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Passion Donais
Portland State University

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Survivor Perceptions of Well-Being After Working with Domestic Violence Advocates in

Healthcare

by

Passion I. Donais

An undergraduate honors thesis submitted in partial fulfillment of the

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Ericka Kimball, Ph.D.

Portland State University

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Abstract

Domestic violence services are typically short term and crisis-oriented, leaving survivors unsupported when outcomes of abuse are long term or chronic; In combination with the nature of disclosure laws, this short term approach to services reduces survivor autonomy and options. Research on alternatives to partitioned services such as integrated approaches or co-located advocates present in shelters and healthcare settings is limited. This study explores the survivor-perceived effects of working with such an advocate on physical, mental, and emotional health. Findings suggest integrated approaches are valuable across all health domains to survivors, including, importantly, those living with difficult to treat conditions such as chronic pain. Recommendations are made to consider survivor health as complex and interrelated, avoid siloed service provision, protect survivor choice by continuing to reduce the gap between services and survivor needs and increasing access to confidential support.

Survivor Perceptions of Well-Being After Working with Domestic Violence Advocates in Healthcare

More than one in three women in the United States have experienced sexual violence, physical violence, stalking, or some combination of the three by a romantic or sexual partner according to the Centers for Disease Control and Prevention's 2015 National Intimate Partner and Sexual Violence Survey (Smith et al., 2018). The United States Department of Justice defines Intimate Partner Violence (IPV) as "physical, sexual, or psychological harm by a current or former intimate partner or spouse," a definition this paper is inclusive of but not limited by. This paper will use the term Domestic Violence (DV) to denote both IPV and any impacts of violence that are experienced by other parties such as children. Studies that used IPV terminology will be retained for fidelity. Concerning an inclusive definition of DV, of the women that experience rape before 18, more than a third (38.8%) were raped by a relative other than a spouse (US DOJ, 2000). The National Center for Injury Prevention and Control (2003) reports the costs of intimate partner rape, physical assault, and stalking at over \$5.8 billion a year. There is a strong body of literature demonstrating the increased health costs of women who experience physical, sexual, and emotional abuse (Bonomi et al., 2009), demonstrating the essential need for effective prevention and treatment models for DV.

There are myriad potential ramifications of surviving DV across physical, psychological, and social domains that may develop into acute and/or chronic health issues (Riedl et al., 2019; Campbell, 2002). The World Health Organization's (2019) *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; ICD-11) defines chronic pain as "pain that persists or recurs for longer than 3 months." Factors such as the severity or presence

of a physical assault are not necessarily connected to chronic pain outcomes as directly as is assumed in a healthcare context (Tiwari et al., 2013). Despite the interrelated nature of DV outcomes, services are typically partitioned and therefore less effective than could be possible (mehrotra, Kimball, & Wahab, 2016).

Literature Review

Domestic Violence Outcomes on Health

Physical health. The literature has an abundance of evidence supporting the direct link between severe physical and/or sexual assault and health problems in women (Carlson, 2005). The physical consequences of DV include musculoskeletal and gastrointestinal disorders, sexually transmitted diseases, and chronic pain (Riedl et al., 2019; Campbell, 2002). More recently, it has been found that less severe acts of physical violence are also associated with health problems, spurring new research that has begun to discover the impact of mental health on previously unexplained DV outcomes (Carlson, 2005). Coker and colleagues (2000) determined that psychological IPV was associated with arthritis, chronic pain, migraine, stammering, sexually transmitted infections, chronic pelvic pain, and stomach ulcers.

Mental health. Post-traumatic stress disorder, depression, substance abuse, and suicidality are among mental health outcomes for survivors (Campbell, 2002; Evanson, 2006). However, the relationship between DV and mental health outcomes is not as unidirectional as once assumed. A critical finding by Sutherland, Bybee, and Sullivan (1998) regarding women experiencing “intimate violence” revealed that injuries themselves had no significant effect on physical symptoms, yet the effects of abuse on physical symptoms appeared to be mediated

through anxiety and depression. None of these health problems can be neatly partitioned; they are complex and interrelated.

Mental health and physical health. Tiwari, Fong, Chan, and Ho (2013) surveyed 300 women from DV shelters in Hong Kong who screened positive for physical, psychological, or sexual abuse by a current or former partner and found the injury severity of survivors in their study did not have a significant effect on chronic pain severity, while the severity of sexual abuse had a significant direct effect on chronic pain severity ($\beta = .20$, 95% CI = 0.03-0.37, $p < .05$). There is evidence that DV is a common worldwide experience, suggesting that the experience of women in Hong Kong are shared by women across the world (Garcia-Moreno et al., 2006). A study on the relationship between PTSD symptoms, IPV, and immune function in uninsured women in Baltimore found that “the mental health effects of IPV help to explain how or why there are differences in physical health and immune function outcomes in abused women” (Woods et al., 2005, p. 170). The connection between DV and chronic pain is especially important considering how difficult chronic pain can be to treat, how long lasting its effects are, and its associated cost (Rashbaum & Sarno, 2003). Coker and colleagues (2000) found that “psychological IPV was as strongly associated with the majority of adverse health outcomes as was physical IPV” (p. 451). DV services need to be broadened to manage the compounded and entangled needs of survivors.

State of Domestic Violence Services

Despite evidence to suggest that services for survivors must coordinate and work simultaneously across societal levels (Dutton et al., 2015; Campbell, 2002), it is much more likely that a survivor encounters short term services isolated to DV needs such as safety

planning, legal advocacy, and shelter services (mehrotra, Kimball, & Wahab, 2016). When DV services do address medical or mental health needs, they are typically focused on immediate and acute medical interventions or siloed mental health regimens (Campbell, 2002). mehrotra, Kimball, and Wahab (2016) have attributed this “fetishization of safety” to the criminalization of DV, and caution that such a paternalistic and binary approach can strip survivors of self-determination, mimicking the power circumstances of the relationship originally in question (p. 157).

As Lindhorst, Meyers, and Casey (2008) find, it is essential that DV survivors are provided with the financial resources necessary to exercise their self-determination, making it crucial that even mechanisms such as welfare provision take the effects of DV into account rather than acting in isolation. Interventions are considered less successful by survivors when they operate as detached entities, as Poleshuck and colleagues (2018) found in their community-based participatory research study.

Gap in Literature

There is a core body of literature concerning the physical health outcomes of DV and a growing portion demonstrating the implications of mental and emotional circumstances on physical outcomes and survivor quality of life. Though there is ample evidence that the existing siloed approach to survivor services is not satisfactory, there is limited information about survivor experience of integrated interventions. This study aims to examine survivor-perceived effects of working with a community-based advocate co-located in shelter and healthcare settings in Oregon.

Project Background

The data in this study expanded on the earlier implementation of the Safer Futures model where community-based advocates are co-located to create partnerships and break down silos between IPV agencies and health care providers (Kimball et al., 2018). These advocates are paraprofessionals certified through 40 hours of IPV-specific training and placed in rural, low-resource environments that would not otherwise have been able to afford social workers operating on-site. In accordance with the call for blended services, the project was designed to increase screening and access to IPV services in health care settings (Kimball et al., 2018). The agencies work with health care workers, training them in universal screening and next steps.

In light of the budding evidence to suggest that the needs of DV survivors can be better met through more integrated treatment, this paper will examine the survivor-perceived effect of working with a co-located, community-based advocate across physical, mental, and emotional health.

Methods

In order to assess survivor experience, data were collected through a Survivor Health Follow-up Survey administered to DV survivors by advocates for six months. This survey was developed in partnership with Portland State University and five community-based DV agencies to gain a better understanding of the influence of working with a community-based advocate on DV survivor health. The survey gathers information on survivor perception of their overall physical, mental, and emotional health, specific health issues including pain, anxiety and depression, changes in health over the past three months, healthy and unhealthy intimate relationship status, and the impact of survivor interactions with the advocate on their overall health. Advocates selected survivors who were at least 18 years old and had at least one contact

with a community-based advocate within a healthcare context in the preceding six months.

Surveys were collected anonymously and survivors were provided a \$10 gift card for participating in the study.

Ethics

This research received approval from the Portland State University Institutional Review Board.

Results

General Overall Health

Survivors were asked to generally rate their physical, mental, and emotional health on a five point scale (1: poor to 5: excellent). Twenty-five (57%) survivors rated their physical health as good to excellent. Nineteen (43%) rated their physical health as poor to OK. Twenty-six (59%) survivors rated their mental health as poor to OK. Eighteen (41%) survivors rated their mental health as good to excellent. Twenty-eight (62%) survivors rated their emotional health as poor to OK. Seventeen (38%) of survivors rated their emotional health as good to excellent.

Survivors were asked whether their physical, mental, or emotional health had kept them from working a job, doing work around the house, or going to school for more than three months, less than three months, or not at all. Twenty-three (51%) survivors indicated that their physical health had restricted them for more than three months, four (9%) survivors indicated less than three months, and 18 (40%) survivors indicated no interruption due to physical health. Twenty (45%) survivors indicated restriction for more than three months due to their mental health while eight (18%) indicated less than three months, and 16 (36%) experienced no interruption due to mental health. Emotional health interrupted 22 (51%) survivors for more than

three months, seven (16%) survivors for less than three months, and did not affect 14 (33%) survivors in those categories.

Survivors were asked to rate how their physical, mental, and emotional health had changed in the last three months on a scale of one to five (1: much worse to 5: much better). In terms of physical health, 20 (44%) survivors rated their change in health as somewhat or much better, 11 (25%) survivors indicated that their health was unchanged, and 14 (32%) survivors rated their physical health as somewhat or much worse. Regarding mental health, 22 (49%) survivors rated their change in health as somewhat or much better, 10 (22%) survivors selected unchanged, and 13 (29%) survivors indicated that their mental health was somewhat or much worse. Twenty-one (48%) survivors indicated that their emotional health was somewhat or much better, 10 (23%) survivors indicated unchanged, and 13 (30%) survivors indicated somewhat or much worse.

Chronic Pain

Thirty-two (71%) survivors indicated that they experienced chronic or "persistent (again and again)" pain and 13 (29%) indicated that they did not.

The 32 survivors that answered affirmatively were asked to select how many days in the past week they experienced chronic pain with 20 (63%) selected seven days, one (3%) selected six days, six (19%) selected five days, two (6%) selected four days, 1 (3%) selected three days, two (6%) selected two days, and no survivors selected one day in the past week.

Wellbeing

Survivors were then asked to report the frequency of headaches or migraines, stomach pain or nausea, and to what extent their health limited their social or fun activities in the past

week on a five point scale (1: Never, 2: Sometimes, 3: About half the time, 4: Most of the time, 5: Always). Twenty-two (49%) survivors reported headaches or migraines about half the time or more frequently, 17 (28%) survivors reported them sometimes, and six (13%) survivors selected never. Twenty-three (51%) survivors reported stomach pain or nausea half the time or more frequently, 13 (29%) indicated sometimes, and nine (20%) selected never. Twenty-three (52%) survivors reported their social or fun activities limited by their health half the time or more frequently, ten (23%) survivors indicated limitations sometimes, and 11 (25%) selected never. On the same five point scale, survivors were then asked to indicate the frequencies at which they felt nervous or anxious, calm or peaceful, sad, angry, and happy. Thirty-seven (84%) survivors reported feeling nervous or anxious half the time or more frequently, six (14%) reported sometimes feeling nervous or anxious, and one (2%) selected never. Ten (23%) survivors reported feeling calm or peaceful half the time or more frequently, 27 (61%) reported feeling calm or peaceful half the time, and seven (16%) selected never. Thirty (67%) survivors reported feeling sad half the time or more frequently, 13 (29%) reported feeling sad sometimes, and seven (16%) selected never. Fifteen (34%) survivors reported feeling angry half the time or more frequently, 24 (55%) selected sometimes, and five (11%) selected never. Seventeen (39%) indicated that they felt happy half the time or more frequently, 24 (55%) reported sometimes, and three (7%) selected never.

Relationships

Twelve (27%) survivors indicated that they were in a current intimate/romantic relationship and 33 (73%) indicated that they were not. Survivors were asked about experiences with their partners in the past week. Table 1 provides complete results.

Table 1*Experiences with partners during the past week.*

Question	Always	Most of the time	About half the time	Sometimes	Never
Does your partner shame or humiliate you in public or private?	8% (n=1)	17% (n=2)	0% (n=0)	33% (n=4)	42% (n=5)
Does your partner support you in spending time with family and friends?	42% (n=5)	8% (n=1)	8% (n=1)	42% (n=5)	0% (n=0)
Is your partner kind and respectful of your choices?	45% (n=5)	9% (n=1)	9% (n=1)	18% (n=2)	18% (n=2)
Does your relationship make you feel worse about yourself?	17% (n=2)	25% (n=3)	0% (n=0)	8% (n=1)	50% (n=6)
Does your partner support your choices for birth control and/or having children?	67% (n=8)	8% (n=1)	8% (n=1)	0% (n=0)	17% (n=2)
Does your partner mess with your birth control and/or try to get you pregnant when you don't want to be?	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	100% (n=12)
Does your partner control any of your medications?	0% (n=0)	0% (n=0)	8% (n=1)	17% (n=2)	75% (n=9)
Are you drinking, smoking, and/or using drugs in order to deal with what is going on in your relationship?	0% (n=0)	8% (n=1)	0% (n=0)	0% (n=0)	92% (n=11)
Does your partner pressure you to smoke, drink, and/or use drugs?	0% (n=0)	0% (n=0)	0% (n=0)	25% (n=3)	75% (n=9)

Working with Advocate

When provided with space to share any other information, some commonly echoed themes included that advocates increased hope, changed life courses, provided information regarding resources and options, increased self worth, and educated about healthy relationships.

Survivors were asked to rate how their physical, mental, emotional, and relationship health had changed as a result of working with the advocate on a scale of one to five (1: much worse to 5: much better). In terms of physical health, 29 (64%) survivors rated their change in health as somewhat or much better, 10 (22%) survivors indicated that their health was unchanged, one (2%) survivor rated their physical health as somewhat or much worse, and five (11%) selected not applicable. Regarding mental health, 37 (84%) survivors rated their change in health as somewhat or much better, three (7%) survivors selected unchanged, no survivors reported that their mental health was somewhat or much worse, and four (9%) selected not applicable. Thirty-nine (87%) survivors indicated that their emotional health was somewhat or much better, three (7%) survivors indicated unchanged, no survivors reported somewhat or much worse, and three (7%) selected not applicable. Concerning relationship health, 24 (55%) survivors reported their change as somewhat or much better, six (14%) indicated no change, one (2%) reported somewhat or much worse, and 13 (30%) selected not applicable.

When asked to estimate the number of meetings they had with the advocate (either by phone, in-person, or via email), 21 (47%) survivors reported less than five, 15 (33%) reported between five and 11, and nine (20%) reported more than 11 meetings.

Survivors were asked if they shared more information with the advocate than they did with other service providers such as medical providers or DHS staff. Thirty-seven (82%)

survivors selected yes, two (4%) selected no, four (9%) selected unsure, and two survivors did not respond.

When asked whether knowing that the advocate would not share any of their information helped the survivors feel more comfortable sharing experiences of unhealthy relationships, 43 (96%) survivors selected yes and two (4%) survivors selected no.

Chronic Pain and Working with Advocate

The data was further analyzed to examine differences between survivors that experience chronic pain and those that did not, and the corresponding impact on their physical, mental, emotional health. The results are displayed in Tables 2 through 5 and are elaborated on in the discussion section.

Table 2

In general, how would you rate your physical, mental, and emotional health?

	Survivors experiencing chronic pain	Survivors not experiencing chronic pain
Physical Health		
Excellent	7% (n=2)	0% (n=0)
Very Good	3% (n=1)	39% (n=5)
Good	29% (n=9)	62% (n=8)
OK	39% (n=12)	0% (n=0)
Poor	23% (n=7)	0% (n=0)
Mental Health		
Excellent	7% (n=2)	0% (n=0)
Very Good	7% (n=2)	15% (n=2)
Good	13% (n=4)	62% (n=8)
OK	55% (n=17)	15% (n=2)
Poor	19% (n=6)	8% (n=1)
Emotional Health		
Excellent	7% (n=2)	0% (n=0)
Very Good	7% (n=2)	15% (n=2)
Good	16% (n=5)	46% (n=6)
OK	47% (n=15)	15% (n=2)
Poor	25% (n=8)	23% (n=3)

Table 3

Has any part of your health kept you from working at a job, doing work around the house, and/or going to school?

	Survivors experiencing chronic pain	Survivors not experiencing chronic pain
Physical Health		
Yes, for more than three months	66% (n=21)	15% (n=2)
Yes, for less than three months	9% (n=3)	8% (n=1)
No	25% (n=8)	77% (n=10)
Mental Health		
Yes, for more than three months	52% (n=16)	31% (n=4)
Yes, for less than three months	26% (n=8)	0% (n=0)
No	23% (n=7)	69% (n=9)
Emotional Health		
Yes, for more than three months	60% (n=18)	31% (n=4)
Yes, for less than three months	23% (n=7)	0% (n=0)
No	17% (n=5)	69% (n=9)

Table 4

How much of the time in the past week has your health limited your social and/or fun activities?

	Survivors experiencing chronic pain	Survivors not experiencing chronic pain
Always	19% (n=6)	0% (n=0)
Most of the time	13% (n=4)	8% (n=1)
About half the time	36% (n=11)	8% (n=1)
Sometimes	19% (n=6)	31% (n=4)
Never	13% (n=4)	54% (n=7)

Table 5*How do you think your health has changed as a result of working with the advocate?*

	Survivors experiencing chronic pain	Survivors not experiencing chronic pain
Physical Health		
Much Better	25% (n=8)	69% (n=9)
Somewhat Better	34% (n=11)	8% (n=1)
Unchanged	25% (n=8)	15% (n=2)
Somewhat Worse	0% (n=0)	0% (n=0)
Much Worse	3% (n=1)	0% (n=0)
N/A	13% (n=4)	8% (n=1)
Mental Health		
Much Better	29% (n=9)	77% (n=10)
Somewhat Better	52% (n=16)	15% (n=2)
Unchanged	10% (n=3)	0% (n=0)
Somewhat Worse	0% (n=0)	0% (n=0)
Much Worse	0% (n=0)	0% (n=0)
N/A	10% (n=3)	8% (n=1)
Emotional Health		
Much Better	41% (n=13)	77% (n=10)
Somewhat Better	41% (n=13)	23% (n=3)
Unchanged	9% (n=3)	0% (n=0)
Somewhat Worse	0% (n=0)	0% (n=0)
Much Worse	0% (n=0)	0% (n=0)
N/A	9% (n=3)	0% (n=0)

Limitations

This study has several limitations. The chance of selection bias was present due to the small number of participants and the convenience sampling used to select them. Therefore findings may not be representative of all survivors involved with advocates. Surveys could only be administered in English or Spanish, so reading ability in either language was required for participation. The survey was adapted from the PROMIS Global Health Scale, a standardized tool, and we did not perform additional reliability and validity testing.

Discussion

Previous studies have identified insufficiencies in existing survivor services, particularly at the intersection between physical and mental health (Coker et al., 2012; Poleshuck et al., 2018; Kimball et al., 2018; mehrotra, Kimball, & Wahab, 2016). This study provides information on the survivor perspective of working with community-based advocates co-located in healthcare settings in Oregon and contributes to efforts to improve survivor experience of formal services. Many of the findings of this study affirm those identified elsewhere, particularly concerning the favorable outcomes of integrated interventions for survivors and the unique realities of those living with chronic pain (Rashbaum & Sarno, 2003; Lindhorst, Meyers, & Casey, 2008; Dutton et al., 2015).

Concerning survivor-perceived experiences of co-located, community-based advocates, there was a foundational advantage in working with a service provider that held a role that was neither limited to or exclusive of health care. There was a consensus among most (82%) survivors that they shared more information with advocates than other service providers, and the confidentiality provided by the advocates also allowed for increased divulgence (96%).

Considering that in the last week before the survey the majority (52%) of survivors reported their social and leisure activities were limited by their health at least half the time, and that their work, education, or housework was limited by their physical health (51%), emotional health (51%), or mental health (45%), it is apparent that survivor health needs are not limited to the physical. The effects felt within all three domains of health were likely to restrict survivor ability and could be contributors to reduced quality of life, as confirmed elsewhere (Rashbaum & Sarno, 2003).

Taking into account the wide range of the health effects of domestic violence, interventions must be similarly far reaching. All three aspects of each survivor's health were surveyed, and the majority of them rated every domain as somewhat or much improved as a result of working with an advocate. While more than 80% of survivors rated emotional and mental health as somewhat or much better, the 64% of survivors that reported improvement in their physical health are particularly notable. They confirm that an advocate working in partnership with health care providers can have a positive effect on the physical status of the survivor (Coker et al., 2012).

Examining chronic pain specifically, those that indicated that they experience chronic pain rated lower on average for general scores of physical, mental, and emotional health, and reported more frequent restriction of their work, education, housework, and social and leisure activities (see Tables 2 through 4). Despite these tendencies, reports of health improvements after working with the advocates were comparable between those that did and did not experience chronic pain, with the majority of both groups reporting much or somewhat better states of physical, mental, and emotional health (see Table 5). The amount of meetings with advocates for

both survivor groups were also very comparable; 39% of those that did not report chronic pain met with the advocate less than five times, 29% between five and 11, and 23% more than 11 times. Of those that did report chronic pain, 50% met with the advocate less than five times, 31% between five and 11, and 19% more than 11 times. Importantly, this suggests that this intervention style is equally valuable to both survivors living with chronic pain and those that are not, and it does not need to be more expensive or resource intensive to serve the former.

Implications for Practice

Mental and emotional health determine survivor quality of life alongside physical health, and should be taken into consideration accordingly. A response to survivor disclosure is not complete if only one aspect of health is addressed, or if treated individually. Partnerships between health care settings, DV agencies, welfare offices, educational institutions, and any other entities that may be the initial point of disclosure for a survivor could contribute to more thorough support, and further integration of services would help reduce the disconnect between survivor health needs and service provision. It seems to be particularly valuable for survivors to speak with confidential advocates, something even a rudimentary partnership would facilitate.

These findings also have important implications for survivors experiencing chronic pain. Working with a co-located advocate resulted in positive health outcomes for the majority of survivors living with chronic pain, with a comparable amount of advocate contact. Survivor themes in a free answer portion of the survey commonly involved increased hope and new awareness of options. Health care settings for those living with chronic pain may not have cultivated an optimistic outlook, making it all the more essential that co-located and integrated advocates encourage hope and affirm survivor worth, regardless of physical diagnosis.

Implications for Research

Considering the context of this study and the findings it presents, it is clear that programs to serve survivors should not be designed or evaluated without survivor input. Future studies concerned with assessing existing services or implementing new interventions must involve survivors in order to ensure services actually meet needs. Protecting survivor choice is one important part of meeting survivor needs. Confidentiality and the legal protections associated (privileged communications) with it are critical to survivor efficacy and should be bolstered. Studies identifying which elements of an integrated approach are specifically beneficial to survivors experiencing hopelessness or chronic pain could lead to more effective treatments and improved outcomes.

In conclusion, although typical DV services involve siloed provision, survivors could be experiencing higher rates of satisfaction with more integrated approaches, even while living with chronic pain. Further research should focus on identifying and improving methods to provide comprehensive support to survivors and dispelling hopelessness.

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