the SF-36 Mental Component Scale, the General Health Questionnaire, Center for Epidemiological Studies Depression scale, and a measure of perceived negative effects of the abuse. In the final summary path model, characteristics of abuse experience explained less than 12 per cent of the variance ion coping measures, problem-focused coping was not related to psychological health, the influence of emotion-focused coping on psychological health was indirect only, and sense of coherence emerged as the only coping measure to have significant direct effects on current emotional health. The ability to cope with abuse appears to be more closely related to attitudinal dispositions than to contextual factors or behavioural management strategies.

Section 6: Completed PhD theses on Abuse against Women

Glennys Parker (PhD, University of Newcastle, supervised by C. Lee. Degree awarded 2004): **Abused Mid-Aged women in Australia: Experiences, Emotional Well-being, and ways of Coping.**

Abstract

This thesis examines the relationship between characteristics of abuse, coping, and emotional well-being among women from the Australian population. Using data from the mid-aged cohort (N = 12339) of the Australian Longitudinal Study of Women's Health, abused women (n = 4268) were identified as an at-risk group for a number of adverse health, behavioural, and social problems. One hundred and forty-three women, who had earlier participated in a targeted survey on their experiences of abuse, completed a second questionnaire that drew on both quantitative and qualitative methods to investigate the strategies used to cope with abuse in adult relationships. This survey included the Revised Ways of Coping Checklist and the Antonovsky Sense of Coherence scale. Multivariate analysis of variance showed that problem-focused coping at the time of the abuse was not related to current emotional health, while emotion-focused coping was related to poor emotional health, and a high sense of coherence was related to better emotional health. Using data from this and the earlier abuse surveys, analysis of covariance indicated that the effect of emotion-focused coping on emotional health was indirect, through its inverse relationship with sense of coherence. In the final summary path model, sense of coherence emerged as the only coping measure to have significant direct effects on current emotional health. Greater use of emotion-focused coping was associated with frequent abuse, with the number of abusers, with talking about the abuse to a medical practitioner, with emotional abuse, with returning to an abusive partner, with feeling a bond with other abused women, with feeling vulnerable to further abuse, and with viewing oneself as a victim, and not with talking about the abuse to family or friends. After controlling for emotion-focused coping, a high sense of coherence was positively related to disclosure of the abuse to family and friends, but inversely associated with abuse from strangers, with frequent abuse, with recent abuse, with talking about the abuse to a psychiatrist, with talking about the abuse to a social worker, with talking about the abuse to a financial advisor, with feeling vulnerable to further abuse, and with viewing oneself as a victim. However, characteristics of abuse experience explained less than 29 per cent of the variance on coping measures. Qualitative analysis of women's own descriptions of useful ways of coping generally identified self-determination and self-affirmation, distancing and distraction tactics, and open disclosure of the abuse. The thesis concludes that coping is more usefully viewed as a personal resource than as a strategy, and its efficacy in situations of abuse will be determined by each woman's perception of the situation, by the degree of challenge to comprehensibility, manageability, and meaningfulness, and by the extent of individual resolve for change.

Deb Loxton (PhD, University of New England, supervised by M. Schofield, R. Hussain & V. Minichiello. Degree awarded 2003): **Domestic abuse and health: Quantitative and qualitative investigations among mid-aged Australian women.**

Abstract

This thesis aimed to examine the relationships between a history of domestic violence and women's health service use, and physical and psychological health in mid-life; to determine factors that mediate the relationship between domestic violence and mid-life health; and to elaborate on these quantitative findings with information from qualitative interviews.

Multiple regression analyses were conducted using data from the mid-aged sample of the Australian Longitudinal Study on Women's Health (also known as Women's Health Australia; WHA). WHA collects self-report data on over 200 health and related variables by mailed surveys every 2 years. The WHA sample was randomly selected from the national Medicare database, and adequately represents the population of Australian mid-aged women. The analyses used data from Survey 1 (1996; N = 14,100; 45-50 years) for health service use, physical health, and mediation analyses, and Survey 2 (1998; N = 11,648; 47-52 years) for psychological health analyses. Qualitative telephone interviews were conducted with a subset of the mid-age sample (2001; N = 26; 50-55 years).

Associations were found between domestic violence and increased health service use; decreased physical health, physical symptoms, and diagnosed illnesses; and diagnoses of psychological disorders and symptoms, and psychoactive medication use. The relationship between domestic violence and physical health was partially mediated by stress, life events, education, income management, and smoking; and the relationship between domestic violence and psychological health was mediated by stress, life events, and social support. In-depth qualitative interviews indicated that domestic abuse affected women's ability to seek health services; directly and adversely affected their physical and psychological health in the short- and long-term; and that mediating factors occurred subsequent to domestic abuse, and adversely effected health. Additional factors (eg. coping strategies) may also mediate the relationship between domestic abuse and health.

This thesis concludes that domestic abuse leads to an increased need for health services; that domestic abuse has direct adverse and long-term consequences for physical and psychological health. Furthermore, domestic abuse affects lifestyle, and causes coping responses that influence physical and psychological health. The thesis findings have implications for future research, practice, and public education.

Appendices

Appendix 1.

Comparison of abused and non-abused women in the ALSWH mid-aged cohort on measures of health-related practices, socio-economic factors, and ethnicity.

Item number[1]	Variable		Missing Cases %	Abused % (*n* = 4268)	Not Abused % (*n* = 7206)	χ^2
M2Q12a	Family doctor/GP	none		8.0	10.2	
		1-2		33.5	41.9	
		3-4		26.0	26.2	
		5-6		15.2	12.0	
		≥7		17.4	9.7	
			6.3			205.26***
M2Q12b	Hospital outpatient clinic/casualty	none		80.6	87.4	
		≥1		19.4	12.6	
			8.5			95.41***
M2Q12c	Specialist doctor	none		56.3	62.0	
		≥1		43.7	38.0	
			8.2			34.92***
M2Q12d	Dentist	none		45.1	42.1	
		≥1		54.9	57.9	
			7.4			9.69**
M2Q12e	Allied health professional	none		46.7	51.8	
		≥1		53.3	48.2	
			6.6			27.71***
M2Q12f	"Alternative" health practitioner	none		67.6	72.7	
		≥1		32.4	27.3	
			6.4			32.61***
M2Q12g	Family planning, women's health centres	none		89.1	92.1	
		≥1		10.9	7.9	
			6.3			30.59***
M2Q20a	Insulin dependent diabetes (Type 1)	never		99.3	99.3	
		yes		.7	.7	
			0			.05

Item number[1]	Variable		Missing Cases %	Abused % (*n* = 4268)	Not Abused % (*n* = 7206)	χ^2
M2Q20b	Non-insulin dependent diabetes (Type 2)	never yes	0	97.1 2.9	97.7 2.3	4.25*
M2Q20c	Heart disease	never yes	0	96.7 3.3	98.4 1.6	35.02***
M2Q20d	Hypertension	never yes	0	79.6 20.4	82.2 17.8	11.77**
M2Q20e	Stroke	never yes	0	98.7 1.3	99.4 .6	17.67***
M2Q20f	Thrombosis	never yes	0	95.4 4.6	96.8 3.2	13.64**
M2Q20g	Low iron level	never yes	0	72.4 27.6	80.4 19.6	98.08***
M2Q20h	Asthma	never yes	0	82.0 18.0	88.9 11.1	109.03***
M2Q20i	Bronchitis/ emphysema	never yes	0	84.9 15.1	90.8 9.2	92.17***
M2Q20j	Osteoporosis	never yes	0	95.5 4.5	97.3 2.7	27.71***
M2Q20k	Breast cancer	never yes	0	97.7 2.3	97.7 2.3	.03
M2Q20l	Cervical cancer	never yes	0	96.6 3.4	98.0 2.0	20.12***
M2Q20m	Bowel cancer	never		99.6	99.7	

Item number[1]	Variable		Missing Cases %	Abused % (n = 4268)	Not Abused % (n = 7206)	χ^2
		yes		.4	.3	
			0			1.17
M2Q20n	Skin cancer	never		89.2	90.8	
		yes		10.8	9.2	
			0			7.65**
M2Q20o	Other cancer	never		97.5	98.7	
		yes		2.5	1.3	
			0			21.16***
M2Q20p	Depression	never		72.0	88.9	
		yes		28.0	11.1	
			0			534.00***
M2Q20q	Anxiety	never		78.8	91.2	
		yes		21.2	8.8	
			0			354.12***
M2Q20r	Other psychiatric disorder	never		97.0	99.4	
		yes		3.0	.6	
			0			106.18***
M2Q21a	Hysterectomy	never		70.4	78.3	
		yes		29.6	21.7	
			0			89.80***
M2Q21b	Both ovaries removed	never		91.3	94.0	
		yes		8.7	6.0	
			0			32.04***
M2Q21c	Prolapse repair	never		88.5	92.5	
		yes		11.5	7.5	
			0			54.60***
M2Q21d	Endometrial ablation	never		93.4	95.4	
		yes		6.6	4.6	
			0			21.66***
M2Q21e	Tubal ligation	never		59.9	63.8	
		yes		40.1	36.2	
			0			17.38***

Item number[1]	Variable		Missing Cases %	Abused % (*n* = 4268)	Not Abused % (*n* = 7206)	χ^2
M2Q21f	Mastectomy	never		98.3	98.6	
		yes		1.7	1.4	
			0			1.25
M2Q21g	Lumpectomy	never		89.7	90.9	
		yes		10.3	9.1	
			0			4.21*
M2Q21h	Breast biopsy	never		89.6	90.0	
		yes		10.4	10.0	
			0			.53
M2Q21i	Cholecystectomy	never		90.9	93.0	
		yes		9.1	7.0	
			0			16.23***
M2Q21j	Cosmetic surgery	never		92.4	95.3	
		yes		7.6	4.7	
			0			41.39***
M2Q21k	Gastroscopy/ colonoscopy	never		77.8	83.9	
		yes		22.2	16.1	
			0			66.59***
M2Q23a	Nerves (e.g. Valium, Serapax)	no		93.0	97.1	
		yes		7.0	2.9	
			9.1			97.87***
M2Q23b	Sleep (e.g. Normison, Mogadon)	no		88.7	94.0	
		yes		11.3	6.0	
			9.2			99.79***
M2Q23c	Depression (e.g. Prozac, Aropax)	no		90.0	96.2	
		yes		10.0	3.8	
			9.5			173.36***
M2Q34/ 35	Smoking	never smoked		47.0	61.5	
		used to smoke		30.1	24.8	
		smokes		22.9	13.7	
			6.4			259.75***
M2Q39/	Alcohol	never		11.8	14.1	

Item number[1]	Variable		Missing Cases %	Abused % (*n* = 4268)	Not Abused % (*n* = 7206)	χ^2
40	consumption	rarely		30.7	27.4	
		light		49.0	52.6	
		moderate/heavy		8.4	5.9	
			6.5			51.64***
M2Q42/ 43	Body Mass Index (BMI)	underweight		5.9	6.4	
		healthy		41.1	43.4	
		overweight		30.5	31.0	
		obese		22.5	19.2	
			7.1			17.59**
M2Q51/ 53	Exercise	inactive		20.2	17.2	
		low active		29.0	32.9	
		moderately active		20.4	20.9	
		high active		30.4	28.9	
			10.6			27.31***
M1Q90	Educational qualifications					
	no formal qualifications			18.7	15.6	
	school/intermediate certificate			29.6	33.2	
	high school/leaving certificate			15.2	17.8	
	trade, certificate, diploma			21.2	19.3	
	undergraduate/higher degree			15.2	14.1	
			.9			43.61***
M2Q54	Occupational status					
	not working			35.5	35.7	
	working			64.5	64.3	
			2.2			.04
M2Q87	Marital status					
	married, de facto			72.3	89.0	
	separated, divorced			21.2	6.0	
	widowed, single			6.4	5.0	
			.6			626.51***
M1Q91	Aboriginal or Torres Strait Islander	no		99.1	99.4	
		yes		.9	.6	
			.6			3.96*
M1Q92	Country of birth					
	Australia			76.8	77.0	
	other ESB			15.3	12.8	
	NESB Europe			5.8	6.3	
	Asia			1.2	3.0	

Item number[1]	Variable	Missing Cases %	Abused % (*n* = 4268)	Not Abused % (*n* = 7206)	χ^2
	Other	1.2	.8	1.0	48.63***

**p<.05, **p<.01, ***p<.001.*

[1] Item numbers refer to the survey (M1 = 1996 ALSWH survey 1 for mid-age women, M2 = 1998 ALSWH survey 2 for mid-age women) and question number from which the data were derived.

Appendix 2.

Comparison of abused and non-abused Mid-Age women on Medicare unit record data, 1998.

Note: Analysis limited to consenters who answered M2q73a (n=8244)

Use of General Practitioner services during 1998

grouped gp attendances 1998	experience abuse ever?		
	No, never	Yes	Total
0-2 gp attendances	1948 37.88	890 28.70	2838
3-6 gp attendances	2083 40.50	1224 39.47	3307
7-12 gp attendances	854 16.61	680 21.93	1534
>12 gp attendances	258 5.02	307 9.90	565
Total	5143	3101	8244

Chi-Square (3df) = 144.6118, p<.0001

Conclusion: Significantly higher use of GPs by women who have experienced abuse.

Analyses of "Frequent attenders" to General Practice (defined as the top 5% of users in a year for a specific age group)

frequent attender to GPs (top 5%)	experience abuse ever		
	No, never	Yes	Total
No	4940 96.05	2837 91.49	7777
Yes	203 3.95	264 8.51	467
Total	5143	3101	8244

Chi-Square (1df) = 75.4832, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse are frequent attenders to General Practice.

Proportion of women who have visited a Psychiatrist during 1998

visited a psychiatrist in 1998	experience abuse ever		
	No, never	Yes	Total
No	5102 99.20	3011 97.10	8113
Yes	41 0.80	90 2.90	131
Total	5143	3101	8244

Chi-Square (1df) = 54.8207, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse visited a psychiatrist in 1998.

Proportion of women who have visited a specialist (other than a psychiatrist) during 1998

visited other specialist in 1998	experience abuse ever		
Frequency Col Pct	No, never	Yes	Total
No	3250 63.19	1885 60.79	5135
Yes	1893 36.81	1216 39.21	3109
Total	5143	3101	8244

Chi-Square (4df) = 4.7668, p=0.0290

Conclusion: No significant difference between women who did and did not experience abuse in visits to a specialist in 1998.

Proportion of women in each quintile of amount spent by Medicare for services out of hospital during 1998

quintiles of amount spent by Medicare	experience abuse ever		
	No, never	Yes	Total
lowest quintile	1133 22.03	517 16.67	1650
second quintile	1081 21.02	567 18.28	1648
third quintile	1046 20.34	604 19.48	1650
fourth quintile	987 19.19	661 21.32	1648
highest quintile	896 17.42	752 24.25	1648
Total	5143	3101	8244

Chi-Square (4df) = 85.1923, p<.0001

Conclusion: Significantly higher amount spent by Medicare for services out of hospital for women who had experienced abuse.

Proportion of women in each quintile of out of pocket expense for services out of hospital during 1998

quintiles of out of pocket cost	experience abuse ever		
	No, never	Yes	Total
lowest quintile (no cost)	1243 24.17	771 24.86	2014
second quintile	839 16.31	447 14.41	1286
third quintile	1029 20.01	619 19.96	1648
fourth quintile	1022 19.87	626 20.19	1648
highest quintile	1010 19.64	638 20.57	1648
Total	5143	3101	8244

Chi-Square (4df) = 5.7982, p=0.2147

Conclusion: No significant difference in out of pocket costs for women who had and had not experienced abuse.

Comparison of abused and non-abused Mid-Age women on Medicare unit record data, 1999

Note: Analysis limited to consenters who answered M2q73a (n=8244)

Use of General Practitioner services during 1999

grouped gp attendances 1999	experience abuse ever?		
	No, never	Yes	Total
0-2 gp attendances	1882 36.59	860 27.73	2742
3-6 gp attendances	2115 41.12	1234 39.79	3349
7-12 gp attendances	873 16.97	707 22.80	1580
>12 gp attendances	273 5.31	300 9.67	573
Total	5143	3101	8244

Chi-Square (3df) = 133.8080, p<.0001

Conclusion: Significantly higher use of GPs by women who have experienced abuse.

Analyses of "Frequent attenders" to General Practice (defined as the top 5% of users in a year for a specific age group)

frequent attender to GPs (top 5%)	experience abuse ever		
	No, never	Yes	Total
No	4927 95.80	2853 92.00	7780
Yes	216 4.20	248 8.00	464
Total	5143	3101	8244

Chi-Square (1df) = 52.5246, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse are frequent attenders to General Practice.

Proportion of women who have visited a Psychiatrist during 1999

visited a psychiatrist in 1999	experience abuse ever		
	No, never	Yes	Total
No	5102 99.20	3013 97.16	8115
Yes	41 0.80	88 2.84	129
Total	5143	3101	8244

Chi-Square (1df) = 52.2988, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse visited a psychiatrist in 1999.

Proportion of women who have visited a specialist (other than a psychiatrist) during 1999

visited other specialist in 1999	experience abuse ever		
Frequency **Col Pct**	No, never	Yes	Total
No	3282 63.81	1919 61.88	5201
Yes	1861 36.19	1182 38.12	3043
Total	5143	3101	8244

Chi-Square (4df) = 3.0997, p=0. 0.0783

Conclusion: No significant difference between women who did and did not experience abuse in visits to a specialist in 1999.

Proportion of women in each quintile of amount spent by Medicare for services out of hospital during 1999

quintiles of amount spent by Medicare	experience abuse ever		
	No, never	Yes	Total
lowest quintile	1119 21.76	530 17.09	1649
second quintile	1070 20.80	580 18.70	1650
third quintile	1047 20.36	601 19.38	1648
fourth quintile	1009 19.62	639 20.61	1648
highest quintile	898 17.46	751 24.22	1649
Total	5143	3101	8244

Chi-Square (4df) = 71.3582, p<.0001

Conclusion: Significantly higher amount spent by Medicare for services out of hospital for women who had experienced abuse.

Proportion of women in each quintile of out of pocket expense for services out of hospital during 1999

quintiles of out of pocket cost	experience abuse ever		
	No, never	Yes	Total
lowest quintile (no cost)	1257 24.44	801 25.83	2058
second quintile	765 14.87	475 15.32	1240
third quintile	1052 20.45	597 19.25	1649
fourth quintile	1037 20.16	614 19.80	1651
highest quintile	1032 20.07	614 19.80	1646
Total	5143	3101	8244

Chi-Square (4df) = 3.3445, p= 0.5019

Conclusion: No significant difference in out of pocket costs for women who had and had not experienced abuse.

Comparison of abused and non-abused Mid-Age women on Medicare unit record data, 2000

Note: Analysis limited to consenters who answered M2q73a (n=8199)

Use of General Practitioner services during 2000

grouped gp attendances 2000	experience abuse ever?		
	No, never	Yes	Total
0-2 gp attendances	1797 35.13	865 28.05	2662
3-6 gp attendances	2113 41.31	1183 38.36	3296
7-12 gp attendances	933 18.24	721 23.38	1654
>12 gp attendances	272 5.32	315 10.21	587
Total	5115	3084	8199

Chi-Square (3df) = 123.5103, p<.0001

Conclusion: Significantly higher use of GPs by women who have experienced abuse.

Analyses of "Frequent attenders" to General Practice (defined as the top 5% of users in a year for a specific age group)

frequent attender to GPs (top 5%)	experience abuse ever		
	No, never	Yes	Total
No	4930 96.38	2859 92.70	7789
Yes	185 3.62	225 7.30	410
Total	5115	3084	8199

Chi-Square (1df) = 54.8142, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse are frequent attenders to General Practice.

Proportion of women who have visited a Psychiatrist during 2000

visited a psychiatrist in 2000	experience abuse ever		
	No, never	Yes	Total
No	5072 99.16	2989 96.92	8061
Yes	43 0.84	95 3.08	138
Total	5115	3084	8199

Chi-Square (1df) = 58.3246, p<.0001

Conclusion: Significantly higher proportion of women who experienced abuse visited a psychiatrist in 2000.

Proportion of women who have visited a specialist (other than a psychiatrist) during 2000

visited other specialist in 2000	experience abuse ever		
Frequency **Col Pct**	No, never	Yes	Total
No	3225 63.05	1874 60.77	5099
Yes	1890 36.95	1210 39.23	3100
Total	5115	3084	8199

Chi-Square (4df) = 4.2707, p=0. 0.0388

Conclusion: No significant difference between women who did and did not experience abuse in visits to a specialist in 2000.

Proportion of women in each quintile of amount spent by Medicare for services out of hospital during 2000

quintiles of amount spent by Medicare	experience abuse ever		
	No, never	Yes	Total
lowest quintile	1078 21.08	569 18.45	1647
second quintile	1104 21.58	529 17.15	1633
third quintile	1045 20.43	595 19.29	1640
fourth quintile	977 19.10	663 21.50	1640
highest quintile	911 17.81	728 23.61	1639
Total	5115	3084	8199

Chi-Square (4df) = 64.6595, p<.0001

Conclusion: Significantly higher amount spent by Medicare for services out of hospital for women who had experienced abuse.

Proportion of women in each quintile of out of pocket expense for services out of hospital during 2000

quintiles of out of pocket cost	experience abuse ever		
	No, never	Yes	Total
lowest quintile (no cost)	1220 23.85	751 24.35	1971
second quintile	805 15.74	506 16.41	1311
third quintile	1070 20.92	568 18.42	1638
fourth quintile	1018 19.90	622 20.17	1640
highest quintile	1002 19.59	637 20.65	1639
Total	5115	3084	8199

Chi-Square (4df) = 7.9250, p=0.0944

Conclusion: No significant difference in out of pocket costs for women who had and had not experienced abuse.