CE 2.5 contact hours

When Partners Turn VIOLENT

Understanding Causality & Signs

By Jessica McCarthy and Denise Stagg

ABSTRACT: *Intimate partner violence (IPV) occurs across all cultures, ethnicities, socioeconomic classes, and educational backgrounds. Nurses should be aware of IPV and causative factors that include personal attributes, stressors, and community issues. The Intimate Partner Exposome conceptual model is used to identify exogenous and endogenous IPV risk factors. In addition, distinctive environmental factors can increase risk for IPV. The purpose of this article is to increase recognition of causative factors and presenting signs to enhance the nurse's ability to identify and assist IPV victims.*

KEY WORDS: *abuse, domestic violence, environmental factors, exposome, intimate partner violence (IPV), nursing, risk factors, victimization*

Isabel, Margaret, Amber, and Daeshona* appear to have little in common. They live in different regions of North America; two are married and two are not. These four women, ages 17 to 46, represent different ethnicities, family structures, and faith backgrounds. The one attribute they share is their experience as victims of intimate partner violence (IPV). Also known as domestic violence, IPV affects individuals across all ethnicities, socioeconomic classes, and educational backgrounds.

Professional nursing is recognized as one of the most respected and trusted professions, based on numerous Gallup Polls (Brenan, 2017). Trust is a key attribute as nurses have a pivotal role in identifying victims of IPV. Early detection and prevention measures are major tools to address IPV. Although discussing IPV may be difficult, nurses are at the forefront of prevention and detection of IPV. As Romans 15:1 states, "We who are strong have an obligation to bear with the failings of the weak, and not to please ourselves" (ESV).

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Why Do They Stay?*

Persons may stay in an IPV situation for many reasons. Only those experiencing the violence can determine the right time to leave. Respect their decisions. Know that the period of time immediately after leaving a violent situation is the most dangerous. Know these common reasons for staying:

- Afraid the abuse will escalate against other family members
- Partner will take the children
- Lack of education or finances to support self
- Belief in the abuser's threats of consequences of leaving
- Misperception that the violence is the victim's fault or that he/she can change the abuser's behavior
- Pressure from family, culture, or faith community to keep the family unit intact
- Abuser's isolation tactics have left the victim feeling cut off from social support or resources

—Sharon T. Hinton, DMin, MSN, RN-BC, Contributing Editor, *JCN*

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TYPES OF IPV

Characterized as a form of aggression perpetrated on an individual by a current or former intimate partner, IPV is categorized into four main types: sexual violence, physical violence, psychological aggression, and stalking (including coercive acts) (Centers for Disease Control and Prevention [CDC], 2017). Data from the CDC's National Intimate Partner and Sexual Violence Survey show that one out of four women and one in 10 men will experience some type of IPV in their lifetime. About 50% of female homicides are due to domestic violence, and one out of 10 victims experienced an IPV event within one month prior to the homicide (CDC). Common reasons for staying in a harmful relationship are addressed in the sidebar: *Why Do They Stay?*

One out of four women and one in 10 men will experience some type of IPV in their lifetime.

Dating violence also is a part of IPV. About 1.5 million high school students experience dating violence in the United States annually. Of these, one in three teens has experienced dating violence and one in 10 has experienced physical violence from a girlfriend or boyfriend (Victimsofcrime.org, 2019). Forty-three percent of college-age women have reported dating violence, with one in three reporting digital dating violence and one in six experiencing sexual assault (National Domestic Violence Hotline, 2017). Signs of dating and digital abuse appear in Table 1.

Nurses can enhance their understanding of IPV risk factors through a broader perspective of causative and moderating factors and work within their communities to decrease occurrence of IPV. The *Intimate Partner Exposome* conceptual model is used to identify exogenous and endogenous factors that contribute to IPV and will highlight the correlation between cause and effect (Juarez et al., 2014). Recognizing risk factors and then addressing those risk factors will enhance preventative strategies to combat IPV.

IPV EXPOSOME MODEL

The *Intimate Partner Violence Exposome Model* (Figure 1) was created using the population-based exposure science approach to health disparities developed by Juarez et al. (2014). The term *exposome* is defined as "the measure of all the exposures of an individual in a lifetime and how those exposures relate to health" (CDC, 2014, para 1). This exposome method combines personal and community attributes with stressors of the

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*All names changed to protect privacy.

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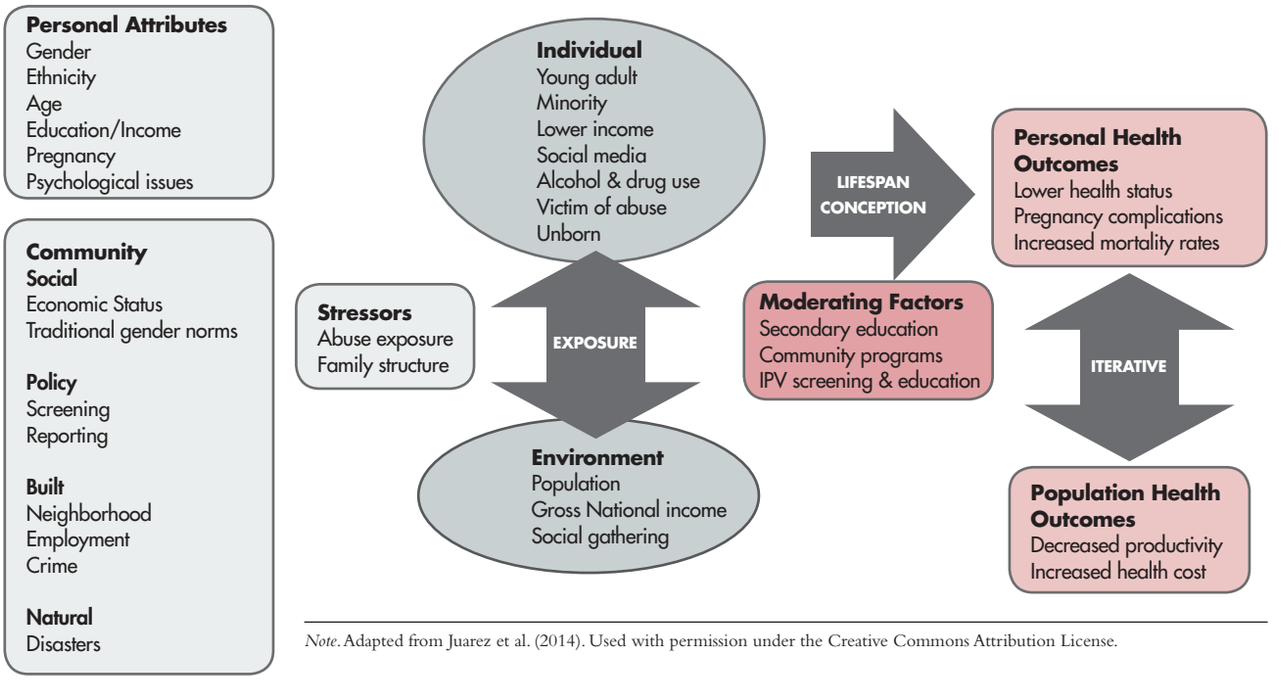
FIGURE 1. Intimate Partner Violence Exposome Model



Note. Adapted from Juarez et al. (2014). Used with permission under the Creative Commons Attribution License.

individual as a template for risk of IPV based on exposure to environment and moderating factors; the method also considers the outcomes of the individual.

Familiarity with each model element is important for nurses because understanding personal attributes, community settings, stressors, environment, and exposure can help to identify those at risk. Then steps can be taken to identify specific groups at risk as well as those who are current victims of IPV, and possibly prevent further episodes. Risk factors for IPV are summarized in Table 2.

Personal Attributes. Certain personal attributes can increase IPV risk. Ethnicity, for example, can determine the frequency of IPV during a person's life. The greatest frequency, 54%, occurs among individuals identified as multiracial. Among Caucasians, the frequency is 35%; 37% among Hispanics; 44% among African Americans; and 46% among Native American and Alaskan Natives (Singh, Petersen, & Singh, 2014).

Age and gender also are indicators. Younger individuals are at increased risk, with approximately 71.1% of female victims and 58.2% of male victims experiencing an initial IPV encounter before age 25 (Breiding et al., 2014). Research also indicates that individuals with lower education and literacy rates have an elevated risk for IPV (Beyer, Wallis, & Hamberger, 2015). In addition, socioeconomic status is an indicator. Individuals earning less than $50,000 annually report lifetime IPV more frequently than those who report an annual income of over $50,000 (Brown, Weitzen, & Lapane, 2013).

Nurses must be aware of the nature and frequency of violence during pregnancy, as pregnancy can increase the potential for IPV. The number one cause of death during pregnancy is homicide by an intimate partner (Alhusen, Ray, Sharps, & Bullock, 2015). Additionally, research suggests that among pregnant women, 28.4% experience emotional abuse, 13.8% endure physical abuse, and 8.0% report sexual abuse (James, Brody, & Hamilton, 2013) at varying times during the pregnancy. According to Weil (2019), over 50% of pregnancies are unplanned and increase IPV risks by a factor of three when compared with nonabused women. One systematic review indicates a direct correlation between IPV and harmful neonatal health effects, such as low birthweight and preterm birth (Alhusen et al.).

According to the American Addiction Centers (2019), alcohol and drug use are common among perpetrators of IPV. One cross-sectional study discovered that approximately 40% of IPV victims use a minimum of one illegal drug. Crack and cocaine are drugs associated with IPV perpetra-

TABLE 1: Signs of Dating and Digital Abuse

Dating abuse
• Forced sex or demanding sex in exchange for taking the victim on a date • Acting overly jealous • Being extremely controlling • Preventing the use of birth control • Demanding to check texts, phone messages, and email • Isolation tactics • Insulting, bullying, or threatening • Threats, especially if one attempts to end the relationship • Actual physical or psychological violence against a person, their pets, or their property
Digital abuse
• Repeated unwanted calls, texts, emails • Harassment on social media sites and group emails • Demanding nude pictures (sexting) • Demanding another's passwords

TABLE 2.
Intimate Partner Violence Exposome Risk Factors

Personal Attributes	Stressors	Community
Ethnicity	Abuse exposure	Economic status
Gender	Family structure	Traditional gender norms
Age		IPV reporting & screening
Education/Income		Neighborhoods
Pregnancy		Employment
Mental health issues		Crime
		Disasters

tors, whereas cannabis is strongly associated with its victims (Bazargan-Hejazi et al., 2014).

Stressors. Poor family dynamics and childhood observations of violence among parents or between a parent and another person heighten one's vulnerability to IPV (Bazargan-Hejazi et al., 2014). Over 34% of those who are either a victim or a perpetrator of IPV experienced childhood abuse (Bazargan-Hejazi et al., 2014). A 2016 study by Al-Modallal showed the risk of severe IPV was three times greater in individuals who experienced childhood abuse and five times greater among those who witnessed mother-to-father violence. Individuals who were physically and sexually abused (covictimized) reported both elevated rates of postbreakup IPV and elevated rates of ongoing pursuit involving intimidation and threats post-breakup (Katz & Rich, 2015).

Another major issue is a woman's financial dependence on her husband or partner. This dependency may prevent a woman from disclosing or reporting an incident because she risks the loss of financial support if the perpetrator is jailed or loses his job (Umubyeyi, Persson, Mogren, & Krantz, 2016).

Community Setting. Community factors that increase the risk are categorized into four environments: *social, policy, built,* and *natural*. Juarez et al. (2014), explain:

> *The natural environment includes exposure measures of air, climate, water, and land; the built environment includes attributes of places we live, work, play, learn and pray, with measures of both quality, quantity, and access; the social environment includes descriptors of social/economic conditions such as poverty, crime, racial segregation, and unemployment found in an area or population; while the policy environment includes data about governmental laws, ordinances and regulations that have either a direct or indirect impact on health. (p. 12871)*
>
> *A person's social community influences the risks and the ability to seek care for IPV, with poverty emerging as a major reason for failure to seek assistance. Diminished income forces the prioritization of all household expenses, and many times healthcare costs are determined as less essential, leaving individuals financially unable to pursue care (Umubyeyi et al., 2016). Patriarchal communities may keep women from pursuing help. When religious beliefs in these communities consider marriage to be permanent, gender disparities are further magnified, creating an environment where a woman may have to accept living with her husband despite the violence. (Umubyeyi et al., 2016)*

Policy environment can impact risk for IPV. Currently, all states except Alabama, New Mexico, and Wyoming mandate reporting of certain identified events wherein the patient's harm relates to violence (Singh et al., 2014). Despite the lack of federal laws mandating the reporting of IPV incidences, the United States Preventative Services Task Force (2018) recommends universal IPV screening for all women of reproductive age, and The National Consensus Guidelines recommend IPV screening for all adolescents and adult

CASE STUDY:
Screening for IPV

Neighbors consider Marlee*, 38, a quiet, gentle woman. She lives with her husband, Peter, and two teenagers on the outskirts of a suburban town. Peter is a self-employed contractor, but seems to have frequent slow periods of work. Despite the family's financial strain, he insists Marlee not to work outside the home.

Marlee tries not to upset Peter, a familiar behavior: her father was very rigid and hard to please. The couple has no real social life. Marlee's main outlet is attending a weekly women's service group. Peter regularly criticizes her involvement with the group as well as her general appearance, "You sure look well-fed" and her housekeeping, "When are going to clean up in here?"

Acquaintances whom Marlee encounters at the grocery store or library often notice she's limping or guarding her side as if in pain, but she says it's just lack of exercise. "Peter says I'm really out of shape," she explains. She generally is silent, her eyes downcast and her mood subdued.

Eventually Marlee ended up at an urgent care center for X-rays, having "fallen off the porch" and bruised her ribs. While waiting for the X-ray results, Becky, the nurse practitioner (NP), asked Marlee for details about accident. Becky suspects IPV and initiates a two-question screening tool. Marlee begins to sob silently after the first question, "Have you ever been hit, slapped, kicked, or otherwise physically hurt by your male partner?" Becky puts her hand on Marlee's shoulder until Marlee is calm. Becky states that intimate partner violence happens to many women, and help is available. She explains that Marlee is not responsible for the hurt she is experiencing, and she wants to be a source of support. Before Marlee leaves, Becky offers her a page with local resources and safe places, as well as her work phone and pager numbers.

Questions for reflection:

- What clues might Becky, the NP, have noted during Marlee's visit?
- How did Becky implement appropriate action with Marlee?
- Could Becky have said or done something else or different in this initial interaction with Marlee? Is spiritual care appropriate?
- What, if anything, should Becky do once Marlee leaves the urgent care center?

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patients, including assessments for both current and past IPV victimization (Futures Without Violence, 2019). Federal regulations have begun to address IPV in the at-risk college population, with The Clery Act and the Violence Against Women Act amendment requiring university officials to report IPV incidents on campus, the incorporation of IPV incident follow-up procedures, and provision of IPV prevention campaigns (Modi, Palmer, & Armstrong, 2014). These regulations aim to address IPV detection for individuals; however, the assessment and detection of IPV must go beyond the individual and include the community's risk factors.

The *built* environment impacts risk for IPV. Some communities are immersed in environments that create socioeconomic and demographic patterns that enhance IPV potential. Domestic violence rates increase in neighborhoods categorized as economically disadvantaged compared with their economically wealthy counterparts (Beyer et al., 2015). A systematic review by Beyer et al. (2015) stated that IPV rates are higher in rural areas, in areas with higher unemployment, and in areas that have lower median household incomes. Higher rates of murder, crime, perceived social disorder, and violent experiences can increase IPV in communities (Beyer et al., 2015).

In the *natural* environment, a natural disaster is an exogenous event that increases IPV potential. Although prevention of a natural disaster is unlikely, preparation for possible outcomes should be considered. Individuals directly impacted by natural disasters may have an increased risk for IPV as a result of displacement, housing and food shortages, and other post-event stressors. Those experiencing stressors prior to the event may experience an increase in current stressors, leading to a sense of loss of control. Those who have not previously experienced stressors may not be able to adequately handle the emotional stress of a natural disaster. Furthermore, community members may experience drastic income, housing, and health repercussions that can increase IVP risk. A combination of any or all of these events heightens risk for abusive conflicts in relationships (Gearhart et al., 2018).

A randomized study of female IPV victims after Hurricane Katrina in 1992 indicated a 35% increase in the prevalence of psychological victimization and a 98% increase in physical victimization. Men had a 17% increase in psychological victimization post-Katrina (Schumacher et al., 2010). Additionally, after Hurricane Andrew, researchers determined that calls increased by 50% to Miami's helpline about domestic abuse (Gearhart et al., 2018).

Individual risk factors make certain individuals at higher risk for IPV. Young adults fall into the age risk category for experiencing their initial IPV encounter. Contributing to the age factor is the likelihood that young adults have lower earnings. The United States Census Bureau (2017) revealed that the annual income for individuals ages 15 to 24 was substantially lower than the total median population. In addition, an individual's financial status is compounded with increased costs of living.

Also significant are depictions of violence against others through popular media that influence young adults, normalizing behaviors that increase IPV risks. One study demonstrated direct correlations between increased IPV risks and reading a fictional series portraying violence against women (Bonomi et al., 2014).

> Nurses must be aware of the nature and frequency of violence during pregnancy.

Income and the health of a nation's economy, as determined by the Gross National Income (GNI), can affect the IPV status of young adults. A recent study of college students worldwide indicated that those living in nations with lower GNIs reported significantly higher levels of violence, regardless of family incomes. Furthermore, IPV rates decreased 9% for every one unit of GNI increase (Sabina, 2013).

Alcohol and substance use impact IPV. More than 20% of male perpetrators of intimate partner abuse use alcohol or drugs immediately before the most recent and severe incidents of violence (American Addiction Centers, 2019). In 2013, an estimated 24.6 million Americans age 12 and older had used an illicit drug in the past month, an increase of 8.3% from 2002 (National Institute on Drug Abuse, 2015). Drug use also impacts IPV risk and is highest among people in their late teens and 20s. According to The National Institute on Alcohol Abuse and Alcoholism (2018), 58% of full-time college students ages 18 to 22 drank alcohol in the past month, compared with 48% of persons of the same age who were not fully enrolled in college.

A *college campus environment* also raises concerns of IPV and justifies careful attention by healthcare professionals. Bliton et al. (2016) noted that "IPV has been shown to reach its peak in adolescence and young adulthood, specifically in college students" (p. 371).

MODERATING THE RISK FACTORS

Factors that moderate the risk for IPV include higher education, increased post-high school education, larger personal income, greater community awareness and safety, and increased individual independence. One significant measure to combat IPV is ensuring an individual's opportunity to obtain a college education. However, enrollment in a college or university program may also place the individual at an increased risk for IPV because of increased exposure to risk factors such as alcohol. What opportunities are available to moderate IPV?

Community Awareness. The template for developing prevention programs can be found in programs such as Start Awareness, Support Action. This model recognizes community-level gender norms and attitudes toward IPV as drivers of risks. The initiative strives to prevent domestic violence by transforming the attitudes and behaviors that influence power imbalances in relationships between men and women (Abramsky et al., 2016).

The secondary analysis of data from this program reveals that a community mobilization intervention to prevent violence against women achieved a community-wide reduction in physical IPV (Abramsky et al., 2016). These study results lend strong support for an increased adoption of community-level approaches for preventing violence; these approaches can be modified and used in various community settings.

Screening. IPV screening is useful for healthcare providers in detecting and preventing IPV on an individual level. Supporters of universal screening postulate that screening allows detection in circumstances where healthcare providers may not accurately question the victim or the victim would not initiate conversation about violence; screening is particularly useful when providers have a limited understanding of IPV (Valpied & Hegarty, 2015). Healthcare professionals who initiate discussions with all patients about IPV offer hope for potential victims. Research revealed that seven out of 10 victims wanted their healthcare provider to ask them privately about IPV, and more than half would reveal they were victims if asked by a healthcare professional (Dudgeon & Evanson, 2014).

Personal Health Outcomes. IPV has compounding effects on individuals. Studies indicate that individuals who experience IPV report a significantly lower health status and higher incidences of severe depression, anxiety, posttraumatic stress disorder, low self-esteem, and suicidal ideation than nonabused individuals (Valpied & Hegarty, 2015). Victims also are significantly more likely to have other long-term health problems, including chronic pain, gastrointestinal problems, headaches or migraines, and sexually transmitted infections (CDC, 2017). The effects of IPV during pregnancy may delay adequate prenatal care, therefore elevating the risk of health issues (Alhusen et al., 2015).

Alcohol is not only a risk factor for IVP but also a potential outcome. One study suggests that some individuals abuse alcohol to cope with ongoing challenges they face because of violence (Øverup, DiBello, Brunson, Acitelli, & Neighbors, 2015).


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TABLE 3: Basic Tips for Nurses in Suspected IPV

• Never attempt to confront an abuser, as this may escalate the violence and make you a target.
• Do not blame the victim for the abuse or criticize the abuser, which may cause the victim to attempt to justify the abuser's actions.
• Resist the urge to rescue; instead, provide care, referral, and resources.
• Never use clichés such as "It's God's will" or "God will help you endure."
• Support the victim's decisions even when you disagree.
• Believe what you are told by the victim until proven otherwise.
• Resist asking for unnecessary details—just listen.
• Speak to the victim alone if possible—be creative on ways to get the victim alone (go to bathroom if you are the same gender, etc.).
• Always interview the victim and possible perpetrator separately.
• Follow your institution's procedures and guidelines for suspected IPV.

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Population Health Outcomes. Three major outcomes—increased healthcare costs, decreased productivity, and lasting effects for victims and families—have far-reaching implications beyond the individual victim and can affect future populations. In 2014, IPV cost $5.8 billion annually in treatment for victims and also created a loss of workplace productivity (Breiding et al., 2014). Compared with women without a history of IPV, health service utilization was 20% higher five years after the victim's abuse ceases; reliance on health services could continue indefinitely (Singh et al., 2014). IPV can bring long-term issues for those born to an IPV victim. Homicide secondary to IPV goes beyond the impact of the loss of one's life; the human suffering of intimate partner homicide often involves the family or bystanders, such as the couple's children, neighbors, and new companions. The ripple effect is enduring. Surviving children not only lose the murdered parent, but they also lose the offender to prison or suicide. These children, whatever their age, are forced to confront an extreme adjustment to their lives (Salari & Sillito, 2016).

Determining IPV outcomes for the young adult population is critical due to the increased risk in this population. The effects of IPV can inhibit a young adult's ambitions and hinder or halt the pursuit of his or her career. Addressing IPV risks through prevention within this community can help to promote and ensure young adults' success.

NURSING IMPLICATIONS

Because IPV occurs across all cultures, ethnicities, educational, and socioeconomic levels, nurses must understand risk factors, assessment, prevention, and intervention methods. Identifying the endogenous and exogenous factors, as shown in the Intimate Partner Violence Exposome Model (Figure 1), can enable nurses to actively reduce potential for violence.

From a biblical perspective, one person committing verbal, emotional, or physical abuse against another person is wrong and never justifiable. Psalm 11:5 describes God's view: "The LORD ex-

Web Resources

- **FaithTrust Institute**—https://www.faithtrustinstitute.org
- **Love is Respect**—https://Loveisrespect.org
- **National Center for Victims of Crime, Dating Violence**—https://victimsofcrime.org/help-for-crime-victims/get-help-bulletins-for-crime-victims/bulletins-for-teens/dating-violence
- **SAMHSA-HRSA Center for Integrated Health Solutions**—https://www.integration.samhsa.gov/clinical-practice/intimate-partner-violence
- **Office on Women's Health**—https://www.womenshealth.gov/relationships-and-safety/domestic-violence

amines the righteous, but the wicked, those who love violence, he hates with a passion" (NIV). Although some may advise staying in a situation where a person is being abused, God advocates for safety: "The prudent see danger and take refuge, but the simple keep going and pay the penalty" (Proverbs 27:12, NIV). Psalm 5, among others, is a declaration of God's desire to keep an abused individual safe. Sharing these passages with someone who is experiencing IPV and is familiar with and open to the Bible can be encouraging and hope producing.

God does not condone harming another person. The Bible speaks specifically to married people in Colossians 3:19: "Husbands, love your wives and do not be harsh with them" (NIV). Although Ephesians 5:22, "Wives, submit yourselves to your own husbands as you do to the Lord" may seem to allow a man to demand submission, verse 21 adds the necessary context: "Submit to one another out of reverence for Christ" (NIV).

Nurses in healthcare facilities can advocate for the implementation of IPV screening for all clients. A nurse's assessment may include observation of physical signs of harm, including bruising and lacerations, and psychosocial indications: anxiety, depression, chronic headaches, a stress-related illness, sleeping and eating disorders, suicide attempts, evasive or shamed behavior, or discomfort in the presence of a partner (Eilers & Power, 2019). The case study, Screening for IPV, provides an example. Table 3 provides additional tips for nurses when dealing with persons experiencing IPV.

Nurses are in an optimal position to foster client relationships and community initiatives based on education and increased awareness. Community awareness and education about IPV can lead to the ability and responsibility to address the issue. Nurses working or volunteering in the community can initiate and support programs to educate residents and connect with at-risk individuals. College, high school, and middle school campuses are also prime sites for nurses to work or volunteer, providing education on IPV prevention and notification of safe spaces for reporting incidences of IPV.

CONCLUSION

Research demonstrates that endogenous and exogenous factors of personal attributes, stressors, and community affect both IPV and the outcomes of IPV. Further investigations of IPV must focus on the environments and the communities at risk for IPV in order to develop prevention strategies. Global-level initiatives to reduce IPV could focus on the economic development and strengthening of financial capital at national levels. Individualized programs need to be developed and implemented along similar lines in smaller communities.

Identification of IPV and other pertinent healthcare issues must expand beyond the focus of an individual's risk factors and treatment to a broader perspective of causative factors and resolutions. Prevention of such health crises and provision of resources for victims should take center stage. Healthcare providers are in a unique position to contribute research to identify exogenous and endogenous factors, determine moderating factors, and analyze the effects of moderating factors and interventions on an individual and the population.

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