

The CE test for this article is available only online at www.NursingCenter.com/CE/CNJ.

By Marjan Zarif

Feeling Shame:

Insights on Intimate Partner Violence

ABSTRACT: *Intimate partner violence (IPV) is a serious health issue; however, many healthcare providers do not routinely ask about IPV or administer screening. Due to the high incidence of this problem, providers must be aware of risk factors, screening methods, and appropriate interventions, and screen all female patients for abuse.*

KEY WORDS: *abuse, domestic violence, screening guidelines*

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



Marjan Zarif, MSN, RN, is a board-certified Family Nurse Practitioner at Carson-Newman College in Jefferson, Tennessee.

The author has disclosed that she has no financial relationships related to this article.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article at <http://www.journalofchristiannursing.com>.

DOI: 10.1097/CNJ.0b013e3181fe3d14

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).



journalofchristiannursing.com

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



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).

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-

tion and what the benefits may be to her. Ask permission before touching; let the patient know what you are going to do then keep explaining and encouraging questions, periodically checking her anxiety level. Maintain eye contact if that is culturally appropriate and do what you can to reduce the power differential between you and the patient such as sit on a low stool at her level. Allow extra time and be prepared, if needed, to reschedule the examination if the patient cannot complete the process (Stanford, 2009).

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

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) |

Source: Material drawn in part from Stanford (2009).

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).



Changed Perspective

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.

ready to leave the abusive home, suggest the following:

- Pack a bag *in advance* and leave it at a friend’s or neighbor’s house. Include cash or credit cards and extra clothes for you and your children. Take a favorite toy or plaything for the children.
- Hide an extra set of car and house keys outside of your house in case you have to leave quickly.
- Take important papers such as:

birth certificates for you and your children, health insurance cards and medicine, deed or lease to your house or apartment, checkbook and extra checks, social security number or green card/work permit, any court papers or orders, driver’s license, or photo ID.

- Child protective service numbers can be found in local telephone books or by contacting local law enforcement or the National Resource Center for

Child Protective Services (NRCCPS), 505-345-2444 or www.nrccps.org.

In addition to assisting the client experiencing IPV, healthcare providers can offer referral information to assist IPV offenders. Many states now have batterer intervention programs to help domestic violence offenders and courts can order offenders to participate in such programs. Healthcare providers can find information on batterer programs through local counseling centers, domestic violence help centers, and the judicial court system.

Further statistics and information on referral sources for IPV victims and offenders, including child protective services, can be found online as supplemental digital content at <http://links.lww.com/NCF-JCN/A6>.

EDUCATION IS ESSENTIAL

Women, healthcare providers, and the public must be educated about IPV. Provide educational materials in the form of pamphlets, referral cards, or display posters located in public (lobby, waiting areas, hallways) and private areas (restrooms, near weighing scales). McFarlane et al. (2006) found that provision of a wallet-sized referral card was as effective as a 20-minute nurse case manager intervention for decreasing violence and increasing use of community resources for abused women. Increased public knowledge regarding the prevalence and severity of domestic violence will help decrease instances in which victims withhold their abuse from healthcare providers (Espinosa & Osborne, 2002).

Interventions such as screening and education can greatly change how women experiencing shame overcome their past. Flinck et al. (2005) found that survival was enhanced by support from family of origin, friends, the healthcare provider, a spiritual community, and positive feedback at work. The women in Flinck’s study felt strengthened as they began to experience a change in their mindsets and lifestyles after IPV. Shame from IPV can be conquered through the intervention of healthcare providers.



Web Resources

- National Domestic Violence Hotline—<http://www.ndvh.org> (phone 800-799-7233; hearing impaired 800-787-3224)
- Nursing Network on Violence Against Women, International—<http://www.nnvawi.org/>
- American College of Obstetricians and Gynecologists—http://www.acog.org/departments/dept_web.cfm?recno=17
- Stanford School of Medicine—<http://domesticabuse.stanford.edu/>
- Centers for Disease Control and Prevention—<http://www.cdc.gov/violenceprevention/intimatepartnerviolence/>

BIBLICAL PERSPECTIVES


God's Word speaks to issues of injustice, including IPV. When appropriate or in Christian settings, Scripture can be shared to encourage victims of abuse. For example, Jesus said in John 10:10, "The thief comes only to steal and kill and destroy; I have come that they may have life, and have it abundantly (ESV)." We can explain to abuse victims that Jesus is saying one of the devil's purposes is to completely annihilate God's children. Satan can do this by using others to hurt us physically and/or emotionally. The good news is that through Jesus we have the right to an abundant life that is filled with joy. As his children, God wants us to feel happy, safe, and unafraid.

A Scripture that can be twisted to make women feel they must "submit" to their husbands, even if abused, is, "Wives, be subject to your own husbands, as to the Lord. For the husband is the head of the wife as Christ also is the head of the church" (Ephesians 5:22-23, NASV). However, the husband's headship suggested here does not mean a role of unquestioned authority to which women are to be blindly obedient. This is a model based on Christ's relationship to the church: Jesus was a servant to all who followed him. He never manipulated, controlled,

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.

Acknowledgment

Denise R. Felsenstein, MSN, RN, C, CRNP, Continuing Education Consultant, Lippincott Williams & Wilkins, Ambler, PA, contributed supplemental digital content to this article to meet requirements for continuing education for Florida nurses. 

Alpert, E. J. (2004). *Partner violence: How to recognize and treat victims of abuse* (4th ed.). Waltham, MA: Massachusetts Medical Society.

Bohn, D. K., Tebben, J. G., & Campbell, J. C. (2004). Influences of income, education, age, and ethnicity on physical abuse before and during pregnancy. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33, 561-571.

Centers for Disease Control and Prevention [CDC]. (2009). *Intimate partner violence and sexual violence victimization assessment instruments for use in healthcare settings*. Retrieved from <http://www.cdc.gov/ncipc/dvp/ipv/ipvandsv-screening.pdf>

Centers for Disease Control and Prevention [CDC]. (2009). *Understanding intimate partner violence: Fact sheet*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/IPV_factsheet-a.pdf

Certain, H. E., Mueller, M., Jagodzinski, T., & Fleming, M. (2008). Domestic abuse during the previous year in a sample of postpartum women. *Association of Women's Health, Obstetric and Neonatal Nurses*, 37, 35-41.

Charles, P., & Perreira, K. M. (2007). Intimate partner violence during pregnancy and 1-year post-partum. *Journal of Family Violence*, 22, 609-619.

Cross-Sudworth, F. (2009). Ethnicity and domestic abuse: Issues for midwives. *British Journal of Midwifery*, 17, 212-215.

Duncan, M. M., McIntosh, P. A., Stayton, C. E., & Hall, C. B. (2006). Individualized performance feedback to increase prenatal domestic violence screening. *Maternal and Child Health Journal*, 10, 443-449.

Espinosa, L., & Osborne, K. (2002). Domestic violence during pregnancy: Implications for practice. *Journal of Midwifery and Women's Health*, 47, 305-317.

Flinck, A., Paavilainen, E., & Astedt-Kurki, P. (2005). Survival of intimate partner violence as experienced by women. *Journal of Clinical Nursing*, 384(14), 383-393.

Goodwin, M. M., Gazmararian, J. A., Johnson, C. H., Gilbert, B. C., Saltzman, L. E., & the PRAMS Working Group. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: Findings from the pregnancy risk assessment monitoring system, 1996-1997. *Maternal and Child Health Journal*, 4, 85-92.

Jeanjot, I., Barlow, P., & Rozenberg, S. (2008). Domestic violence during pregnancy: Survey of patients and healthcare providers. *Journal of Women's Health*, 17(4), 557-567.

Kataoka, Y., Yaju, Y., Eto, H., Matsumoto, N., & Horiuchi, S. (2004). Screening of domestic violence against women in the perinatal setting: A systemic review. *Japan Journal of Nursing Science*, 1(2), 77-86.

Libbus, K. M., Bullock, L. F., Nelson, T., Robrecht, L., Curry, M. A., & Bloom T. (2006). Abuse during pregnancy: Current theory and new contextual understandings. *Issues in Mental Health Nursing*, 27(9), 927-938.

Lindgren, M. S., & Renck, B. (2008). "It is still so deep-seated, the fear": Psychological stress reactions as consequences of intimate partner violence. *Journal of Psychiatric and Mental Health Nursing*, 15(3), 219-228.

Lutz, K. F. (2005). Abused pregnant women's interactions with healthcare providers during childbearing year. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 34(2), 151-161.

Martin, S. L., Harris-Britt, A., Li, Y., Moracco, K. E., Kupper, L. L., & Campbell, J. C. (2004). Changes in intimate partner violence during pregnancy. *Journal of Family Violence*, 19, 201-210.

McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006). Secondary prevention of intimate partner violence: A randomized controlled trial. *Nursing Research*, 55(1), 52-61.

McFarlane, J. M., Parker, B., & Cross, B. (2001). *Abuse during pregnancy: Prevention and intervention* (2nd ed., pp. 20-21). White Plains, NY: March of Dimes.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health*, 15(5), 599-611.

Smith, E. (2008). Domestic violence in pregnancy. *International Journal of Childbirth Education*, 23(3), 22-25.

Stanford School of Medicine. (2009). *Observing during the patient encounter*. Retrieved from <http://domesticabuse.stanford.edu/screening/observing.html>

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. National Institute of Justice, & Center for Disease Control. Retrieved from <http://www.ncjrs.gov/pdffiles1/nij/181867.pdf>