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Intimate Partner Violence: Promoting the Need for Adequate Screening, Assessment and Interventions for Physical and Mental Conditions Resulting from Intimate Partner Violence

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Abstract

Intimate partner violence is a public health problem having tremendous impact on women's health. Also, intimidate partner violence, also known as domestic violence is the primary cause of injury to women in the United States. Physical and psychiatric problems are the result of domestic violence with victims having increase use of health services compared to those not abused. Often, domestic violence is not identified in the health services organizations when victims access health care. This analytical review of the literature addressed existing research and literature on the current status of intimate partner violence. *The Holistic Model Based on Adequate Screening, Assessment and Interventions for Improving the Health Outcomes in Victims of Intimate Partner Violence* is a useful model for guiding health professionals in recognizing the relevant of violence when women present certain illnesses in diverse health services organizations. Strategies for improving the health outcomes for this group include: (a) adequate screening, assessment and interventions; (b) more education for health professionals on assessing victims of violence; (c) domestic violence included in the curriculum of universities and colleges for health professionals; (d) continuing education on domestic violence in the workplace; and (e) assess for signs and symptoms of domestic violence and conduct valid screening and assessment tools on patients in certain health services organizations when women access care. More policy development is needed for victims of intimate partner violence to improve health outcomes.

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Key Words: Women, domestic violence; intimate Partner violence ; inequalities; physical health conditions; mental health conditions; screening; assessment; intervention

Introduction

Domestic violence is a prevalent public health problem in our society affecting thousands of women worldwide (Kennedy, 2015a,b). According to the CDC National Center for Injury Prevention and Control [CDC], (2014), it is estimated that approximately (1-4) women are affected by domestic violence each year and in the United States, approximately 1.5 million women are raped or physically assaulted by an intimate partner annually. Domestic violence typically is more than one incident in a relationship (Ellsberg, Jansen, Heise, Watts & Garcia-Moreno, 2008).

CDC (2014) uses the term intimate partner violence (IPV), which is defined as intentional, emotional, or physical abuse by a spouse or ex-spouse, boyfriend, or date. The term is more inclusive and may replace domestic violence. Partners do not need to be married. Intimate partner abuse includes abuse by a current or former spouse or a romantic or cohabitation partner (e.g., dating or same sex partner) consisting of an intimate partner, current or former nonmarital partners (dating or same-sex partner) (Kennedy, 2007; Kennedy, 2015a, b).

Intimate partner violence cuts across all ethnic, racial, socioeconomic and educational lines (Kennedy, 2007). It is estimated that more than 1 in 3 women (35.6%) and more than (1 in 4) men (28.5%) in the United States have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime (CDC, 2013). Approximately, 17.7 million of women and (2.8) million men experience rape or attempted rape at some point of their life (Basile, & Smith, 2011). However, the focus of this paper will be on female victims of domestic violence.

Overview of Domestic Violence

Intimate partner violence is a public health problem having tremendous impact on women's health (Caldwell, Swan, & Woodbrown 2011; Dami et al., 2017; Farbood, Adelman, & Mckinnon, 2014). It is a growing multifaceted problem around the globe (Kennedy, 2015a, b).

Women are more likely to experience some type of domestic violence compared with their men counterpart (Trevillion, Oram, Feder, & Howard, 2012). Furthermore, women experience more intimate partner violence and more severe injuries compared with men (Kennedy, 2007; Tjaden & Thoennes, 2000a, b). Women are more likely to experience frequent assaults and report greater fear for their lives compared with men (Finney, 2006; Howard, Trevillion, & Agnew-Davies, 2010). They are assaulted by partner approximately 7 times more than men (Povey et al., 2005).

Physical and psychiatric problems are the result of domestic violence with victims having increase use of health services compared to those not abused (Trevillion et al., 2012). Domestic violence is associated with increase cost of health care to include medical and psychiatric healthcare cost (Bonomi, Anderson, Rivera, & Thompson, 2009). Victims of abuse are more likely to experience adverse health outcomes (CDC, 2014).

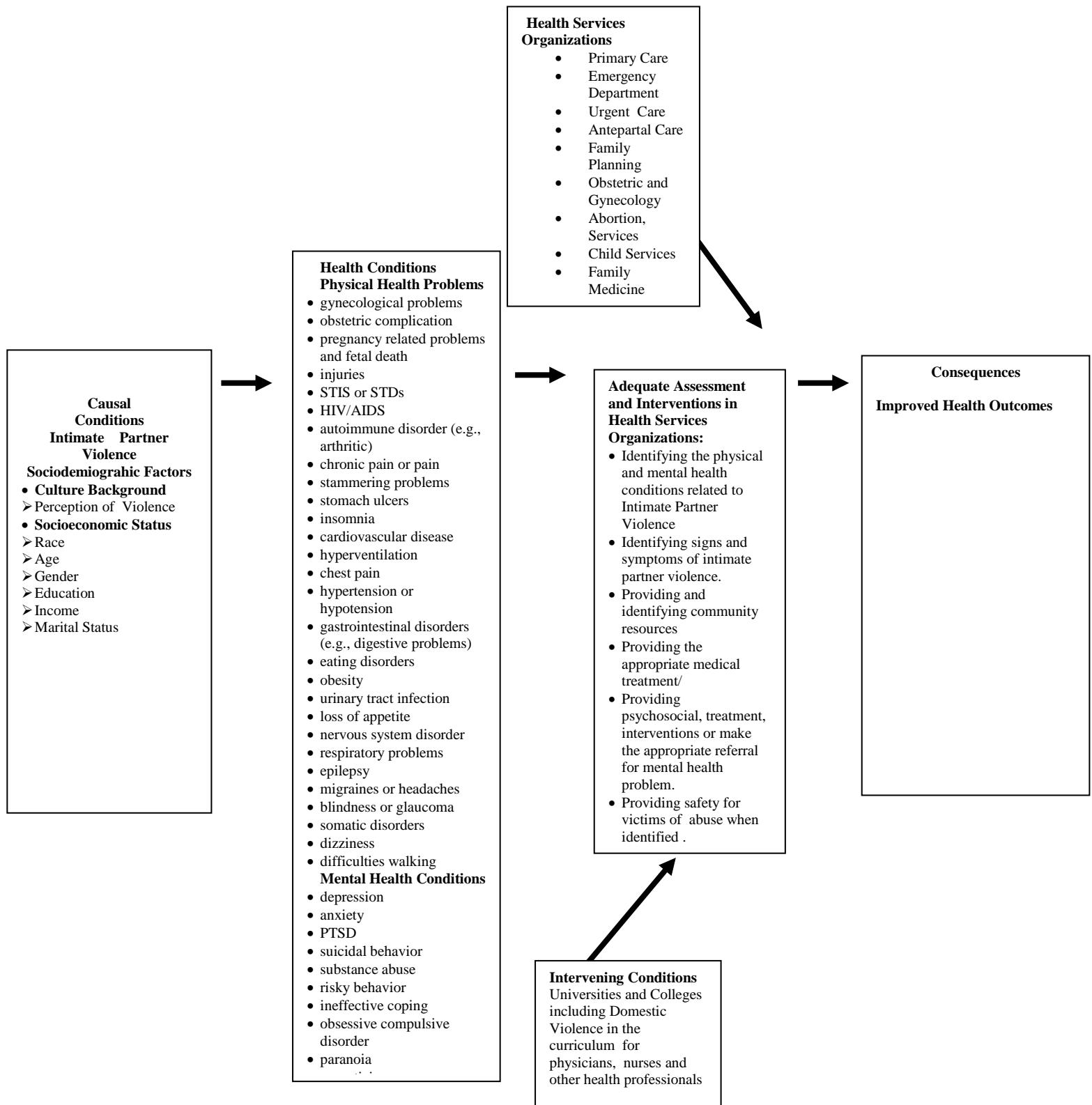
The next section addressed the conceptual model used as a guide to identify victims and assess health conditions related to intimate partner violence in primary care and other health services organizations. The main concepts of this model will be identified.

The Conceptualization of Health Promotion Strategies for Improving the Health Outcomes for Victims of Intimate Partner Violence

This analytical review of the literature addressed existing research studies and significant literature on the current status of intimate partner violence. In Figure 1: *A Holistic Model Promoting Adequate Screening, Assessment and Interventions for Improving the Health Outcomes in Victims of Intimate Partner Violence* is a useful model for guiding health professionals in recognizing the relevant of violence when women present certain illnesses in

diverse health services organizations, such as primary care, emergency urgent care, specialty care, outpatient laboratory services and pharmaceuticals

Figure 1: A Holistic Model Promoting Adequate Screening, Assessment and Interventions for Improving the Health Outcomes in Victims of Intimate Partner Violence



This model is a holistic approach addressing the biopsychosocial-spiritual perspective when treating female victims of intimate partner violence. Despite access to these health services organizations, only a small proportion of abused women are identified by health professionals (Hage, 2006).

Universal screening is when a clinician provide a brief screening of every female patient through age 64 for domestic violence, as opposed to only screening certain patients because of risk factors or warning signs (US Department of Human Services ,[USDHS, 2013]. Screening may consist of a few short, open-ended questions asked by a clinician to the patient. It can also be facilitated by the use of forms or other assessment tools (USDHS, 2013). The health assessment is an evaluation of the health status of an individual by performing a physical examination after obtaining a health history (Mosby's Medical Dictionary. 2016). This procedure includes various laboratory tests to confirm a clinical impression or to screen for dysfunction. The depth of investigation and the frequency of the assessment vary with the condition, age of the client and the healthcare organization in which the assessment is performed. The person's response to any dysfunction present is observed and noted. The techniques of the health assessment include inspection, palpation, percussion and auscultation (Mosby's Medical Dictionary, 2016). For example, a health provider may identify symptoms of domestic violence when performing a thorough health assessment. Counseling may include provision of basic information, including on how a patient's health concerns may relate to violence and referrals for additional assistance when patients disclose abuse to the appropriate authority (USDHS, 2013).

Historically, in 1992 the *Joint Commission on the Accreditation of Hospitals and Health Care Organizations* [JCAHO, 2009] mandated that emergency department develop written protocols for identifying and treating survivors of domestic violence based on receiving hospital accreditation. Since, then other health associations support the screening across healthcare specialties. American Medical Association (AMA), American Congress of Obstetrician Gynecologists (ACOG) and the American Nurses Association (ANA) recommend routine universal screening. The screening includes not just physical abuse but other signs of abuse. Despite, this recommendation, screening is relative low across healthcare specialties. Debate in the medical community continues over what the appropriate and frequency and conditions of screening should be given with clinician's limited time and resources.

Often, health providers treat the injury or illness without addressing the underlying cause or causes that contributes to them (Hage, 2006). If abuse of women is unrecognized, referrals are not made to the needed services or resources (Lipski, & Caetano, 2007). Research reported that when victims of domestic violence access certain health services organization, health professionals have a tendency to focus more on treating the injuries and consequences of domestic violence while overlooking violence as the cause of symptoms and injuries (Husso, Virkki, Notko, Holma, & Laitila, 2012). Victims of domestic violence typically will not disclose the abuse unless direct questions are asked (Bacchus, Mezey, & Bewley, 2006; Howard & Hunter, 2008; Rose, Trevillion & Woodall, 2011). Female victims of domestic violence typically do not disclose IVP because of self-blame, hopelessness, the urge to protect their family and feeling powerlessness. Typically, health professionals don't ask about partner violence to avoid offending them and not knowledgeable what support is needed. Therefore, health professionals need to recognize the relevant of violence when women present certain illnesses (Alhabib, Nur & Jones, 2009). Research reported that health professionals lack knowledge and

skills needed to intervene with victims and families (Hayward, & Weber, 2003; Ramsey et al., 2012).

Intimidate partner violence, also known as domestic violence is the primary cause of injury to women in the United States (Felbinger & Gates, 2008). The challenges of identifying domestic violence in diverse health services organizations will be addressed. The Advanced Practice Nurse especially in primary care and other health services organizations can play a useful role in screening, assessment and identifying victims of domestic violence when they enter their health services organizations. Research indicates that not every clinician is equally likely to screen this group (USDHHS, 2013). However, health professionals are more likely to screen if educated on domestic violence. In addition, nurses are more likely to screen compared to physicians.

Sociodemographic Factors

In this model, certain *sociodemographic factors* assisted in identifying victims of domestic violence to include: (a) cultural perspective, (b) socioeconomic status which includes education, income and occupation (c) race, (d) age, (e) gender and (f) marriage status. Understanding the sociodemographic factors will assist health providers such as physicians and nurse practitioners in adequately assessing women who are at risk when accessing their services.

In this model, *health conditions* consist of physical and mental health conditions. In primary care and other health services organizations where female victims of intimate violence access health care, health providers often treat the physical conditions not identifying the intimate partner violence as related to these conditions. Also, the mental health problem may not be identified because health professionals may focus on the physical health conditions.

Cultural Perspective

Cultural violence consists of traditions, norms and practices of certain culture groups used to justify or legitimize direct or structural violence which may be exemplified by religion and ideology, language, art, empirical science and formal science (Galtung, 1969). The meaning of violence varies in diverse culture groups based on cultural practices of different countries (Alhabib et al., 2009; Kennedy, 2015 a, b). Sometime, violence varies within the same culture group. For example, a woman from Asian culture is brought up to believe in the greater need for the family instead of the individual. Women in the poorest nations may believe that beating wives are justified. However, in developed and developing countries, women tend to hold beliefs that justify violence against women (Alhabib et al., 2009; Kennedy, 2015b).

Abused women are characterized by the subordination of women in society, the objectification of women and the power inequalities of women in the social structure (Sampselle et al., 1992). Violence against women derives from cultural patterns, especially the traditional practices and the acts of extremism linked to race, sex, language or religion (Kennedy, 2015a, b.). Cultural hierarchies dictate women's subordinate position, which developed from a patriarchal world where social arrangements are stratified and determined by gender (Kennedy, 2015a, b.). Men who batter frequently believe that it is their right to discipline their partners to control them (Watts & Zimmerman, 2002).

Social, political, economics and culture factors affect women's lives in relation to domestic violence (Alhabib et al., 2009; Kennedy, 2015, a, b). These factors include poverty, inequalities, new articulation of patriarchies in specific regions, and the legacies of colonialism and racism (Sokoloff & Pratt, 2005; Kennedy, 2015a, b.). In certain countries such as Arab and Islamic, domestic violence is not considered a major issue; however the incidence of violence is increasing (Alhabib et al., 2009). Domestic violence may be considered a private matter and the wife may consider the abuse is justified. Certain excerpts from religious beliefs have been used

to promote violence against women (Alhabib et al., 2009). However, the abuse is more likely to be that of culture practices than of religion.

Socioeconomic Factors

Domestic violence occurs across all socioeconomic level; however, women in the lowest income households have (7 times) the abuse rates of those in the highest income households (Kennedy, 2007; Rennison, & Welchans, 2000). In addition, women with children under 12 experience twice the rate of abuse than those without young children.

Studies of the socio-demographic correlated with domestic assault revealed higher rates of violence among poorer, less educated, unmarried, African-American, Latino and urban couples (Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008). Factors such socioeconomic status, ethnicity and unemployment contribute to a woman being abused (Kwesinga, Bell, Pattie, Moe, & 2007; Tolman, & Rosen, 2001). Blacks and whites with the same economic characteristics have similar rates of intimate partner violence and levels of economic distress in disadvantaged neighborhood (Benson & Fox, 2004).

Education. Education level and the environment had a direct effect on the incident of violence (Persily & Abdulla, 2000). Scholars found higher rates of violence in couples when woman's educational status was higher than her husband's status (Horning, McCullough, & Sugimoto, 1981).

Increase immigration has accompanied lower education status among women, poor households contributing to the abuse of women (Rennison & Welchans, 2000). Women with young children who are more dependent in their relationships and with fewer resources are more likely to be abused in a relationship (Kennedy, 2007).

Income. Research indicated that low income and female headed households have a high incidence of abuse (Lutenbacher & Hall, 1998). Women in lower income are more frequently victims of domestic violence than wealthier women (Rennison & Welchans, 2000). Women who are cohabitating may be more able to leave abusive relationships and may therefore be expected to experience lower levels of violence (Villarreal, 2007). Researchers suggested that the greater isolation and the implied lower level of commitment by the male partner may actually place them at greater risk (Villarreal, 2007).

Occupation. The occupation of women varies with intimate partner violence and women. Moe (2007) found women living in a shelter who were highly educated with successful careers. They were not ignorant but their circumstance prevents them from living safe in their present environment to include home and work regardless of salary. Unemployment contributes to a woman being abused (Kwesinga, Bell, Pattie, & Moe, 2007). The lack of jobs and chronic unemployment may be contributing factors in the violence of women.

CDC (2012) reported that women in healthcare, production and office/administration had the highest proportion of homicides related to intimate partner violence. Over half of the homicides committed by intimate partners occurred in parking lots and public buildings.

Race. Black women are (35%) more likely to be abused than White women and (2.5 times) more likely to be abused than women of other ethnic groups (e.g., Hispanics and Asian/Pacific Islanders) (Kennedy, 2007; Rennison & Welchans, 2000). Factors for making a person more at risks for domestic violence are being young, black, poor and divorced or separated (Kennedy, 2007; Rennison & Welchans, 2000). However, other research reported that Indian/Alaskan Native women experience higher rates of physical abuse (Tjaden & Thoennes, 2000a, b). Also, domestic violence caused the premature death among African American women between the ages of 15-44 (Campbell, Sharps, Gary, Campbell, & Lopez, 2002).

Age. Women aged 16 to 24 experienced the highest per capita rate of domestic violence (U.S. Department of Justice, 2005). Approximately, (23 to 52%) of women have experienced abuse during pregnancy (Humphries, Parker, & Campbell, 2001; U. S. Department of Justice, 2000). Young women between 16 to 29 years report domestic violence incidents more frequently than older women (Campbell, 2002).

Gender. Although women are less likely than men to be victims of violent crimes overall, women are (5 to 8 times) more likely to be raped assaulted or murdered by a romantic/intimate partner (Mahoney, Williams & West, 2001). Intimate violence victims experience multiple victimizations by the same perpetrator over time (Mahoney, Williams, & West, 2001).

Research reported that men and women engage equal levels of abuse and control, such as diminishing the partner's self-esteem, isolation, jealousy, using children and economic abuse (Coker et al., 2002; Hammock & O'Hearn, 2002). However, men engage in higher levels of sexual coercion and can more easily intimidate physically (Coker et al., 2002; Hammock & O'Hearn, 2002). Research reported that men and women assault one another and strike the first blow at approximately equal rates (Archer, 2000). Individuals who are controlling of their partners in their relationship are much more likely to also be physically assaultive, and this holds equally for both male and female perpetrators (Felson & Outlaw, 2007). However, in some cases, societal norms support female perpetrator in abuse home (Straus, Kaufman-Kantor, & Moore, 2017). Men tend to kill their female partners after an extended period of abuse, whereas females usually kill male partners in self-defense or at least to preempt what they perceive to be inevitable further victimization (Kennedy, 2007; Websdale, 1998)

Marriage Status. Marital status is also a demographic of domestic violence (Bauer, Rodriguez, Perez, & Stable, 2000; Persily & Abdulla, 2000). Divorced and separated women are much more likely to report being abused than married women (Rennison & Welchans, 2000). Women especially young children are more dependent on their relationships and have fewer alternatives for self-sufficiency outside their relationships and consequently, are more likely to be abused (Rennison & Welchans, 2000)

Health Conditions in Victims of Intimate Partner Violence

This section consists of the common *health conditions* found in victims of domestic violence. The model included "Health Conditions" to include the physical health conditions and the mental health conditions based on research studies on intimate partner violence.

Physical Health Conditions

Abused women had higher rates of physical health problems (Basile & Smith, 2011; Campbell, 2002; Coker, Smith & Fadden 2005; Dutton et al., 2006; Felbinger & Gates, 2008; Husso et al., 2012; Jaffe, Baker, & Cunningham, 2004; Trevillion, Agnew-Davies, & Howard, 2013; Trevillion et al., 2012). Some of the common problems are complain of headaches, insomnia, hyperventilation, chest pain, back pain and pelvic pain (Dutton et al., 2006). Common injuries included head injuries, contusions, abrasions, minor lacerations, fractures, sprains and injuries during pregnancy (Dutton et al., 2006). Research reported that women with a history of victimization use more medical services than nonvictimized women (Basile & Smith, 2011). In a comprehensive review of the literature, Dillon reported that intimate partner violence was associated with poor physical conditions such as poor functional health, somatic disorders, chronic pain, gynecological problems and increase risk of STIs. In addition, HIV/AIDS was associated with a history of sexual abuse and violence.

Women who are victims of domestic violence suffer a range of physical, emotional and psychological effect or injuries (Trevillion et al., 2013; Trevillion et al., 2012). Women

experienced intimate partner violence suffer numerous physical problems such as bruises, lacerations, contusions, abrasions, sprains, fractures and head traumas (Dutton et al., 2006; Trevillion et al., 2012).

Injuries sustained during violent episodes related to physical and psychological abuse are linked to a number of adverse physical health effects including arthritic, chronic neck or back pain, migraine and other frequent headaches, stammering problems, sexually transmitted infections, chronic pelvic pain and stomach ulcers (Jaffe et al., 2004). Other problems reported as associated with abuse are insomnia, hyperventilation, chest pain, back pain and pelvic pain (Dutton et al., 2006). Even hypotension has been reported in abused women and contributes to morbidity and mortality (Campbell, 2002). Visits to the emergency department were often followed by a recent abusive episode (Campbell, 2002).

According to CDC (2014), women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner are more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than men and women who did not experience these forms of violence. Women who had experienced these forms of violence were also more likely to report having asthma, irritable bowel syndrome and diabetes than women who did not experience these forms of violence.

Women who are abuse use more health services than non-abused women (Bonomi et al., 2009; Rivara, Anderson, Fishman, Bonomi, & Reid, 2007). Campbell et al. (2002) in a research study of women who experience IPV found poor general health, headaches, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, pelvic pain, painful intercourse, urinary tract infection, loss of appetite, abdominal pain and digestive problems. A cross-sectional survey was conducted by Coker, Smith, and Fadden (2005) of 1,152 women in the United States who attended a family practice clinics from 1997 to 1998 to examine the types of disabilities among IPV victims (including physical, psychological and sexual abuse) compared with non-abused IPV victims (including physical, psychological and sexual abuse). The investigators found that women with current and past IPV were more likely to report disability preventing work, generalized chronic pain, nervous system disorder, respiratory problems, epilepsy or migraines, chronic disease, autoimmune condition and blindness or glaucoma. Women with current IPV had a stronger association with disability by category except generalized chronic pain. In an analysis of the *National Violence Against Women Survey (NVAWS)*, Coker et al. (2002) found that women who were victims of IPV had a greater risk for poor health, chronic diseases and injuries.

Gynecological problems are often associated with victims of domestic violence (Felbinger & Gates, 2008). These common gynecological problems include pelvic pain, sexual transmitted diseases and HIV/AIDS. HIV/AIDS have a long-term effect of the health care in victims of sexual abuse (Felbinger Gates, 2008). Victims of domestic violence often experience obstetric complications such as miscarriage, premature labor, placental separation (Feblinger, 2008). These complications often lead to the death of mother or fetus. Gynecological problems like recurring or chronic pelvic pain, sexually transmitted diseases and HIV usually have a long-term effect of the victims (Feblinger, 2008). In women who experience domestic violence, obstetric complications such as miscarriage, premature labor and placental separation can contribute to very serious outcomes like death of the mother or fetus.

Ruiz-Perez, Plazaola-Castano and del Rio Lozano (2007) compared 1,402 women's experiences to psychological abuse, physical abuse and sexual abuse to chronic illnesses in Spain

who attended 23 of chosen family practices. There was an overall positive association between intimate partner violence and poorer physical health.

Husso et al., (2012) conducted a study on reviewing the understanding of health providers about the importance for screening for intimate partner violence. This study used 6 focus groups consisting of 30 nurses, social workers, physicians and psychologists working in health care in Finland Health Care District. The results of findings in this study reported a tendency for health professionals to focus on fixing the injuries and consequences of domestic violence while bypassing violence as the cause of symptoms and injuries.

Research and literature reports of physical and mental conditions. Research reported physical and mental health conditions in studies (Bonomi et al. 2006; Bonomi, Anderson, Rivara, & Thompson, 2007b; Dutton et al., 2006; Eaton et al., 2016; Gass, Stein, Williams, & Seedat, 2010; Lacey, Sears, Matusko, & Jackson , 2015; Lipski & Caetano, 2007; Pereira, Lovisi, Pilowsky, Lima, & Legay, 2009; Stene, Jacobson, Dyb, Tverdal, & Schei, 2013). Physical and mental problems reported long and extensive health consequences. Lipski and Caetano (2007) reported physical and mental health problem associated with IVP: (1) arthritis, chronic pain syndromes such as neck or back pain, migraine or other types of headache, chronic pelvic pain; (2) gynecological problems, including sexually transmitted diseases and exposure to HIV/AIDS; (3) gastrointestinal disorders such as peptic ulcers, chronic irritable bowel syndrome and frequent indigestion diarrhea or constipation; (4) pregnancy related problems, such as prenatal fetal injury, complications of pregnancy and presentation of labor without prenatal care (Lipski & Caetano, 2007). In addition to the physical and mental problems, the list of reported health consequences was long and extensive.

A worldwide observational study of 24,097 women was conducted by Ellsberg et al. (2008) in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand, Serbia and Tanzania. A standardized questionnaire was used to allowed women to self-report their overall health status, difficulty walking, difficulty with daily activities, pain, memory loss, dizziness and vaginal discharge. The results of this study showed significant associations between lifetime experiences of physical violence, sexual violence, or both by a male intimate partner and a wide range of self-reported physical and mental health problems in women.

Health behavior and coping effected health outcome among victims of intimate violence (Dillion et al., 2013; Gass et al., 2010). Dillon et al. (2013) conducted a comprehension review of research literature on mental and physical health and intimate partner violence. Findings from these studies reported that IVP was associated with mental health conditions as such depression, PTSD, anxiety, self-harm and sleep disorder. The presence of PTSD had an additional effect on health behavior, coping and health outcomes for chronic diseases such as diabetes, cancer, HIV/AIDS and heart disease which may require strict medical compliance and adherence to care regimen (Dillion et al., 2013). Gass et al. (2010) examined data from cross-sectional data from South Africa Stress and Health Study. Researchers assessed exposure to intimate partner violence, health-risk behaviours, health-seeking behaviours and chronic physical illness among a sample of 1,229 married and cohabiting women. Results of findings reported the prevalence of reported violence was 31%. This correlated with several health risk behaviors such as smoking, alcohol consumption, use of sedatives, analgesics, cannabis and health seeking behaviors. IPV wasn't suggestively linked with chronic physical illness, although rates of headache, heart attack, and high blood pressure reached near significance. These women also had a higher rate of visits to doctors and healers and substance use was linked to the cause or progression of chronic illnesses.

Bonomi et al. (2006) in a study of 3,429 of insured women between the ages of 18 and 64 years old were analyzed for sexual and physical intimate partner violence with depression and overall physical health. Results indicated adverse health effects in women exposed to sexual intimate partner violence and persisted many years after the abuse stopped. Compared to never abused women, women with both physical and sexual intimate partner violence had increased prevalence of depression and physical symptoms. Abused women were also more likely to report only fair or poor health as opposed to good health. In a cross-sectional study Lacey et al. (2015) evaluated the association between intimate partner violence and mental and physical health status of US Caribbean Black and African American women over 3 years (2001-2003). Severe intimate partner violence was associated with negative mental and health outcomes in these groups with difference patterns. Research findings reported an increase risks for lifetime dysthymia, alcohol dependence and poor perceived health in African American victim of partner abuse in contrast to binge eating disorder among Caribbean Black women.

Stene et al. (2013) in a population-based cohort study of Norwegian women aged 30-60 years using a cross-sectional data and clinical measurement from Oslo Health Study (2000-2001) reported physical and psychological effects related to intimate partner violence. Cross-sectional analyses showed that women who reported physical and/or sexual IPV and psychological IPV alone were more often smokers compared with women who reported no IPV. Physical and/or sexual violence was associated with abdominal obesity, low high-density lipoprotein cholesterol and elevated triglycerides. Bonomi et al. (2007b) examined the health outcomes in women exposure to physical intimate violence, sexual IPV or sexual and physical IPV and the burden of sexual IVP. A random sample of insured women (N=2876) was solicited to participate in a telephone interview to assess lifetime exposure to physical IVP only, or physical and sexual IVP (Behavioral Risk Factor Surveillance System) and mental, social and physical health. Results of findings reported that compared to never abused women, pronounced adverse health effects were observed for women with sexual exposure. Women with physical and sexual IVP had more symptoms, reported fair to poor health. In a second, analysis women with sexual IPV or physical and sexual IPV has lower score and increase depression compared with physical IPV only.

Eaton et al. (2016) conducted a case-control study of women with an ICD9 diagnosis of IPV enrolled in 2005-2006 Kaiser Permanente Northern California. Participants were matched on visit date, age, and facility with women without such a diagnosis. The study population was divided into subsets: ages 45-53 years (318 cases, 1588 controls); ages 54-64 years (200 cases, 1000 controls). Data were extracted from electronic records of all calls to AACC in the 12-month period preceding case anchor dates. Results of findings reported the presence of psychiatric problems, injuries, headache and UTI. Information of women in electronic medical record can be useful in identifying patterns of symptoms and diagnosis among women in midlife age.

Mental Health Problems

Research has consistently demonstrated a strong association between mental health problems and intimate partner violence (Al-Modalla et al. 2012; Avidbegovic & Sinanovic, 2006; Basile & Smith, 2011; Bonomi et al., 2009; Campbell, 2002; Ehrensaft, Moffit, & Caspi, 2006; Dami et al., 2017; Ferrari, et al. , 2016; Golding, 1999; Hirth & Berenson , 2012; Lipski & Caetano, 2007; Peltzer, Pengpid, McFarlane, & Banyini , 2013 Pereira et al., 2009; Pigeon et al., 2011; Thananowan & Vongsirimas, 2014; Trevillion et al., 2013; Voss et al., 2006; Zlotnick, Johnson, & Kohn, 2006) . Often women who are battered developed mental health disorders (Campbell, 2002). The long experience of IVP resulted in depression and post-

traumatic stress disorder (PTSD) (Pereira et al. 2009). Psychological abuse was a significant predictor of post-traumatic stress disorder (PTSD) which was (3 to 5 times) more prevalent among abused women, but not abused men (Ehrensaft et al., 2006).

Domestic violence involves injury, illness, isolation and complex psychosocial problems (Lipski & Caetano, 2007). Partner violence may function as an acute or chronic stressor that leads to adverse mental health or physical health outcomes (Lipski & Caetano, 2007). For example, post-traumatic stress disorder is common among people who encounter intimate partner violence with an average prevalence of (64%) across studies (Lipski & Caetano, 2007). Posttraumatic stress disorder (PTSD) includes emotional numbness, trouble sleeping, flashbacks or reliving the incident, feeling easily startled and avoiding reminder on traumatic events (Basile & Smith, 2011). Furthermore, mental health problems like anxiety, depression and posttraumatic stress disorder are associated with the effects of domestic violence (Trevillion et al., 2012).

Regardless if the females' exposure to violence was long or short-term, there is a strong association with mental health problems (Trevillion et al., 2012). A paucity of research has reported intimate partner violence directly affected mental health conditions, especially depression and PTSD (Ehrensaft et al., 2006; Golding, 1999; Lee, Pomeroy & Bohman, 2007; Pereira et al., 2009; Trevillion et al., 2012; Trevillion et al., 2013). However, inconsistent results of research findings have been reported across ethnic groups, which could be related to cultural norms or stigmas.

Intimate partner violence accounts for approximately, (8%) of the overall disease burden for women ages (18 through 44 years). These diseases included higher rates of depression, anxiety and suicide plus increased harmful health related to behaviors such as tobacco alcohol, and other substance abuse (Vos et al., 2006).

Golding (1999) conducted a meta-analysis of abused women. The results of finding reported the mean prevalence of depression and PTSD among abuse women was 47.6% and 63.3% respectively. However, among the general population the prevalence of depression ranged between 10.2% and 21.3% and PTSD rates from 1.3% and 12.3% amongst general population.

In a cross-sectional study of 210 pregnant Latina women by Rodriquez, Heilemann, Fielder, Nevarez, and Mangione in a prenatal clinic, the relationship between IPV and PTSD or depression was examined. Findings of this study reported that pregnant women who had experience IVP were at greater risk for depression than women who did not experience IVP. Pregnant women who were positive for IVP and had experience 2 traumas had more significant PTSD symptoms and depression symptoms compared to pregnant women who were negative for IPV and had not experienced trauma or had experience fewer than two traumas.

Using a structure equation modeling, lee et al. (2007) examined the mediating effects of social support and coping and association of abuse and psychological outcomes (e.g., depression and PTSD) of 100 Caucasian women and 61 Asian women. Findings reported the level of IVP directly affect psychological outcomes through coping and social support. There was a direct affect of the level of IPV on psychological outcomes for Asian women but no affect for Caucasian women. Pigeon et al. (2011) in a study examined the insomnia and nightmares among 121 women exposed to intimate partner violence. Participants with and without depression were compared on demographic, abuse and sleep characteristics as were those with and without suicidality. Results revealed clinically significant insomnia and nightmares were observed in 46% and 32% of participants, respectively. Depressed women had more severe PTSD and were more likely to have insomnia and to have nightmares than nondepressed women.

Zlotnick et al. (2006) conducted a national survey of 6,451 of women who experienced domestic violence. Findings from this study reported a relationship between the degree of physical violence and depression. Participants who experience IVP were at a greater risk for a long-term depression and more excessive digress of depression. Yoshihama, Horrocks, and Kamano (2009) conducted a population-based study of 2,400 women in Japan. This study examined the relationship between health indicators and IPV in a stratified cluster sample. Findings from study found relationships between IPV and 9 of 11 health indicators among women who experienced emotional abuse and women who reported emotional abuse plus physical or sexual abuse. Women who reported emotional abuse plus physical or sexual abuse were at greater risk of a number of distress symptoms and suicidal symptoms after adjusting for age, relationship status, number of children, education and socioeconomic status compared to women who reported no IPV. Women who experienced only emotional abuse reported higher suicidal ideology and a greater amount of distress. Ali, Mogren and Krantz (2013) in a cross-sectional study of 759 Pakistani women between the ages of 25 and 60 years reported women with intimate partner violence was associated with mental health problems. The strongest associations were found for suicidal thoughts and physical violence, sexual abuse, and psychological abuse.

Wittenberg, Joshi, Thomas, and McCloskey (2007) led a qualitative focus group study of 8 groups consisting of 40 women. Participants reported that intimate partner violence affected their physical functioning, social functioning, emotional and psychological functioning and their children's functioning. Al-Modalla et al. (2012) in a research study of 101 Jordanian married or engaged women working in administrative and academic position reported an association of IPV and mental health conditions. Nearly half of the participants reported partner violence. Compared with non-abused women, abused women showed significantly higher levels of depressive symptoms and stress, while self-esteem did not differ significantly between the two groups.

In a case control study by Peltzer et al. (2013) of 268 women in a South African district, there were a substantial number of women who had experienced intimate partner violence that currently had post-traumatic stress disorder and depression. This study concluded that physical and sexual violence contributed to the predication of post-traumatic stress disorder. Hirth and Berenson (2012) in a cross-sectional sample of 2414 young African American, Hispanic and white women examined depression in these groups. Twenty-four percent reported a level of depressive symptoms that warranted further evaluation for major depressive disorders. White women also reported higher rates of PTSD symptoms, IPV and traumatic events.

Avidibegovic and Sinanovic (2006) conducted a randomized controlled trial study of 283 women from Bosnia and Herzegovina above the age of sixteen. Some of these women were from the general population while others were refugees, domiciles and women receiving psychiatric treatment. The findings from this study disclosed moderate to high neuroticism, moderate to severe depression, higher intensity of psychological symptoms of somatization, paranoid tendencies, obsessive compulsive disorder, and anxiety.

Ferrari et al. (2016) conducted a cross-sectional study of 260 women 16 seeking help at two domestic violence and abuse services in a voluntary sector in two United Kingdom communities. In this study variables included age, education, income, current relationship, number of children, employment, mental health status from the past, use of marijuana, alcohol abuse, severe abuse, emotional abuse, physical abuse, harassment, subjective well-being, depression, anxiety and post-traumatic stress disorder. Women domestic violence abuse survivors who sought support

from the domestic violence abuse services were shown to have experienced high levels of abuse faced depression, post-traumatic stress disorder and anxiety.

Dami et al. (2017) conducted a survey of 142 people who visited a primary care through emailing and social networking. The sample consists of 18 (12.7%) men and 124 (87.3%) women. Results of finding reported that intimate partner violence effect the mental health of victims contributing to severe depression and other mental health disorders. Kothari et al. (2016) in a cross-sectional study of 301 postpartum women 2 months after delivery examined socioeconomic status moderated the association between intimate partner violence (IPV) and postpartum depression. Results of findings reported that 10% of participants screened positive for postpartum depression, 21.3 % screened positive for current or previous adult emotional or physical abuse by a partner, and 32.2 % met poverty criteria. Findings reveal that IPV was strongly associated with postpartum depression, outweighing the influence of socioeconomic status upon depression for postpartum women.

Pigeon et al.(2011) examined 121 women who were exposed to domestic violence. Participants with and without depression was compared on demographic, abuse and less characteristics and those with and without suicidality. Research findings reported insomnia and nightmare in 46% and 32% of participants. Women wth depression has more severe PTSD and more likely to have insomnia and nightmares than nondepressed women. Victims of domestic need to be evaluated for sleep disturbance and treatment considerations need to include comorbid mental health symptoms. Thananowan and Vongsirimas (2014) compared women's (stress, depression, self-esteem and social support) among non-abused and abused women, specific (physical, sexual and emotional violence) on the mental health of abused in Thailand women, and identify the influence of specific types of violence on stress, depression, self-esteem and social support. Results revealed that abused women reported significantly higher stress and depression and had lower self-esteem and social support than non-abused women. Women who experienced emotional violence had significantly higher stress and depression but lower self-esteem and social support than those experiencing physical and sexual violence. Only emotional violence had a significant effect on stress. Sexual violence was the strongest predictor of depression, self-esteem and social support. Physical violence had no effect on mental health.

Screening, Health Assessment and Interventions for Intimate Partner Violence

Females need to be screened for domestic violence when they access the healthcare organizations. An adequate assessment may be completed if needed based on results of screening. Interventions or referrals are based on their individual needs (USDHHS. 2013).

Battered women seek help daily for trauma, medical and psychological problems in different health services organizations to include primary care (e.g. family medicine, antepartal care, family planning, gynecological, post-abortion services and child services) (Garcia-Moreno et al., 2014, a,b). Emergency services are more likely to treat women who are injured or raped (Garcia-Moreno et al., 2014, a, b). Despite women experiencing injuries from domestic violence seeking treatment in the emergency department; research indicates that women are commonly not asked about intimate partner violence (USDHHS. 2013).

Women who experience partner abuse or sexual assault have a greater likelihood of having reproductive problems, mental health problems, chronic health problems and more negative behaviors including substance abuse and even death (Global Health Council, 2005). Women exposed to childhood violence may result in increased alcohol abuse, substance abuse, self-harm and victimization later in life (Garcia-Moreno et al., 2014, a, b).

Access to health care may be limited in rural areas and lack adequate skilled staff (Quaraisha et al., 2010). Other barriers include the stigmatization, discriminatory attitudes and the limited practice of health provider (Quaraisha et al., 2010). Victims of sexual violence face challenges in access to care and scarcity of resources (Quaraisha et al., 2010). Survivors of rape may fear perpetrator and repeated episode of violence from the perpetrator. Victims of domestic violence typically will not disclose the abuse unless direct questions are asked (Rose et al., 2011).

As mentioned, despite access to these health services organizations, only a small proportion of abused women are identified by health professionals (Hage, 2006; Lipski, & Caetano, 2007.) Often, health providers treat the injury or illness without addressing the underlying cause or causes that contributes to them (Hage, 2006). In the worst case scenario, their abuse goes unrecognized and without referral (Lipski, & Caetano, 2007.) This is especially true for women who are employed outside of the home. Their non-reporting is attributed to several reasons: guilt, shame because they feel that they should know better, fear of losing one's job and economic reasons (Hage, 2006). Health professionals especially nurses, who are on the front-line, often are not prepared to handle victims of domestic violence when they access the healthcare system (Felbinger & Gates, 2008; Hayward & Weber, 2003; Ramsey et al., 2012). More education is needed for health professionals to increase their knowledge when victim of violence access their services. Ramsey et al. (2012) conducted a prospective observational cohort study in 48 general practices from Hackney in London and Bristol, United Kingdom. Findings from this study reported the lack of health professionals e.g., doctors and nurses in basic knowledge in domestic violence. However, their attitudes toward women experiencing domestic violence were generally positive. The research reveals the need for more training on assessment and intervention and the availability of local domestic violence services. Therefore, the author proposes that domestic violence needs to be included in curriculum of health professionals in universities and colleges. Also, continuing education is needed in the workplaces. Health professionals in various organizations identified work priorities, fears about offending patients, lack of confidence and expertise in dealing with domestic violence as a barrier in caring for this group (Trevillion et al., 2012).

Research reported that health professionals lack knowledge and skills needed to intervene with victims and families (Hayward, & Weber, 2003; Ramsey et al., 2013). In one study by Hayward (2013), victims viewed nurses as unconcerned, uninterested, judgmental and unwilling to help. Therefore, it is important for nurses to be aware of their own attitudes and beliefs about domestic violence to better care for victims. Often, patients who access the healthcare system are not comfortable about disclosure of these experiences because of shame, embarrassment and the fear of danger for self and children if perpetrator is aware of disclosure (Trevillion et al., 2012). Health professionals need to be aware that the perpetrator may cover up or deny violence toward patients. Victims may have difficulties sharing experiences out of fear and may try to avoid or put away traumatic experiences of abuse.

Health professionals need to recognize the relevant of violence when women present certain illnesses (Alhabib et al., 2009). Also, healthcare professionals are often less confidence in dealing with domestic violence because of fears about defending patients and workplace priorities as a barriers (Agar, Read, & Bush, 2002; Minsky-Kelley, Hamberger, Pape et al., 2005). They fear further violence by perpetrator because of disclosure. In addition, victims are shamed and embarrassed of the situation and fear children may be removed. In some cases, the victims may block this traumatic experience (Rose et al., 2011). Healthcare professionals can assist patients in overcoming self-blaming behavior (Ellsberg et al., 2008). Therefore, they need

to provide a supportive therapeutic relationship with patients. Healthcare professionals need to be trained in domestic violence (Ellsberg et al., 2008). They need to ensure the safety of patient experiencing domestic violence as a priority (Ellsberg et al., 2008). These victims access the healthcare system more in comparison to the general population (MacMillian et al., 2006). Victims of domestic violence typically will not disclose the abuse unless direct questions are asked (Bacchus et al., 2006; Howard & Hunter, 2008; Rose et al., 2011).

Health professionals need to have a trusting, supportive, non-judgmental approach when conversing with suspected victims to facilitate an awareness of abuse. This approach will be effective in assisting patients with disclosure of abuse and overcoming barriers of abuse (Trevillion et al., 2012). Confidentiality is important to assist patients in feeling safe and encouraging disclosure. Health professionals need to provide patients who are victims of abuse with safety plan at home, community resources (e.g., support groups) and advocacy groups (Trevillion et al., 2012).

Victims of domestic violence experience being fearful, concerned for safety and post traumatic stress disorder (PTSD) symptoms and the need for health care when injured (CDC, 2013). Also, they need resources on contacting a crisis hotline, housing services, victim's advocate services and legal services (CDC, 2013).

A standard risk assessment and documented report of violence incidents (e.g., injuries) would be useful when clients access health organizations (Ellsberg et al., 2008). Typically, victims of domestic violence have increase contact with health services (MacMillian, Wathen, Jamieson et al., 2006).

Strategies when assessing. Recommendations for identifying health promotion strategies will be addressed based on research studies. In a meta-analysis study by O'Doherty et al. (2014) examined eight studies with 13027 women whether healthcare professionals asked about abuse, discussed abuse, and/or documented abuse in participating women's records. Results of findings reported that it may be more effective to educate healthcare professionals to ask women who show sign of abuse or those in high risk groups and provide them with a supportive response and information and plan them for their safety. Universal screening intervention that includes health professionals just asking if they experience domestic violence was not effective. Healthcare professionals need to identify signs and symptoms of intimate partner violence rather than just screening.

According to Prosman, Lo Fo Wong, and Lagron-Janssen (2014) research has reported that a prevalence of 37-41% women in entering family practice have experience intimate partner violence. These women often do not disclose IVP because of self-blame, hopelessness, the urge to protect their family and feeling powerlessness. Health professionals typically don't ask about partner violence to avoid offending them and not knowledgeable what support is need.

A descriptive cross sectional study by Hanson (2010) investigated risky health behaviors of 1,608 adolescent women reporting intimate partner violence. Findings showed that adolescent women who reported intimate partner violence or forced sex were more likely to engage in risky behaviors and less likely to be engaged in health enhancing behaviors. This study further emphasized the need for health providers to ask patients about intimate partner violence since risky behaviors can lead to health problems in the future. A cross sectional survey was conducted by Miller et al. (2010) of 448 English and Spanish speaking adolescent females being seen in the healthcare setting who were screened for intimate partner violence. Less than one third of participants were ever screened for intimate partner violence by their health providers.

These same patients using adolescent clinics appear to be a population that is at higher risks for intimate partner victimization regardless of the reason of seeking for care.

Intimate partner violence is a growing concern with the older women (Bonomi et al., 2007a). Bonomi et al. (2007a) randomly sampled 370 English-speaking women 65 year old and older from healthcare systems using a cross-sectional telephone interview. Using the BRFSS, lifetime partner violence prevalence was 26.5%; 18.4% of women experienced physical or sexual violence and 21.9% experienced nonphysical violence (threats or controlling behavior). The implication of study suggested a need to for increased efforts to address partner violence in older women. Researcher suggested tools with questions to address violence and other health issues. However, best practice protocols need to be in place when women report abuse (Ellsberg et al., 2008).

Research has reported that a lack of privacy, negative feelings and attitude regarding screening and a lack of time (Farbood et al., 2014). Health professionals need to routinely administer a valid domestic violence risk assessment in their practice to assess victims of domestic violence (Bonomi et al. 2007b; Ellsberg et al., 2008).

In the model, when improving better health outcomes for this group, a holistic approach is needed focusing on the biopsychosocial-spiritual aspect for victims of intimate partner violence. This approach encompasses every aspect of the person. These strategies are needed:

- Conducting risk assessment or screening tools in health services organizations where they access care (Bonomi et al, 2007b; Ellsberg et al., 2008). Screening instruments for intimate partner violence can be useful in identifying victims of intimate partner violence (Nelson, Bougatsos, & Blazina, 2014). Universal screening involves a standardized assessment of all patients, regardless of their reasons for seeking medical attention or patient history (Wathen & MacMillan, 2012). A diversity of recommendations have been made by organizations related to universal screening to be included as part of routine health histories, new patient encounters, screening frequent regardless of warning signs and risk factors and women of childbearing age (USDHHS, 2013). Research has reported numerous effective screening tools. The use of screening is effective in reducing intimate partner violence and improving health outcomes.
- Identifying the physical, mental health conditions and risky behavior related to intimate partner violence (Alhabib et al., 2009). Often, the physical problems are identified and treated and the mental health problem may be overlooked .Mental health problem may not be identified because the health professionals may focus on the physical health conditions.
- Assessing for sign and symptoms of intimate partner violence was found to be more useful than just universal screening (O'Doherty et al., 2014). The signs and symptoms of intimate partner violence are useful when health providers are conducting a health assessment. Research reported that when victims of domestic violence access certain health services organization, health professionals have a tendency to focus more on treating the injuries and consequences of domestic violence while overlooking violence as the cause of symptoms and injuries (Husso, Virkki, Notko, Holma, & Laitila, 2012).
- Providing and identifying community resources (CDC, 2013; Quaraisha et al., 2010; Trevillion et al., 2012). It is important to identified community resources to victims of domestic violence and perpetrators. These resources may include

social services, counseling services and support groups. Health professional need to provide resources on contacting a crisis hotline, housing services, victim's advocate services and legal services (CDC, 2013).

- Providing the appropriate medical treatment (Hage, 2006; Lipski, & Caetano, 2007). It is essential to provide the appropriate medical treatment for the specific conditions. If abuse of women is unrecognized, referrals are not made to the needed services or resources (Lipski, & Caetano, 2007). . The health providers treat the injury or illness without addressing the underlying cause or causes that contributes to them (Hage, 2006). Health professionals need to recognize the relevant of violence when women present certain illnesses (Alhabib et al., 2009).
- Providing the appropriate interventions after a women disclose abuse through the screening process (USDHHS, 2012). Psychosocial treatment is provided or the appropriate referrals are made for mental health problem or clergy services (Howard & Hunter, 2008; Rose et al., 2011). Some health services organizations may have medical and mental health services (Howard & Hunter, 2008; Rose et al., 2011). However, other health services organizations such a primary care may focus more on the physical conditions and treat patients with anxiety and those with mild and moderate depression. However, certain patients with complex mental problem need to be referred to mental health services or faith-based services. Research reported diverse forms of interventions have shown improvement in patient outcomes.
- Providing safety for victims of abuse when identified (Ellsberg et al., 2008; Kennedy, 2007; Kennedy, 2015a, b; Trevillion et al., 2012). Health professionals need to ensure that the victims are safe to include contacting the criminal justice system or legal services if needed, providing client with contact information related to escape plan and local shelter for victims of abuse.

Summary

A holistic approach is needed when improving the health outcomes of victims of intimate partner abuse. A thorough comprehensive assessment needs to incorporate information about a client's physiologic, psychosocial, spiritual health, cultural and environmental factors as well as client's developmental status. The health assessment process should include data collection, documentation and evaluation of the client's health status and responses to health problems and intervention (USDHS, 2013). Physical and psychiatric problems are the result of domestic violence with victims having increase use of health services compared to those not abused (Trevillion et al., 2012). Often, domestic violence is not identified in the health services organizations when victims access care. Typically, health providers treat the injury or illness without addressing the underlying cause or causes that contributes to them (Hage, 2006). In the worst case scenario, their abuse goes unrecognized and without referrals (Lipski, & Caetano, 2007).

Health professionals need to recognize the relevant of violence when women present certain illnesses in commonly attend health services organizations (Alhabib et al., 2009). Adequate assessment and interventions in health services organization are needed (Bonomi et al, 2007b; Ellsberg et al., 2008). Domestic violence needs to be included in curriculum in universities and colleges for health professionals. Continuing education on domestic is needed in the workplace for health professionals. In addition, healthcare professionals need to conduct valid screening and assessment tools in health services organizations where women access care. Future

evidence-based research is needed to identify effective approaches to screening for identifying more effective interventions to improve women health outcomes.

Conclusion

To conclude, more evidence-based research is needed to assist health professionals in finding more solutions to better assess victims of domestic violence and interventions to improve health outcomes. Future strategies needed to include protocol, standards, guidelines and policy development for identifying victims of intimate partner violence when they access health services organizations.

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