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Health Indicators, Social Support, and Intimate Partner Violence Among Women Utilizing Services at a Community Organization

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A B S T R A C T

Purpose: Intimate partner violence (IPV) against women is a significant public health concern. This study examines the physical and mental health status and relationship to social support for women seeking services to end IPV at a walk-in community organization that serves the community at large, including a shelter for abused women.
Methods: One hundred seventeen (117) English-speaking women between the ages of 18 and 61 years participated in a self-administered survey. Physical, mental, and oral health, social support, and IPV homicide lethality were measured using standardized instruments.
Results: Social support was the most important factor related to better health. The participants who had more social support reported better physical ($p < .05$), mental ($p < .01$), and oral health ($p < .05$), and a lower level of psychological distress ($p < .01$) and depression ($p < .01$) compared with participants who reported less social support. The participants living in the shelter reported worse physical health ($p < .05$) but better mental health ($p < .05$) than the participants not living in a shelter. Older age and low income were related to oral health problems, whereas older age, low education level, and unemployment were related to poor mental health.
Conclusion: The present study adds to the evidence that social support contributes to improving physical and mental health for women who experience IPV. The findings also suggest the importance of providing or referring women to mental health services.

Introduction

Intimate partner violence (IPV) against women is a significant public health concern. One quarter to one half of all women in the United States will be victims of IPV in their lifetimes (Black et al., 2011; Bonomi et al., 2007; Coker et al., 2002; Rodriguez, Valentine, Son, & Muhammad, 2009). IPV can lead to adverse health and social outcomes among women, their families, and communities (Goodman, 2006). Many women who experience IPV suffer mental and physical health consequences that may negatively affect their social functioning (Hathaway, Mucci, Silverman, Brooks, Mathews & Pavlos, 2000) and hinder their ability to obtain health or mental health care services, seek safety, and change their abusive situation, care for their children, or seek employment (Rodriguez et al., 2009; Wilson, Silberberg, Brown & Yaggy, 2007).

Little is known about the health status and social support for women who seek help at a walk-in community organization, or how a community organization can respond to the health or mental health problems among its clients. Most studies on the health of women who experience IPV have been conducted in health care settings and residential shelters (e.g., Goodkind, Gillum, Bybee & Sullivan, 2003; Rodriguez et al., 2009; Straus et al., 2009; Sullivan & Bybee, 1999). These studies show that poor social support compromises the mental and physical health of women who experience abuse and highlights the need for short- and long-term advocacy programs. However, women who experience IPV and seek services to end abuse from non–shelter-based services such as community walk-in centers may experience different types of physical and mental health problems and social support needs than women seeking help at a health care or shelter setting.

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The objective of this study was to identify physical and mental health issues associated with IPV among women seeking help at a walk-in community organization to understand unmet needs for planning intervention and prevention programs. We chose to study women who sought help at a Family Justice Center (FJC) in a large western city. FJCs originally started in San Diego, California, in 2002 and have been recognized as a successful model for IPV prevention and intervention (Gwinn, Strack, Adams, Lovelace & Norman, 2007–2008). FJCs provide a range of free services from housing assistance to obtaining a protection order in one location in a non-shelter setting for community members seeking to end IPV. The wraparound model of service delivery provided by the FJC in a supportive non-shelter environment is designed to strengthen a women's ability to cope with the impact of the violence while she is accessing and understanding the multiple and complex services available to alleviate and end violence.

There are 54 FJCs located in 25 U.S. states. Each FJC site has processes and staffing to assess and provide for victim safety during the intervention process (Gwinn & Strack, 2010). All FJCs are unique and mirror the needs of the local community, and include the key partners who provide services to families experiencing IPV. The FJC where we conducted our study provides walk-in services including advocacy, shelter, support groups, guidance counseling, and access to public benefits, police, legal advice, and employment options. The FJC is in a downtown location that includes a crisis shelter and transitional housing for 200 women and their families.

Methods

Study Population

This study was reviewed and approved for human subjects protection by the university's institutional review board. This cross-sectional study was conducted in collaboration with the FJC staff during 4 months in 2012. The FJC staff members were involved in developing the survey instrument, the study protocol, recruitment strategies, and interpreting the study results. The FJC serves approximately 50 to 70 clients per month. Clients eligible for the study were women aged 18 years or older who speak and read English and were seeking walk-in services at the FJC. The investigators were at the FJC at random time blocks every week during the study period. After a women's initial intake interview, the FJC staff asked eligible women if they wanted to participate in a health survey. After undergoing informed consent, each participant filled out a self-administered survey that took approximately 15 minutes to complete. The investigators were available to answer any questions while participants were taking the survey. After completion, participants received cash remuneration of $10.

Measures of Health

As we were developing the survey, the staff expressed concern and interest in understanding more about the mental health needs of women accessing the services at the FJC. In addition, dental health was added to our health concerns because several of the staff noted poor oral hygiene among some of the clients. As a result, three measures of mental health and one measure of physical and one measure of oral health were selected for inclusion in the survey.

Measures of physical and mental health

The Short Form (SF)-12 uses 12 items and a 5- or 3-point Likert scale (e.g., 1 [all of the time] to 5 [none of the time]) to measure physical and mental health functioning (Ware, Kosinski & Keller, 1996). The SF-12 provides two composite scores, a physical component summary (PCS) and a mental component summary (MCS). Each score is standardized to a mean (*SD*) of 50 for the U.S. population with a range of 0 to 100 (Ware, Koshinski, & Turner-Bowker, 2002). Higher scores indicate better health functioning (McDowell, 2006).

The General Health Questionnaire (GHQ) is a 12-item tool designed to measure psychological distress. Respondents report if they had recently experienced a particular behavior, using a 4-point scale (less than usual, no more than usual, rather more than usual, or much more than usual) and generates a total score from 0 to 12. Higher scores indicate worse psychological distress (Goldberg et al., 1997). A score of 3 was used to determine the cutoff point for psychological distress (Goldberg et al., 1997).

The Patient Health Questionnaire (PHQ-9) is a nine-item survey that uses a 4-point Likert scale (from 0 [not at all] to 3 [nearly every day]) to measure depression. PHQ-9 scores for the level of depression severity are defined as minimal, 0 to 4; mild, 5 to 9; moderate, 10 to 14; moderately severe, 15 to 19; and severe, 20 to 27 (Kroenke, Spitzer & Williams, 2001). The PHQ-9 score was used for describing the overall level of self-reported depression. The responses were not verified by a clinician.

The Michigan Oral Health-related Quality of Life Scale (MOHRQoL) Adult Version measures a respondents' overall perception of their oral health, including function, pain, psychological and social aspects, and injuries to the teeth or mouth (Inglehart & Bagramian, 2011). The MOHRQoL includes 14 items measured using a 5-point Likert scale (e.g., "My teeth and gums cause discomfort" on a scale from 1 [strongly disagree] to 5 [strongly agree]). We used the grand mean of the responses for analysis, which generates a score from 1 to 5. Higher scores indicate worse oral health-related quality of life. Although the MOHRQoL is not normed, a recent study reported an average score of 2.16 among general adult dental patients (McFarland & Inglehart 2010).

Measures of Social Support and Sociodemographic Characteristics

Social support was measured by the 19-item Medical Outcomes Study Social Support Survey (MOS-SSS; Sherbourne & Stewart 1991). A respondent was asked whether social support was available in four domains. For example, "Someone whose advice you really want" (emotional/informational support), "Someone to take you to the doctor if you need it" (tangible support), "Someone who hugs you" (affectionate support), and "Someone to have a good time with" (positive social interactions). The MOSS-SSS uses a 5-point Likert scale (1 [none of the time] to 5 [all of the time]). Higher scores indicate more social support. The grand mean from each participant was used for data analysis.

Measure of IPV Severity

The severity of IPV was measured with the 20-item Danger Assessment, a validated instrument designed to assess risk factors for IPV homicide in intimate relationships (Campbell, Webster, & Glass, 2009). The instrument uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide. Risk factors include past death