Philosophical Stance and Socio-Ecological Factors that Silence Women Who Experience Intimate Partner Violence

by

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Abstract

Background

Intimate Partner Violence (IPV) is a global health issue with long-term physical and mental health impacts. Most women may endure IPV silently before they disclose the problem and seek effective help. Healthcare providers are potential and feasible points of disclosure of IPV. To overcome barriers of disclosure, healthcare providers, especially nurses, need to have an integrated understanding of how their interactions with affected women are shaped by factors within their profession, the healthcare and community milieu, as well as factors related to affected women; and how these could reinforce silencing about the violence. Although some studies have been done in this area, we found a dearth of literature summarizing and synthesizing those studies.

Objective

This thesis aimed to identify the dominant conceptualizations within the nursing profession and the socio-ecological factors which silence women who have experienced intimate partner violence from their male partners. It unfolds in two phases: In the first phase, I explored nursing theory conceptualizations that could affect care practices and could potentially silence women, and in the second phase, I investigated factors related to women and their environment, which reinforced silencing of women about IPV. For the first phase, I explore the potential effects of the philosophical stance of nursing theories on the interactions between nurses and women who experience IPV. For the second phase, I employ an ecological model (micro-, meso-, exo-, and macrosystems) to synthesize and interpret factors affecting the silencing of women who experience IPV.

Design

We used critical interpretive synthesis and integrative review design for the first and the second phase, respectively.

Method

For the critical interpretive synthesis, we followed the steps described by Dixon-Woods et al. (2006). We hand searched nursing theory books to identify the five most commonly used nursing theories. Then, we searched PubMed, CINAHL, and Scopus to identify articles which report on the application of theories in the caring context of IPV. For the integrative review, we followed the steps described by Whittemore and Knafl (2005). We screened articles searched at seven electronic databases namely PubMed, Medline, Scopus, CINAHL, Web of Science, Sociological Abstract, and Gender Studies against pre-defined eligibility criteria using a web application, Rayyan.

Findings

During the first phase, we identified the five most commonly used nursing theories. The findings revealed that nursing theories express predominant conceptualizations about care and care recipients, which are not commensurate with the principles of care identified by the four studies which applied the different theoretical framework in the caring context of IPV. This misalignment between the conceptualization of nursing care and the defining qualities of a patient could lead nurses to respond inappropriately, hence, silencing women rather than supporting them. In the second phase, we identified 21 articles for the analysis. The microsystem level factor was the most influential in reinforcing silencing. However, each subsystem interacts with each other to affect women's response to IPV.

Conclusion

It is imperative that nurses develop the knowledge and skills to establish therapeutic interactions with women who have experienced IPV. Underpinning such development is the careful consideration of an appropriate theoretical framework. This framework could be based on the principles of care identified by this study and could incorporate the understanding of ecological influences on silencing about IPV and on shaping the responses of nurses to affected women.

Preface

This thesis is an original work of Bijaya Pokharel which has been presented in manuscript format. It consists of two manuscripts, preceded by an introduction section and followed by a conclusion section.

The introduction section describes the problem under investigation, objectives and links the two manuscripts.

The first manuscript, A critical interpretive synthesis: Reconceptualizing care for women experiencing Intimate Partner Violence has been submitted to the Journal of Nursing Scholarship.

The second manuscript, An ecological analysis of factors influencing the silencing of women who experience intimate partner violence: An integrative review, will be published in a relevant journal.

The conclusion section describes the primary outcomes, recommendations, and limitations.

I was responsible for problem formulation, data collection, analysis, and manuscript preparation. My co-supervisors, Prof. Kathy Hegadoren and Dr. Elisavet Papathanasoglou, have been included as co-authors for both manuscripts. Prof. Hegadoren provided conceptual input and feedback for the first manuscript. Dr. Papathanasoglou assisted with data search and provided conceptual and editorial feedback. For the second manuscript, Prof. Hegadoren assisted with article screening, provided conceptual, and editorial feedback and Dr. Papathanasoglou provided valuable conceptual and editorial feedback.

Dedication

To my parents, Sita Sharma Pokharel and Bishnu Prasad Pokharel.

Acknowledgements

I would like to extend my heartfelt gratitude to my supervisors, Prof. Kathy Hegadoren and Dr. Elisavet Papathanasoglou, without whom I would not have been able to accomplish my graduate study.

I am forever grateful to the donors who made it possible for me to receive bursaries which reduced my financial burden significantly.

Special credit for all my life successes always goes to my beloved parents.

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Cheers to my dear friends who supported me emotionally during these challenging two years.

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Philosophical Stance and Socio-ecological Factors that Silence Women Who Experience Intimate Partner Violence

For my master's thesis, I studied a global public health issue, Intimate Partner Violence (IPV). I focused on silencing of women about their experiences of IPV and the role of health care providers, especially nurses, in breaking the silencing. The World Health Organization (WHO) (2018) defines IPV as the "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors". For this study, I focus on IPV perpetrated by male partners against their female partners. IPV is a worldwide phenomenon affecting one-third of the female population, regardless of socio-economic status (Garcia-Moreno et al., 2006; WHO, 2018). However, these global statistics focus on physical and sexual IPV only. There is a dearth of global data on other forms of IPV such as psychological, forms of aggression, and controlling acts. Also, the current estimate of the physical or sexual forms of IPV could be a significant underestimation of the problem due to the issue of silencing associated with IPV (O'Doherty, Taft, Hegarty, Ramsay, Davidson, & Feder, 2014).

Silencing about any form of violence against women is not a novel issue. However, silencing about IPV is unique due to the co-habiting relationship between the perpetrator and the victim, the emotional bonds inherent in such a relationship, involvement of children, and the frequent delay associated with recognizing the issue (Ahmad, Driver, McNally, & Stewart, 2009; Ogunsiji, Wilkes, Jackson, & Peters, 2012; Towns & Adams, 2009). Several theories have been proposed to explain the process which an affected woman goes through before she discloses her experiences of violence (Landenburger, 1989; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Ptacek, 1999). The commonality between these theories is the concept that disclosure of IPV is a lengthy and multi-layered process. Women who experience IPV are at higher risk of

physical health problems such as acute injuries, disabilities, gastrointestinal problems, and chronic pain; mental health issues such as Post Traumatic Stress Disorder (PTSD), depression, anxiety, stress, eating disorders, and suicidal attempts; reproductive health problems like unsafe abortion, sexually transmitted infections, vaginal bleeding, pelvic infection, urinary tract infections, sexual dysfunction, and fistulas; and behavioral issues such as substance use disorders and unprotected sexual behaviors (Campbell, 2002; Garcia-Moreno et al., 2006; Jewkes, Sen, & Garcia-Moreno, 2002). Since silencing about IPV means that women stay in the violent relationship for a longer duration, the risk of these health problems increases proportionately. Thus, silencing about IPV is a significant public health issue that needs to be addressed.

This thesis aimed to explore the factors reinforcing silencing of women about their experiences of IPV perpetrated by their male partners. I accomplished the objective in two phases.

When I embarked on this thesis, I was curious about how healthcare providers could potentially silence women who experience IPV. A common factor encountered in the literature was nurses' inappropriate responses resulting from inadequate educational preparation and training (McGarry, Kench, & Simpson, 2013; Signorelli, Taft, & Gomes, 2012; Wathen, MacMillan, & Freeman, 2006). However, I assumed that the roots of the problem might be deeper. Individual and collective conceptualizations of a problem and of those affected often precede responses and actions regarding the problem (Meleis, 2012). In nursing, collective conceptualizations of health, disease, individuals and of nurses' roles are strongly influenced by an extensive theoretical basis encompassing a number of grand theories and theoretical frameworks (Meleis, 2012). The philosophical stance of nursing theories, although currently overlooked, could offer a potential explanation for the inappropriate responses of nurses to

women experiencing IPV. Thus, we aimed to explore the potential effect of the philosophical stance of those nursing theories most frequently used in the educational preparation of nurses on the care of women who experience IPV. We also synthesized empirical literature, which studied the application of theoretical frameworks in the caring context of IPV. The comparison of the dominant concepts put forth by nursing theories and the caring principles suggested by the empirical literature helped to identify a significant theoretical gap. I have discussed the details in the first manuscript.

The next phase focused on identifying the ecological factors that are beyond the control of the healthcare providers, which could reinforce silencing of women about their experiences of IPV. The understanding about the interaction of these multilayered factors with healthcare providers and the potential effects of that interaction in the caring context of IPV is imperative to address the theoretical gap. IPV is a complicated issue and developing a framework to address silencing about the issue would require an understanding of how women are interacting with their environment, how the different components of their environment are interacting with each other, and how healthcare providers could respond to affected women by considering these findings. So, for the second phase, we aimed to use an ecological model to examine the factors influencing the silencing of women who experience IPV. We used a public health lens and focused on healthcare providers in general rather than nurses only. The findings of this phase can provide valuable input to the design of policies and interventions for healthcare providers in the caring context of IPV, which are presently non-existent. I have discussed the details of this process in the second manuscript.

A Critical Interpretive Synthesis: Reconceptualising Care for Women Experiencing Intimate Partner Violence

What is Known?
Women experiencing Intimate Partner Violence (IPV) are hesitant to disclose their experiences of violence to healthcare providers. The hesitance has been attributed to inadequate or irrelevant responses from healthcare providers.

Where is The Gap?
Nurses are the largest group of healthcare providers. The potential role of philosophical stance of theoretical body of nursing in shaping care practices has been overlooked.

What Does this Study Add?
This study analyzes the philosophical stance of foundational nursing theories, compares it against the principles of care relevant to the context of IPV, and proposes solutions for addressing the gap.

Intimate Partner Violence (IPV) is a global public health problem and constitutes an infringement of fundamental human rights (UN Women, 2016). The prevalence of physical or sexual IPV directed against women is varied but significant across different countries around the world. Differing definitions of IPV and methods of data collection contributes to the wide range of prevalence rates (Garcia-Moreno et al., 2006). Globally, up to 38% of the murders of women are committed by their intimate male partners (World Health Organization, 2018). IPV has pervasive and enduring impacts on the health of women who have or are currently experiencing IPV (Stockman, Hayashi & Campbell, 2015; Tsai, Tomlinson, Comulada & Rotheram-Borus, 2016). Thus, this paper focuses on the acts of IPV directed against women by their male partners. Unless otherwise stated, we will use the term women to refer to women who experience IPV.

Background

Silence about IPV is a typical response in women across different countries and cultures

(Lassier, Nystrom, Lugina, & Emmelin, 2011; Ogunsiji et al., 2012; Towns & Adams, 2009). Recently, there is an increased focus on the ways silencing is perpetrated by the healthcare system and healthcare providers (Guruge, 2012; Usta, Antoun, Ambuel, & Khawaja, 2012). Women may access healthcare for multiple reasons, including IPV-related injuries, and chronic impacts of living in the context of IPV (Boyle, Jones & Lloyd, 2006). Thus, the role of healthcare providers, especially nurses, in helping the women experiencing IPV cannot be over-emphasized (Davila, 2006).

There is literature that highlights the challenges women have while disclosing IPV to nurses. When women manage to disclose, nurses are not prepared to respond appropriately (Davila, 2006; Guruge, 2012; McGarry et al., 2013). This paper examines a potential explanation for the inappropriate response, the philosophical stance of the nursing theoretical body which is introduced early in nurses' education, in shaping the interaction between nurses and women.

Design and Method

We employed a critical interpretive synthesis design (Dixon-Woods et al., 2006). This review allows critical synthesis of existing literature to identify gaps often followed by conceptual innovation (Dixon-Woods et al., 2006).

Formulating a Research Question

We used an iterative approach to develop a specific research question. For the first phase, we posed the question: What are the key concepts in nursing theories, which could significantly impact the care practices of nurses? As we identified key concepts, we then explored how the nursing theories have been applied to the caring context of IPV and if the key concepts identified earlier have evolved to fit the context.

Searching the Literature

We performed the literature search in two phases. In the first phase, we identified nursing

theories to be critiqued. We aimed to include nursing theories which nursing students frequently encounter during their academic preparation. We performed a search of books using the keyword "nursing theor*"at the University of Alberta Library online search portal in May 2017. The date limit was set between 2007 and 2017 assuming that frequently used books would have recent editions. We included the books which dedicated at least one chapter to the analysis of a nursing theory or theories and were published in the English language. We excluded books which: a) analyzed the application of nursing theories to specific contexts; b) were the primary work of a nursing theorist.

Following analysis of the nursing theories and models of care delivery, we searched, in collaboration with an expert librarian, CINAHL, PubMed and Scopus in June 2017 to explore the application of nursing theories in the caring context of IPV. Please refer to Appendix I for the search terms used. We did not set any date limit.

The inclusion criteria were: studies a) addressing a population of adult women who experience IPV directed by male partners; b) exploring applications of a nursing theory or model or framework in guiding the interaction between nurses and women. The exclusion criteria were; a) Studies focusing on IPV directed against men or Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ). We did not include gray literature.

Study Selection and Data Extraction

For the first phase, two independent reviewers (BP, EP) screened titles and chapters for eligibility and reviewed chapters to identify eligible sources and to extract data. The extracted data from theory chapters included frequency of discussion of nursing theories, conceptualization of caring and care recipients. If a book discussed a particular theory in several chapters or portions of chapters, it was still counted as a single citation. The cut-off point for the theories

was decided through consensus among the reviewers (BP, EP, KH). For the analysis of the selected theories, the respective theorist's original publication was studied.

For the second phase, two independent reviewers (BP, KH) screened titles and abstracts for eligibility and reviewed articles to identify eligible studies and to extract data. Given the iterative nature of the project, frequent meetings between the reviewers (BP, EP, KH) were held to refine the data extraction process.

Quality Assessment

Given the nature of the literature under consideration and the limited number of articles generated from the search, quality assessment was used to inform the synthesis process and not as a basis for exclusion of studies. For the research papers, we used the criteria provided by the Joanna Briggs Institute quality appraisal tools (McArthur, Klugarova, Yan, & Florescu, 2015; Moola et al., 2017; Lockwood, Monn, & Porritt, 2015).

Conducting an Interpretive Synthesis

We performed a Reciprocal Translational Analysis (RTA) of the findings, as described by Dixon-Woods et al (2006). We identified the key concepts from the nursing theories and the research studies. Then, we compared these concepts to formulate a conclusion. After applying the inclusion and exclusion criteria, we selected 73 books. Based on the frequency of citations in the selected books, we chose six nursing theories for analysis. Figure 1 presents the book and theory selection flowchart.

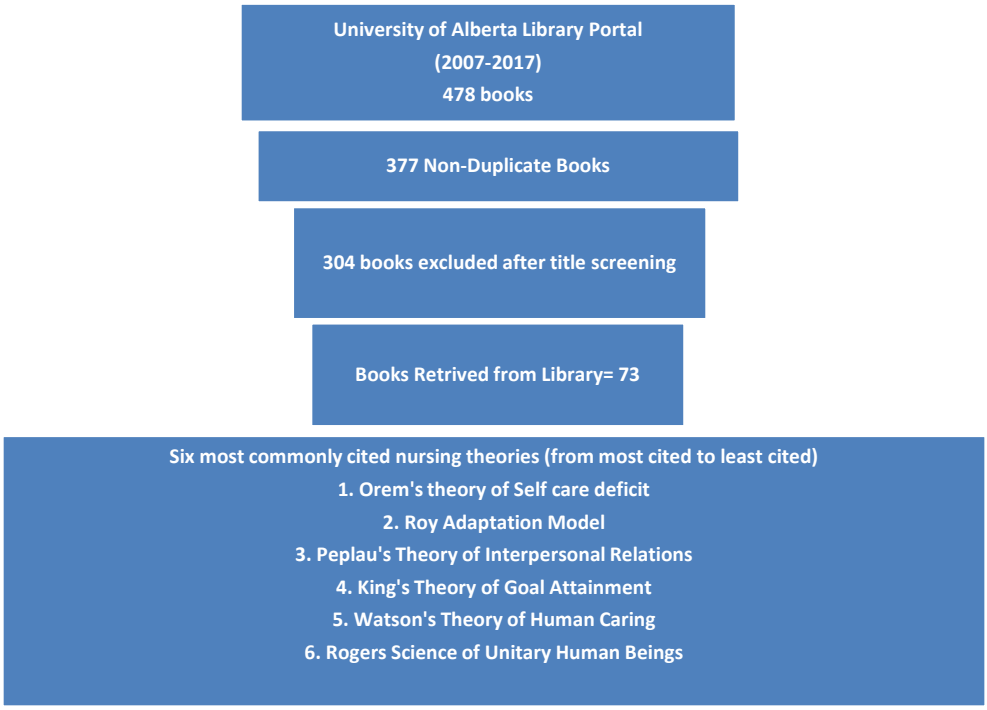

Figure 1. Book and theory selection flowchart

First Phase

Orem's Self Care Deficit Theory of Nursing, Rogers Science of Unitary Human Beings, Roy's Adaptation Model, Peplau's Theory of Interpersonal Relations, Watson's Theory of Transpersonal Caring, and King's Theory of Goal Attainment were the most commonly addressed nursing theories. Orem's theory was the theory most commonly analyzed in nursing books and thus the most visible as compared to other theories. Two key concepts were discussed by all nursing theories: conceptualization of care and care recipients.

Conceptualization of caring. All theories explain the role of the nurse as that of an expert who helps care recipients to live a balanced life. However, the concept of balance and the intensity of a nurse's responsibility are put forth differently by each theory. We identified four key themes.

Balance between Self and Environment. The theories generated by Roy, King, Peplau and Rogers embrace the concept of maintaining the balance between individuals and their environment (King, 1990; Rogers, 1994; Roy, 1970). Roy introduces the relationship between adaptation and well-being (Roy, 1970). She also purports that continued adaptation leads to purposeful existence. On the other hand, Rogers considered a body of unique nursing science knowledge as fundamental for the stated purpose of nursing to promote health and well-being. She developed a conceptual system focused on the dynamic, unitary, irreducible nature of people and their worlds (Rogers, 1994). Similarly, King prioritized balance between the personal, interpersonal and social system of an individual (King, 1990).

Balance of Nurse-patient relationship. Peplau emphasized an essential perspective. She encouraged nurses to introspect, analyze a patient's situations and to examine their own bias. A non-biased, therapeutic, and democratic interactional relationship between nurses and care recipients forms the central tenet of the theory (Peplau, 1988; Peplau, 1997).

Balance between Needs and ability. On the other hand, Orem's conceptualization of care is aiding an individual through the period of self-care deficiency that has resulted from the illness (Orem, 2001). Orem's Self-Care Deficit Theory of Nursing put forth the concept of self-care continuum. The theory presented nursing care as the maintenance of balance between the needs of care recipients and their ability to fulfill those needs.

Balance between mind and body. Watson emphasizes the importance of moral

commitment to caring (Watson, 1996). Watson recommended nurses to consider mind and body in unison to reach the human core of care recipient. She presented nurses merely as co-participants in the process of healing (Watson, 1988).

Conceptualization of care recipients. The grand nursing theories have, purposefully or not, delineated specific characteristics for persons who qualify as care recipients. We identified three key themes.

Disturbed health-illness continuum. Peplau's Theory of Interpersonal Relations puts forth the conceptualization of care recipients as the individuals with disturbed health-illness continuum (Peplau, 1988, p. 6). An acute care perspective, pertinent to hospital settings dominates this theorist's work (Peplau, 1988). Roy's Adaptation Model conceptualizes care recipients like the approach by Peplau and Orem, with a greater emphasis on the health-illness continuum (Roy, 1970). Orem described, "situations of personal health" as the criterion which qualifies a person for nursing care (Orem, pp. xiii-20).

Spiritual and unitary beings. Watson's Theory of Human Caring regards care recipients as "spiritual beings with human experience" (Watson, 1996, p. 148). Rogers Science of Unitary Human Being underpins beliefs about the holistic nature of nursing care in providing health services. The belief that nurses are more holistic in their view of patients remains an important tenet of nursing education.

Diminished ability. King's Theory of Goal Attainment defines care recipients as individuals unable to fulfill the responsibilities expected of them (King, 1990).

Second Phase

To understand if the prevailing nursing theories apply to the caring context of IPV, we first identified the principles of care that are relevant to the caring context of IPV. We focused on

the application of these theories and other middle range theories in that context. We identified four articles for final analysis. Figure 2 presents the article selection flowchart. Please refer to Table 1 for the summary of the selected articles.

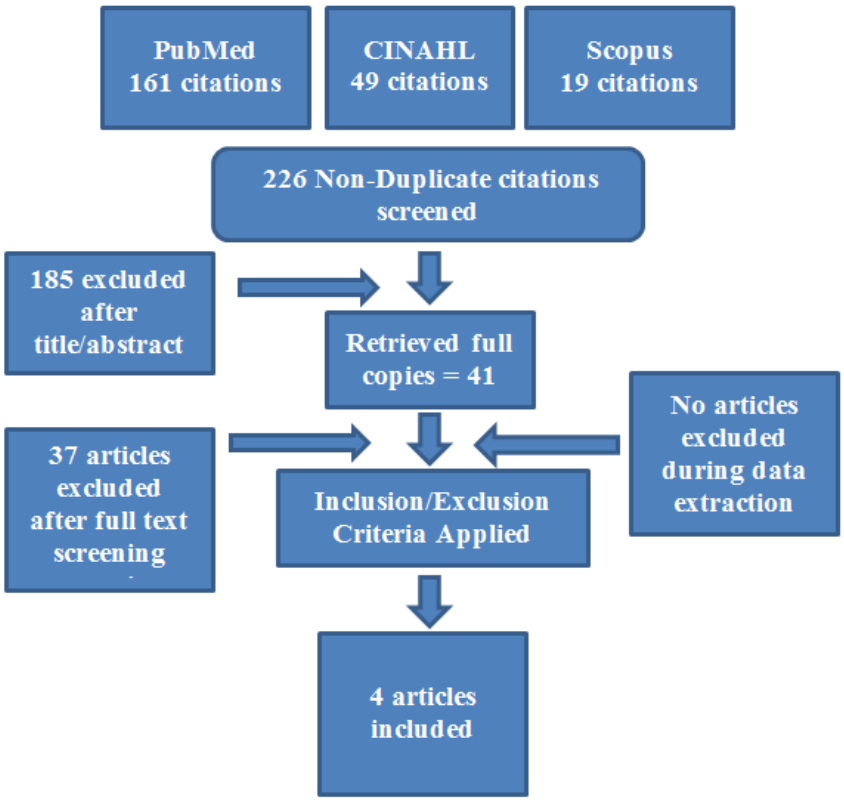

Figure 2. Article selection flowchart

The search of literature revealed that only a limited number of theories were applied in the caring context of women who experience IPV. Rather, the current focus is on deriving a unique practice framework or model, whose theoretical basis does not originate from a specific nursing concept or theory. The findings have been categorized into themes that highlight the ideal principles of care relevant to women.

Patient centered approach. Woman-centered approach is a critical aspect while caring for women who experience IPV (Bradbury-Jones, Clark, Parry, & Taylor, 2016). Nurses are

expected to consider the environment of women that includes, but is not limited to, socio-demographic, familial and cultural contexts to provide the best possible care (Teixeira et al., 2015). Also, Campbell and Campbell (1996) elaborated on the importance of providing care to women based on the stage of violence: as the severity of IPV varies according to the stage. Patience on the part of nurses is critical to women's need, and preferences change as they move through different stages of IPV (Refer to Table 1.) (Campbell & Campbell, 1996).

Empowerment. Empowerment is women's "control over safety choices" and adoption of "a philosophy of shared power" in the nurse-women relationship (Bradbury-Jones et al., 2016, pp. 3-5). The concept of empowerment focuses on nurses' responsibility to prepare and empower women rather than to suggest for women to leave the violent relationship (Bradbury-Jones et al., 2016). Similarly, the extent of involvement and direction of the nurse-women relationship is decided by women and facilitated by nurses (Butler & Snodgrass, 1990). Nurses are expected to educate women to help them define their problem and make them aware of the resources in case they decide to take protective measures (Campbell & Campbell, 1990). An effective practice is nurses' engagement in effective communication with women to promote their autonomy, participate in "open and unprejudiced listening" to promote shared decision making and ultimately empower women (Butler & Snodgras, 1991; Bradbury-Jones et al., 2016; Campbell & Campbell, 1996; Teixeira et al., 2015).

Intersectoral coordination. When women are empowered to disclose their situation to nurses, ideal responses of nurses would be through intersectoral coordination (Campbell & Campbell, 1996; Butler & Snodgrass, 1991; Teixeira et al., 2015). Women might often ask nurses to understand their overall situation and offer practical solutions (Butler & Snodgrass, 1991). Under such circumstances, nurses' knowledge about the development of a safety plan,

referrals to police, judicial services, women's shelters and employment services would be helpful (Guruge, 2012).

Cultural competence. The concept of cultural competency was introduced in 1966, through the notion of transcultural nursing pioneered by Leininger (Dayer-Berenson, 2011, p.15). There are several components of cultural competence such as advocacy, language sensitivity, and patient-centered response which are critical in the caring context of IPV (Campbell & Campbell, 1996). The advocacy component requires the nurse to look beyond routine care and recognize that women belonging to a particular race or ethnicity are either less or more privileged than others. Nurses should not hesitate to inquire about practices that make women feel humiliated, and they should also raise their voice against such practices (Campbell & Campbell, 1996). Similarly, best practice would be assuming that all women irrespective of their socio-demographic characteristics are equally at risk of being a victim of IPV (Campbell & Campbell, 1996). The practice of cultural competency could bridge the gap between different levels of understanding of women and nurses (Campbell & Campbell, 1996; Dayer-Berenson, 2011, p.12).

All articles touch the themes discussed, but each emphasizes one theme more than the other. In conclusion, the analysis revealed that limited attempts had been made to apply nursing theories to design care guidelines for women experiencing IPV.

Table 1. Summary of Identified Studies Applying Theoretical Frameworks to the Care of Women Who Experience Intimate Partner Violence

Authors (Authors in Order of References)	**Year of Publication**	**Article Title**	**Study Method**	**Study Population**	**Concepts Explicated In The Study**
Bradbury-Jones, Clark, Parry and Taylor	2016	Development of a practice framework for improving nurses' responses to intimate partner violence	Discursive Paper	Women who experience IPV	Critical analysis of three concepts; awareness, recognition and empowerment and their possibility of translation to nursing practice.
Campbell and Campbell	1996	Cultural competence in the care of abused women	Discussion Paper	Women who experience IPV	Stage specific response of nurses to IPV using Landenburger's theory of the process of entrapment in and recovery from a violent relationship: Binding, enduring, disengaging, and recovery.
Butler and Snodgrass	1990	Beyond abuse: Parse's theory in practice	Case study	Women who experience IPV	Intersectoral care coordination
Teixeira, Moura, da Silva, Queiroz, de Souza, and Netto	2015	Intimate partner violence against pregnant women: The environment according to Levine's theory	Qualitative study	Pregnant women who experience IPV	Individualized and Comprehensive Care

Note. IPV=Intimate Partner Violence

Interpretive Synthesis

In this section, we analyze if the nursing theories have put forth the concepts that are relevant to the caring context of IPV. The themes generated from the research studies aid our understanding of principles of care which are relevant to the caring context of IPV. We compare the conceptualization of care put forth by the nursing theories with themes from the research articles.

Focus on Health Conditions

The predominant focus of nursing theories is on a demarcated health condition which makes it difficult to apply the concept to women who experience IPV. On the other hand, the theories infer a power differential between nurses and care recipients. The emphasis on the expertise of the nurse and the consequent power differential add to the risk of silencing among women who experience IPV.

Disease-related Conceptualization of Care Recipients

A pattern can be deduced from the analysis of the selected six nursing theories. Although the theorists might begin by explaining broad conceptualization of nursing concepts, as they progress into the process of explication, they do not maintain their focus on the breadth of care. This could be the result of complex interaction among the unconscious bias and the socialization into the dominant health-care paradigm. For this reason, the nursing theories could have strengthened the concept of a "patient" as a person with disease/illness/disability. This conceptualization is important since the way nurses conceptualize the characteristics of a potential recipient of care could affect their attitudes and role-perception about approaching women whose attributes and circumstances may not fit within the expected role of "patient" (Hall & Ritchie, 2011, p. 65). Also, silencing of women is reinforced when IPV is not validated as a health problem which fits the definition of illness (Odero et al., 2014). If nurses adopt this

philosophy of care, initiation of effective interaction between nurses and women might be hindered.

Moreover, nursing theories present nurses as the experts who care "for" the patient. However, the findings of the theory application articles reviewed defy this concept as they reveal that women want nurses to act merely as facilitators and empower them to make their own decisions (Bradbury-Jones et al., 2016; Butler & Snodgrass, 1991; Campbell & Campbell, 1996; Teixeira et al., 2015). In other words, women want the nurses to care "with" them.

Discussion

For the first time, we critically reviewed nursing theories, along with studies implementing theoretical frameworks into the care of women who experience IPV to gain an understanding of embedded notions that could act as barriers or enhancers when caring with women who experience IPV. While nursing scholars support the principle of integrating personal values with a relevant nursing theory to guide nursing practice, this may not result in best possible care for women who experience IPV as the theories do not necessarily support the infrastructures which constitute comprehensive caring process (Meleis, 2012; Cody, 2009, p. 406).

Caring as a concept in nursing has several connotations (Morse, Solberg, Neander, Botoroff, & Johnson, 1990). In line with our findings, Morse et al (1990) discussed five interpretations of caring in nursing deriving from 35 authors. Those interpretations shared a commonality, that is, the concept of caring "for". This conceptualization of care might reinforce nurses' power over the clients who are at the receiving end of care. Thus, it may be appropriate to challenge the philosophy of "caring for" by acknowledging individuals' participation in their care and the importance of their lived experience. Therefore, we propose the concept of caring

“with”.

’Caring with’, in nurse-women interactions, can be interpreted as the process of empowering the women to care for themselves. Although the nursing theories do emphasize that patients and nurses should set goals of care together, they do not elaborate on the expertise that the care recipients bring to the relationship. Moreover, the theories do not suggest that assumption of a passive role by nurses can also enhance the interaction between nurses and care recipients. Thus, student nurses that are exposed to these theories may develop a philosophy that nurses should always take active initiative by caring "for", which may not always be pertinent to nurse-women interactions in the context of IPV. Moreover, the frequent use of the term “nursing goals” as opposed to the rare use of the term “patient goal”, reinforces the dominance of nurses in the caregiving process. Nevertheless, the philosophical stance of nursing theories analyzed in this study lays a foundation for promoting positive interaction between nurses and women, because they emphasize essential concepts such as therapeutic self-care needs, non-biased nurse-patient relationship, cultural sensitivity, holism, and moral commitment to caring. On the other hand, analysis of the identified theory-application studies supports a philosophy of care that embraces empowerment, intersectoral care, cultural competence, and patient-centeredness. Although the philosophical underpinnings of nursing theories and the principles of care highlighted in the identified studies are not irreconcilable, there seems to be an important difference in the respective foci.

Conclusion

A comprehensive framework which embraces both the essential principles of nursing theory as well as the concepts that have been foundational to guide the interaction between nurses and women seems to be lacking. We recommend that shift of focus of the theoretical

foundation of nursing from caring for to caring with is required.

Implications for Nursing Education, Practice, and Research

The findings discussed in this paper might be generalizable beyond women experiencing IPV. The concept of caring "with" could apply to any caring context where greater emphasis is on self-care and shared decision making. This study also adds to discussions about the effect of the foundational theoretical body of nursing in shaping our care practices. Future research could focus on developing an overarching nursing framework which embraces the concept of caring with and is applicable for and beyond the context of IPV.

Limitations

A major limitation of this paper is the assumption on which the paper is based. This paper assumes that nurses, to some extent, derive their philosophy of care from the nursing theories that they study during and frequently come across in their early nursing careers that might not apply to every nurse. Limited time and resources have also prevented in-depth and comprehensive analysis of all significant nursing theories.

Clinical Resources

Women abuse: Screening, Identification and Initial Response. http://rnao.ca/sites/rnao-ca/files/BPG_Women_Abuse_Supplement_Only.pdf

Domestic violence: What can nurses do?. https://www.crisisprevention.com/Blog/September-2011/Domestic-Violence-What-Can-Nurses-Do

Factors Influencing Silencing of Women Who experience Intimate Partner Violence: An Integrative Review

Intimate Partner Violence (IPV) refers to “acts of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" perpetrated by an intimate partner (United Nations, 1993). IPV is a global problem prevalent irrespective of socio-economic status, age, and ethnicity. According to the World Health Organization (WHO), one in three women experiences physical and/or sexual IPV (Garcia-Moreno et al., 2006). Comprehensive data from 48 cross-country surveys conducted revealed the prevalence of IPV between 10% and 69% (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). For this review, we define IPV as acts of violence perpetrated by a present or former male partner against a female partner who are/were in a legal marital or a cohabiting relationship. The impact of IPV increases or is persistent when affected women do not disclose the problem, a common phenomenon termed silencing (Gammeltoft, 2016). Silencing is the inability or unwillingness of the affected person to share their experiences of violence (Gammeltoft, 2016). As disclosure or silencing of IPV is the outcome of complex interactions between individuals and environmental factors (Alaggia et al., 2012), we used an ecological lens to examine factors which silence women or create barriers to disclosure of violence by women.

Background

Silencing is a common coping mechanism used by affected women to deal with experiences of violence (Gammeltoft, 2016). Gammeltoft describes two types of silencing, deliberate and subconscious. Deliberate silence is “that the individual is in conscious control of” and subconscious silence “shrouds that which people try to push out of attention and awareness” (Gammeltoft, 2016, p. 429). In most cases, breaking the silence is a process which follows

chronic failure of strategies employed by the affected women to mitigate the consequences of or to terminate the violence (O'Doherty et al., 2014). Thus, women might suffer from IPV for a significant period before they decide to disclose the experience and seek help (Garcia-Moreno et al., 2006). In the United Kingdom, affected individuals endured IPV for an average of 2.3 years before seeking useful help (Safe Lives, 2015). Global data on an average period that an affected woman suffers before seeking help for IPV is not clear and further research in this area is imperative.

Silencing about violence could increase the duration of exposure to IPV, creating a stressful living condition for a longer duration which could predispose women to several stress-related disorders. Evidence from a 2005 WHO multi-country study showed that IPV is associated with the deterioration of physical and mental health and lower quality of life of women who experience IPV as compared to unaffected women (Ellsberg et al., 2008; Rees et al., 2011). However, the causal relationship between IPV and mental health is unclear. A recent meta-analysis implied that women with mental health disorders may be more susceptible to IPV, as women suffering from depression [Odds Ratio (OR) 2.77], anxiety (OR 4.08), post-traumatic stress disorder (PTSD) (OR 7.34) are at higher risk of IPV (Trevillion et al., 2012). Moreover, affected women consume higher healthcare resources compared to unaffected women (Bonomi, Anderson, Rivara & Thompson, 2009). The most severe, and sadly not uncommon, outcome of IPV and silencing about the violence is death (Campbell, 2005). According to a study conducted in the United States using the data between 2003 and 2014, 55.3% of homicide cases of women were related to IPV (Petrosky et al., 2017).

Effective interventions to promote disclosure of IPV could be designed and tested if thorough knowledge on the factors influencing silencing about IPV is acquired. Several studies

have been done over the years to explore this issue. An integrated understanding of the factors at the individual, intrapersonal, and community levels, though essential, is missing. Thus, we aim to use an ecological lens (microsystem, mesosystem, exosystem, and macrosystem) to examine the factors influencing the silencing of women who experience IPV.

Theoretical Framework

We used an ecological framework to synthesize evidence from identified studies. The ecological model was initially put forth by Bronfenbrenner to study the impact of the ecological environment on child development. According to their model, there are four levels of ecological influence nested within each other moving from innermost to outermost levels as microsystem, mesosystem, exosystem, and macrosystem which all impact a developing human being (Brofenbrenner, 1979). The central tenet of the theory is the interrelationship between a person and the constituents of their setting and the outcome of the interrelationships as measured by changes in the person's behaviors (Richard, Gauvin, & Raine, 2011). Over the years, there have been novel applications of the ecological model, especially centered on studying the integrated effect of environmental factors with other influences on health related behaviors (Fisher, 2008). Similarly, a complex interplay among individual and environmental factors may determine the outcome of disclosure or silencing of IPV (Alaggia et al., 2012). Thus, we used an ecological framework to encompass a broad range of literature, which address potential influences of environmental factors on silencing of women who experience IPV. For this study, findings were coded based on the following description for each level: (a) Microsystem: Women's perception of their roles and responsibilities, types and nature of their interpersonal relationships, and activities performed by them in relation to their roles and responsibilities; (b) Mesosystem: Relationships amongst the factors within the microsystem; (c) Exosystem: Professional and

social life of family members, family member's network of friends, healthcare system, legal system, and other help agencies; and (d) Macrosystem: Cultural norms and beliefs, gender norms, policies, religion, and ideologies.

Design

We used an integrative review design to synthesize the findings. An integrative review allows a broader understanding of an issue through the synthesis of findings from experimental and nonexperimental studies, theoretical papers, and empirical literature (Whittemore & Knafl, 2005). Thus, we deemed the integrative review as an appropriate design for the study.

Method

Problem Formulation

The question which guided this review was, "What are the factors at various ecological levels of influence which promote and sustain silencing of women who experience Intimate Partner Violence?"

Eligibility Criteria

We included studies if they were (a) published in English between 2007 and 2018; (b) explored the issue of IPV perpetrated by a former or present male partner against their female partner; (c) included women who have experienced IPV as the study population; (d) discussed factors influencing silencing; and (e) followed quantitative, qualitative or mixed methods study design. We excluded the studies if they (a) included children, teenager, elderly or Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) or focused on women with co-morbidities or pregnancy as the study population; (b) focused on definition, ideological discourse, or conceptual analysis; (c) used any type of review design; (d) focused on other types of violence such as war violence, elderly abuse, adolescent dating violence, forced marriage, or honor killing; and (e)

focused on post-disclosure experiences. The web application, Rayyan, was used to screen the articles (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016). Two reviewers (BP, KH) screened the articles simultaneously. We resolved any discrepancies through discussion.

Literature Search Stage

We used seven databases: Scopus, PubMed, Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Web of Science, Sociological abstract, and Gender Studies. With significant help from a content-expert librarian, we used different combinations of search terms to extract relevant studies. Search terms used were: Domestic violence, battered women, Intimate Partner Violence, gender-based violence, partner violence, spouse violence, silence, disclosure, secrets, wife, husband, marital rape, batterer, assault, and beat. The date limit was set based on a threshold study published in 2006 by the United Nations (United Nations, 2006) which included an in-depth study of all forms of violence perpetrated against women.

Data Extraction and Quality Appraisal

Data extraction was done using a data extraction table, including objective, design, population, method of data collection, findings, and ecological classification of the findings (Table 2). The quality assessment was done using Joanna-Briggs Institute quality appraisal checklist (Table 3). There are different checklist available based on the study designs which allows rigorous and accurate evaluation of the methodological quality (Moola et al., 2017; Munn, Moola, Lisy, Riitano, & Tufanaru, 2015; Lockwood et al., 2015).

Data Analysis and Data Reduction

We extracted quotes relevant to the problem under investigation. We did not report descriptive and inferential statistics included in the identified studies because the research question guiding this review did not require analysis of numerical data. We categorized the

quotes into ecological levels of influence based on the aforementioned definitions. Then, the quotes were coded to identify sub-themes under each ecological level of influence. Lastly, we formulated the conclusion and recommendations based on the analysis. We used tables to display the data from each study in a succinct and organized manner.

Reporting and Comparison of Data

We compared the themes from each study to identify any similarities, differences or patterns. We used a table to arrange the data and facilitate easy comparison for the readers.

We used a diagram to display the final arrangement of factors influencing the silencing of women who experience IPV into four ecological levels of influence.

Findings

The initial literature search yielded 8264 non-duplicate citations. The article selection flowchart is presented in Figure 3. After the application of inclusion/exclusion criteria, we included 21 full-text articles for analysis.

Study Characteristics

We have summarized the studies in Table 2. The included studies followed a qualitative design (n=15), survey or cross-sectional design (n=4), mixed-methods design (n=1), and one study was a research report published by an International Non-Governmental Organization (INGO). The qualitative studies were mainly conducted using interviews (n=13), focus group discussions (n=3), storytelling (n=1), secondary data (n=1), and observations (n=1). The population under study were affected women (n=5,957), key informants and community informants (n=80), and professionals from different sectors (n=29). The studies were conducted in Canada (n=3), United States (n=6), New Zealand (n=2), Australia (n=3), Sweden, Ghana, Bangladesh, China, Nepal, and Armenia.

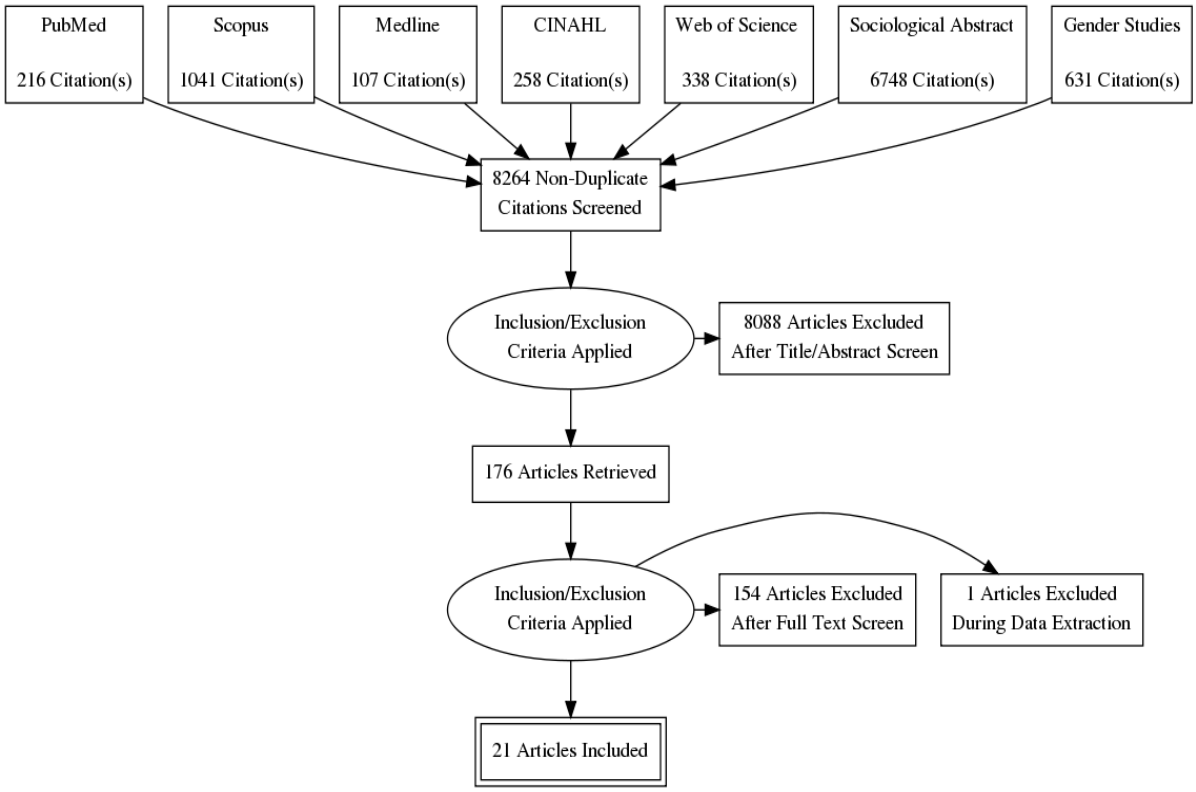

Figure 3. Article Selection Flowchart

We have organized the findings by discussing sub-themes under the ecological levels (microsystem, mesosystem, exosystem, and macrosystem) to facilitate reader's understanding. Since Brofenbrenner (1979) elucidated that the ecological levels of influence are nested within each other, we present the possible interaction between the factors in Figure 4.

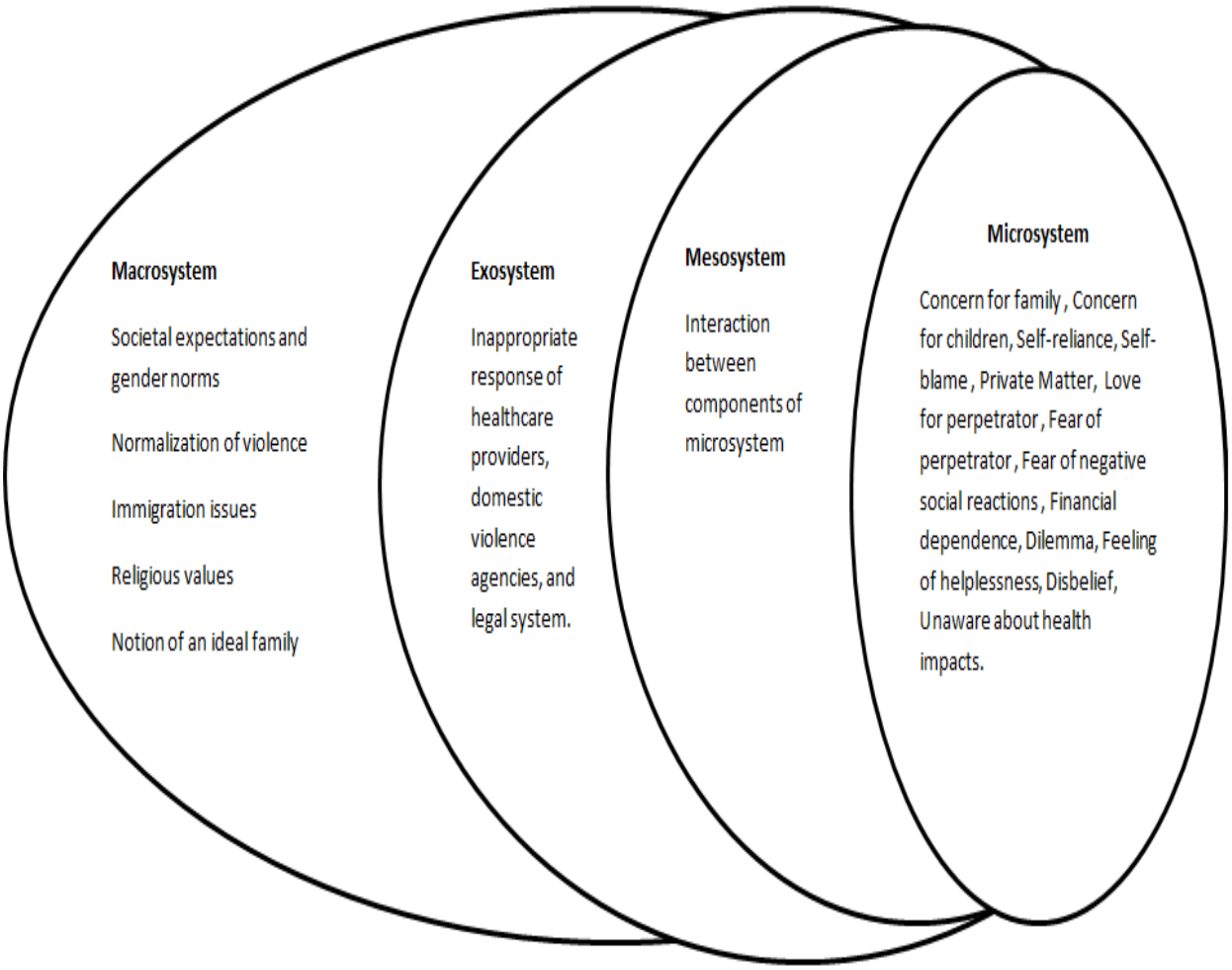

Figure 4. Ecological Model of Factors Influencing Silencing of Women Who Experience Intimate Partner Violence

Microsystem

All studies but one discussed findings related to microsystem. The sub-themes were recurrent. There were considerable similarities, as well as several contrasts in the findings across studies conducted in various countries. We identified 13 sub-themes related to the microsystem.

Concern for family. Most women were worried about their family as to why they avoided disclosure. Women perceived that their families and their parents would suffer disrespect and the family name would be ruined due to the stigma associated with the IPV (Ahmad et al., 2009; Amnesty International, 2008; Parvin, Sultana, & Naved, 2016). They

considered themselves as the tie maintaining the relationship between the husband's family and their family, which would be threatened following the disclosure of IPV (Ahmad-Stout, Nath, Khoury, & Huang, 2018). They did not want to disturb the equilibrium of their family (Wendt, 2009).

Concern for children. Women were deeply concerned about the impacts of disclosure of IPV on their children. Women perceived that single-parent families are not ideal for children's upbringing, expressed concern for their children's safety, and were scared that their children could be taken away from them (Ahmad et al., 2009; Alaggia et al., 2012; Haselschwerdt & Hardesty, 2017; Montalvo-Liendo et al., 2009; Silva-Martinez, 2016).

Self-reliance. Trust on one's ability and a strong sense of responsibility to deal with the IPV was a common sub-theme. Women recalled being very strong minded at the beginning and thus withheld disclosure (Ahmad et al., 2009). They also reported the use of emotional blunting as a strategy to self-resolve the problem (Alaggia et al., 2012). Women tried to work out the problems on their own rather than seeking help (Karp, 2015; Wendt, 2009).

Private matter. Affected women were hesitant to disclose contemplating their experiences as a private matter that should be hidden from the public eye (Ahmad-Stout et al., 2018; Mac-Gregor et al., 2016; Silva-Martinez et al., 2016).

Self-blame. Self-blame was the most common sub-theme in the microsystem (n=9). Women were ashamed of choosing a wrong life partner and of being a victim, perceived disclosure of IPV as betrayal of their partners, and were scared of being blamed or embarrassed (Haselschwerdt & Hardesty, 2017; Mertin, Moyle, & Veremeenko, 2015; Owusu, 2016; Parvin et al., 2016; Puri, Tamang, & Shah, 2011; Towns & Adams, 2009). They developed self-hatred for their inability to become an ideal wife (Rujiraprasert, Sripichyakan, Kantaruksa, Baosoung,

& Kushner, 2009). Women had developed an ideal image of their partner which, although, contrasted with their violent behavior was hard to replace. Thus, they perceived that they could have wronged their partners in some ways to provoke the violence (Towns & Adams, 2016).

Love for the perpetrator. Affected women did not disclose IPV because they still had affection for their partners. Women did not want to deface their partner's image as a loving husband (Rujiraprasert et al., 2009). After a violent event, perpetrator's immediate remorse and often short term changes in behavior allowed women to believe that their husbands had changed (Karp, 2015; Towns & Adams, 2016; Towns & Adams, 2009). This sub-theme was common in developed nations such as the US and New Zealand.

Fear of the perpetrator. Some women were restrained or threatened by perpetrators, which prevented them from disclosing IPV. For example, women reported experiences of being emotionally neglected by their partner after having disclosed the violent experiences to the perpetrator's family member (Owusu, 2016). In some cases, the male partner would exercise control over their partner's means of communication and their mobility and use threats of increasing violence or death to instill fear (Ahmad-Stout et al., 2018; Silva-Martinez et al., 2016).

Fear of adverse social reactions. Women preferred to remain silent rather than be abandoned by their social circle (Owusu, 2016). They were scared of being labeled a liar and of being perceived as a culprit rather than a victim (Ahrens, Rios-Mandel, Isas, & Carmen-Lopez, 2010; Silva-Martinez et al., 2016). Fear of ridicule and prejudice were strong factors reinforcing silencing about IPV (Loke et al., 2012).

Financial dependence. Lack of alternative living arrangements and dependence on the perpetrator for other means of living forced women to stay in the violent relationship (Ahrens et al., 2010; Silva-Martinez et al., 2016).

Dilemma. Women were unable to make a firm decision on whether disclosing the IPV and seeking help would be necessary or be helpful (Loke et al., 2012).

Feeling of helplessness. Affected women delayed disclosure as they perceived that they would not be or cannot be helped out of the violent relationship (Ahrens et al., 2010; Ogunsiji et al., 2012).

Disbelief. Women had the notion that IPV always happens to other people. Thus, when it happened to them, they used denial to manage their day to day lives (Ahrens et al., 2010; Towns & Adams, 2016).

Unaware of the health impacts. One study reported that women were not aware of the health impacts of IPV (Mertin et al., 2015).

Mesosystem

Mesosystem represents the interactions between the sub-themes mentioned above. Women were found to vacillate among the factors, forestalling making a firm decision, thus reinforcing the continued silence.

Exosystem

A small number of studies reported on factors related to professional agencies, which had the potential to reinforce silencing about IPV. A recurrent sub-theme was inappropriate responses from professionals in the healthcare system and community social service agencies. Women anticipated that nurses would advise leaving the violent relationship if they disclosed IPV (Alaggia et al., 2012; Montalvo-Liendo et al., 2009). They were fearful that disclosure to

professionals from community agencies could worsen the situation or would not be of any help (Ahrens et al., 2010; Ogunsiji et al., 2012; Rujiraprasert et al., 2009).

Macrosystem

Multiple macrosystem level factors emerged from the findings. The sub-themes are presented below.

Societal expectations and gender norms. Society has a repertoire of pre-established views and roles for women. Women disclosing their experiences of IPV would contradict their expected roles as nurturer, family protector, and a pillar for a happy family. The need to be a real woman, wife and mother was a substantial factor reinforcing silencing (Ahmad et al., 2009; Alaggia et al., 2012; Towns & Adams, 2009). In contrast, women in Nordic society hesitated to disclose IPV because of a robust social ideology against violence, which would pressure them to leave the violent relationship right away (Ormon, Sunnqvist, Bahtsevani, & Levander, 2016). However, the most common gender norms preferred women who stayed quiet and supported her family, regardless of the violent situation (Towns & Adams, 2009).

Normalization of violence. Violence perpetrated by the husband against wife was considered normal until the outcome involved severe injuries (Alaggia et al., 2012; Ahrens et al., 2010). Notably, findings were from South-Asian and Latina immigrants residing in North America, showed that women perceived verbal and emotional IPV as acceptable behavior (Ogunsiji et al., 2012).

Missing law. A study conducted in Armenia reported that the country did not have any law with regards to IPV (Amnesty International, 2008).

Immigration issues. There was a gamut of hindrances faced by immigrant women, especially the ones with undocumented status. Fear of deportation upon seeking help from police

was a substantial barrier to disclosure (Alaggia et al., 2012; Silva-Martinez et al., 2016). Women shared that lack of strong community support and services for immigrants maintained their silence (Ahrens et al., 2010). Some women had their husband as primary visa applicants. Thus, the disclosure of IPV could lead to separation from their partner, and affected women might have to leave the country (Ogunsiji et al., 2012).

Religious values. A single study discussed this sub-theme (Wendt, 2009). The findings revealed that, although affected women contemplated leaving the violent relationship, they could not act because it conflicted with their Christian values (Wendt, 2009). They also shared that if the religious leaders of their congregation had supported them better, they could have broken their silence sooner (Wendt, 2009).

Ideal family. Disclosure of IPV negated the ideology of a happy and perfect family set by the society (Haselschwerdt & Hardesty, 2017; Amnesty International, 2008). Thus, women refrained from disclosing IPV experiences.

The findings related to microsystem, mesosystem, and exosystem did not vary significantly between countries. However, there were some different social ideologies at the macrosystem level. Regardless, all these factors reinforced the silencing of women who have experienced IPV.

Table 2. Summary of the Studies Included in the Review

Date	Author	Objective/country	Design/Population	Data collection	Findings (Factors influencing silencing)	Ecological analysis
2018	Ahmad-Stout, Nath, Khoury, & Huang	To explore the experiences of IPV of South Asian women **United States**	Qualitative n=22 South Asian Immigrant women	Semi-structured Interviews	● Fear of perpetrator. ● Concern for family well-being. ● IPV considered a private family matter.	Microsystem
2017	Haselschwerdt & Hardesty	To explore the process of secrecy & disclosure of IPV by women of middle & higher socioeconomic status **United States**	Grounded theory n=10 mothers who experienced IPV & n=17 social service providers	Interviews	● Ashamed of choosing the wrong partner. ● Worried about children's safety.	Microsystem
					● Disclosure would contrast the notion of an ideal & happy family enforced by the society.	Macrosystem
2016	MacGregor et al	To identify the socio-demographic characteristics which increases disclosure & factors influencing non-disclosure of intimate partner violence	Survey n=2,831 women	Questionnaire	● Women perceived that IPV was not other's business & thus were embarrassed to share their experiences.	Microsystem

		Canada				
2016	Ormon, Sunnqvist, Bahtsevani, & Levander	To explore disclosure of partner violence by women at their recent visit to a psychiatric clinic **Sweden**	Cross-sectional study n= 77 women	Questionnaire	● Public debate in Sweden expected women to leave the violent relationship right away.	Macrosystem
2016	Owusu	To explore how silence strengthens men's power to commit violence against women **Ghana**	Qualitative n=20 women & 4 key informants	Semi-structured interviews	● Women felt guilty for reporting their husband whilst living with them ● Women were scared of being expelled from the house.	Microsystem
					● Issues of IPV were considered private by Ghanaian society	Macrosystem
2016	Parvin, Sultana, & Naved	To explore the extent & type of help-seeking by victims of partner violence living in urban slums of Bangladesh **Bangladesh**	Cross-sectional survey n= 2604 women	Questionnaire	● Women were scared they would be blamed for not being an ideal wife. ● Concern for family	Microsystem
					● Normalization of violence	Macrosystem

2016	Silva-Martinez	To study the experiences of undocumented Latina-immigrant women who have experienced IPV. **United States**	Critical ethnography n=9 participants & n=20 observations	Interviews and observations	● Fear of perpetrator ● Financial dependence ● Insecurity about public knowledge of IPV in one's house ● Fear of negative social reaction ● Language barrier	Microsystem
					● Immigration issues	Macrosystem
2016	Towns & Adams	To explore the socio-cultural influences which created ambiguity about the actions of women & hence reinforced their silencing surrounding issues of IPV **New Zealand**	Qualitative n=20 women	Semi-Structured interviews	● Self-blame ● Disbelief that violence could happen to them ● Change in perpetrator behaviors ● Blaming oneself for inability to please the husband	Microsystem
2015	Karp	To share own experiences of violence **United States**	Autobiography	Storytelling	● Love for perpetrator ● Self-reliance	Microsystem

2015	Mertin, Moyle, & Veremeenko	To find out the rate of disclosure of IPV by women to the general practitioners **Australia**	Cross-sectional study N=87 women	Questionnaire	• Self-blame • Fear of perpetrator • Unaware of health impacts of IPV	Microsystem
2012	Alaggia, Regehr, & Jenney	To examine ecological factors which influence disclosure of intimate partner violence **Canada**	Mixed methods n=66 women and n=32 key informants.	In-depth interviews and focus groups	• Self-reliance • Concern for children	Microsystem
					• Inappropriate response from the healthcare providers	Exosystem
					• Societal expectations from a woman • Immigration issues	Macrosystem
2012	Loke, Wan, & Hayter (2012)	To explore the lived experience of women victims of intimate partner violence **China**	Qualitative n=9 women	Face to face interview	• Self-blame • Dilemma • Fear of negative social reaction	Microsystem
2010	Ahrens, Rios-Mandel, Isas, & Carmen-Lopez	To explore the factors which affected disclosure of sexual assault & intimate partner violence by Latinas	Qualitative n=65 women	Focus group	• Disbelief and denial	Microsystem
					• Normalization • Immigration issue • Societal expectations	Macrosystem

		United States			from a woman	
2012	Ogunsiji, Wilkes, Jackson, & Peters	To explore the experiences of intimate partner violence of West African immigrant women residing in Australia **Australia**	Qualitative n=18 women	Face to face interview	● Fear of perpetrator	Microsystem
					● Normalization	Macrosystem
2011	Puri, Tamang, & Shah	To explore the perceived definition of sexual violence within marriage & its consequences among married women **Nepal**	Qualitative n=39 for free listing & n=15 for case histories	Free listing and Interviews	● Self-blame	Microsystem
2009	Ahmad, Driver, McNally, & Stewart	To explore the reasons for delayed help-seeking from	Qualitative SA immigrant women, n= 22	Focus Group Discussions	● Concern for family ● Concern for children ● Self-reliance	Microsystem

		healthcare professionals by women who experienced IPV **Toronto, Canada.**			● Societal expectations	Macrosystem
2009	Montalvo-Liendo et al	To identify the factors which promoted disclosure of IPV by Mexican women **United States**	Qualitative n= 26 women; n= 26 key informants	Semi-structured interview	● Fear of perpetrator ● Concern for children ● Love for perpetrator	Microsystem
					● Inappropriate responses from nurses	Exosystem
2009	Rujiraprasert, Sripichyakan, Kantaruksa, Baosoung, & Kushner	To explore and analyze the process of disclosure of IPV by women living in Northeastern Thai region **Thailand**	Qualitative (Grounded theory + Feminist standpoint theory)	Interview	● Self-blame ● Love for perpetrator ● No injury=No Harm	Microsystem
					● Unhelpful response from agencies	Exosystem
					● Societal expectations	Macrosystem

2009	Towns & Adams	To explore ideological dilemmas which silences women who experiences violence from their male partners **New Zealand**	Qualitative n=20	Semi-structured interviews	● Self-blame ● Love for perpetrator	Microsystem
					● Societal expectations ● Social values ● Gender Norms	Macrosystem
2009	Wendt	To explore women's experiences of intimate partner violence & the role of culture in shaping those experiences **Australia**	Qualitative n=21 women, 18 community informants & 12 human service workers.	Secondary data collection (analysis of cultural narratives), Semi-structured interviews,	● Self-reliance ● Concern for family ● Concern for children ● Ideal family ● No law addressing domestic violence	Microsystem
					● Societal expectations	Macrosystem
2008	Amnesty International	To explore the context & extent of domestic violence in Armenian society **Armenia**	INGO report	Interviews	● Concern for family ● Ideal family	Microsystem
					● No law addressing domestic violence	Macrosystem

Note. IPV=Intimate Partner Violence; INGO=International Non-Governmental Organization.

Table 3 Quality Assessment of the Selected Articles

Quality Assessment Criteria for Qualitative Studies (Yes/No/Unclear/Not Applicable)										
Author and year	Congruity between philosophical perspective and the research methodology	Congruity between the research question and research objective	Congruity between the research methodology and the data collection methods	Congruity between the research methodology and the representation and analysis of data	Congruity between research methodology and the interpretation of results	Statement locating the researcher culturally or theoretically	Influence of the researcher on the research, and vice-versa	Participants and their voices adequately represented	Research ethics and approval from a recognized body	Appropriate conclusions
Ahmad-Stout et al (2018)										
Haselschwerdt & Hardesty (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Owusu (2016)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Unclear	Yes	Yes
Silva-Martinez	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes

(2016)										
Towns & Adams (2016)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Alaggia et al (2012)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Loke et al (2012)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Ogunsiji et al (2012)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Puri et al (2011)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Ahrens et al (2010)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Ahmad et al (2009)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Montalvo -Liendo et al (2009)	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	Yes
Rujirapra sert et al	Yes	Yes	Yes	Yes	Yes	No	Unclear	Unclear	Yes	Yes

(2009)										
Towns & Adams (2009)	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Yes	Yes	Yes
Wendt (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality Assessment Criteria for Case Report (Yes/No/Unclear/Not Applicable)										
Author and Year	Clear description of demographic characteristics	Patient history and clearly described	Clinical condition on presentation clearly described	Clear description of diagnostic tests or assessment methods	Clear description of interventions	Clear description of post-intervention clinical condition	Identification of adverse events	Takeaway lessons provided		
Karp (2015)	Yes	Yes	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Yes		
Quality Assessment Criteria for Prevalence studies (Yes/No/Unclear/Not Applicable)										
Author and year	Sample frame appropriate to the target population	Appropriate sampling methods	Adequacy of the sample size	Detailed description of study subjects and settings	Data analysis conducted with enough coverage	Valid methods used for the identification of	Condition measured in standard and reliable	Appropriate statistical analysis	Adequate response rate OR low respons	

					of the identified sample	condition	way		e rate managed properly	
MacGregor et al (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Ormon et al (2016)	Yes	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	Unclear	
Parvin et al (2016)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Unclear	
Mertin, Moyle & Veremeenko (2015)	Yes	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	Unclear	

Discussion

The findings presented a complex array of interpersonal and environmental factors which reinforce the silencing of women who experience IPV. In this section, we examine the interactions among the ecological subsystems.

The microsystem factors were related to affected women's emotions, expectations, beliefs, and their interaction with their partners. From the volume and nature of the sub-themes categorized under microsystem, we could infer that women oscillate among the above-mentioned factors while trying to make a decision, which could predispose them to emotional distress. However, we also found that women were often oblivious to the harmful impacts of violence on them, their children, and their family. Lack of knowledge about the health impacts has been found as the main reason for not seeking professional support (Djikanovic et al., 2012; Prosman, Lo Fo Wong, & Lagro-Janssen, 2014). Since microsystem factors relate to a person's role, emotions, and responsibility, we sought to understand if and how the microsystem factors relate to the macro- and exolevel factors.

We noticed considerable overlap between the macro- and microsystem factors. Women's expectations from oneself, such as the roles and responsibilities of a mother, wife, daughter-in-law and a woman, reverberated with the societal expectations from a woman. We could infer a directly proportional relationship between the values that women abided by and the values of the society. The interaction between the micro-, and the macrosystem factors and their ability to reinforce silencing of affected women could be occurring through acknowledgment, indoctrination, and reinforcement of each other's values. A study conducted in New Zealand among 956 women revealed that 76.7% of women had shared their experiences of IPV with someone, mostly to either close friends or family members or both (Fanslow & Robinson, 2010). However, responses from the informal support system might reinforce silencing due to the

macrosystem factors such as normalization of violence (Voith, 2017). Thus, interventions targeted at breaking silence, if, delivered through prominent societal members and religious leaders might be a practical solution.

Under the exosystem theme, we discuss a single sub-theme, inappropriate response from healthcare providers. The scant sub-theme could be accounted for by the exclusion of studies that explored screening for IPV but did not discuss silencing from women's perspective. To understand how other subsystems interact with exosystem, we hereby use an example of contrasting findings. On the one hand, women were found to be hesitant to disclose their experiences of IPV to the health care providers due to fear of inappropriate responses such as suggesting that the women leave, being judgmental, and not listening to the affected women's stories. On the other hand, we found that women lied about the violence even when asked because they believed that the perpetrator would change (Montalvo-Liendo et al., 2009).

Similarly, women might be struggling with micro-, and macrosystem factors before they ever contact the exosystem. Thus, when women manage to overcome the other barriers and disclose their experiences to the health care providers, getting any inappropriate response might force them back into their protective shell of silencing. Thus, healthcare providers should be able to create a safe ambiance where women feel free to overcome or challenge other subsystem factors, which perpetuate silencing.

The complications in the exosystem factors are escalated by the predominant political macrosystem factors, such as immigration issues, child welfare programs, and missing, weak or poorly enforced laws against IPV. It would be essential to clarify how these political macrosystem factors may or may not affect women's interactions with healthcare providers.

Further research with regards to how these issues complicate the roles of health care provider's response in how women interact with such service providers is essential.

The above discussion highlighted possible patterns of interaction among the ecological subsystems. The care provided by the healthcare providers could be significantly improved by a better understanding of ecological subsystem factors which reinforce silencing. It would be helpful if they can develop an insight into their positions amidst the array of ecological subsystem factors and the compound effect of these factors on care provision.

Conclusion

Several factors at the various ecological levels of influence interact in complex and individualized ways to motivate affected women's behavior. The significant factors at play influencing an affected woman's decision in staying silent are macrosystem and microsystem factors. The interaction between these factors also shape the way in which women interact with exosystem factors. Thus, healthcare providers' prior anticipation and understanding of these factors would be advantageous in care provision. We suggest that interventions targeting the macrosystem factors could be most influential in changing women's response to violence experiences. At individual as well as societal levels, education about the health impacts of IPV on self and children could be another important strategy to break the normalization of violence.

Implications for Practice and Research

The findings derived from the ecological analysis could be used by healthcare providers to situate themselves and affected women seeking care amidst the multilayered factors. The understanding could be used to plan the best possible care for the affected women. A future direction of research could be an ecological examination of interventions targeting the silencing of women about IPV. It would be interesting and helpful to observe if and whether the interventions are addressing the factors reinforcing silencing identified by this review. Similar

reviews with focus on pregnant women, LGBTQ population, and indigenous women could also be an area of focus. This review could also act as a reference for prioritizing and designing interventions to address the issue of silencing surrounding IPV. As for nursing education,

Limitations

Due to the variation of research papers included in this review, we were not able to analyze the relation of silencing with the impacts of IPV. Since we did not have a large pool of findings from each country or region, we were not able to analyze any potential impact of cultural differences.

Conclusion

This thesis aimed to identify the factors influencing silencing of women who have experienced IPV. The first phase explored the predominant conceptualizations of nursing theories which could shape inappropriate responses of nurses to affected women resulting in silencing about IPV. The second phase used an ecological framework to examine the factors reinforcing silencing of women who have experienced IPV. In this section, I have discussed the main findings from these two phases.

The first phase revealed that there is lack of a clear and appropriate theoretical framework to inform nurses' approach to care, while interacting with women who have experienced IPV. The existing conceptualization about care and care recipients were not relevant to the caring context of IPV which could have shaped the inappropriate responses of nurses to women who experience IPV resulting in silencing about the violence. The findings from the four studies revealed four themes, which need to be embedded in a fundamental caring approach: empowerment, patient-centered care, intersectoral coordination, and cultural competence. We found that the concept of caring "with" the women should be the central tenet in the caring context of IPV. However, the findings from the first phase were not conclusive with regards to the structure of a potential theoretical framework.

The findings from the second phase of the thesis provide more insight towards the formulation of a care framework. Analysis of the ecological factors influencing silencing revealed that the ecological subsystems interact among each other. Healthcare providers need to recognize the fact that women summon a lot of courage to overcome the microsystem and macrosystem barriers when they choose to disclose their experiences of IPV. It would be essential for healthcare providers to have an insight into this difficult positioning of women

amidst layers of intermingling ecological factors. It is crucial to understand that women will not disclose their experiences until they have overcome the ambivalence borne as a result of their complex interaction with the ecological subsystems. Thus, the central tenet of the care could be maintaining an open and continuous channel of communication with the affected women. The caring approach could also incorporate information on how the macrosystem factors such as immigration and social welfare issues could potentially affect interactions between nurses and women who experience IPV. A key message inherent in the interdependent factors is that the major desired outcomes of care should come from affected women themselves. Thus, a single caring approach would not be applicable to women across different communities and diverse individual circumstances. It would be necessary to customize the care based on the variation in the ecological factors surrounding affected women.

There are several limitations to this study. We do not discuss the ways in which cultural differences could be addressed. We were limited in our abilities to assess how the macrosystem factors, such as societal expectations, could impact the values upheld by the healthcare providers while interacting with women from the same or a different community. Also, we did not analyze the effect of macrosystem factors such as immigration issues, child welfare issues, and laws in the caring context of IPV. Given the nature of the study, we were not able to analyze the relationship between silencing and the impacts of IPV. Future research could address these limitations.

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Appendix I

Search Terms used in the Second Phase of the First Manuscript

CINAHL: ((MH "Domestic Violence") OR (MH "Battered Women") OR (MH "Intimate Partner Violence") or) or (partner* or family or "gender based" or domestic or spous* or wife or marital or husband*) n3 (abuse* or violence or batter* or beat*) or (partner* or spous* or wife or wives or marital or husband*) n3 rape) AND ("nurs* theor*" or "nurs* model*")

PubMed : ((("nursing theor*") OR "nursing model*")) AND ((((partner* OR family OR domestic OR spous* OR wife OR wives OR marital OR husband* OR women))) AND ((abuse* OR violence OR batter* OR assault* OR beat*) AND (partner* OR spous* OR wife OR wives OR marital OR husband*)))

Scopus: (TITLE-ABS-KEY (("battered females" OR "domestic violence" OR "intimate partner violence" OR "partner abuse" OR "physical abuse" OR "domestic violence"))) AND (TITLE-ABS-KEY (("Nursing Theor*" OR "Nursing Model*")))

Appendix II

Search Terms Used in the Second Manuscript

Scopus: (TITLE-ABS-KEY ("battered females" OR "domestic violence" OR "intimate partner violence" OR "partner abuse" OR "physical abuse" OR "domestic violence") AND TITLE-ABS-KEY ("silen*" OR "disclosure"))

PubMed: ((partner* OR family OR domestic OR spous* OR wife OR wives OR marital OR husband* OR women) AND (abuse* OR violence OR batter* OR assault* OR beat*) OR (partner* OR spous* OR wife OR wives OR marital OR husband*) AND rape) AND ("non disclos*" OR secret OR secrets OR secrecy OR silent* OR silenc*)

Sociological Abstracts: all((partner* OR family OR domestic OR spous* OR wife OR wives OR marital OR husband* OR women) NEAR/3 (abuse* OR violence OR batter* OR assault* OR beat*) OR (partner* OR spous* OR wife OR wives OR marital OR husband*) NEAR/3 rape) AND all(silenc* OR silent*)

EBSCO CINAHL: ((MH "Domestic Violence") OR (MH "Battered Women") OR (MH "Intimate Partner Violence") or) or (partner* or family or "gender based" or domestic or spous* or wife or marital or husband*) n3 (abuse* or violence or batter* or beat*) or (partner* or spous* or wife or wives or marital or husband*) n3 rape) AND (silenc* or silent* or secret or secrets or secrecy or "non disclos*")

Gender Studies Database: ((partner* or family or domestic or spous* or wife or wives or marital or husband* or women) n3 (abuse* or violence or batter* or assault* or beat*) or (partner* or spous* or wife or wives or marital or husband*) n3 rape) AND (silenc* or silent* or secret* or secrecy or "non disclos*")

Web of Science: ((partner* or family or domestic or spous* or wife or wives or marital or husband* or women) near/3 (abuse* or violence or batter* or assault* or beat*) or (partner* or spous* or wife or wives or marital or husband*) near/3 rape) AND TOPIC: (silenc* or silent* or secret* or secrecy or "non disclos*")

Medline: The following search terms were used: battered females, women, disclosure, silen*, domestic violence, intimate partner violence, non-partner abuse, physical abuse and psychodiagnosis.