

Full Length Research Paper

Employment, experiences of intimate partner violence, and health related quality of life

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Accepted 1 June, 2009

We wanted to study the relationship between being unemployed or not, health related quality of life (HRQOL), and intimate partner violence (IPV) among women who had just arrived at a women's shelter and one year later. This seems as an important issue as employment rates are quite low among abused women. In measuring HRQOL, SF-36 was used both at baseline and follow-up. Lower scores in SF-36 are reflecting poorer functioning. Physical and psychological violence at baseline were measured by Severity of Violence against Women Scale and Psychological Maltreatment of Women Index. T-tests were used in the comparing analyses among unemployed women with those who took part in work life outside their homes. Significantly more psychological violence was reported by those who were unemployed compared to those who were employed at baseline. No significant differences in physical violence were reported. Those who were unemployed had higher HRQOL in all domains both at baseline and in follow up except physical health at baseline and physical health and bodily pain at follow-up. Among women who had experienced IPV, psychological violence may lead to unemployment. Better physical health and less bodily pain were reported among the employed women than the unemployed, but other HRQOL domains were better among the unemployed.

Keywords: Intimate partner violence, employment, quality of life.

INTRODUCTION

In the last few decades an increasing number of women have entered areas of work outside their home. Being employed is considered valuable, insofar as the women achieve economic self-sufficiency and independence, increased safety, social connectedness and self-esteem. Employment might also represent a mental respite (Rothman et al., 2007). The prevalence of acts of physical violence from a previous or current partner for women in Norway was 26.8% during lifetime, 5.5% during the last year and 8.8% of these reported having been exposed to life-threatening IPV (Neroien and Schei, 2008).

Women who have experienced intimate partner violence (IPV) exhibit a higher rate of unemployment than those who have no such experiences (Neroien and Schei, 2008). Studies suggest that women with IPV experiences frequently have problems handling the work-situation because of the problems in their private lives (Rothman and Corso, 2008) and that disclosure and work place support may be important for staying employed

(Rothman et al., 2007; Swanberg et al., 2007; Tolman and Wang, 2005). The best predictor for whether women would leave their abusive partner was found to be women's income in USA (Anderson and Saunders, 2003).

The relationship between being unemployed or not, health related quality of life (HRQOL), and the degree of physical and psychological violence reported are not yet covered, and studies about IPV and employment are mostly from USA.

Considerably impaired HRQOL has been found among women with IPV experiences (Alsaker et al., 2006; Lafaye et al., 2003). We hypothesized that women exposed to IPV who took part in work life outside their homes would report higher HRQOL and lower rates of IPV than those who were unemployed, so we compared these two groups. Based on HRQOL, our results showed the opposite.

METHODS

Study sample

Women who had stayed in women's shelters in Norway for at least

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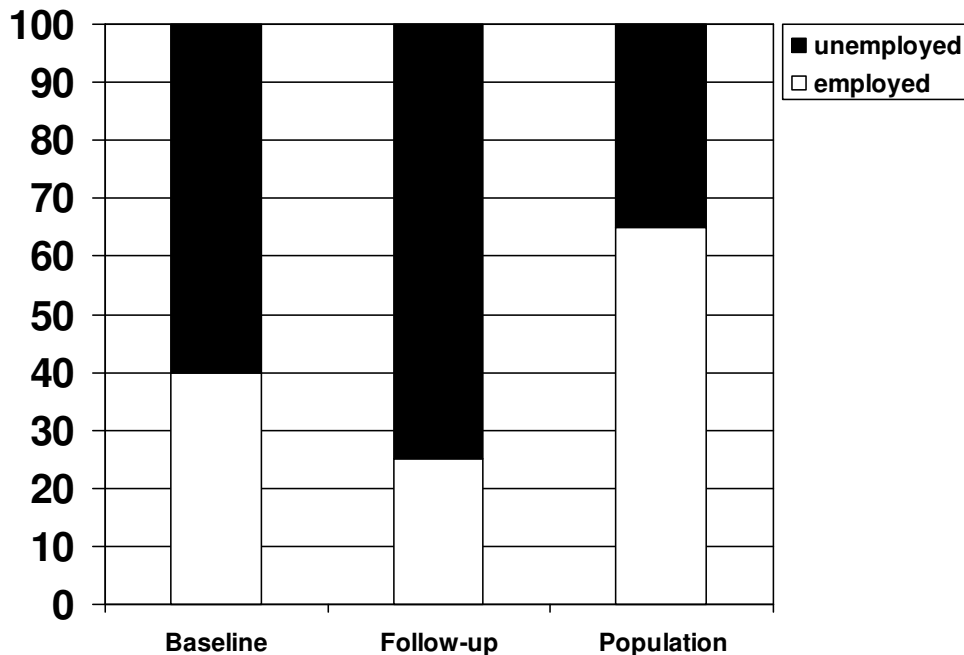


Figure 1. Percent of employment and unemployment among women at Norwegian women's shelters (baseline $n = 87$) and one year later (follow-up $n = 24$) and in the general population of women aged between 15 and 75 in 2003 (Statistics, Norway).

1 week in 2002/2003 and understood Norwegian were asked to fill out a questionnaire. The response rate was 41% at baseline. To obtain data for the follow-up study one year later, we asked the participants ($n=87$) to fill out a separate note giving us their personal identification number and permission to search for them in the National Population Registry. This permission was given by 57 women.

One year later we searched for the participants in the National Population Registry and phoned the women we found. The first question asked was whether she was safe to talk at the phone right now. If so, we reminded her of the baseline study and asked if she still wanted to participate in the follow-up study and if it was safe to send a questionnaire to her home address. Of the 57 women at baseline who wanted to participate, we got phone contact with 27 and 24 of these answered the follow-up questionnaire. Twenty did not have or did not answer their phone, we could not find the right identity of ten and three did not send their questionnaire back. Only those who both had left their partners and had the same employment status at baseline and follow-up ($n=17$) were included in the comparing baseline and follow-up analysis.

Ethical approval

The Regional Committee for Medical Research Ethics for Western Norway and the Norwegian Data Inspectorate approved the project. Informed consent was obtained from all participants. WHO has ethical and safety recommendations for this type of research. The safety of the respondents and the research team is paramount and should infuse all project decisions. Ensuring confidentiality is essential both for the women's safety and for the data quality (Garcia-Moreno, 2002; Sullivan and Cain, 2004). The study included actions aimed at reducing any possible distress caused to the participants by the research. Ethical considerations and safety considerations were crucial both in the design process and in the implementation process for the study and especially in the data collection process

like described previously.

Questionnaires

We used the SF-36 for measuring HRQOL both at baseline and one year later. Health-related quality of life (HRQOL) was obtained by using the SF-36 Health Survey, which consists of 36 items divided into eight scales. The scales are physical functioning, role limitations due to physical problems, role limitations due to emotional problems, bodily pain, social functioning, vitality, mental health (five items) and general health (five items). Raw scores for each scale range from 0 to 100 and adjusted median score from 0 to 50, with lower scores reflecting poorer functioning (Ware et al., 2000). Experienced physical and psychological violence were measured with all items in the instruments Severity of Violence Against Women Scale (SVAWS) (Marshall, 1992) and Psychological Maltreatment of Women Index (PMWI) (Tolman, 1989) at baseline only. In the follow-up study eight questions about threats and acts of physical violence, based on the types of violence which were most common experienced in the baseline study, were used (Alsaker et al., 2008). All instruments have been tested for validity and reliability and have been used worldwide (Fayers and Machin, 2000; Tolman, 1999; Ware et al., 2000).

Analysis

We used t-test's examining differences between those who were employed and those who were not employed in experiences of physical and psychological violence reported at baseline, using sum scores of SVAWS and PMWI and paired sample t-test comparing HRQOL reported from baseline to follow-up. Follow-up score and change in score (follow-up score minus baseline score) were calculated among those who both had left their partners and had the same employment status at baseline and follow-up ($n=17$). Paired

Table 1. Number of participants, mean scores and standard deviation of HRQOL (SF-36) at baseline and follow up among the employed and unemployed women at Norwegian women's shelter.

SF-36 Quality of life domains		Baseline ¹⁾			N	Follow-up ²⁾		Change* in score
		N	Mean	SD		Mean	SD	
Physical health	Employed	33	46.0	10.6	4	42.4	15.6	1.8
	Unemployed	50	42.4	12.9	13	40.2	11.1	-0.2
Role-physical	Employed	32	35.3	9.4	4	36.3	12.6	1.7
	Unemployed	50	39.6	10.7	13	38.6	10.4	2.1
Bodily pain	Employed	34	40.8	12.8	4	41.5	14.5	4.8
	Unemployed	48	41.8	12.9	11	39.1	14.4	-3.0
General Health	Employed	34	39.5	10.9	4	35.3	5.4	-2.3
	Unemployed	50	41.3	11.4	13	39.1	5.1	-0.6
Vitality	Employed	34	33.9	10.0	4	47.6	5.2	10.3
	Unemployed	47	37.0	9.7	13	48.1	4.5	16.1
Social functioning	Employed	34	25.9	12.5	4	33.9	3.0	4.4
	Unemployed	48	31.1	15.4	11	36.7	4.7	9.1
Role-emotional	Employed	32	29.8	9.7	4	30.4	15.8	-0.0
	Unemployed	50	32.6	11.2	11	31.7	11.0	4.0
Mental health	Employed	34	19.7	11.5	4	39.5	8.2	21.3
	Unemployed	50	24.4	13.4	11	39.6	6.7	22.6

SD=Standard deviation

Bold typography is related to the highest score

¹⁾ Mean score baseline was among all the participants at baseline (n = 87).²⁾ Follow-up score and change in score were calculated among those who both had left their partners and had the same employment status at baseline and follow-up (n = 17).

*Change in score: Follow-up score minus baseline score among those who both had left their partners and had the same employment status at baseline and follow-up (n = 17).

sample t-test was used to compare change in score from baseline to follow-up among the employed and unemployed (n=17).

RESULTS

The sum score of experiences of psychological violence were significantly higher among the unemployed compared to the employed at baseline ($p=0.038$). No significant difference in reported physical violence was found. At baseline 40% of the women reported taking part in work outside of their home. Among the participants who had left their partners 25% were employed one year later (Figure 1).

The respondents in the follow-up study (n = 24) and the non-respondents (n = 65) did not differ significantly regarding place of residence, age, employment, experiences of physical or psychological violence and HRQOL at baseline (Alsaker et al., 2008). No significant difference in HRQOL scores were found comparing employed and unemployed both at baseline and follow-up (n = 17). Significant difference in change in score from baseline to follow-up were found among the unemployed in mental health and vitality ($p<0.001$) and among the employed in mental health ($p<0.01$), although these numbers were small.

The unemployed ones reported higher quality of life scores than the employed ones in all SF-36 domains ex-

cept physical health at baseline. In follow-up the unemployed also reported lower HRQOL in bodily pain, indicating more pain than the employed (Table 1). These results were not significant, but they showed a trend of higher HRQOL reported among the unemployed. Change in scores for HRQOL between baseline and follow-up (n = 17) showed that the unemployed reported more improvement in all domains except for physical health and bodily pain. In general health both the employed and unemployed reported lower scores in follow-up than baseline, although these findings also were non-significant.

DISCUSSION

The significantly more psychological violence found among the unemployed respondents than the employed respondents in our study is supported by a population-based sample of 6.698 Californian women (Kimerling et al., 2008). PMWI includes 56 acts about humiliation and isolation, and not being allowed to work by their partner is one such act reported by 38% of the participant at baseline in our study (Alsaker, 2008). Unexpectedly, a trend of higher HRQOL was reported among those who were unemployed than those who were employed. The lower HRQOL among the employed may be explained by findings from USA showing that women exposed to IPV more frequently skip work, come too late or leave too early,

and reported sickness more than other women, due to living with an abusive partner (Tolman and Wang, 2005; Wuest et al., 2008).

As disclosure of living with IPV is rare, and the victim may lie about the reasons for being absent from work and this may give rise to guilt and shame and low self esteem. In addition physical and psychological abuse in intimate relationship may represent a type of disrespect that does lasting damage to one's basic confidence. One's basic confidence gets subsequently broken up from the outside, thus destroying the most fundamental form of practical relation to the self namely one's underlying trust in oneself. Hence, the further consequence, coupled with a type of social shame, is the loss of trust in oneself and the world, and this affects all practical dealings with other subjects, even at a physical level (Honneth, 1995).

Women with disabilities rates have been found to have an increased risk of IPV (Brownridge et al., 2008) and a significantly higher frequency of problems with walking, carrying out daily activities, pain, memory and dizziness (Garcia-Moreno et al., 2006) as well as posttraumatic stress disorder (Kaysen et al., 2003), depression, suicide or anxiety were found among those who had experienced IPV than among those who had not experienced this (Eberhard-Gran, et al., 2007). Bodily and psychological problems may make life as an employee quite difficult, and may explain the higher rates of unemployment as well as less improvement and lower scores in physical health and pain domains among the unemployed found in our study.

Limitations in our study include the low response rate in the baseline study as well as the small number of participants in the follow-up study as well as the fact that one year follow-up may be a short time in relation to the experiences of IPV. Lack of significant results may be due to the small sample. The selection of women seeking refuge at shelters implies that the results cannot be generalized to women exposed to IPV in the general population.

As work is important for the possibility to leave an abusive partner as well as for a life free from violence and fear, and higher quality of life, we need to find answers to help these women. Further research and larger samples are needed.

Funding

This study is partly financed by Norwegian Foundation for Health and Rehabilitation with the aid of EXTRA funds.

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