PREVALENCE OF ABUSE

A nationally representative sample of 8,000 U.S. women showed that 20% had been sexually and/or physically abused by a current or former spouse (Tjaden & Thoennes, 2000). Estimates are that as many as 69% of women have been abused at least once in their lifetime (Pico-Alfonso et al., 2006). The impact of intimate partner violence (IPV) on a woman’s psychological and physical well-being is significant. Women of all ages, socioeconomic status, education, and race encounter abuse (Smith, 2008). Many factors play a role in the occurrence of the abuse, and the prevalence varies depending on geographical location and on how abuse is defined (Libbus et al., 2006). The role of the healthcare provider (HCP) is critical in screening and providing assistance for the abused woman and her children.

The U.S. Centers for Disease Control and Prevention (CDC) defines abuse as follows:

- Physical abuse is when a person hurts or tries to hurt a partner by physical force.
- Sexual abuse is forcing a partner to take part in a sex act when the partner does not consent.
- Verbal abuse is the use of words to control and/or manipulate (Smith, 2008).
- Threats of abuse include the use of words, gestures, weapons, or other means to communicate the intent to cause harm.
- Emotional abuse is threatening a partner or her possessions or loved ones, or harming a partner’s sense of self-worth and includes stalking, name-calling, intimidation, or not letting a partner interact with friends and family (CDC, 2009).

The cycle of abuse involves a pattern of violent acts leading to the “honeymoon phase” in which the abuser is apologetic (Smith, 2008, p. 23). Subsequent violent acts tend to be more aggressive in nature. One study found a significant increased rate (0.83) of sexual abuse at the onset of pregnancy (Martin et al., 2004). An estimated 30% to 75% of children are abused in families in which a parent is abused (Smith, 2008).
FEELING SHAME

IPV often leads to negative repercussions. Studies have found abused women suffer from depression, anxiety, and posttraumatic stress disorder (e.g., Certain, Mueller, Jagodzinski, & Fleming, 2008; Smith, 2008). Significant factors lead to the woman feeling shame. Women, in a study exploring the experience of IPV, help received, and survival (Flinck, Paavilainen, & Astedt-Kurki, 2005), viewed their lives as “loveless and devoid of emotion” while in the abusive relationship. They felt as if they were used as sexual objects; extramarital affairs were common. One woman stated, “He said he needs another woman because I don’t satisfy his requirements” (p. 386). The women were made to feel worthless. Their view of marriage was tainted, and they felt fear and shame for the failure of the marriage. Other factors contributing toward shame were sexual, psychological, economic, and spiritual abuse. Sexual abuse was depicted as forcing sex, treating women as objects, and inflicting pain. Psychological abuse consisted of name-calling, rejection of the woman’s values and feelings, and derogatory statements about the woman’s appearance, sexuality, and intelligence. Physical abuse included punches, tearing off clothes, tying her to the bed, choking her, or not letting her sleep. Spiritual abuse involved preventing the woman from going to church or reading her Bible (Flinck et al., 2005).

The women blamed themselves for “sexual frigidity, appearance, personality, and marital discord” (Flinck et al., 2005, p. 387). They felt they had failed in fulfilling the duties of the Christian wife: “I thought that I had no right to divorce without any biblical grounds, and I had no courage to do it” and “If I leave him, everybody thinks that it is me who is to blame” (p. 387). The women felt like they had to keep their relational problems secret, but through time, they began to express their anger, hate, and self-hatred. Consequences of shame included
bitterness, disappointment, abandonment, self-rejection, and loss of self-confidence. Five of the seven women reported suicidal ideation and three had a desire to hurt their spouses. These emotions prompted some of the women to seek help. The shame also caused the women to feel less feminine and conceal their bodies. They described themselves as doormats, whores, utensils, or pieces of furniture (Flinck et al., 2005). Clearly, victims of abuse require intervention from healthcare providers.

**FACTORS IN IPV**

Risk factors for hurting a partner include drug and alcohol use, observing or being a victim of violence as a child, increased stress, and not having a job (CDC, 2009). Studies have shown that certain ethnicities are correlated with IPV. Charles and Perriera (2007) and Certain et al. (2008) found that Hispanic women were more likely to experience IPV during pregnancy compared to White women. Goodwin et al. (2000) found a higher prevalence of abuse in Black women. Other researchers have found that Hispanic and Black women experience more emotional abuse than White women (Bohn, Tebben, & Campbell, 2004; Charles & Perriera, 2007). Additionally, certain cultures are more patriarchal than others. In some, the husband makes all the decisions for the family and answers all questions directed to his wife. Some religious affiliations believe men are superior to women (Cross-Sudworth, 2009).

In light of these findings, a woman’s culture and ethnicity must be considered when screening for abuse. The healthcare professional must be sensitive to cultural mores and to the fact that women may not comprehend the significance of abuse nor understand the law pertaining to IPV. Language may be a barrier to effective communication and assessment. To help solve this problem, healthcare systems should train staff about various cultural beliefs and supply language-appropriate information in written form. A translator should be available to assist the healthcare worker in communicating with clients (Lutz, 2005).

**PROVIDING SUPPORT**

Healthcare professionals are often the first individuals who interact with the woman exposed to IPV (Lindgren & Renck, 2008). However, the majority of women do not discuss personal IPV unless questioned (Flinck et al., 2005). Although a serious health issue, many providers do not routinely ask women about IPV and do not want to administer routine screening (Duncan, McIntosh, Stayton, & Hall, 2006; Flinck et al., 2005). Factors associated with healthcare professionals not asking questions about IPV include language and cultural barriers, the patient being accompanied by the perpetrator, lack of knowledge and training, fear of offending women, time constraints, and lack of resources to help the patient (Jeanjot, Barlow, & Rozenberg, 2008). Flinck et al. (2005) found that women desired the healthcare professional to be direct and empathetic when inquiring about IPV. They wanted the provider to be patient and ask the questions without condemning. One victim stated: “When I told the doctor what he had done to me, the doctor could have asked if I needed help or something instead of just examining the bruises and contusions impersonally” (p. 388). The sidebar “Changed Perspective” shows how God can use Christians to encourage women who have experienced IPV as well as change our hearts and attitudes about supporting them.

Although women may show apprehension about sharing, healthcare providers must care enough to screen for IPV, especially if abuse is suspected. Table 1 offers a list of physical and pelvic examination findings suggestive of abuse. When interviewing a woman suffering from IPV, be sincere and accepting of the victim. When abuse is suspected, there are ways to make the patient and examination more comfortable. Ask if there are any parts of the examination, such as breast or pelvic, which are particularly difficult and ask what could be done to make the examination more comfortable. Give the patient as much control as possible telling them you will stop at any time if they need you to. Remind the patient why you are performing the examina-
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes or No. By whom? Total number of times?

Since you’ve been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes or No. By whom? Total number of times?

Within the last year, has anyone forced you to have sexual activities? Yes or No. By whom? Total number of times?

Have you ever been emotionally or physically abused by your partner or someone important to you? Yes or No. By whom? Total number of times?

Are you afraid of your partner or anyone listed above? Yes or No.

**TABLE 1: Findings Suggestive of Intimate Partner Violence**

- Unexplained injuries
- Injuries in various stages of healing
- Injuries can be bruises, burns, welts, bite marks, fractures or dislocations, “defensive injuries” on torso, arms, facial or dental trauma, genital area
- Injury during pregnancy, especially to abdomen or breasts
- Evidence of choking—hoarseness, difficulty swallowing or breathing, scleral hemorrhage, new seizure, unexplained stroke
- Neurologic changes—tingling, numbness, hearing or visual loss
- Reluctance to remove clothing; partially undresses
- Difficult eye contact
- Flat affect
- Unexplained crying or excessive discomfort
- Exaggerated startle response to touch
- Avoidance behavior (keeps knees together, withdrawal from examiner, increased muscle tension during examination)


**TABLE 2: Abuse Assessment Screen (AAS)**

1. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes or No. By whom? Total number of times?
2. Since you’ve been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes or No. By whom? Total number of times?
3. Within the last year, has anyone forced you to have sexual activities? Yes or No. By whom? Total number of times?
4. Have you ever been emotionally or physically abused by your partner or someone important to you? Yes or No. By whom? Total number of times?
5. Are you afraid of your partner or anyone listed above? Yes or No.

Source: Used with permission from McFarlane et al. (2001).

**SCREENING FOR IPV**

Screening for abuse is vital to detect IPV; however, consider patient safety before initiating screening. First, make sure privacy is maintained. Second, the patient should not be accompanied by her partner. Third, the woman’s children, family, and friends should not be present. Fourth, abstain from using any friends or family as an interpreter. Fifth, be familiar with the reporting laws for your state to understand your responsibility to the patient. Finally, documentation of physical and emotional findings is critical for legal purposes.

Screening can utilize verbal questioning or written questions with oral follow-up. Questions used by healthcare professionals significantly increase the detection rate of IPV. Develop a comfortable and personal style of asking the same IPV screening questions of every woman on a regular basis. Be sure to ask questions in privacy to ensure the woman’s safety and help her answer honestly. Remember to ask questions in a culturally competent manner for women of various ethnicities. Practice and adopt a compassionate and sensitive method of questioning women using a standardized tool, such as the Abuse Assessment Screen (McFarlane, Parker, & Cross, 2001) (Table 2). A positive response to any of the questions would constitute a positive screen for domestic abuse (Kataoka, Yaju, Eto, Matsumoto, & Horiuchi, 2004; Lutz, 2005).

The CDC suggests the “RADAR” guideline be used in screening for IPV:
- R—routinely screen every patient
- A—ask directly, kindly, nonjudgmentally
- D—document findings
- A—assess patient’s safety
- R—review options and provide referrals (Alpert, 2004, as cited in CDC, 2009)

Healthcare professionals also should include screening for emotional abuse because many women do not positively correlate violence with emotional abuse (Lutz, 2005). In general, healthcare professionals can label the perpetrator’s actions as abuse and acknowledge the problem.

**INTERVENTION**

Healthcare providers should establish a plan for managing the care of women encountering IPV that includes safety planning and use of community resources (Lutz, 2005; McFarlane, Groff, O’Brien, & Watson, 2006). The plan can include contacts for shelters, substance abuse programs, other housing, information on how to obtain a restraining order, and safety planning. If the patient is
When I began volunteering at a shelter for battered and abused women, I remember thinking how tough this experience would be, expecting to encounter many downtrodden women. My preconceived notions were squashed when God opened my eyes and changed my perspective.

I had the pleasure of meeting a 45-year-old woman who had recently escaped a physically abusive relationship of 10 years. She grew up in an abusive home and witnessed her mother being beaten on a daily basis, which became “normal” to her. She told herself that she would never get married to a man like her father. She said her first marriage was consumed with substance abuse that eventually led to physical abuse and her second marriage went the same direction. In both relationships, she was controlled and not allowed to wear makeup or nail polish, get haircuts, and so on. Just a few days before my meeting her, she had encountered a severe beating, which left her bruised from head to toe. Her husband had left her for several days with no food and disconnected phone lines. In a moment of mental clarity, she left and never looked back.

Hearing her story caused me to feel much love for her. We sensed God loving us through each other when we hugged good-bye. She wept as if relieved. I have continued to visit and demonstrate that I care about her concerns and well-being. I invest a few hours every weekend, but the transformation in both our lives is invaluable. God has shown me that the simple act of listening with an open heart is transformational. I have new insight into the face of domestic violence and realize the importance of educating future clients and the community about domestic violence.
threatened, hit, or intentionally frightened people. God instructs the husband to be like Christ was to the church. This means a husband is expected to love and serve his wife and to put her needs before his own. A wife is to be cherished. Colossians 3:19 says, “Husbands, love your wives, and do not be harsh with them” (ESV). Clearly a husband should never be violent or aggressive toward his wife. Christ instructs that a husband should respect and care for his wife. Although wives are instructed to respect their husbands, this does not mean wives are expected to tolerate abuse or be a doormat.

Many other Scriptures are helpful to show our value to God (1 Corinthians 3:16-17), and that he does not want us to experience harm and wants us to live without fear and abuse (John 8:3-11). Scriptures such as these can be used to encourage patients caught in the trap of abuse.

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