Intimate Partner Violence and Health

A Critique of Canadian Prevalence Studies

Jocalyn P. Clark, MSc PhD candidate[1,2]
Janice Du Mont, EdD[2]

ABSTRACT

Objective: The Canadian Public Health Association, along with other professional organizations, has identified intimate partner violence (IPV) as a priority health issue to which the health professions must respond. This study synthesizes Canadian studies on the prevalence of IPV against women, focusing in particular on the stated implications for women's health and health care.

Methods: Medical and social science databases were searched for all articles pertaining to IPV in Canada for 1974 through September 2000. Reference lists of these and other related publications were consulted to supplement the literature review. Data on study characteristics, methods, and results were extracted by two independent reviewers. Discrepancies were resolved by consensus.

Results: Sixteen studies were identified in this review, 11 population-based and 5 conducted in clinical settings. Age, ethnicity, and socioeconomic status were not consistently documented, making comparisons and evaluations of generalizability difficult. Annual prevalence of IPV in Canada was found to range from 0.4% to 23%, with severe violence occurring from 2% to 10% annually. Less than two fifths (37.5%) of the studies incorporated a health-related measure.

Interpretation: This review reveals a paucity of Canadian prevalence data on IPV, marked by design and methodological issues. Poor quality data may pose a challenge to articulating and establishing a coordinated health care response to eliminating IPV in Canada.

La traduction du résumé se trouve à la fin de l'article.

1. Department of Public Health Sciences and the Institute for Women's Studies and Gender Studies, University of Toronto, Toronto, ON
2. The Centre for Research in Women's Health, Toronto
Correspondence and reprint requests: J.P. Clark, The Centre for Research in Women's Health, Sunnybrook & Women's College Health Sciences Centre, 790 Bay St, 7th Floor, Toronto, ON M5G 1N8, Tel: 416-351-3800 ext. 2716, Fax: 416-351-3746, E-mail: j.clark@utoronto.ca
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Since the 1970s, intimate partner violence (IPV) has received broader recognition in Canada, largely due to the work of women's groups, social advocates, and feminists. In response to this growing concern, the Canadian Nurses Association, the Canadian Psychiatric Association, and the Society of Obstetricians and Gynecologists have developed policy statements and practice guidelines for their members.[1-5] Their overall purpose is the promotion of early detection and treatment of IPV in Canada, recognizing that male violence against women has potentially severe health implications to which the health care professions must respond.

The Canadian Public Health Association (CPHA) has recognized that living with threats of or actual violence is in fundamental opposition to the conditions necessary for good health. In fact, the scope and health effects of IPV were highlighted in its 1994 publication, *Violence in Society: A Public Health Perspective.*[4] This report noted that one quarter of women have been assaulted by a current or previous partner and that some have feared for their lives. The sequelae articulated include: suicidal thoughts, suicide attempts, alcohol and drug dependency, miscarriage, and low birthweight infants. Certain groups of women (e.g., Aboriginals, those with disabilities) may be disproportionately affected. Accordingly, CPHA has advocated a policy action plan aimed at eliminating violence in society. Chief among its recommendations are recognition of violence as a priority health issue and further documentation of its extent and effects. Concern is expressed that the existing research may not accurately reflect the scope or potential costs of the problem.

CPHA's 1994 public health recommendations and professional associations' guidelines drew upon limited Canadian data focusing on the prevalence and health effects of IPV. This begs the question: Is there a sufficient body of methodologically rigorous studies upon which to base a specifically Canadian coordinated public health response? We undertook a systematic review of the published medical and social science literature in order to address this question. Specifically, we reviewed and synthesized prevalence reports on IPV in Canada, comparing study characteristics, methods, and results and focusing in par-

TABLE Ia

Comparison of Study Characteristics: Population-based Studies

Study	Sample Size	Setting	Sample Generation	Sample Description*		
				Age (yr.)	Ethnicity	Socioeconomic Status
Brinkerhoff and Lupri, 1988[17,a]	562 couples	Calgary	Random digit dialing technique (RDD)[b]	NS	NS	Lower/working: Husband (44.8%); Wife (53.9%)
Canadian Urban Victimization Study (CUVS), 1985[18]	61,000 women and men[c]	Vancouver, Edmonton, Winnipeg, Toronto, Montreal, Halifax, St. John's	RDD	16+	NS	NS
General Social Survey (GSS), 1988[19]	10,000 women and men[c]	Canada	RDD	15 +	NS	NS
GSS, 1999[16]	14,269 women, 11,607 men	Canada (10 provinces)	RDD	15+	NS	NS
Grandin and Lupri, 1997[20,d]	652 women, 471 men	Canada	RDD	18+	NS	NS
Kennedy and Dutton, 1989[21]	1045 women and men	Alberta	Random sample from city enumeration and telephone directory	18+	NS	NS
Randall and Haskell, 1995[22]	420 women	Toronto	Random sample from residential addresses	18-64	NS	NS
Ratner, 1993[23]	406 women	Edmonton	RDD	18-82 mean 39.4, SD 14.3	NS	25.4% combined income <$30,000
Smith, 1985[24]	315 women	Toronto	Version of RDD	18+	NS	40.3% family income <$30,000
Smith, 1987[25,e]	604 women	Toronto	Version of RDD	19-50	36.1% non-Canadian born	16.9% family income <$30,000; 23.8% unemployed; 21.7% <high school
Violence Against Women (VAW) Survey, 1993[26,f]	9056 women[g]	Canada (10 provinces)	RDD	18+	NS	20.7% household income <$30,000 (women currently married only)

* Studies may have collected data on sample characteristics from their populations, but they were not included in the published reports. Many published reports did not provide socioeconomic characteristics of the sample or the data were ambiguous;[21] however, it was reported that demographics were representative of the city[18,24,25] province,[21] or nation.[15,16,20]

NS = not specified in the published report.

[a] Also published in Grandin et al.[37]

[b] RDD typically involves a systematic selection of residences from the telephone directory by taking every nth residence, excluding businesses, after a random start.[17] Statistics Canada claims that only 1% of females in the 10 provinces live in households without telephones.[26]

[c] Total sample size; sample size of population used to derive intimate partner violence prevalence rates was not specified.

[d] Also published in Lupri,[38] reports on the intimate partner violence component of the 1986 Canadian Life Survey.

[e] Also published in Smith.[39]

[f] Based on Rodgers[26] report of the "ever married" (including common law partnerships) subsample.

[g] Sample size for ever married group was extracted from Statistics Canada Family Violence in Canada: A Statistical Profile.[15]

ticular on the stated implications for women's health and health care.

METHODS

Consistent with the International Cochrane Collaboration methodology for systematic reviews (www.cochrane.org), research databases were searched for all articles pertaining to IPV in Canada for the period 1974 through September 2000. MEDLINE, PsycInfo, HEALTHSTAR, CINAHL, Social Science Abstracts, Sociofile, Criminal Justice Abstracts, Canadian Research Index, Contemporary Women's Issues, Women's Resources International, and Women's Studies Abstracts Databases were searched using the following terms which may have appeared anywhere in the article: "intimate partner violence," "family violence," "domestic violence," "spouse abuse," or "battered women", and "incidence" or "prevalence", and "Canada." This search strategy identified 436 articles. Review of their abstracts resulted in 34 which met the following criteria: 1) surveyed individuals with no known history of assault by a previous or current intimate partner; 2) measured the prevalence of assault by a previous or current intimate partner; and 3) was based on Canadian data. A complete review of these articles resulted in 9 being included in the study.

A search of the reference lists of these articles and health associations' guidelines,[1-7] articles by Canadian violence researchers,[8-14] and consultation with the recent Canadian National Forum on Health, the joint Canada-USA Forum on Women's Health, and Statistics Canada's Family Violence Profiles' publication lists[15,16] identified another 7 articles. Handsearching of Canadian public health, medical, psychology, and sociology journals did not result in additional studies. Overall, 16 articles were included in this review.

The data synthesized from these 16 articles included study characteristics (sample size, setting, sample demographics including age, ethnicity, socioeconomic, and marital status), study methods (data collection tools, relationship characterizations,

TABLE Ib

Comparison of Study Characteristics: Clinic-based Studies

Study	Sample Size	Setting	Sample Generation	Sample Description		
				Age (yr.)	Ethnicity	Socioeconomic Status
Hoffman and Toner, 1988[27]	25 women	Toronto general hospital and psychiatric research institute	Psychiatric in-patients	17-80 mean 36.5, SD 13.6	NS	NS
Janssen et al., 1998[28]	198 women	Vancouver women's hospital	Obstetric nurses	22+	NS	NS
Martins et al., 1992[29]	275 women	Toronto family practice unit at teaching hospital	Patients seen during 2-week period	16+ mean 36.2	NS	NS
Muhajarine and D'Arcy, 1999[30]	543 women	Saskatoon District community-based prenatal services	Pregnant patients seen during 1-year period	15-40 mean 24.6	66.6% English or French; 16.8% Aboriginal	44.9% low income; 32.4% not completed high school
Stewart and Cecutti, 1993[31]	548 women	Ontario public prenatal clinic, private family MD and obstetrician offices, teaching hospital	Pregnant patients at 20 weeks or greater	14-46 mean 29.0, SD 5.3	54.0% born in Canada	29.2% unemployed or receiving social assistance; 12.0% not completed high school

NS = not specified in the published report.

violence measures, health outcome measures, time period surveyed), and study results (type of violence, prevalence of violence over time, health status and health care outcomes, stated public health implications). Two reviewers independently extracted data and discrepancies were resolved by consensus.

RESULTS

Comparison of study characteristics

Of the 16 studies reviewed, 11 (68.8%) were population-based[16-26] and 5 (31.2%) were conducted in clinical settings.[27-31] The samples were composed of women, men, and couples and ranged in size from 25 to 61,000. Almost two fifths (36.6%) of the population-based studies were national in scope and all drew upon the Random Digit Dialing (RDD) approach to generate samples. Age, ethnicity, and socioeconomic status were not consistently documented, making comparisons across the 16 studies and an evaluation of their generalizability difficult (see Tables Ia and Ib).

Comparison of study methods

As presented in Tables IIa and IIb, all studies reviewed used self-administered questionnaires and/or personal interviews to collect data on violence outcomes. Fourteen (87.5%) relied on self-reports made by female victims and two (12.5%) on self-reports made by male perpetrators. Almost three fifths (56.3%) utilized a version of the Conflict Tactics Scale (CTS)[32] to measure violence and two relied on a version of the Abuse Assessment Screen (AAS).[33] Three (18.8%) supplemented these violence measures with additional questions and one used a qualitative interview method to explore in detail women's experiences of abuse throughout their lives. Only 37.5% included a measure to evaluate a health or health care-related consequence of IPV.

Comparison of study results

As presented in Tables IIIa and IIIb, the annual prevalence of physical abuse and emotional abuse among women in Canada ranged from 0.4% to 18.3% and 13.1% to 23.0%, respectively. Severe violence was reported in the order of 2.3% to 9.9% per year. Over their lifespan, 8.0% to 36.4% of Canadian women were physically or sexually assaulted by their male partners and 5.7% to 6.6% experienced physical assault during pregnancy. Only a quarter of studies reported the physical health effects of IPV. Similarly, psychological health effects were reported in only 25.0% of studies. Less than one third (31.3%) of the studies reported findings relevant to the provision of health care for assaulted women.

CRITIQUE OF RESEARCH FINDINGS

To our knowledge, this is the first study to systematically review and synthesize Canadian findings on the prevalence of intimate partner violence, with a particular focus on the implications for women's health and health care. Results suggest that as many as 23.0% of women in Canada are abused each year. While the magnitude of this finding is striking, it has been generated from a very small number of studies, most of which date back to the early 1980s. Only six studies have been published since the CPHA statement was released in 1994. Nevertheless, it may be timely for CPHA to revisit its position on IPV in light of more recent data.

In updating intervention and prevention strategies, attention must be paid to the quality of data. Few of the reviewed studies discussed IPV in relation to health. While five reported health care outcomes, their findings were limited in scope. For example, the Canadian Urban Victimization Survey (CUVS) stated only that the vast majority of women thought counselling should be available[19] and Martins and colleagues[29] commented on the under-documentation of abuse in the primary care setting. In terms of the health status of women who had been abused, only five studies reported relevant findings; all of these found that the physical and psychological sequelae were severe. The generalizibility of these results, however, are limited by the small amount of data. Further, meaningful comparisons across these studies are complicated by their divergent samples and measures.

Indeed, different study designs pose limitations on our understanding of IPV and

TABLE IIa

Comparison of Study Methods: Population-based Studies

Study	Data Collection Method	Relationship Categorization	Violence Measure	Health Outcome Measure	Time Period
Brinkerhoff and Lupri, 1988[17]	Self-administered questionnaire and face-to-face interview	Marital partner or co-habitator	*Male self-reports of violent acts committed against female partner;* Modified CTS	None	Past year
CUVS, 1985[18]	Telephone interview	Spouse or ex-spouse	Questions about victimization experiences	Physical injury; Received medical treatment	Past year
GSS, 1988[19]	Telephone interview	Spouse or former spouse	Questions about victimization experiences	None	Past year
GSS, 1999[16]	Telephone interview	Partner or former partner	Questions on physical and sexual violence, among questions about other crimes	Physical injury; Received medical attention	Past year; Past 5 years
Grandin and Lupri, 1997[20]	Self-administered questionnaire and face-to-face interview	Marital partner or co-habitator	*Male self-reports of violent acts committed against female partner;* Modified CTS	None	Past year
Kennedy and Dutton, 1989[21]	Questionnaire-based telephone or face-to-face interview	Marriage-like partner	Modified CTS	None	Past year
Randall and Haskell, 1995[22]	In-depth face-to-face interview	Male partner	Questions about victimization experiences	None	Ever
Ratner, 1993[23]	Questionnaire-based telephone interview	Marital, common-law, or live-in partner	CTS	GHQ[a] and CAGE;[b] Questions about physical health problems and health care utilization	Past year
Smith, 1985[24]	Telephone interview	Current or previous husband or partner, or boyfriend or date	Modified CTS; Open-ended questions about abuse	None	Past year; Ever
Smith, 1987[25]	Telephone interview	Present or former husband, live-in partner, boyfriend, or date	Modified CTS; Supplementary questions on abuse (incl. sexual assault)	None	Past year; Ever
VAW, 1993[26]	Questionnaire-based telephone interview	Current or previous marital or common-law partner	Modified CTS	Emotional effect; Physical effect; Alcohol, drug, and medication use; Health care-seeking	Since age 16; Past year

[a] The GHQ refers to the General Health Questionnaire[40] which is used to measure psychiatric morbidity, consisting of four subscales (somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression). Each item is scored on a multiple-response scale, from zero (not at all) to three (much more than usual). The sum gives subscale and total scores.[23]

[b] The CAGE, which stands for "Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers" questionnaire,[41] is used to screen for alcoholism and consists of four questions that serve as indicators of problem drinking. Alcohol dependency is considered present if there are at least two positive responses.[23]

TABLE IIb

Comparison of Study Methods: Clinic-based Studies

Study	Data Collection Method	Relationship Categorization	Violence Measure	Health Outcome Measure	Time Period
Hoffman and Toner, 1988[27]	Face-to-face interview	Current or previous spouse or partner	CTS and questions about sexual assault	None	Ever
Janssen et al., 1998[28]	Self-administered questionnaire	Current or past partner	Modified AAS	None	Ever
Martins et al., 1992[29]	Self-administered questionnaire	Marital or common-law partner	Modified CTS	Suicidal ideation; Emergency department use	Present
Muhajarine and D'Arcy, 1999[30]	Face-to-face interview	Husband or boyfriend, or ex-husband (63.3% of total sample)	AAS	None	During pregnancy and past year
Stewart and Cecutti, 1993[31]	Self-administered questionnaire	Common-law or legal husbands, ex-husbands, or boyfriends or ex-boyfriends	Questions about physical, verbal abuse, psychologic abuse, threats to safety	GHQ; FHLC;[a] Physical injury	During pregnancy and before pregnancy

[a] FHLC refers to the Fetal Health Locus of Control scale,[42] an 18-item instrument of three scales measuring "internal control," "powerful others," and "chance." Each corresponds to the women's perceptions of how the health of the fetus is determined and is strongly correlated with attitudes and risk-related behaviours of the mother during pregnancy.[31]

TABLE IIIa

Comparison of Study Results and Stated Public Health Implications: Population-based Studies

Study	Violence Measured	Prevalence (Estimates), Ever	Prevalence (Estimates), During Last Year	Health Outcomes	Stated Public Health Implications
Brinkerhoff, and Lupri, 1988[17]	Overall Severe	– –	10.3% 4.8%	Not evaluated	"…severity of the injury, pain, and damage [unknown]…" (p.429)
CUVS, 1985[18]	Physical	–	0.4%	Physical injury (61.0%); Medical attention received (27.0%)	81.0% of female spousal assault victims said that counselling should be available
GSS, 1988[19]	Physical or sexual	–	1.5%	Not evaluated	None stated
GSS, 1999[16]	Physical or sexual Emotional or financial	8.0% (5 yr) 19.0% (5 yr)	3.0%	Physical injury (40.0%); Medical attention required (15.0%)	None stated
Grandin and Lupri, 1997[20]	Physical Overall Minor Severe	 – – –	 18.3% 9.3% 9.9%	Not evaluated	"…potentially devastating physical and psychological consequences that some of the life-threatening violent acts may have on the victims" (p.440)
Kennedy and Dutton, 1989[21]	Physical Overall Severe	 – –	 11.2% 2.3%	Not evaluated	"[In future studies]… 'aftermath' questions regarding use of police and hospital services must be developed and implemented" (p.52)
Randall and Haskell, 1995[22]	Physical Assault	27.4%	–	Not evaluated	"The effects are often long term and devastating" (p. 9)
Ratner, 1993[23]	Physical Psychological	– –	10.6% 13.1%	Physically abused had highest scores on somatic complaints, anxiety and insomnia, social dysfunction and depression; those psychologically abused had 5.3 times and physically abused 8.1 times the alcohol dependency	"…wife abuse is a major public health issue which warrants attention....in early identification of abused wives, early intervention, and ideally, prevention of abuse and its associated health problems" (p. 249)
Smith, 1985[24]	Physical	18.1%	10.8%	Not evaluated	None stated
Smith, 1987[25]	Physical Severe physical	36.4%[a] 11.3%[a]	14.4% 5.1%	Not evaluated	None stated
VAW, 1993[26]	Physical or sexual Emotional	29.0% 35.0%	3.0%[b] –	85.0% experienced emotional effects; 45.0% were physically injured (bruises, cuts, broken bones, miscarriages); 24.0% used alcohol, drugs, or medication to cope; 40.0% saw a doctor or nurse for medical attention; 50.0% of those physically injured had to take time off from everyday activities	"the psychological effects of intimate partner violence can be far-reaching" (p. 10); "women may use a variety of ways to cope with their partners' abusive behaviour" (p.11)

[a] Affirmative responses to the modified CTS and supplementary questions. Rates for CTS-only were 25.0% for physical assault and 7.1% for severe physical assault.
[b] Percentage based on total currently married population (n=6690).

health, as well as on the synthesis of findings across studies. On the one hand, national population-based studies are valuable sources of information for incidence and prevalence estimates. They are considered the most sophisticated and reliable sources for understanding population-wide phenomena. For example, the 1993 Violence Against Women (VAW) survey was designed specifically to provide a focused, representative picture of Canadian women's experience of violence over their adult lives.[11,26] However, as with all population-based survey techniques, the use of standard random digit dialing excludes women without

TABLE IIIb

Comparison of Study Results and Stated Public Health Implications: Clinic-based Studies

Study	Violence Measured	Prevalence, Ever	Prevalence, During Last Year	Health Outcomes	Stated Public Health Implications
Hoffman and Toner, 1988[27]	Physical			Not evaluated	"…history of spouse abuse is associated with in-patient psychiatric admission, although the cause and effect relationships have not yet been delineated" (p.58)
	Overall	76.0%	–		
	Minor	72.0%			
	Major	60.0%			
	Sexual	36.0%	–		
Janssen et al., 1998[28]	Overall	38.0%	–	Not evaluated	"In an obstetric setting where pregnancy is known risk factor for abuse, health care professionals must undertake the responsibility to identify, intervene with, and prevent violence against women." (pp. 322-323)
	Physical	14.6%	–		
	Sexual	8.1%	–		
	Emotional	26.9%	–		
Martins et al., 1992[29]	Physical (incl. rape)	–	12.0% (current)	5.6% used ER after being abused; 4.0% contemplated suicide because of their relationship	"Physician education and training also has been poor... The health and societal impacts of wife abuse are significant" (p.79)
	Mental	–	23.0% (current)		
Muhajarine and D'Arcy, 1999[30]	Physical			Not evaluated	"For many women, physical abuse is only one of many problems that endanger their health during pregnancy" (p. 1010)
	During pregnancy	5.7%[a]	–		
	Previous year	–	8.5%[a]		
Stewart and Cecutti, 1993[31]	Physical			Abused pregnant women experienced greater psychologic distress and were more likely to think that chance rather than their own behaviour affected their fetus' health; women abused during the current pregnancy sustained pneumothorax, stab wounds, concussions, fractures, perforated ear drums, abrasions, dental injuries, bruises, vaginal bleeding, and premature labour; 66.7% received medical treatment for abuse and 1 woman (2.8%) told her prenatal care provider about abuse	"Assessment for abuse should be standard care for all prenatal patients…" (p. 1262)
	During pregnancy	6.6%	–		
	Before pregnancy	10.9%	–		

[a] These findings are based on the entire sample size.

phones (e.g., the poor, homeless and institutionalized) and Aboriginal women living on reserves.[8,34] These women may be among the most vulnerable to IPV and yet their experiences are missing from the literature. Their exclusion appears to belie CPHA's recommendation for strengthening community action that ensures the full participation of women regardless of their socioeconomic status, gender, race, culture, age, or sexual orientation.[4:iv]

While clinic-based studies provide relative ease of access to relevant samples of women (including diverse groups of women who can be accessed in their own communities), their non-random designs preclude generalizability. The location of clinic-based research in health-related settings is helpful for investigating the health effects of abuse and for developing strategies for detection and treatment. They do not, however, provide a sufficient picture of rates of IPV in the Canadian population. Further, this systematic review illustrates that studies of this type are rare: only five have been published in the last 25 years and amount to a combined study group of just 1,589 women. Despite the CPHA policy recommendations to incorporate qualitative research,[4:vi] only one study reviewed used a qualitative, open-ended method to document women's personal experience of IPV.

A further methodological limitation of these studies derives from the violence measurement tools used. The Conflict Tactics Scale (CTS), for example, has been criticized for its focus on physical rather than psychological abuse and for failing to measure forms of abuse such as burning, suffocation, squeezing, and sexual assault.[8,24] DeKeseredy argues that the CTS is a largely decontextualized tool, unable to explore the motives of violence, assemble information about the perpetrator, and detail the circumstances surrounding violent acts.[8] As a result, the scope of IPV is underestimated.

Finally, all of these studies fail to reveal fully the social factors that contribute to the perpetuation of IPV in Canada. Across the published reports, information about age, ethnicity, and socioeconomic status was

either not included or poorly documented. Vulnerabilities to IPV may vary across social circumstances.[12] As such, further research that can "shed light on various dimensions of women's experiences… according to their diverse life contexts"[22:10] is crucial.

CONCLUSION

CPHA has identified IPV as a priority health issue, and alongside other key professional associations, is well positioned to advance policy and leadership in this area. At present, it may be that one factor challenging the establishment of a broadly implemented, coordinated response is the limited amount and poor quality of information available to policy planners. This review found few Canadian prevalence studies and most were marked by design and methodological limitations. We strongly support CPHA's 1994 call for further documentation of the extent and effects of violence. This research must use standard definitions and methods of data collection and reporting.[35,36] With expanded research on IPV, situated within the broad social determinants of health framework, CPHA in conjunction with others could fulfill a pivotal leadership role. Such efforts would seem crucial to CPHA's recommendation[4:v] for a "national, priority health goal to eliminate violence in Canada."

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RÉSUMÉ

Objectif : L'Association canadienne de santé publique, comme d'autres organisations professionnelles, considère la violence entre partenaires intimes (VPI) comme une question prioritaire pour les professionnels de la santé. On fait ici une synthèse des études canadiennes sur la prévalence de la VPI à l'endroit des femmes, surtout dans l'optique de ses conséquences énoncées sur la santé des femmes et sur les soins de santé qu'elles reçoivent.

Méthode : On a répertorié dans les bases de données médicales et de sciences sociales canadiennes tous les articles sur la VPI au Canada de 1974 à septembre 2000. Pour compléter l'enquête bibliographique, on a consulté les listes de référence de ces articles et de publications connexes. Deux examinateurs indépendants ont extrait des données sur les caractéristiques, les méthodes et les résultats des études et se sont concertés là où leurs constatations différaient.

Résultats : L'examen a permis de trouver 16 études, dont 11 études représentatives et cinq réalisées dans des conditions cliniques. L'âge, l'appartenance ethnique et le statut socio-économique n'y étaient pas documentés systématiquement, ce qui a compliqué le travail de comparaison et d'évaluation de la généralisabilité. Selon les constatations, la prévalence annuelle de la VPI au Canada varie entre 0,4 % et 23 %, et celle de la violence grave, entre 2 % et 10 %. Moins des deux cinquièmes des études (37,5 %) intégraient une mesure de la santé.

Interprétation : Cet examen témoigne de la rareté des données canadiennes sur la prévalence de la VPI et des vices de conception et de méthode des études existantes. La piètre qualité des données pourrait être un obstacle pour les responsables de la santé qui veulent articuler et établir une stratégie coordonnée d'élimination de la VPI au Canada.