Prevalence and associations of partner abuse in women attending Russian general practice

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Background. Although a solid body of international general practice studies focuses on epidemiological issues of partner abuse against women, there is no research in Russian primary care targeting its cultural diversity to provide sufficient evidence for health care intervention towards this important public health issue.

Objectives. To measure lifetime and 1-year prevalence of partner abuse among women attending Russian general practice, to test for associations between lifetime partner abuse and socio-demographic factors and to assess the acceptability to women of GPs asking about partner abuse.

Methods. Cross-sectional self-administered questionnaire survey in 24 general practices in St Petersburg. Russian Composite Abuse Scale was administered to consecutive woman patients. Prevalence was reported as proportions and logistic regression was used to test associations.

Results. One thousand two hundred and thirty-two respondents (age range 16–70 years); 70% response. Lifetime prevalence of partner abuse was 37.1% [95% confidence interval (CI) = 34.4–40.0%] and 1-year prevalence was 7.2% (95% CI = 4.6–11.2%). The multivariate analysis showed that cohabiting women were 1.9 (95% CI = 1.3–2.8) times more likely and divorced women were 2.3 (95% CI = 1.1–4.8) times more likely to be abused than married respondents. Only 34.7% (95% CI = 31.5–38.0%) of women would agree to GPs asking about partner abuse.

Conclusions. The high prevalence of partner abuse is consistent with international findings in general practice-based studies. The predominantly negative attitude of women towards being asked about abuse is a challenge to future domestic violence interventions in Russian practices.

Keywords. Domestic violence, general practice, primary care.

Introduction

The prevalence of partner abuse varies internationally. The World Health Organization multi-country study reported a lifetime prevalence of physical and sexual partner abuse ranging between 15% and 71%, with 4–54% respondents disclosing partner abuse in the past year.\textsuperscript{1} In two Russian population studies, the prevalence of lifetime physical partner abuse among married women was 25%, increasing to 33% among divorced women.\textsuperscript{2,3} A population survey among 18- to 44-year-old women in St Petersburg estimated an 8% 1-year prevalence of physical abuse and 2% 1-year prevalence of sexual abuse.\textsuperscript{4} Partner abuse causes significant morbidity and disability among women with the biggest impact on their mental and reproductive health,\textsuperscript{1,5–8} resulting in high utilization of primary care.\textsuperscript{9} Cross-sectional surveys in Australian, USA, UK, Ireland and Canadian general practice have reported a lifetime prevalence of partner abuse between 23% and 55% of women. The 1-year prevalence varied from 15% to 20%.\textsuperscript{10–14} Most prevalence studies in clinical populations also have tested associations between partner abuse and a range of socio-demographic factors. Younger age, separated or divorced status, earlier school leaving age and lower income are often associated with partner abuse.\textsuperscript{10,12,13} Other characteristics, such as pregnancy, children and ethnicity, are less constantly associated.\textsuperscript{14,15}

Three cross-sectional surveys conducted in USA, UK and Italian general practice estimated that between 68% and 85% of women patients thought that routine screening for partner abuse was acceptable. The views of abused and non-abused women were similar.\textsuperscript{14,16,17} Currently, there is insufficient evidence
to implement a screening programme for partner abuse against women either in health services generally or in specific clinical settings, with the possible exception of antenatal care and mental health services. 18

In Russia, part of primary care for adults is provided through polyclinics by GPs serving geographically defined population of 1200–1500. 19 There are no studies in Russian primary care settings measuring prevalence of, associations with and acceptability of being asked by clinicians about partner abuse. There is no validated Russian tool to measure prevalence of partner abuse in clinical population.

The present study aimed (i) to develop a Russian version of the Composite Abuse Scale (CAS) 20 to measure the lifetime and 1-year prevalence of partner abuse among women patients of GPs, (ii) to determine associations between lifetime partner abuse and socio-demographic factors and (iii) to assess the acceptability to women of being asked about partner abuse by GPs.

Methods

Development of a Russian language CAS

We used a forward–backwards translation method to develop the Russian version of the CAS. 20 The initial translation was done by NL and was then discussed in a group comprising of NL, a psychologist, a GP and a patient. Discussion in this group resulted in a small changes in wording. The revised version was then translated back into English by a bilingual colleague. This back translation had no substantive differences from the original CAS and therefore the Russian (CAS-R) version needed no further changes. To test the test–retest reliability and internal consistency of the CAS-R, we conducted a survey of 32 female residents in the Department of Family Medicine, St Petersburg Medical Academy of Postgraduate Studies. Respondents completed the questionnaires twice in 2 weeks and responses were matched and compared for test–retest reliability.

Like the original English language scale, the CAS-R consisted of 30 items measuring four dimensions of abuse: severe combined (8 items), physical (7 items), emotional (11 items) and harassment (4 items). Respondents were asked to circle the frequency of the each item on a six-point Likert scale from ‘never’ to ‘daily’ in a 12-month period. A woman was defined as abused if her total CAS-R score was equal or more than the previously obtained cut-off score of 7 derived from an Australian general practice population. 20

Participants and methods

We conducted a multi-centred cross-sectional survey in St Petersburg from April to November 2007. We randomly sampled 25 of 46 general practices, located in 12 of 18 city administrative districts. Two research postgraduates worked in parallel in waiting rooms invited consecutive woman who attended the practices to complete the questionnaire. They worked for 3–5 days at each practice recruiting patients from 9.00 to 19.00 hours. Inclusion criteria: women patients, aged 15–70 years, attending the practice and able to self-complete a questionnaire. Exclusion criteria: health condition precluding completion of questionnaire, accompanied by a man or a child >3 years. The survey included demographic questions (age, education, employment, marital and economic status, pregnancy status and number of children) and the CAS-R. The survey concluded with three questions about patients’ attitudes to being asked about partner abuse by their GPs, including being asked about abuse when presenting in a practice with an unrelated problem, a form of screening.

Ethical approval of this study was given by the St Petersburg Medical Academy of Postgraduate Studies Ethic Committee.

Statistical methods

All analysis was performed with Stata (version 10). Internal consistency of the CAS-R was assessed with Cronbach’s alpha; its test–retest reliability was analysed with the Spearman’s rank correlation coefficient. The data were analysed for potential clustering by practice through calculation of the intraclass correlation coefficient for the main outcome (lifetime prevalence of partner abuse). Descriptive statistics (proportions and mean) were used to characterize the sample. To measure the lifetime prevalence of partner abuse, we calculated the proportion of women with the total CAS-R score equal or more than the cut-off score of 7 in women who have ever been in an adult intimate relationship. To estimate the 1-year prevalence of partner abuse, we calculated the proportion of abused women, who experienced abuse in the last 12 months in a subsample of respondents with a current partner. We then used the cut-off scores for each of the CAS-R subscales to calculate the prevalence of severe combined, physical, emotional abuse and harassment. 20

We used logistic regression to estimate the independent associations between lifetime partner abuse and the socio-demographic characteristics of the respondents. The main outcome (dependent variable) was lifetime partner abuse among woman patients of GPs. All socio-demographic characteristics were treated as exposure (independent) variables. The association of lifetime abuse with each socio-demographic variable was first analysed univariably and those factors that were associated at ≥20% level were used in the multivariable model to calculate odds ratio and 95% confidence intervals (CIs). Fifty-six (4.7%) respondents.
with missing data were excluded from the univariable and 18 (1.5%) from the multivariable analyses.

To examine the acceptability of asking about and screening for partner abuse, we calculated proportions of positive, negative and uncertain responses. We compared proportions of positive responses reported by abused and non-abused women with 95% CIs.

Results

Composite Abuse Scale-Russia

Test–retest reliability of the CAS-R was good (Spearman’s rank correlation coefficient 0.93) with high internal consistency for the four subscales (Cronbach’s alpha ≥ 0.8). The mean score of total abuse scale was 5.2 (SD = 12.0), of severe combined abuse subscale 0.6 (SD = 2.1), of physical abuse subscale 1.0 (SD = 3.8), of emotional abuse subscale 2.4 (SD = 5.4) and of harassment subscale 0.9 (SD = 1.9).

Participants

Twenty-four of 25 randomly selected practices took part in the study. One thousand and forty-two participants were invited to participate at the survey. One thousand and forty-five eligible women consented to participate, of whom 1232 provided completed data. Between 44 and 61 consecutive patients were recruited in each practice. Illustration 1 shows the flow of participants. Participant response rate was 70% (range 52–84% between practices). We excluded 31 respondents from the analysis because they had never been in an adult intimate relationship (Figure 1).

Respondents had a mean age of 43.6 years (age range 16–70). They had spent a mean of 14.4 (SD = 4.5) years in education. Most women reported being in an intimate relationship in the last year (740/1197, 62%); 457 respondents (38%) had intimate partners in the past. The demographic characteristics of the sample are presented in the Table 1.

Lifetime prevalence

There was little clustering by practices for the lifetime prevalence of partner abuse (intraclass correlation coefficient 0.003; 95% CI = 0.000–0.015). The prevalence of lifetime partner abuse was 37.1% (95% CI = 34.4–40.0%), of severe combined abuse 27.2% (95% CI = 24.7–30.0%), of physical abuse 33.8% (95% CI = 31.1–36.5%), of emotional abuse 41.3% (95% CI = 38.5–44.1%) and of harassment 22.9% (95% CI = 20.5–25.3%).

One-year prevalence

Only 457 of 740 women in current relationship completed the question about the timing of abuse. We used this subsample to calculate the 1-year prevalence of abuse. For these 457 women, the 1-year prevalence of abuse by their current partners was 7.2% (95% CI = 4.6–11.2%), of severe combined abuse 4.7% (95% CI = 2.9–7.6%), of emotional abuse 9.2% (95% CI = 6.7–12.6%), of physical abuse 6.4% (95% CI = 4.3–9.4%) and of harassment 4.0% (95% CI = 2.4–6.8%).

Socio-demographic factors

We performed univariable and multivariable analysis only for lifetime partner abuse in women who have ever been in an adult intimate relationship (n = 1201) because of the high proportion of missing data from the question about the timing of abuse in the subsample of women in a current relationship. We compared the profile of socio-demographic variables of respondents in a current relationship who fully completed the questionnaire with those who did not complete the question about the timing of abuse and found a difference in their mean age (P < 0.001). Women in current relationships from the group with missing data were older: mean age 42.0 years (95% CI = 40.3–43.6) compared with women who fully completed the questionnaire (38.3 years, 95% CI = 37.0–39.5).

In the univariable analysis, women who disclosed abuse in a questionnaire were more likely to be younger (<37 years), cohabiting or divorced, live on their own and less likely to own a house or flat (Table 2). The multivariable analysis found that only marital status was associated with lifetime abuse (Table 3): cohabiting women were 1.9 times more likely to be abused (95% CI = 1.3–2.8) than married respondents. Divorced women were 2.3 times (95% CI = 1.8–3.7) more likely to have a lifetime experience of abuse than currently married women.

Attitudes towards doctors asking about partner abuse

Only 16/1159 (1.4%; 95% CI = 0.8–2.4%) respondents reported that they had ever been asked by their GPs if they have been threatened by their intimate partners, 12/1155 (1.0%; CI = 0.5% to 2.1%) if they had been hit, injured or abused and 7/1160 (0.6%; 95% CI = 0.3% to 1.2%) if they had been forced to have sex by their current or a previous partner. Only third of women (402/1159, 34.7%; 95% CI = 31.5–38.0%) would agree to be asked by their GPs whether they were being threatened, hit or hurt by their partners. Almost half of respondents (43.4%; 95% CI = 40.1–46.8%) did not want to be asked whether they have being forced to have sex. Only 22.0% of respondents (95% CI = 19.2–25.0%) reported that they would not object to being asked by their GPs about partner abuse if they had come for a reason not connected to this issue. There was no significant difference in abused and non-abused women’s attitudes to being asked about or screened about abuse.
Discussion

Summary of main findings
This paper reports the first epidemiological study of partner abuse in Russian primary health care measuring its lifetime and 1-year prevalence, socio-demographic associations and women’s attitudes to asking and screening about this issue.

The CAS-R had good test–retest reliability and internal consistency. We found that more than one in three women (37.1%; 95% CI = 34.4–40.0%) attending GPs had ever been abused by their current or former intimate partner. Among women in current intimate relationships, the 1-year prevalence of abuse was 7.2% (95% CI = 4.6–11.2%).

In multivariable analysis, the only association between lifetime partner abuse and a demographic characteristic was divorced or cohabiting status.

The majority of respondents had never been asked by their GPs about partner abuse and did not want to be asked about this issue when presenting in the practice with an unrelated problem.

Strengths and limitations of the study
The strengths of our study are a representative sample of general practices and patients within these practices in a major Russian city, a high response rate for an epidemiological study and a multidimensional definition of partner abuse measured by a validated scale, albeit in a translated form. Limitations include the cross-sectional nature of the survey, sampling from only one city, incomplete data on the 1-year prevalence of partner abuse and no demographic data on non-respondents. Our 1-year prevalence is probably an underestimate because it does not include women without a current partner abused by their former partners.

Comparison with existing literature
We compared our findings with recent studies in general practice internationally and Russian population...
The number of women who reported lifetime partner abuse in our study was similar to an Australian survey in general practice, conducted with the CAS\(^4\) and an Irish study.\(^4\) Russian women reported a slightly lower prevalence of physical abuse but similar prevalence of sexual abuse compared with a study in UK general practice.\(^4\) Our 1-year prevalence was lower than comparable Canadian and US studies\(^10,12\) and similar to a Russian population survey conducted in St Petersburg.\(^4\)

The lifetime prevalence of partner abuse in our clinical population survey was higher than Russian population lifetime prevalence.\(^2,3\) This corresponds with an analysis of higher prevalence of abuse in clinical than in population samples for which the most likely explanation is that partner abuse damages women’s health and results in greater health care use.\(^18,22\) The demographic associations of partner abuse in our study were consistent with the findings of Hegarty et al.\(^23\) and Richardson et al.,\(^14\) who reported associations between partner abuse and young age, separation and divorced status and low incomes. The proportion of Russian respondents for whom asking about and screening for partner abuse is acceptable was three to four times lower than in other general practice-based studies, although the absence of association between acceptability and abuse status was consistent with other studies.\(^14,16,17\) Predominantly negative attitude to doctors’ asking and screening in our sample might be explained by women not perceiving partner abuse as a health care issue or a more general lack of recognition of partner abuse as anything other than a secret problem. Russian society has a strong traditional patriarchal ideology, in which partner abuse is largely considered a private problem to be managed within the family.\(^24,25\) According to evidence based largely on North American research, women have reported many barriers to disclosure of intimate partner abuse at individual, family and societal level. Internal barriers include embarrassment and shame, denial or minimization of abuse, emotional bonds to partner, hope for change, staying for the sake of the children, normalization of violence and fear of

### Table 1: Demographics of respondents completed the Russian Composite Abuse Scale, n (%)

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In paid job (n = 1197)</td>
<td>839 (70.1)</td>
</tr>
<tr>
<td>Owns accommodation (n = 1192)</td>
<td>949 (79.3)</td>
</tr>
<tr>
<td>Owns car (n = 1193)</td>
<td>857 (49.0)</td>
</tr>
<tr>
<td>Has children (n = 1197)</td>
<td>871 (72.8)</td>
</tr>
<tr>
<td>Has been pregnant in the past year (n = 1187)</td>
<td>39 (3.3)</td>
</tr>
<tr>
<td>Currently pregnant (n = 1187)</td>
<td>29 (2.4)</td>
</tr>
<tr>
<td>Marital status (n = 1194)</td>
<td>550 (45.9)</td>
</tr>
<tr>
<td>Married</td>
<td>166 (13.9)</td>
</tr>
<tr>
<td>Divorced</td>
<td>143 (11.9)</td>
</tr>
<tr>
<td>Widow</td>
<td>143 (11.9)</td>
</tr>
<tr>
<td>Never married</td>
<td>166 (13.9)</td>
</tr>
<tr>
<td>Living with a spouse/partner (n = 1191)</td>
<td>687 (57.4)</td>
</tr>
</tbody>
</table>

The number of respondents completing each demographic question varies.

### Table 2: Univariable analysis of socio-demographic factors of lifetime partner abuse

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>All responses</th>
<th>Not abused, n (%)</th>
<th>Abused, n (%)</th>
<th>Prevalence (%)</th>
<th>OR (95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All responses</td>
<td>1201</td>
<td>755</td>
<td>446</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>248</td>
<td>155 (20)</td>
<td>93 (21)</td>
<td>38</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>16–26</td>
<td>186</td>
<td>95 (13)</td>
<td>91 (21)</td>
<td>49</td>
<td>1.60 (1.01–2.53)</td>
<td>0.05</td>
</tr>
<tr>
<td>27–37</td>
<td>251</td>
<td>147 (20)</td>
<td>104 (23)</td>
<td>41</td>
<td>1.18 (0.82–1.70)</td>
<td>0.36</td>
</tr>
<tr>
<td>38–48</td>
<td>314</td>
<td>207 (27)</td>
<td>107 (24)</td>
<td>34</td>
<td>0.86 (0.55–1.36)</td>
<td>0.50</td>
</tr>
<tr>
<td>49–59</td>
<td>200</td>
<td>150 (20)</td>
<td>50 (11)</td>
<td>25</td>
<td>0.56 (0.36–0.87)</td>
<td>0.01</td>
</tr>
<tr>
<td>≥60</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>551</td>
<td>378 (50)</td>
<td>173 (39)</td>
<td>31</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>166</td>
<td>87 (12)</td>
<td>79 (18)</td>
<td>48</td>
<td>1.98 (1.31–3.01)</td>
<td>0.003</td>
</tr>
<tr>
<td>Divorced</td>
<td>149</td>
<td>77 (10)</td>
<td>92 (21)</td>
<td>54</td>
<td>2.61 (1.84–3.69)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Widowed</td>
<td>143</td>
<td>104 (14)</td>
<td>39 (9)</td>
<td>27</td>
<td>0.82 (0.55–1.22)</td>
<td>0.31</td>
</tr>
<tr>
<td>Never married</td>
<td>167</td>
<td>108 (14)</td>
<td>59 (13)</td>
<td>35</td>
<td>1.19 (0.78–1.82)</td>
<td>0.39</td>
</tr>
<tr>
<td>Living with a spouse/partner</td>
<td>688</td>
<td>448 (59)</td>
<td>240 (54)</td>
<td>35</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>245</td>
<td>135 (18)</td>
<td>110 (25)</td>
<td>45</td>
<td>1.51 (1.13–2.01)</td>
<td>0.008</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeowner</td>
<td>951</td>
<td>617 (62)</td>
<td>334 (35)</td>
<td>35</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>332</td>
<td>177 (23)</td>
<td>155 (35)</td>
<td>47</td>
<td>1.63 (1.29–2.07)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>No</td>
<td>175</td>
<td>125 (17)</td>
<td>50 (11)</td>
<td>29</td>
<td>0.75 (0.48–1.16)</td>
<td>0.19</td>
</tr>
</tbody>
</table>

OR calculated using logistic regression, CI adjusted for clustering effect. OR, odds ratio; CI, confidence interval.
implications and by education programmes for physicians to develop the skills to ask sensitively about abuse and refer abused women to appropriate support and advocacy.

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