OCCUPATION: A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Occupational Studies

Volume 3
Issue 1 *December 2018*

Article 3

12-1-2018

The Interprofessional Exploration of Occupational Deprivation (OD) in Intimate Partner Violence (IPV) to inform the Health Professional

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Authors' Note

(Chane Wray, OTD-S & Cheryl Mae Granada OTD-S) This manuscript is submitted in partial fulfillment of the requirements of OTD 8300: Occupational Science towards the Entry-Level Doctor of Occupational Degree, and for consideration to publish in OCCUPATION: *A Medium of Inquiry for Students, Faculty & Other Practitioners Advocating for Health through Activity*

Abstract

One of the most common forms of violence against women is intimate partner violence (IPV), a public health issue affecting one in three women globally and one in four in the nation (World Health Organization [WHO], 2016). IPV produces long-term impressions as it is defined as any behavior within an intimate relationship that causes physical, psychological or sexual harm (WHO, 2016). Women affected by IPV are inclined to isolate themselves socially decreasing their participation in daily routines (Gorde et al., 2004). The prolonged preclusion of women from necessary/meaningful occupations such as child rearing and social interaction is a conflict outside their control and is identified as occupational deprivation (OD) (Whiteford, 2010). This problem concerns different disciplines such as psychology, nursing, social work, law enforcement, and occupational therapy. The authors of this exploratory paper searched the databases of EBSCOHost, ProQuest, and Google Scholar to identify articles relevant to the topic from a variety of fields. Limitations of these studies included articles geared to (a) violence against women (b) violence occurring within heterosexual relationships (c) specific IPV service providers (d) proposed solutions for programs within the United States. This exploratory paper investigates the OD of women affected by IPV by understanding the perspectives, experiences, and recovery process to inform health professionals when working with survivors of IPV. Overall there is a need for collaboration among disciplines to further address OD in IPV.

Keywords: IPV, occupational deprivation, occupation, interdisciplinary

The Interprofessional Exploration of Occupational Deprivation (OD) in Intimate Partner Violence (IPV) to inform the Health Professional

Globally, violence against women is at an all-time high (World Health Organization [WHO], 2016). The most common type of violence affecting women is called intimate partner violence (IPV). IPV produces long-term impressions as it is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm; One in three women have reported experiencing IPV within a relationship, thereby characterizing IPV as a major health concern and a significant violation of women's human rights (WHO, 2016). Women affected by IPV are inclined to isolate themselves socially, decreasing their participation in daily routines (Gorde, Helfrich, & Finlayson, 2004). The prolonged preclusion of women from necessary/meaningful occupations such as child rearing and social interaction is a conflict outside of their control due to the fear, control, and power of their intimate partner. This is identified as occupational deprivation (OD) (Whiteford, 2010). OD as a construct is a type of occupational injustice, which Wilcock (1998) describes as stemming from the belief that not all people are afforded equal opportunities to participate in occupations of choice. Deprivation from occupations has demonstrated irreparable consequences to health and wellbeing of the individual (Backman, 2010). External factors including those that are social, economical, environmental, geographic, historic, cultural, or political in nature are all known to produce incidences of OD. IPV may be characterized by one or several of these external factors, therefore, various disciplines including, but not limited to psychology, nursing, social work, law enforcement, and occupational therapy have a role in addressing associated factors within OD, and the dangers of IPV on women. This exploration of the literature aims to understand the global perspective of IPV, the individual's personal experience, and the process of recovery in relation to OD in order

to inform the health professional on current issues and potential areas of development within the scope of IPV prevention and management.

Problem Statement

IPV is a major health concern often overlooked. At this time there is a lack of literature available that explores the occupational deprivation of women affected by intimate partner violence (IPV), and an even greater need of literature that address IPV across disciplines in order to better inform the health professional.

Objectives

1. To explore the connection between disciplines concerned with OD in women affected by IPV.
2. To pose solutions in bridging the gap between disciplines concerned with OD in women affected by IPV.

Methodology

The search terms used in the exploratory paper include IPV, occupational deprivation, occupation, and interdisciplinary. The databases EBSCO Host, ProQuest, AJOT, and Google Scholar were utilized. From the following articles generated in each database, the articles that focused on women in heterosexual relationships were reviewed followed by articles that explored IPV effects on occupations. The next step were to review articles published after the year 2000 and within the following professions; nursing, occupational therapy, social work, psychology, and law enforcement. Our final review consisted of articles commenting on all the above criteria along with the perspectives, experiences, and recovery of women affected with IPV.

Exploration of the Literature: The Results

Through the exploration of the literature three major concerns emerged that were seen to affect the manifestation of IPV. These included a skewed social perspective of IPV globally, a misunderstanding of the victims lived experience of IPV, and barriers preventing successful recovery. Clarity about these three concerns will aid in a better understanding of the phenomenon of IPV by various health professionals. In addition, clarification may assist health professionals a sequential understanding of IPV (perspectives, experiences, and recovery), which may assist service providers a better appreciation of their professional role and obligations when working with victims of IPV. While exploring the occupational science construct of OD, there was a lack of research to inform the health professional. The gap in the literature may be filled by descriptive and followed by relational research. For example, descriptive research will aid in providing an evidence base for the lived experience of IPV, while relational research will aid in building a collaborative approach to care for victims of IPV.

Understanding the perspectives of IPV

The WHO (2016) has recognized the unequal position of men and women, and the use of violence to resolve conflict within a relationship to be a typical factor of IPV. Multi-country studies report community minimization of IPV, which supports the perpetrator opposed to victim cyclical factors in the continuance of abuse. This is seen in the deep-rooted community norms pertaining to respect and family values; factors which pose a barrier to women seeking help (Sullivan, Nguyen, Allen, Bybee, & Juras, 2005; Hyman et al., 2006). This manifestation of sex-role stereotyping exemplifies the social and cultural judgments made about the expectations of men and women in society; these traditional ideologies on gender roles and male dominance have not only been shown to increase occurrence of IPV but also have been shown to deprive

women from engagement within occupations (Whiteford 2010; WHO, 2016). Understanding the social perspectives of IPV is important in addressing the issue of OD in women affected by abuse as the social context influences occupations at the individual level (Iwama, 2010). Therefore, to address occupations at the individual level we must also explore the experience of IPV.

Understanding the experiences of IPV

It is readily misunderstood why women who are victim to IPV remain in a relationship with their perpetrator. Research suggests most women stay in abusive relationships when faced with IPV because many times men are inclined to use tactics that threaten life and inhibit partner autonomy (Hamberger & Larsen, 2015). Current research reports women are more likely to be physically abused when faced with IPV (Hamberger & Larsen, 2015). One study sampled injuries of both sexes in the emergency room produced from IPV and reported that women were more likely than men to sustain injuries and reported higher rates of lifetime and in-past-year injury than men (Phelan et al., 2005). Another study looked at the type of injuries incurred in women battered by IPV and reported women suffered more central nervous system injuries, internal injuries, broken bones, broken teeth, burns, scratches, bruises, and welts whereas men suffered more lacerations and cuts (Arias & Corso, 2005). Consequently, women who sustain such injuries from physical abuse are more likely to try to conceal signs of injury by isolating themselves from the community, resulting in a decrease in participation of daily routines (Humbert, Englemen, & Miller, 2014). Physical abuse is not the only area of concern as psychological abuse is the most common and unforeseen cause of IPV (WHO, 2016). Emotional abuse has been described as controlling the woman, calling the woman inappropriate names, and disrespecting the woman's belongings along with verbal threats (Hyman et al., 2006). Such

tactics increase already prevalent person factors such as low self-esteem, insecurity, and depression (Centers for Disease Control and Prevention, 2016). Occurrences of physical, psychological, and sexual trauma resulting from IPV are all significant causes in the deprivation of social participation and causes an inability to maintain function within areas of health management and maintenance.

Studies have shown young couples' reliance on one another for socioemotional support and direct financial assistance is a major reason why abuse is prolonged in women (Copp, Giordano, Manning, Longmore, 2016). Moreover, immigrants experience IPV at significantly higher rates due to the increased need for the aforementioned supports. Their experience with IPV is emphasized by the affliction of having to adapt to a new area while also experiencing isolation (Hamberger & Larsen, 2010). Women from Ethiopia describe isolation as a significant factor in their experience with IPV as the perpetrator did not allow them to go to school, learn English, visit others or even leave the house without permission (Sullivan et al., 2005). Such constraints limit the victim's ability to pursue the occupations of education and work, increasing the need for partner dependence.

Unsupportive social environments further prolong partner dependency. Within many cultures, it is known that IPV occurs and it continues to be an accepted practice (Sullivan et al., 2005). These social environments perpetuate IPV and make women ashamed to talk about their experience of abuse to others (Bacchus et al., 2016). Women immigrants continue to be especially susceptible because their social environment is non-existent as many times all their social supports are far away (Sullivan et al., 2005). There is also a systems advantage described as the government (immigration officials, welfare, child support, public housing, etc.) that leaves legal assets to be controlled by the man (perpetrator) who helped bring the woman immigrant

(victim) to the area (Sullivan et al., 2005). Consequently, OD and IPV are often heightened by restriction to such resources.

Women affected by IPV who lack social and financial resources are often chained to the physical environment of an abusive household (Zufferey et al, 2016). Limited availability of housing separate from perpetrator, inability to make housing payments alone, poor rental history, bad credit, or criminal histories prevent women affected by IPV from obtaining housing on their own (Clough, 2014). Additionally, a woman who attempts to escape an abusive household and has a child/children is also challenged with providing a safe home environment for her child/children (Meyer, 2012), which makes the occupation of child rearing particularly difficult. Children were reported to be the most commonly mentioned factor inhibiting women from leaving an abusive relationship. In addition, most women base such decisions on what they believed was best for their children (i.e. keeping the family together or protecting the child/children from partner threats) (Meyer, 2012). Child rearing further complicates IPV as women are often constrained from seeking help as the primary caregivers within the family (Sullivan et al, 2005). This is a conflict for women who are in IPV relationships and women who are recovering from IPV.

Understanding the Recovery of IPV

Women who have managed to leave abusers are not yet emancipated. IPV produces long lasting effects on the emotional, psychological, and physical being of the individual, suggesting that various disciplines hold a significant role not only in understanding, but also in aiding in victim recovery. Recovery can be defined as the process of leaving an abusive relationship and the reclaiming of one-self. Eight participants interviewed in-depth using the Kawa Model and associated river drawings identified ideals of gaining self-reliance, inner strength, self-

sufficiency, and self-love as productive to the process of recovery (Humbert et al., 2014). Success in recovery requires addressing person factors associated with high risks of IPV must be addressed. Low self-esteem, emotional dependency, and depression are correlated highly with IPV and return to abusive spouses; therefore, restoring empowerment to the victim through self-worth is essential to recovery (Centers for Disease Control and Prevention, 2016). Establishing self-worth for victims requires collaboration among professionals to encourage standards of non-tolerance through education and social supports.

Education is an indispensable resource for women who are experiencing IPV or who are in the recovery phase of IPV. Education not only grants women academic knowledge, but also provides education that will encourage social empowerment, self-confidence, and the ability to use information and resources available in society (Jewkes, 2002). Skills accumulated through educational resources have the possibility to translate into financial wealth, which furthers empowerment for women experiencing IPV (Jewkes, 2002). Education surrounding health information and women's rights is essential to recovery, as many who experience IPV, specifically immigrants, are unaware of what constitutes intimate partner violence and what legal actions are available during or after experiencing IPV (Sullivan et al., 2005). Education that raises IPV knowledge will assist victims in identifying and distinguishing between healthy and unhealthy relationships, preventing women from returning to abusers or entering abusive partnerships in the future (Bacchus et al., 2016).

Women who establish strong social supports are less likely to experience isolation and return to an abusive relationship therefore healthy social participation is necessary occupation of recovery (Jewkes, 2002). Research has identified supportive services essential to achieving stability after experiencing IPV and recovery setbacks (Sullivan et al., 2005). Women who have

experienced IPV significantly report feeling re-victimized and stigmatized when turning to agencies for assistance (Sullivan et al., 2005; Bacchus et al., 2016). Providing trusted professionals who are readily available to help allows the victim to comfortably talk about their experience to non-family members who can provide non-judgmental and objective advice (Bacchus et al., 2016). Furthermore, social support provides the victim with resources for housing, employment, and organizations in which access was previously restricted. However, agencies who are unfamiliar with the victim's roles and occupations may require additional, timely requirements from the victim that prohibit them from obtaining services critical to their recovery (Sullivan et al., 2005). An interdisciplinary team approach including social workers, occupational therapists, psychologists, family counselors, and law enforcement teams whom are trained in providing client-centered care may be ideal in providing the individualized care for women recovering from IPV.

Reflection

The outstanding paucity of literature pertaining to IPV and its impact on occupation reflects the challenges health disciplines, including occupational science face in addressing physical, psychological, and sexual abuse. This theoretical exploration accentuates the need for different levels of occupational science research, starting with descriptive, and slowly moving up the relational and later higher levels intended to progressively promote awareness and establish guiding evidence on the correlation of, and interventions for IPV and OD.

Comprehensive understanding of IPV requires increased data collection from women who have been a victim of abuse, as well as increased collaboration between professionals including occupational therapists, social workers, psychologists, legal teams, and occupational scientists who are able to collect, interpret and analyze data necessary to implement prevention

and intervention strategies therapeutic to occupational restoration. Thorough reflection on each discipline's role within IPV management is the first step in global collaboration and action against OD.

Restoration for victims of IPV lies in global efforts of professionals in multiple contexts to promote awareness and advocate for women's rights as well as strengthen community responses to violence against women. Lack of, and poor social supports were identified as perpetuating factors in the occurrence of IPV, therefore, social workers play a vital role in providing supports necessary to aid in the recovery of OD. As counselors, case managers, and advocates social workers provide services that prevent crises, help individuals cope with everyday stressors, and support community needs (Edleson, Lindhorst, & Kanuha, 2015). Social workers assist in the restoration process by identifying and obtaining services advantageous to occupational participation. For victims of IPV such services include providing reliable and affordable childcare, housing, and employment, for successful occupational participation in areas of child rearing, home management, education, and work. However, social workers remain stagnant in their imperative role in the screening and assessment of IPV which holds significant implications for identifying victims (Murphy & Quimet, 2008), improvements is this area may aid in preventing further occurrences of occupational deprivation.

Law enforcement and health professionals also play an active role in responding to and providing help for women experiencing abuse. Officers are routinely first call responders in instances of domestic disputes (Cerulli, Edwardson, Hall, Chan, & Conner, 2015), and similarly as health care providers nurses have the opportunity to screen first hand and detect IPV (Daniel & Milligan, 2013). However, the issue lies in poor response training, as professionals sometimes lack the knowledge about the dynamics of the violence and its impact on the individuals within

the household (Blaney, 2010). These professions have a significant influence on the occurrence and continuance of IPV as they work to identify and prevent injuries that later restrict women from engaging in social participation, which in turn may discourage efforts to seek help and occupational restoration from the community or other health professions.

Understanding IPV requires understanding the significant impacts on mental health. Profoundly entrenched social and cultural perspectives as well as varying contextual factors motivate IPV; psychologists play a role in understanding psychopathology and neuropsychopathology in the perpetration of abuse (Corvo & Johnson, 2013). The role of psychologists may include addressing a family history of violence, academic history (Lohman et al., 2013) and mental health diagnoses. Understanding such factors will not only be beneficial in providing recovery to victims, but also in understanding perpetrators and their motives, to aid in early detection and prevention of IPV.

A key issue of IPV is the pattern of abusive behavior by the abuser to establish fear, power, and control over an intimate or formerly intimate partner (American Occupational Therapy Association [AOTA], 2007). This issue affects how any individual performs in their activities of daily living and occupational roles and signifies a need for occupational therapy professionals. Research has supported the relationship between women affected by IPV and their occupations, however they have not yet explored the facets of their different occupations throughout the course of IPV. Such implications include job exploration (Chronister & McWhirter, 2003), self-care, financial management (Gorde et al., 2004), and child rearing (Sullivan, 2005). There may be fewer studies focusing on the implications of IPV with occupational roles such as being a homeowner in negotiating a safe home (Zufferey et al., 2016) and in many cultures, being a wife/respected member of society (Hyman et al., 2006). Lastly

there is need of research concerning the lack of occupations for women affected with IPV in all areas of ADL, IADL, education, leisure, and sleep/rest (American Occupational Therapy Association, 2014). This warrants the role of occupational therapy in OD of women affected by IPV as a priority area of research.

Discussion

The dangerous nature of IPV on women requires the collaborative work of healthcare, social work, and safety and security professionals to address OD among women surviving IPV. The roles of the different disciplines on improving occupational opportunities for women barred with OD have been reviewed however there are several challenges that still warrant improvement to provide women with occupational justice. OD is described as a condition in the environment in which individuals for reason beyond their control are unable to participate and engage in occupations necessary for their spiritual, mental, physical, or economic well-being for extended periods (Whiteford, 2010). The research supports personal accounts from women described as being occupationally deprived with IPV being the main cause (Anderson & Saunders, 2003; Sullivan et al., 2005; Hyman et al., 2006; Meyer, 2012). IPV is a known public health issue with currently over one third of American women (35.6%) experiencing rape, physical violence, and or stalking by an intimate partner in their life (Black et al., 2011) contributing to their lack of meaningful occupations and performance. IPV is continued today (WHO, 2016) due to the complex nature of the cycle of abuse (Hamberger & Larsen, 2015) and stagnant action by many disciplines. So how can disciplines collaborate to address this problem?

Psychology's specialty in addressing the mental health of individuals faced with trauma such as isolation, insecurity, depression, and abuse are essential in rehabilitating women severely affected by IPV. The professional help of psychologists/counselors with this population is often

inaccessible to women especially when women in poverty are more likely to be affected by IPV (Jewkes, 2002). The implementation of counselors with psychology backgrounds in equal access clinics, women's clinics, or even safe phone lines are some ways women can easily start to open up about their experiences. The discipline also helps researchers understand the nature of IPV and how this knowledge may apply to many practices (Lohman, Neppl, Senia, & Schofield, 2013). Similarly, psychologists and other health professionals such as nurses, therapists, and aides may be the first point of contact for many women affected by IPV therefore healthcare education systems should incorporate screening for individuals affected by IPV.

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is a position adopted by the United Nations that mandates the protection and equal opportunity for women by recommending specifics to nation-states on how to eliminate violence against women and girls. The United States has not adopted this position however social work has made strides to protect women such as the establishment of certification programs that focus on group/individual counseling using psychoeducational methods to change beliefs, attitudes, and behavior of perpetrators while encouraging them to own responsibility for their violence (Edleson, Lindhorst, & Kanuha, 2015). Other initiatives such as the passing of the Violence Against Women Act (VAWA) in 1994 have expanded over the past two decades however IPV must be revisited at the policy level through passage of newer and stronger legislation to get more disciplines and individuals involved in enabling occupational opportunities for women. A role of social work is providing resources for women who are challenged by life circumstances such as affordable housing, support groups, shelters, food pantries, and help to get back or start work (Edleson, Lindhorst, & Kanuha, 2015) for women recovering from IPV. For women experiencing IPV addressing the protection and safety is of utmost importance.

Such groups of professionals that can make a greater impact on the safety of women would be the role of safety personnel such as law enforcement at local, state, and national levels. Cerulli et al. (2015) reported that in New York, domestic violence incident reports (DVIR) were processed 54% more often when an injury occurred instead of each time a domestic dispute was reported. This discrepancy may be one way to detect women barred by IPV and OD. The New York law mandates specific documentation under all circumstances meeting any relationship and crime at the scene of any domestic dispute, yet many reports and incidents may still be covered or unrecorded (Cerulli, Edwardsen, Hall, Chan, & Conner, 2015). Even with policy mandates there are still professional roles that need improvement. The results of the study imply revisiting law enforcement educational and ethical practice.

The occupational determinants of an area, which include its economic, policy, and cultural environment govern the accepted forms of, and opportunities for, occupational engagement (Whiteford, 2010). Does America provide enabling opportunities for women at the economic, policy, and cultural level? On average, full-time workingwomen are paid 78 cents compared to the dollar that a man makes, which perpetuates a male dominant society (The White House, 2016). Policy for protection and elimination of discrimination of women is still non-existent despite the movements of surrounding nations (Edleson, Lindhorst, & Kanuha, 2015) and American social media is inundated with women displayed as sexual figures and viewed as subordinate (Baker, 2005). If the environment does not enable groups of people then those groups are asserted with scenarios of injustices leading to OD (Whiteford, 2010). Occupational science addresses OD and injustices in populations by disseminating research in understanding experiences and testing out interventions performed by occupational therapists (OTs) (Molineux, 2010). Therefore. research disseminating information about understanding women who have

experienced/experience IPV is essential for professionals to provide client-centered services by using an occupational justice framework (Whiteford, 2010).

In studying OD as and occupational science construct it is important to generalize occupational science jargon (i.e. occupational deprivation, occupational justice, occupational alienation, marginalization, and occupational disruptions) among different disciplines as well a consistently using terms to describe IPV as a single phenomenon (i.e. domestic violence and abuse mean IPV).

Conclusion

Overall accountability of service providers who work with women affected by IPV such as healthcare professionals, social workers, and safety & security personnel should be reviewed and progress to implement new practices. One step in addressing each professions issues is through an assessment of perspectives of service providers. This may be assessed through the Survivor-defined Advocacy scale (SDAS). The scale assesses overall client centeredness and trustworthiness in services provided to women affected by IPV and measure if services are truly survivor-defined. The assessment looks at victim blaming as a concern and supports client's independent decision making. The revision of the SDAS determines service providers attitudes about their work and is useful to clients because it obtains providers baseline perceptions of their responsibilities and is useful to researchers as an efficient measure of survivor defined attitudes of IPV at local state and national agency levels (Kulkarni, Herman-Smith, & Ross, 2015). Collaborative actions implemented throughout the phases of IPV may be the catalyst for reduction and elimination of violence against women globally.

Limitations

The exploratory research focused on the professions of nursing, psychology, social work, law enforcement, and occupational therapy; therefore, our literature search did not include all potential service providers of women affected by IPV. IPV is a complex and traumatizing cycle that warrants different skills from professionals other than the disciplines included in this exploratory paper. Another limitation to our search was the focus on violence against women because of the prevalence of IPV in this gender group. Additionally, the exploration of violence that occurred within heterosexual relationships was solely researched due to the lack of knowledge and literature of IPV within homosexual relationships. Lastly the exploratory paper focused on solutions for programs within the United States (U.S.) instead of taking an international platform in addressing IPV as there are many cultural differences outside of the U.S. however, research on how IPV affects women immigrants was accounted for.

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