A SCOPING REVIEW OF INTIMATE PARTNER VIOLENCE IN WOMEN WITH EPISODIC DISABILITIES WITH CLINICAL IMPLICATIONS FOR HEALTHCARE PRACTITIONERS

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Abstract

Intimate partner violence (IPV) affects one in three women. Those living with episodic disabilities such as multiple sclerosis, fibromyalgia, chronic fatigue syndrome, systemic lupus erythematosus, and rheumatoid arthritis face an elevated risk of violence. Fluctuating and overlapping symptoms with IPV complicate recognition and contribute to under-identification. This scoping review mapped evidence on IPV among women with episodic disabilities to identify knowledge gaps and inform healthcare practice. Following Joanna Briggs Institute methodology, searches were conducted across five databases and grey literature. Eligible qualitative, quantitative, and mixed-methods studies included women 18 years and older with specified conditions who have experienced IPV. Women experienced diverse forms of IPV affecting quality of life, mental health, and disease activity. Clinical challenges included differentiating IPV symptoms from disease flares, time constraints and gaps in training, screening tools, and referral pathways. Findings will inform education, guidelines, and system-level interventions to strengthen IPV identification, response, and care coordination.

Dedication

This thesis is dedicated to the people whose unwavering love, encouragement, and belief in me carried me through this journey. I could not have done this without you for you have given me the courage to embrace the uncomfortable, persevere through uncertainty, and continue growing into the clinician I aspire to be

To Michael, this program has challenged us in ways neither of us could have anticipated. Thank you for your endless patience, encouragement, and support throughout every late night, stressful moment, and self-doubt.

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List of Abbreviations

CNO: College of Nurses of Ontario

CTFPHC: Canadian Task Force on Preventative Health

USPSTF: United States Preventative Services Task Force

WHO: World Health Organization

Chapter One

Background, Study Purpose, and Research Question

Introduction

This thesis is organized into four chapters. In Chapter One, I provide the background and context for the study by outlining intimate partner violence as a global public health issue, introducing the relationship between disability and violence, discussing the concept of episodic disability, and highlighting the relevance of this topic to healthcare practice, particularly Nurse Practitioners. The chapter concludes by presenting the purpose of the study and the research question guiding this scoping review. In Chapter Two, I describe the methodology used to conduct the scoping review. Guided by the Joanna Briggs Institute framework, this chapter outlines the eligibility criteria, search strategy, information sources, evidence selection process, data extraction procedures, and methods of data analysis and presentation (Peters et al., 2024). Chapter Three presents a synthesis of findings from the included literature and grey literature sources. The results are organized into four key categories that describe the prevalence and patterns of intimate partner violence, disability-related risk factors, the impact of violence on health and experiences of episodic disability, and healthcare-related factors influencing the identification of and response to intimate partner violence among women living with episodic disabilities. Finally, Chapter Four discusses the findings in relation to the broader literature, highlighting implications for clinical practice, education, policy, and future research. The thesis concludes with a summary of the study's contributions and recommendations for improving recognition, response, and support for women living with episodic disabilities who experience intimate partner violence.

While this study aims to improve clinician identification, response, and care coordination for women with episodic disabilities experiencing intimate partner violence among, and inform targeted education, clinical guidelines, and system-level interventions to enhance healthcare practitioners’ capacity to deliver safe, equitable, and comprehensive care for this population, this

thesis places particular emphasis on the role of Nurse Practitioners in Canada in identifying and responding to women with episodic disabilities experiencing intimate partner violence, reflecting its completion as part of the Master of Science in Nursing and Primary Health Care Nurse Practitioner programs. As demand for accessible, high-quality primary care continues to grow within Canada and internationally, Nurse Practitioners are being increasingly recognized as essential providers in addressing healthcare gaps, improving access to comprehensive care, and advancing health equity for underserved and structurally marginalized populations, including women (Canadian Nurses Association [CNA], 2026). Women continue to experience disproportionate inequities in health and healthcare, including barriers to reproductive health, persistent wage disparities, underrepresentation in health research, and, as explored in this thesis, the intersecting challenges of episodic disability and intimate partner violence. Despite increasing recognition of these issues, they remain pervasive within both society and healthcare systems. Grounded in holistic, person-centred, and trauma- and violence- informed practice, the broad scope of practice and emphasis on health promotion and disease prevention, makes Nurse Practitioners uniquely positioned to identify and respond to intimate partner violence, deliver comprehensive and equitable care, and advocate for system level changes that better support women living with episodic disabilities. The findings from this scoping review provide important evidence to inform Nurse Practitioners education, clinical practice, research, and policy development, with the goal of improving the recognition of and response to intimate partner violence among women living with episodic disabilities.

Background

Intimate Partner Violence as a Public Health Issue

The World Health Organization (WHO) defines intimate partner violence as "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (WHO, 2026). Globally, approximately one in three women, or about 30%, reporting having experienced intimate partner violence in their lifetime however, this estimate is likely conservative due to substantial underreporting (WHO, 2026). Women are disproportionately affected by intimate partner violence when compared with men, with the highest risk observed among adolescent girls, women of older age, women with disabilities, transgender women, and women who engage in sex work (Government of Canada, 2025a; WHO, 2026). These disparities reflect the intersecting effects of of discrimination, dependence, and pervasive gender inequality experienced across diverse social and economic contexts (Government of Canada, 2025a; WHO, 2026). Intimate partner violence is a pervasive public health problem that transcends cultural, geographic, and socioeconomic boundaries and can result in profound short and long-term physical, psychological, social, and economic consequences for survivors, their families, and their communities (Government of Canada, 2025a; WHO, 2026). Social and economic costs include isolation, inability to work, wage losses, limited ability to care for themselves and their children and families (Government of Canada, 2025a; WHO, 2026).

In Canada, the burden of intimate partner violence is disproportionately borne by women, in particular Indigenous women (Government of Canada, 2025a; Royal Canadian Mounted Police [RCMP], 2026). Rates of intimate partner violence in Canada have increased since 2014, with reported incidents of intimate partner sexual assault rising by an estimated 163% and intimate partner physical assault by 14% (Government of Canada, 2025a). In 2022, an estimated 117,093 individuals aged 12 and older were victims of intimate violence (Government of Canada, 2025a).

Furthermore, between 2011 and 2021, there was an estimated 1,125 gender-related homicides, approximately two-thirds of which were perpetrated by an intimate partner (Government of Canada, 2025a).

The economic burden of intimate partner violence in Canada is substantial. In 2009, the most recent national estimate available, the societal cost of intimate partner violence was estimated at approximately 7.4 billion dollars across multiple sectors, reflecting its far-reaching consequences (Government of Canada, 2021). These costs include expenditure associated with the criminal justice system such as police and correctional services, as well as the civil justice system, including divorce and separation proceedings and child protection services (Government of Canada, 2021). However, the greatest proportion of these costs is borne by survivors themselves through healthcare expenditures, lost wages and education opportunities, reduced productivity, and the physical and psychological consequences of pain and suffering (Government of Canada, 2021).

Recognizing the profound health, social, and economic consequences of gender-based violence, the Government of Canada launched the National Action Plan to End Gender-Based Violence in 2022, recognizing intimate partner violence as both a public health issues and a violation of human rights violation (Government of Canada, 2022). The National Action Plan envisions a Canada free from gender-based violence by addressing the social norms and structural determinants that contribute to gender-based violence, improve timely and culturally safe access to services, and enhance outcomes for survivors (Government of Canada, 2022).

Health Consequences of Intimate Partner Violence

The health consequences of Intimate partner violence are extensive and include acute and chronic physical injuries, such as headaches, chronic pain syndromes, and traumatic injuries;

mental health conditions, including depression, anxiety disorders, post-traumatic stress disorder, and substance use disorders; sexual health consequences, such as unintended pregnancies and sexually transmitted infections including HIV; and adverse reproductive outcomes, including an increased risk of miscarriage (Government of Canada, 2025a; WHO, 2026). At its most severe, intimate partner violence may result in homicide and is a well-established precursor to to intimate partner homicide (Government of Canada, 2025a; Sutton, 2023; WHO, 2026). Individuals who experience intimate partner violence often require complex, multidisciplinary care to address these long-term physical, psychological and social consequences of abuse. The care requires secondary to these adverse health consequences place a substantial burden on the healthcare system through increased utilization of emergency departments, primary care services, mental health services, and hospital admissions. For example, in Ontario, intimate partner violence has been associated with a 17% increase in healthcare expenditures, with annual Ontario Health Insurance Plan costs estimated at approximately 762 million annually (Dusing et al., 2025; Metheny et al., 2026). The substantial burden associated with intimate partner violence underscores the critical role of healthcare professionals in recognizing, responding to, and supporting individuals experience violence.

Healthcare Response to Intimate Partner Violence

The health sector plays a critical role in preventing and responding to intimate partner violence through a multi-faceted approach (WHO, 2026). Key responsibilities include establishing policies, protocols, and training standards; providing comprehensive trauma- and violence- informed services; generating evidence through research; supporting the coordination of care across sectors; and advocating for survivors (WHO, 2026).

Despite the central role of healthcare, intimate partner violence remains under-recognized by healthcare providers, and evidence suggests that relatively few medical professional's routinely screen patients for intimate partner violence (Alhalal, 2020; Barnard et al., 2018; Clark et al., 2017; Marshall et al., 2019; Sawyer et al., 2017; Tarzia et al., 2021). A systematic review found that fewer than 50% of healthcare providers reported consistently screening for intimate partner violence, while one study reported that Nurse Practitioners screened only 36% of patients on average (Alvarez et al., 2017; Sutherland & Hutchinson, 2019). Healthcare providers including nurses, Nurse Practitioners, physicians, allied health professionals, paramedics, and pharmacists identify numerous personal, organizational, and systems-level barriers to addressing intimate partner violence (Alhalal, 2020; Barnard et al., 2018; Clark et al., 2017; Marshall et al., 2019; Sawyer et al., 2017; Tarzia et al., 2021). These barriers include inadequate organizational policies and programs, limited training, absence of standardized response protocols and referral pathways, and negative attitudes and beliefs that hinder screening and identification of intimate partner violence (Alhalal, 2020; Barnard et al., 2018; Clark et al., 2017; Marshall et al., 2019; Sawyer et al., 2017; Tarzia et al., 2021).

Health care research is also lacking and although substantial literature has described the epidemiology of intimate partner violence in Canada, there is comparatively little research that has examined the implementation and effectiveness and of interventions to prevent violence or improve outcomes for survivors (Wathen et al., 2025). Addressing these gaps is essential to informing evidence-based policies and healthcare practices that effectively identify, support, and improve outcomes for individuals experiencing intimate partner violence and intersecting factors such as disability that place women at increased risk of experiencing intimate partner violence.

The Intersection of Disability and Intimate Partner Violence

Certain factors increase women's risk of experiencing intimate partner violence, and disability has consistently been identified as a significant risk factor due the complex interplay of social, economic, and structural inequities (Anyango et al., 2025; García-Cuéllar et al., 2022; Hervé et al., 2025). Women living with disabilities may experience power imbalances within intimate relationships, increased dependence on partners for physical, financial, or emotional support in addition to reduced autonomy, which may heighten vulnerability to intimate partner violence (Hervé et al., 2025). Disability may also contribute to social and physical isolation, limiting access to supportive relationships, healthcare services, community resources, and opportunities to seek help or safely leave abusive relationships (Hervé et al., 2025). These disparities arise not from disability itself, but instead reflect the intersecting effects of social, structural, and systemic barriers that shape women's experiences and vulnerability to intimate partner violence (Government of Canada, 2025a; WHO, 2026).

Understanding Episodic Disability

An estimated eight million Canadians identify as having a disability, with women reporting higher disability rates than men (Hébert et al., 2024). The understanding of disability has shifted over time and has come to recognize that not all disabilities can be viewed in the conventional way of remaining permanent and unchanged. Episodic disabilities are dynamic in nature with individuals experiencing episodes of limitations or increases in severity, with periods of good health (Morris et al., 2019). The unpredictable and often unseen nature of episodes leads to changing requirements and the need for support over time and may intensify the stigma of these 'invisible illnesses' (Colombo et al., 2025; Joachim & Acorn, 2000). Conditions such as multiple sclerosis, chronic fatigue syndrome, fibromyalgia, systemic lupus erythematosus, or rheumatoid arthritis share clinical and social characteristics and are characterized by fluctuating

symptoms, periods of remission and exacerbation, and substantial impacts on physical, psychological, and social functioning in addition to their predominance in women between the ages of 20 and 40 (Albrecht et al., 2025; Clauw, 2014; Episodic Disabilities Network [EDN], 2015; Faro et al., 2016; Intriago et al., 2019; Multiple Sclerosis Society of Canada, 2009; Ngo et al., 2014; Perricone & Shoenfeld, 2019; WHO, 2025). Women with episodic disabilities may be particularly vulnerable to the intersecting effects of of discrimination, dependence, and gender inequality as their fluctuating symptoms, periods of functional impairment, and often invisible nature of disability creates unique challenges in recognizing, disclosing, and responding to intimate partner violence.

Implications for Nurse Practitioner Practice

Nurse Practitioners play an essential role in the identification, assessment, and management of both episodic disabilities and intimate partner violence. As autonomous primary care providers, Nurse Practitioners are uniquely positioned to establish longitudinal therapeutic relationships that foster trust, continuity, and provide opportunities for disclosure of intimate partner violence (CNA, 2010; College of Nurses of Ontario [CNO], 2023; CNO, 2024). Their broad scope of practice, emphasis on health promotion and disease prevention, and commitment to person-centered and trauma- and violence- informed care enable them to recognize the complex physical, psychological, and social consequences of intimate partner violence while addressing broader determinants of health that influence women's safety and well-being (CNA, 2010; CNO, 2023; CNO, 2024). In addition to providing comprehensive assessment and medical management, Nurse Practitioners coordinate care across multidisciplinary teams, facilitate referrals to community and social support services, advocate for patients, and contribute to the development of individualized safety plans (CNA, 2010; CNO, 2023; CNO, 2024).

Despite their central role in healthcare, little evidence exists to guide clinicians including Nurse Practitioners in recognizing and responding to intimate partner violence among women living with episodic disabilities (Alhalal, 2020; Barnard et al., 2018; Clark et al., 2017; Marshall et al., 2019; Sawyer et al., 2017; Tarzia et al., 2021) Women living with episodic disabilities present unique challenges in the recognition and management of intimate partner violence. Many symptoms associated with episodic conditions including chronic pain, fatigue, anxiety, depression, sleep disturbances, cognitive changes, and reduced functional capacity overlap considerably with the physical and psychological manifestations of intimate partner violence (Parsons & Braun, 2024; Rovenský & Payer, 2009; Schone, 2019; Scott & Broom, 2022; Sperry, 2009; Vicard-Olagne et al., 2021; Watad et al., 2024). Consequently, healthcare providers may attribute these symptoms solely to an underlying health condition, while indicators of abuse remain unrecognized.

Synthesizing the available evidence is necessary to inform clinical practice, education, and future research and address and important gap in knowledge regarding the intersection of intimate partner violence and episodic disability. The findings from this scoping review have the potential to inform Nurse Practitioner education, clinical assessment, screening practices, and referral pathways, while identifying priorities for future research and policy development. Ultimately, improving understanding of this intersection may enhance the ability of the Nurse Practitioners to recognize intimate partner violence earlier, deliver equitable and trauma- and violence- informed care, and improve health outcomes for women living with episodic disabilities.

Conclusion

Intimate partner violence is a significant global public health concern that disproportionately affects women and is associated with profound physical, psychological, social, and economic consequences. Women living with disabilities experience an elevated risk of intimate partner violence; however, little is known about the specific experiences of women living with episodic disabilities, whose fluctuating and often invisible conditions may create unique vulnerabilities and barriers to support. Episodic disabilities, including multiple sclerosis, fibromyalgia, chronic fatigue syndrome, systemic lupus erythematosus, and rheumatoid arthritis, are characterized by periods of wellness interrupted by episodes of illness or disability, creating complex interactions between health, dependence, and social circumstances. The purpose of this thesis is to explore and map the existing literature on intimate partner violence among women living with episodic disabilities and to identify gaps in knowledge that may inform future research, policy, and healthcare practice. Guided by the research question, *what is known about intimate partner violence within the context of women living with an episodic disability?* this thesis employs a Joanna Briggs Institute scoping review methodology to examine and synthesize the current state of evidence.

Chapter Two

Methods

Introduction

In this chapter, I first discuss the theoretical underpinning guiding this scoping review. I then outline the methods used to conduct a scoping review examining the existing evidence on intimate partner violence among women living with episodic disabilities. Given the scarce but evolving body of the literature in this area, a scoping review was selected as the most appropriate approach to systematically map the breadth, range, and characteristics of existing evidence while identifying gaps requiring further investigation (Peters et al., 2024). Scoping reviews are particularly valuable when a body of literature has not previously been comprehensively synthesized and when the objective is to explore the extent, nature, and distribution of knowledge rather than evaluate intervention effectiveness (Peters et al., 2024). I conducted the review utilizing the Joanna Briggs Institute methodology for scoping reviews, which provides a rigorous and transparent framework for evidence synthesis (Peters et al., 2024).

In this chapter, I also describe the review purpose and research question, eligibility criteria, search strategy, information sources, evidence selection procedures, data extraction methods, and approach to data analysis and presentation. Together, these methods ensure a systematic and reproducible process for identifying, organizing, and synthesizing the available literature related to intimate partner violence among women living with episodic disabilities (Peters et al., 2024).

Theoretical Underpinning

Intersectionality

Intersectionality is a theoretical framework first introduced in the late 1980's by Kimberlé Crenshaw to examine how multiple dimensions of identity, particularly race and gender, interact to shape the experiences of women of colour encountering violence (Crenshaw, 1991). Rather

than viewing systems of oppression as operating independently, Crenshaw argued that racism, sexism, classism, and other forms of structural inequality are interconnected and mutually reinforcing (Crenshaw, 1991). Individual identities are therefore not experiences in isolation but instead represent a complex convergence of social locations that influence how individuals experience privilege, discrimination, and access to resources (Crenshaw, 1991). Through this framework, Crenshaw demonstrated that the experiences of women of colour cannot be fully understood by examining either race or gender alone, as these identities intersect to create distinct forms of marginalization and violence (Crenshaw, 1991).

Since its introduction by Crenshaw, the intersectionality framework has been widely adopted across various disciplines including public health, nursing, medicine, sociology, psychology, disability studies, and health equity research (Borras, 2021). It is now recognized as an essential framework for understanding how multiple intersecting social identities and systems of power shape health outcomes, access to care, and experiences of inequity (Borras, 2021; Tao, 2024). Rather than examining characteristics such as gender or disability independently, intersectionality recognizes that these factors interact within broader social, political, and structural contexts to produce unique experiences (Borras, 2021; Tao, 2024). Within healthcare research, intersectionality has become increasingly important for examining health inequities experiences by populations with multiple marginalized identities (Borras, 2021; Tao, 2024). For example, women with episodic disabilities may experience forms of discrimination related to gender identity and disability which influence an individual's risk of experiencing intimate partner violence, their ability to disclose abuse and access health services, and the responses they receive from providers and support systems.

This thesis adopts an intersectionality framework to examine how gender and episodic

disability intersect to shape women's experiences of intimate partner violence. Using this framework acknowledges that these experiences are embedded within broader systems of structural inequality and are further influenced by social identities and contextual factors. (Borras, 2021; Crenshaw, 1991; Tao, 2024) An intersectional lens informed the development of the research question and guided data extraction, analysis, and interpretation of findings. Specifically, it facilitated the examination of how the included studies considered the influence of gender and disability on women's experiences of intimate partner violence, access to healthcare and support services, and interactions with healthcare providers (Borras, 2021; Crenshaw, 1991; Tao, 2024). Applying this framework enabled a more comprehensive understanding of the complexities that influence women with episodic disabilities experiences of intimate partner violence (Borras, 2021; Crenshaw, 1991; Tao, 2024). Furthermore, applying this framework highlights the importance of developing equitable, trauma- and violence- informed, and person-centred healthcare interventions and policies that address these intersection determinants of health.

Positionality

As the researcher, my professional background is as a registered nurse and Nurse Practitioner student committed to advancing equitable, trauma- and violence- informed, and person-centred care for women informed the development of this thesis. My initial interest in women's health stemmed from personal experiences navigating contraceptive care, which highlighted the importance of equitable, respectful, and evidence informed reproductive healthcare. Their interest subsequently broadened to encompass women's health more generally, with a particular focus on health equity, access to care, and the social and structural factors that influence women's health outcomes.

This interest was further shaped during a clinical placement in a remote Inuit community in Nunavut, where the researcher observed the profound impact of intimate partner violence on the health and wellbeing of women and families. The placement provided insight into how violence is experienced within the context of broader structural inequities, including the ongoing effects of colonialism, geographic isolation, housing insecurity, limited access to healthcare and social services, and the intersection of gender and Indigenous identity. These experiences reinforced an understanding that intimate partner violence cannot be fully understood through an individual lens but instead occurs within complex social, political, historical, and cultural contexts. While these experiences influenced my interest in the topic, they also stress the importance of approaching the literature with humility and avoiding assumptions based on individual clinical experiences.

I had no prior involvement in intimate partner violence or disability research before undertaking this thesis and I do not have the lived experiences of these factors. Furthermore, I recognize my social location as a White, able-bodied women educated within the Canadian healthcare system and acknowledge that this position affords privileges that differ from the experiences of many women represented within the included literature. As the researcher, I recognize that these social positions may influence how evidence is interpreted and there is risk of unintentionally privileging dominant healthcare perspectives or overlooking the influence of structural and systemic inequities experiences by marginalized populations. Maintaining awareness of these potential biases was therefore an essential component of the research process.

Reflexivity was incorporated throughout each stage of the scoping review to promote transparency and methodological rigor. I engaged in ongoing self-reflection to critically examine how subjective experiences, professional values, and assumptions about intimate partner

violence, disability, and healthcare delivery could influence study selection, data extraction, synthesis, and interpretation of findings. Decisions made throughout the review were guided by the predefined review protocol and the Joanna Briggs Institute methodology to minimize subjective interpretation and ensure consistency (Peters et al., 2024). Applying an intersectionality framework further encouraged critical consideration of how multiple systems of power and oppression shape women's experiences rather than attributing findings solely to individual characteristics or disability. Throughout the review, conscious efforts were made to remain grounded in the evidence, to represent the findings of included studies accurately, and to acknowledge areas of uncertainty and gaps within the literature.

Recognizing these influences does not eliminate bias; rather, reflexivity enhances the trustworthiness and credibility of qualitative and scoping review research by making the researcher's perspectives explicit and encouraging critical engagement with how knowledge is produced (Olmos-Vega et al., 2022). By acknowledging my positionality and employing systematic, transparent methods throughout the review process, I sought to produce findings that faithfully represented the existing evidence while contributing to a more nuanced understanding of intimate partner violence among women living with episodic disabilities.

Research Purpose

The purpose of this scoping review is to map the current evidence on intimate partner violence among women living with an episodic disability to identify key gaps in knowledge. These gaps will be used to inform future research, healthcare practices and influence health and social interventions for women living with intimate partner violence and episodic disabilities.

Research Question

The research question guiding this scoping review is as follows: what is known about intimate partner violence within the context of women living with an episodic disability?

Methodology

This scoping review was conducted in accordance with the Joanna Briggs Institute methodology for scoping reviews (Peters et al., 2024). Scoping reviews, also known as "mapping reviews," are a systematic and rigorous method of synthesizing evidence in areas of research that may be emerging or not yet comprehensively reviewed (Peters et al., 2024). Their primary purpose is to map the breadth, range, and characteristics of existing evidence while identifying gaps that warrant further investigation (Peters et al., 2024). In addition, scoping reviews can be used to clarify key concepts and definitions within the literature and to identify questions that should guide further research (Peters et al., 2024). Unlike systematic reviews, which are designed primarily to evaluate the effectiveness of interventions, scoping reviews seek to explore the extent, nature, and distribution of knowledge within a given field (Peters et al., 2024). Common reasons for undertaking a scoping review include: (a) to serve as a precursor to a systematic review, (b) to identify available evidence in a field, (c) to identify and analyze knowledge gaps, (d) to clarify key concepts and definitions, (e) to examine how research has been conducted on an issue or topic, and (f) to identify key characteristics or factors related to a particular concept or phenomenon (Peters et al., 2024).

The Joanna Briggs Institute outlines a systematic and transparent approach to conducting scoping reviews that is guided by a clearly defined review question (Peters et al., 2024). The review question is commonly developed using the Population-Concept-Context (PCC) framework recommended by the Joanna Briggs Institute, which aids in defining the scope of the review and establishing appropriate eligibility criteria (Peters et al., 2024). The population

identifies the group of interest, the concept defines the primary phenomenon being explored, and the context specific the setting or circumstances relevant to the review question (Peters et al., 2024). In accordance with the Joanna Briggs Institute, a scoping review follows an *a priori* protocol that is developed prior to undertaking the review that outlines the review objectives, eligibility criteria, methods for evidence identification and selection, data extraction procedures, and plans for data synthesis and reporting (Peters et al., 2024). The protocol promotes methodological transparency and consistency while reducing the potential for bias throughout the review process (Peters et al., 2024). Predefined inclusion and exclusion criteria guide the selection of evidence sources which typically specify types of participants, the core concept of interest, the context, and the types of evidence sources (Peters et al., 2024). A clear and comprehensive search strategy is then developed to identify both published and unpublished sources of evidence across multiple databases designed to be as reproducible as possible (Peters et al., 2024).

Study selection is conducted in a staged process, beginning with independent screening of titles and abstracts and followed by full-text reviews of potentially eligible sources (Peters et al., 2024). Screening is typically undertaken by at least two independent reviewers with any disagreements resolved through discussion or consultation with an additional review (Peters et al., 2024). Data extraction utilizes a standardized process to ensure consistency and commonly includes details such as author, year, objectives, characteristics or number of participants, concept, and context (Peters et al., 2024). Unlike systematic reviews, scoping reviews do not typically seek to assess intervention effectiveness, and findings are instead synthesized descriptively to map available evidence and identify patterns, characteristics, and gaps within the literature (Peters et al., 2024). Depending on the nature of evidence, synthesis may include

numerical summaries, thematic analysis, content analysis, or narrative synthesis (Peters et al., 2024). To enhance transparency and reproducibility, scoping reviews are reported in accordance with PRISMA Extension for Scoping Reviews (Peters et al., 2024). Reporting includes a flow diagram illustrating the number of records identified, screened, excluded, assessed for eligibility, and ultimately included in the review, accompanied by a narrative description of the process (Peters et al., 2024).

A scoping review was selected as the methodological approach for this study because it was best suited to addressing the research questions while acknowledging the emerging yet limited body of evidence in this field. The aim of this review was to provide a broad but comprehensive overview of the literature examining intimate partner violence among women living with episodic disabilities, map the existing evidence base, and identify areas in which further research is needed. By synthesizing and characterizing the current literature, this review seeks to establish a foundation for future research and contribute to a more comprehensive understanding of this under-explored area. From a clinical perspective, the findings also have the potential to inform healthcare practice by identifying gaps in existing knowledge, highlighting the types of evidence available, and supporting the development of more informed, evidence-based approaches to the recognition and care and women living with episodic disabilities who experience intimate partner violence.

Inclusion Criteria

The eligibility criteria for this scoping review were developed using the Population-Concept-Context framework recommended by the Joanna Briggs Institute (Peters et al., 2024). For this review, the population compromised women living with episodic disabilities, the concept focused on intimate partner violence, and the context was global in scope.

Participants

This review included literature involving individuals who self-identified as women and were 18 years of age or older. Eligible studies focused on women diagnosed with one or more episodic conditions defined as "marked by fluctuating periods of degrees of wellness and disability. In addition, these periods of wellness and disability are unpredictable" (Realize, 2024, para. 1). While the list of episodic disabilities is continuously expanding, this study specifically focused on the following episodic disabilities: multiple sclerosis, chronic fatigue syndrome, fibromyalgia, systemic lupus erythematosus, or rheumatoid arthritis. These conditions were selected based on their recognition within episodic disability literature and because they share clinical and social characteristics relevant to the review question. Specifically, multiple sclerosis, fibromyalgia, chronic fatigue syndrome, systemic lupus erythematosus, and rheumatoid arthritis are characterized by fluctuating symptoms, periods of remission and exacerbation, and substantial impacts on physical, psychological, and social functioning in addition to their predominance in women between the ages of 20 and 40 (Albrecht et al., 2025; Clauw, 2014; Episodic Disabilities Network [EDN], 2015; Faro et al., 2016; Intriago et al., 2019; Multiple Sclerosis Society of Canada, 2009; Ngo et al., 2014; Perricone & Shoenfeld, 2019; WHO, 2025). Episodic disabilities such as but not limited to mental health conditions, chronic obstructive pulmonary disorder, cystic fibrosis, Parkinson's, and amyotrophic lateral sclerosis or ALS were not included in this study as these disabilities may differ in ages of onset, gender distribution, visibility of disability, disease trajectories which affect caregiving needs, in addition to different risk factors through which intimate partner violence may interest with disability (ALS Society of Canada, 2024; Alzheimer Society of Canada, 2023; Cystic Fibrosis Canada, 2025; Government of Canada, 2025b). Limiting the review to the conditions discussed supported a more focused

and conceptually coherent synthesis of the literature while allowing for exploration of the ways in which fluctuating disability may influence the experience and identification of intimate partner violence.

Studies involving men were excluded because the review specifically sought to examine the experience of women, who are disproportionally affected by intimate partner violence. Furthermore, women are more likely to experience episodic patterns of disability, whereas men commonly report continuous functional limitations (Morris et al., 2019).

Studies involving individuals younger than 18 were excluded from this scoping review because the episodic conditions of interest are predominantly adult-onset disorders and aligns with epidemiological evidence demonstrating the highest rates of police reported intimate partner violence occur among young adult women (Burczycka & Conroy, 2017; Perricone & Shoenfeld, 2019).

Studies examining women living with HIV/AIDS were excluded because the intersection of HIV/AIDS and intimate partner violence has been extensively investigated and represents an established body of literature, including systematic reviews, meta-analyses and intervention studies (Li et al., 2014; Marshall et al., 2018). Excluding this population allowed the review to focus on episodic disabilities that have received comparatively less attention within the intimate partner violence literature.

Concept

The focus of this review is intimate partner violence, defined by the WHO as “behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (WHO, 2024). Included sources examined women who are presently experiencing intimate

partner violence or who have a history of intimate partner violence involving a current or previous partner. Intimate partners may be marital or non-marital and of any gender identity. Exclusions included men experiencing intimate partner violence, perpetrators of intimate partner violence, or women experiencing violence from non-partner family members.

Context

Studies from any income setting (low-, middle- or high-income countries) and language background were eligible. This study focused specifically on studies published since 2022 onwards.

Sources

This scoping review considered quantitative research, mixed-methods studies, qualitative studies, systematic reviews meeting the inclusion criteria, and grey literature (e.g., reports, policy documents, working papers, and government publications). Conference abstracts and blog posts were excluded as these sources typically would not provide sufficient detail to allow for rigorous assessment and meaningful extraction of findings.

Information Sources

Databases searched included MEDLINE (Ovid), CINAHL, Embase, PsycINFO, and Scopus Peters et al., 2024). Grey literature was searched via governmental and professional organizations related to episodic disabilities included in the review.

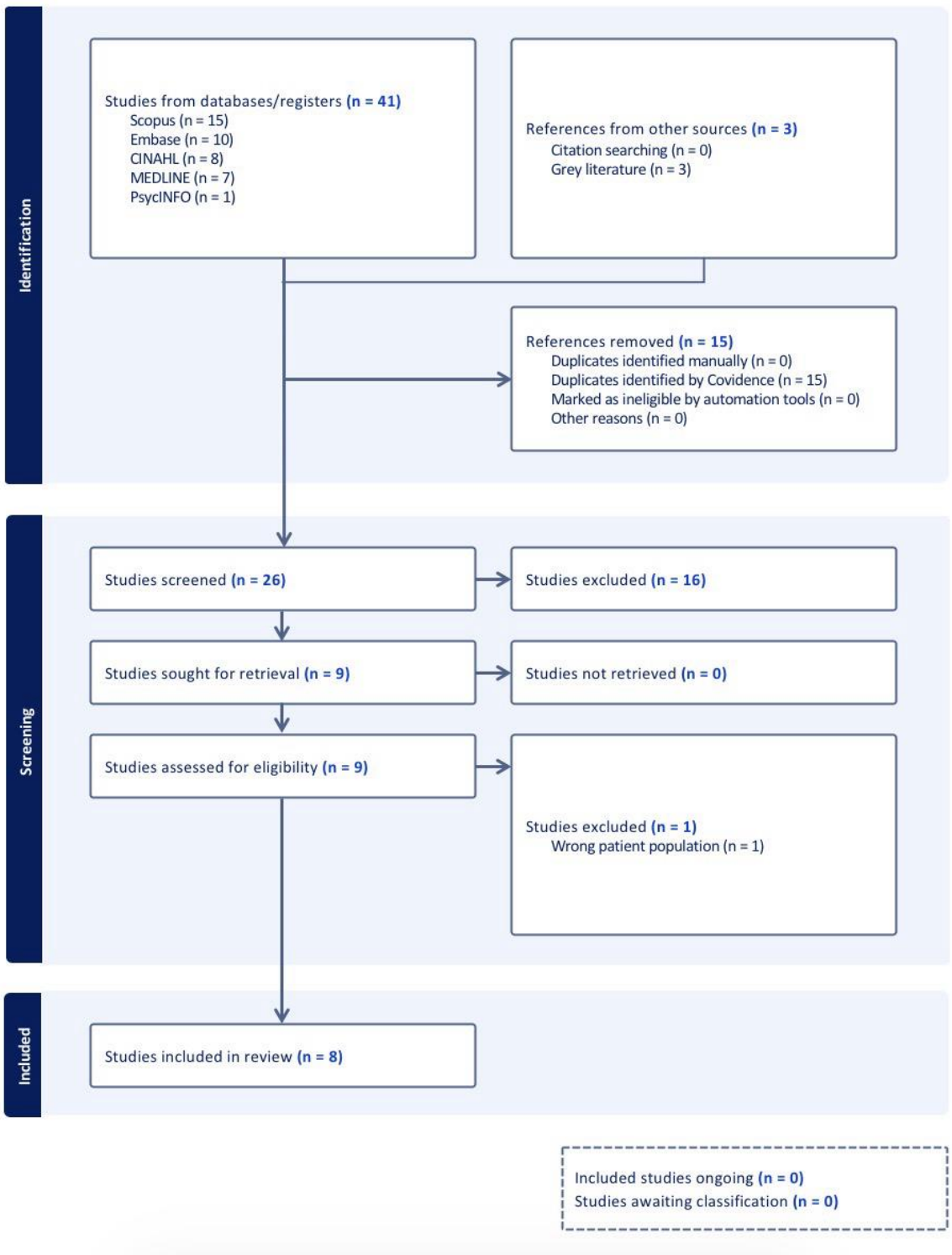
Search Strategy and Evidence Selection

The selection process followed the Joanna Briggs Institute four-step evidence screening framework, using the index terms and keywords highlighted in the *a priori* scoping review protocol (Peters et al., 2024). An initial search of the databases with specified index terms from the scoping review protocol was conducted on February 14, 2026. Heading one pertaining to

violence resulted in 33, 312 articles from the years 2022-2026 using the following index terms and keywords: intimate partner violence, spousal abuse, spousal violence, dating violence, and intimate partner abuse. Heading two pertaining to episodic disabilities resulted in 316, 629 articles from the years 2022-2026 using the following index terms and key words: episodic disabilities; autoimmune disease; arthritis, rheumatoid; lupus erythematosus, systemic; lupus nephritis; lupus; arthritis; multiple sclerosis; fibromyalgia; fatigue syndrome, chronic; and chronic fatigue syndrome. When heading one and two were combined, this resulted in a total of 41 articles. These articles were imported into Covidence, and duplicates were identified by Covidence and removed resulting in 26 studies. First, titles and abstracts were selected and reviewed by M.P and K.C based on the eligibility criteria, who then discussed and resolved any disagreements. Eligibility criteria did not need to be refined during these discussions (Peters et al., 2024). 16 studies were deemed irrelevant by these two reviewers, leaving nine studies to be screened by full-text reviews by the two reviewers noted above. Of these nine studies, one study was excluded due to incorrect patient population, leaving eight studies for data extraction. Reference lists of included works were screened to find additional sources and grey literature was searched using Google Scholar and ProQuest Dissertations & Theses considering both published and unpublished work (Peters et al., 2024).

Figure 1

PRISMA Diagram



Data Extraction

One independent reviewer (M.P) extracted data from each of the eight included source, while two additional reviewers (R.H and N.A) extracted data from four studies each. Extraction was guided by questions related to: (a) identifying intimate partner violence within this population and existing assessment approaches; (b) informing the development of appropriate interventions; and (c) determining how health and social services can better support these women. A draft data charting form, based on the Joanna Briggs Institute Manual for Evidence Synthesis, was used and refined throughout the review (Peters et al., 2024). As this is a scoping review, included sources did not undergo critical appraisal (Peters et al., 2024).

Data Analysis and Presentation

To analyze the data, a content analysis approach was employed. Findings were first coded to capture key concepts and will then grouped into broader categories (Bernard et al., 2017). These results were then analyzed for patterns, allowing for the identification and organization of factors pertaining to intimate partner violence and women living with episodic disabilities, to synthesize what is currently known about this topic (Bernard et al., 2017).

The findings were then summarized descriptively to address the central question: What is known about intimate partner violence among women living with episodic disabilities? A summary table will present information such as publication year, country, population characteristics, sample size, key concepts, methodology, and the specific health conditions examined (Peters et al., 2024). Search and selection results are documented using a PRISMA flow diagram (figure A).

Chapter Three

Synthesis of Findings

Synthesis of Findings

In this chapter, I present the findings from a scoping review examining intimate partner violence among women living with episodic disabilities, including multiple sclerosis, rheumatoid arthritis, and systemic lupus erythematosus. I begin by outlining the study selection process and characteristics of the included literature, followed by a synthesis of findings derived from both research and grey literature sources. The results are organized into four key categories that capture the breadth and complexity of this issue: the prevalence and patterns of intimate partner violence, disability as a risk factor, the impact of intimate partner violence on episodic disabilities, and healthcare-associated factors. Through this organization, I highlight the intersections between intimate partner violence and episodic disabilities, drawing attention to both individual and structural influences that shape vulnerability, experiences of violence, and access to care.

A comprehensive search of the literature was conducted, yielding a total of 41 citations with three additional references identified through grey literature searching. Following the removal of fifteen duplicates, 26 titles and abstracts were screened, and nine full-text publications were determined to be eligible for full-text review. One publication was subsequently excluded after full-text review, due to an inappropriate patient population. A summary table identifying these sources with rationale for exclusion is provided in Figure 1. In total, eleven publications met the inclusion criteria for this review, comprising eight research articles and three grey literature sources. The study selection process is illustrated in Figure 1, providing transparent overview of screening and inclusion decisions. The dataset includes both empirical research and grey literature such as clinical and community-based resources, allowing for a more comprehensive understanding of the topic.

The included publications represented a geographically and methodologically diverse body of literature, with studies conducted across Iran, Mexico, Canada, United States, and Australia. Although no language restrictions were applied, all identified sources were published in English, and no non-English studies were included in the review. While the geographic diversity enhances the transferability of the findings while also highlighting the influence of differing sociocultural and healthcare contexts, the absence of non-English literature may have limited the breadth of evidence and may have resulted in omission of perspectives from non-English speaking populations.

Extracted findings are presented in two appendices, distinguishing between research and grey literature sources. In terms of clinical focus, most studies examined multiple sclerosis (n = 6), followed by systemic lupus erythematosus (n =2), with additional studies addressing overlapping conditions of multiple sclerosis, systemic lupus erythematosus, and rheumatoid arthritis. There were no studies that examined chronic fatigue syndrome or fibromyalgia.

A qualitative content analysis was conducted to synthesize findings across sources, resulting in the identification of four interrelated categories: (a) the prevalence and patterns of intimate partner violence among women with episodic disabilities, (b) disability as a multifactorial risk factor for intimate partner violence, (c) the impact of intimate partner violence on disease experiences and health outcomes, and (d) healthcare-associated factors influencing identification and response. These categories reflect both the complexity of intimate partner violence as it intersects with episodic disabilities and the multi-level factors – individual, relational, and systemic, that shape women's experiences. Together, they provide a conceptual framework for understanding how intimate partner violence is experienced, influenced, and addressed within this population.

Prevalence and Patterns of Intimate Partner Violence and Episodic Disabilities

This section synthesizes current evidence on the prevalence and patterns of intimate partner violence among women living with episodic disabilities, highlighting the scope, forms, and lives realities of violence within this population. Understanding both the extent and nature of intimate partner violence is critical to situating it as a significant and under-recognized public health issue, as well as to informing responsive clinical and policy interventions. In addition to quantifying prevalence, this section examines how intimate partner violence is experienced, including its co-occurrence, chronicity, and distribution across key sociodemographic groups.

Across studies, intimate partner violence was consistently reported at high rates among women with episodic disabilities. This body of evidence demonstrates that intimate partner violence is not a marginal issue within this population, but rather a pervasive and significant concern across diverse clinical and geographic contexts. Prevalence estimates varied across studies depending on population and measurement tools, ranging from 24–50%, with some studies reporting rates as high as 63% among women with multiple sclerosis (Campos-Tinajero et al., 2024; Etemadifar et al., 2025; Freedman et al., 2024; Manouchehri et al., 2022; Michaelson, 2024; Ponce-Santillán et al., 2025). The variability in reported rates may reflect differences in study design, definitions of intimate partner violence, and disclosure practices, rather than a true absence of risk in certain groups. Overall, these findings highlight the substantial burden of intimate partner violence among women with episodic disabilities and reinforce the need for consistent and sensitive measurement approaches.

The patterns of intimate partner violence identified across studies were multi-dimensional, encompassing physical, emotional/psychological, sexual, and economic domains (Etemadifar et al., 2025; Horne & Ford, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026;

Ponce-Santillán et al., 2025; Venkatachalam, 2024). This multi-dimensionality emphasizes that intimate partner violence in this population extends beyond physical harm and includes forms of coercion and control that may be less visible but equally impactful. Across studies, psychological or emotional violence was the most frequently reported subtype, followed by physical violence, while sexual violence was reported less frequently yet still clinically significant (Etemadifar et al., 2025; Manouchehri et al., 2022; Nesbitt et al., 2026; Ponce-Santillán et al., 2025). Importantly, many patients reported experiencing facing multiple forms of violence concurrently (Etemadifar et al., 2025; Manouchehri et al., 2022; Nesbitt et al., 2026). Studies also reported that intimate partner violence was additionally characterized as chronic and recurrent, with many individuals citing repeated and ongoing abuse rather than isolated events (Etemadifar et al., 2025; Nesbitt et al., 2026). These findings suggest that intimate partner violence is often experienced as cumulative and sustained over time, which may intensify its impact on health and complicate pathways for support and intervention.

Notably, several studies identified overlapping sociodemographic patterns between intimate partner violence and episodic disabilities. These patterns point to shared axes of vulnerability that position certain groups at greater risk of experiencing both disability and violence. Both disproportionately affect younger women, particularly those in their reproductive years, suggesting heightened vulnerability during this life stage (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Michaelson, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). One study specifically examined intimate partner violence in pregnant and postpartum women with multiple sclerosis and found higher rates of intimate partner violence when compared to non-pregnant women, indicating that certain life stages may confer an

increased risk (Ponce-Santillán et al., 2025). While some studies reported associations between intimate partner violence and factors such as education, marital status, income, and employment, findings were not entirely consistent across settings, suggesting the influence of broader sociocultural contexts (Manouchehri et al., 2022; MeTooMS). These findings enhance the importance of an intersectional lens, as vulnerability to intimate partner violence is shaped not only by individual characteristics, but also by shifting social, economic, and cultural contexts.

Disability as a Risk Factor for Intimate Partner Violence

Disability emerged as a significant and multifactorial contributor in increasing vulnerability to intimate partner violence. This body of literature positions episodic disabilities not as an isolated risk factor, but as part of a broader constellation of intersecting conditions that shape exposure to violence. Across studies, women with episodic disabilities were consistently identified as being at increased risk of violence when compared to populations without disability (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). Importantly, this increased vulnerability is not attributable to disability alone, but rather to the intersection of physical, psychological, social, and structural factors (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). These findings highlight the importance of moving beyond individualistic explanations and toward a more integrated understanding of risk that accounts for multiple, interacting dimensions of vulnerability.

At the individual level, disease-related factors such as physical impairment, fatigue, and cognitive dysfunction contribute to decreased autonomy and increased dependence on others,

frequently intimate partners, for activities of daily living and personal care (Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Michaelson, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). These functional limitations can alter relationship dynamics in ways that shift power and control, creating conditions that may be exploited in abusive relationships. Dependence may heighten exposure to violence by creating dynamics that may facilitate coercion and control, while simultaneously reducing the ability to leave unsafe environments. As a result, disability-related impairments are not only health challenge but also social determinants that shape safety, agency, and access to support.

Beyond individual factors, the literature emphasizes that vulnerability in this population reflects structural and systemic inequalities. These broader forces create the social conditions in which intimate partner violence becomes more likely and more difficult to address for women with episodic disabilities. Cultural and societal factors such as ableism, marginalization and gender norms create conditions in which violence is more likely to occur and reinforce power imbalances within intimate relationships and limit access to support for this population (Freedman et al., 2024; Manouchehri et al., 2022; Michaelson, 2024; Nesbitt et al., 2026). Women with disabilities often experience lower income and reduced employment, which contribute to financial dependence on intimate partners, which has been associated with increased vulnerability to abuse. (Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Pol-Patil et al., 2023; Nesbitt et al., 2026). Additional factors inherent to episodic disabilities such as isolation, stigma, fluctuating and often invisible symptoms, and discrimination further compound this risk (Horne & Ford, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). Collectively, these findings stress that

vulnerability to intimate partner violence among women with episodic disabilities is produced and sustained through the interaction of individual impairments and inequitable social structures, reinforcing the need for multi-level interventions that extend beyond the individual to address systemic barriers.

The Impact of Intimate Partner Violence on Episodic Disabilities

This section examines the ways in which intimate partner violence shapes health outcomes and disease experiences among women living with episodic disabilities, highlighting its multifaceted and potentially compounding effects. Although firm conclusions regarding a causal relationship between intimate partner violence and episodic disabilities outcomes cannot yet be established, the existing literature consistently demonstrates that intimate partner violence is associated with a wide range of adverse health consequences, affecting both physical and psychological well-being, as well as disease-related outcomes (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Michaelson, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). These findings suggest that intimate partner violence functions as a significant co-occurring factor that may exacerbate existing health vulnerabilities, even in the absence of clearly established causal pathways.

Across studies, intimate partner violence was linked to a broad range of adverse psychological outcomes such as depression and anxiety, as well as reduced quality of life, with individuals who had not experienced violence demonstrating compatible lower levels of fatigue and neuropsychological symptoms (Campos-Tinajero et al., 2024; Manouchehri et al., 2022; Michaelson, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). Intimate partner violence also has a notable impact on social and functional domains, with

evidence suggesting that experiences of abuse may impair individuals' ability to engage in self-care, increase reliance on others, and limit participation in daily and social activities (Manouchehri et al., 2022; Pol-Patil et al., 2023). Together, these findings highlight the pervasive influence of intimate partner violence across multiple dimensions of health, extending beyond clinical symptoms to affect overall functional and quality of life.

Importantly, intimate partner violence appears to have implications for disease activity and progression (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Ponce-Santillán et al., 2025). For example, in women with systemic lupus erythematosus, exposure to intimate partner violence was positively correlated with higher disease activity scores and poorer physician assessments of disease control (Campos-Tinajero et al., 2024). Similarly, in multiple sclerosis populations, evidence suggests that trauma and stress related to intimate partner violence exposure may contribute to earlier disease onset, increased relapse rates, and poorer long-term outcomes. These associations point to potential psychophysiological mechanisms through which chronic stress and trauma may influence immune and neurological processes; however, further research is required to confirm these relationships (Das & Zhang, 2025; Etemadifar et al., 2025; Nesbitt et al., 2026). Overall, these findings underscore the need to consider intimate partner violence not only as a social issue, but also as a factor that may meaningfully shape disease trajectories and clinical outcomes in women with episodic disabilities.

Healthcare-Associated Factors

This action highlights the ways in which healthcare systems influence the identification, documentation, and response to intimate partner violence among women with episodic disabilities, highlighting critical gaps in care. Despite the high prevalence and significant impact of intimate partner violence, studies consistently reported that healthcare systems were

inadequately equipped to recognize and respond to violence in this population (Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023). Evidence suggests intimate partner violence in women with episodic disabilities remains under recognized and underreported, due to a variety of factors such as disease- and patient-related barriers, provider related barriers, and structural and systemic challenges (Etemadifar et al., 2025; Freedman et al., 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023). Notably, evidence from two multiple sclerosis studies conducted in clinical settings demonstrated a discrepancy between patient reported and documented abuse, with up to 40% of patients reporting intimate partner violence, while no cases were formally recorded in clinical encounters, highlighting a significant gap in both the identification and documentation of intimate partner violence (Freedman et al., 2024; Nesbitt et al., 2026). Collectively, these findings suggest that healthcare systems may play a critical yet under-optimized role in addressing intimate partner violence, with missed opportunistic for identification and intervention.

Disease and patient related barriers exist because of the overlapping symptoms of intimate partner violence and episodic disabilities. This overlap creates diagnostic and interpretive challenges that can obscure the presence of violence in clinical encounters. Symptoms such as fatigue, cognitive changes, and psychological distress, while general and obscure, contribute to the misattribution of symptoms to the disease processes instead of intimate partner violence (Nesbitt et al., 2026; Ponce-Santillán et al., 2025). Patients may also be reluctant to disclose their experiences of violence due to fear, stigma, or concerns regarding their safety (Freedman et al., 2024; Michaelson, 2024; Venkatachalam, 2024). As a result, intimate partner violence may remain hidden with routine clinical presentations, further complicating timely recognition and support.

Several provider-related barriers contribute to the gap in identification. These barriers reflect both gaps in training and broader discomfort in addressing intimate partner violence within clinical practice. Providers frequently report limited education and training in identifying and addressing intimate partner violence resulting in lack of confidence, uncertainties regarding professional responsibilities, limited awareness of referral pathways and available supports, and discomfort discussing intimate partner violence in clinical settings (Campos-Tinajero et al., 2024; Freedman et al., 2024; Nesbitt et al., 2026; Venkatachalam, 2024). These factors contribute to inconsistent screening and response practices, limiting the ability of healthcare professionals to effectively support patients experiencing violence.

Structural and systemic challenges also play a significant role. These challenges reflect broader limitations in how healthcare systems are organized to respond to complex, intersection health and social issues. The absence of standardized screening protocols, validated tools, and clinical guidelines contributes to inconsistent practices among clinicians (Freedman et al., 2024; Nesbitt et al., 2026). There is considerable debate in the literature regarding screening practices, with some organizations recommending routine screening, and some placing emphasis on case finding when indicators are present (Campos-Tinajero et al., 2024; Freedman et al., 2024; Manouchehri et al., 2022; Nesbitt et al., 2026). This lack of consensus further contributes to variability in care and uncertainty among providers.

Finally, the literature highlights a significant evidence and implementation gap. Despite growing recognition of intimate partner violence in this population, research remains limited in both scope and application. Research on intimate partner violence in episodic disabilities remains limited (Etemadifar et al., 2025; Horne & Ford, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). Few studies have been conducted examining effective screening

strategies, intervention models or clinical outcomes and addressing these gaps is essential to improving identification, response, and overall care for individuals with episodic disabilities experiencing intimate partner violence. These limitations reinforce the need for targeted research that can inform evidence-based practice and guide system level changes.

At the same time, the literature identifies several key facilitators that may enhance the recognition and response to intimate partner violence in this population. Facilitators to the identification of intimate partner violence in women with episodic disabilities studies include the implementation of trauma- and violence- informed approaches, strong therapeutic relationships between provider and patients, provider education and training, multidisciplinary and integrated care models (Etemadifar et al., 2025; Freedman et al., 2024; Michaelson, 2024; Nesbitt et al., 202; Ponce-Santillán et al., 2025; Venkatachalam, 2024). These findings highlight the potential pathways for improving practice, emphasizing the importance of relational, educational, and system-level strategies in addressing intimate partner violence.

In conclusion, the findings presented in this chapter demonstrate that intimate partner violence is a prevalent, multifaceted, and consequential issue among women living with episodic disabilities. Across the included literature, intimate partner violence emerged not only as a common experience, but as one that is shaped by intersecting individual, relational, and structural factors, and associated with significant implications for psychological well-being, functional capacity, and disease related outcomes. The synthesis of findings highlighted how vulnerability to intimate partner violence is produced through the interaction of disability- related impairments, social inequities, and systemic barriers within healthcare systems, while also revealing critical gaps in the recognition, documentation, and response to violence in clinical settings. At the same time, the literature points to promising facilitators, including trauma- and

violence-informed approaches, strong therapeutic relationships, and integrated models of care, which may support more effective identification and intervention. Together, these findings provide a comprehensive understanding of the complex relationships between intimate partner violence and episodic disabilities and establish a foundation for the subsequent discussion chapter, where these results are interpreted in relation to existing knowledge and considered in terms of implications for practice, policy, and future research.

Chapter Four

Discussion and Conclusion

Discussion

This scoping review was completed to examine what is currently known about intimate partner violence among women living with episodic disabilities. Although the evidence base remains limited, the findings reveal several important patterns across the literature. This review demonstrates that intimate partner violence is prevalent and consequential within this population, highlighting a complex and under-recognized intersection of health and social vulnerability with implications for healthcare interactions. In addition, several clinical, social, and structural factors complicate the identification and response to intimate partner violence for women with episodic disabilities. In this discussion chapter, I interpret these findings within the broader context of intimate partner violence while emphasizing key clinical, structural, and research implications for clinicians, including Nurse Practitioners. Several key issues emerged from this review and guided the discussion that follows: how intimate partner violence may remain concealed within the context of epidemic disability; the role of dependence and intersection of social inequities in shaping vulnerability; and the implications of violence for health and healthcare delivery, in addition to Nurse Practitioner practices, policy, and future research.

Intimate Partner Violence as an Invisible Health Issue within Episodic Disability

Despite the high prevalence of intimate partner violence in women living with episodic disabilities, the findings of this review highlight its persistent under-recognition within healthcare settings. This under-recognition appears to result from the convergence of disease-related, patient-related, provider-related, and systemic factors that collectively limit opportunities for identification and intervention (Etemadifar et al., 2025; Horne & Ford, 2024; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025).

At the patient- and disease-related level, considerable symptom overlap between intimate partner violence and episodic disabilities creates diagnostic ambiguity and increases the likelihood that indicators of abuse are misattributed to underling disease processes, rather than considered potential manifestations of violence (Nesbitt et al., 2026; Ponce-Santillán et al., 2025). Common health consequences of intimate partner violence include depression, anxiety, chronic pain, fatigue, sleep disturbance, gastrointestinal symptoms, cognitive difficulties, and increased healthcare utilization (Vicard-Olagne et al., 2021). These manifestations closely resemble those experienced by women living with episodic disabilities such as multiple sclerosis, systemic lupus erythematosus, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, all of which are characterized by fluctuating physical and psychological symptoms and frequent interactions with the healthcare system (Parsons & Braun, 2024; Rovenský & Payer, 2009; Schone, 2019; Scott & Broom, 2022; Sperry, 2009; Watad et al., 2024). Consequently, new or worsening symptoms may be interpreted as disease progression or exacerbations rather than prompting consideration of violence as an underlying or contributing cause.

This pattern reflects the concept of diagnostic overshadowing, whereby symptoms are attributed to an existing diagnosis rather than consideration of alternative or co-occurring conditions (Hallyburton, 2022; Shefer et al., 2014). Originally described as the attribution of physical symptoms to mental illness resulting in delayed or inadequate care, the concept has since expanded to include the misattribution of symptoms to an established physical diagnosis (Hallyburton, 2022; Shefer et al., 2014). Within the context of episodic disability, diagnostic overshadowing may lead healthcare providers to interpret chronic pain, fatigue, mood changes, sleep disturbances, or functional decline solely as manifestations of the underlying disease, while overlooking the possibility that these symptoms reflect ongoing abuse or trauma.

This challenge may be particularly pronounced for women living with episodic disabilities because many of these conditions are considered “invisible illnesses,” in which symptoms are not readily observable and often rely on patients’ subjective reports. Women with invisible illnesses frequently describe having their symptoms minimized, questioned, or dismissed by healthcare providers, contributing to feelings of disbelief and reduced confidence in seeking care (Herrmann-Werner & Malterud, 2003). Similar experiences have been documented among survivors of intimate partner violence, whose trauma-related symptoms may also lack obvious physical findings (Aguillard et al., 2022; Silva et al., 2022). Emerging evidence from the trauma literature supports this interpretation by recognizing that trauma is frequently expressed through physical as well as psychological symptoms (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Chronic exposure to violence can contribute to persistent pain, fatigue, sleep disturbances, gastrointestinal complaints, headaches, cognitive dysfunction, and autonomic dysregulation, many of which overlap with the clinical presentation of episodic disabilities (SAMHSA, 2014; (WHO, 2013). These experiences may further increase the risk that violence-related symptoms are normalized, minimized, or interpreted exclusively because of chronic illness.

Furthermore, the findings of this review suggest that repeated healthcare encounters do not necessarily translate into improved recognition of intimate partner violence (Freedman et al., 2024; Nesbitt et al., 2026). Women living with episodic disabilities often require ongoing monitoring and management, which are commonly structured around disease activity, symptom management, medication monitoring, and functional assessment. While these assessments are essential, this approach may unintentionally obscure the broader contexts such as violence that

are influencing health. Consequently, opportunities to identify violence may be missed, despite regular contact with the healthcare system.

For Nurse Practitioners and other healthcare providers, these findings suggest that intimate partner violence may remain hidden within routine chronic disease management and reliance on disease-focused assessment alone, risks overlooking violence-related symptoms that mimic disease progression, creating missed opportunities for early identification, intervention, and referral. Incorporating trauma- and violence- informed assessment and consideration of intimate partner violence may improve recognition and support more comprehensive, person-centred care.

Dependence, Power, and Control Within the Context of Episodic Disability

The findings of this review suggest that disability-related dependence on intimate partners may increase women's vulnerability to intimate partner violence by altering power dynamics within intimate relationships. Unlike permanent disabilities, episodic disabilities are characterized by periods of symptom exacerbation and remission, resulting in fluctuating levels of functional ability and independence (Morris et al., 2019). During periods of exacerbation, women may require increased assistance with activities of daily living, transportation, medication management, financial responsibilities, childcare, or attending healthcare appointments (Brownridge, 2006; Colombo et al., 2025; Joachim & Acorn, 2000; Saxton et al., 2001). While caregiving within intimate relationships can provide important emotional and practical support, these changing care needs may also create opportunities for coercion and abuse when one partner assumes control over resources that are essential to the woman's health and independence (Brownridge, 2006; Nosek et al., 2001). Controlling access to medications, mobility aids, transportation, finances, communication, or healthcare appointments for example,

may function as a mechanism of control, limiting a woman's ability to manage their health, maintain social connections, or seek emergency assistance (Nosek et al., 2001; Saxton et al., 2001). Episodic disability may intensify these power imbalances by increasing reliance on an intimate partner during periods of illness, resulting in increased dependence and limited control, and simultaneously affecting opportunities to leave abusive relationships or access external supports (Breiding & Armour, 2015). These findings amplify the importance of understanding disability-related dependence as a dynamic factor that interacts with power in intimate relationships, rather than as a characteristic of disability itself.

These findings suggest that assessments of intimate partner violence among women living with episodic disabilities should extend beyond screening for physical or psychological abuse to include exploration of caregiving arrangements and disability-related dependence, as changing caregiving roles, patterns of dependence, and access to essential resources may shape relationship dynamics and create opportunities for abuse. Nurse Practitioners and other healthcare providers should assess who manages medications, transportation, finances, healthcare appointments, and assistive devices, as control over these resources may represent manifestations of control rather than supportive caregiving.

Understanding Vulnerability Through an Intersectional Lens

Overall, the findings of this review demonstrate that women living with episodic disabilities experience disproportionately high rates of intimate partner violence and highlights that vulnerability is shaped by intersecting influences that extend beyond the disease itself. The convergence of social, structural, and systemic factors highlights the need to understand vulnerability through an intersectional lens, as vulnerability cannot be understood solely through the characteristics of the condition. Rather, experiences of stigma, discrimination, social

isolation, unemployment, income insecurity, and financial dependence collectively shape women's exposure to violence and their ability to seek safety and support.

As introduced in the methodological framework, intersectionality recognizes that health experiences are shaped by the interaction of multiple social identities and systems of power rather than by any single characteristic in isolation (Crenshaw, 1991). Accordingly, the increased vulnerability observed among women living with episodic disabilities cannot be attributed to disability alone. Instead, it reflects the cumulative and intersecting influences of gender inequality, ableism, socioeconomic disadvantage, social exclusion, and structural barriers that shape women's lives and opportunities. Applying Crenshaw's intersectionality framework helps explain why women living with episodic disabilities may experience unique patterns of risk that differ from those associated with either disability or gender alone (Crenshaw, 1991). Women with episodic disabilities often occupy multiple marginalized positions at once, needing to navigate the effects of gender-based discrimination alongside ableism, financial insecurity, reduced employment opportunities, and barriers to healthcare and community participation (Etemadifar et al., 2025; Freedman et al., 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023). These intersecting systems of oppression may reinforce one another, resulting in increased dependence on intimate partners, limiting access to supportive resources, and reducing opportunities to leave abusive relationships. Importantly, vulnerability is therefore produced not solely by impairment or fluctuating health status, but by the social and structural conditions that shape how disability is experienced within society.

An intersectional perspective also highlights that women's experiences of intimate partner violence are neither uniform nor static. The episodic nature of these conditions introduces additional complexity, as periods of symptom exacerbation may increase reliance on partners for

practical, financial, or emotional support, while remission may temporarily restore independence. These overlapping circumstances create environments in which violence may be more easily enacted and less readily recognized.

Collectively, these findings suggest that healthcare providers should adopt a broader understanding of disability that extends beyond symptom management and individual level risk factors alone. While assessment of disease activity remains essential, focusing exclusively on manifestations of disease may overlook the social determinants of health and structural conditions that contribute to women with episodic disabilities vulnerability to violence. Trauma- and violence- informed, person-centred care should therefore incorporate assessment of social isolation, financial insecurity, housing stability, employment, caregiving responsibilities, and access to community supports to better identify women at risk and facilitate comprehensive, equitable care. Effective responses to intimate partner violence among women living with episodic disabilities require approaches that acknowledge the interaction between individual health needs and the broader social conditions in which violence occurs.

Psychological Violence as the Predominant Experiences

A notable finding of this review was that psychological and emotional abuse were reported more frequently than physical violence among women living with episodic disabilities (Etemadifar et al., 2025; Manouchehri et al., 2022; Nesbitt et al., 2026; Ponce-Santillán et al., 2025). Psychological abuse may be particularly prevalent among women living with episodic disabilities because these forms of abuse enable perpetrators to exploit existing vulnerabilities while remaining largely invisible to others. As discussed previously, dependence on intimate partners during periods of symptom exacerbation may create opportunities for perpetrators to

exert control without the use of physical violence. These behaviours may be difficult to identify, yet profoundly restrict autonomy, decision-making, and access to healthcare and supports.

The predominance of psychological violence also raises important questions regarding how intimate partner violence is recognized within healthcare settings. Historically, healthcare responses to intimate partner violence have emphasized visible physical injuries, despite growing recognition that psychological abuse can occur in the absence of physical assault and may have equally significant consequences for health and well-being (Metheny et al., 2026). For women living with episodic disabilities, the absence of obvious physical injuries may further reduce opportunities for abuse to be identified, particularly when healthcare encounters are focused primarily on monitoring disease activity. Emotional distress, worsening pain, fatigue, sleep disturbances, anxiety, depression, reduced treatment adherence, or declining functional status may instead be interpreted as expected manifestations of the underlying condition rather than potential consequences of ongoing abuse. This may result in psychological violence remaining concealed despite frequent interactions with healthcare providers.

The cumulative effects of psychological abuse may be particularly detrimental for women managing episodic disabilities. Emotionally abusive relationships have been associated with diminished self-esteem, reduced self-efficacy, increased psychological distress, and poorer quality of life, all of which may affect ability to adhere to treatment recommendations, engage in symptom management strategies, attend healthcare appointments, or seek assistance from support networks. Findings from this review also suggest that chronic exposure to psychological abuse may also contribute to heightened stress responses and worsening symptom burden, creating a reciprocal relationship in which deteriorating health further increases dependence on abusive partners.

These findings reinforce that the health consequences of intimate partner violence extend beyond physical injuries and may influence disease management and overall well-being among women living with episodic disabilities. The findings suggest that healthcare providers should adopt a broader understanding of intimate partner violence that extends beyond the identification of physical violence, as this may overlook the forms of abuse most experienced by women living with episodic disabilities. Assessment should therefore include routine exploration of psychological abuse, coercive control, emotional manipulation, and threats, recognizing that these experiences may have profound implications for women's health, safety, functional status, and quality of life.

Intimate Partner Violence as a Determinant of Health

An important finding of this review was the consistent association between intimate partner violence and poorer mental health, reduced quality of life, greater symptom burden, and, in some studies, increased disease activity among women living with episodic disabilities (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). While existing studies demonstrate associations between intimate partner violence and worsened psychological health, increased disease activity, and reduced quality of life, the causal pathways underlying these relationships remain poorly understood (Campos-Tinajero et al., 2024; Das & Zhang, 2025; Etemadifar et al., 2025; Freedman et al., 2024; Horne & Ford, 2024; Manouchehri et al., 2022; Nesbitt et al., 2026; Pol-Patil et al., 2023; Ponce-Santillán et al., 2025). Nevertheless, the consistency of these findings across diverse episodic conditions suggests that intimate partner violence should be considered not only

because of poor health but also as an important social determinant of health that may influence chronic disease experiences and outcomes.

Several interrelated mechanisms may explain these associations. Emerging evidence from trauma research and psychoneuroimmunology suggests that chronic exposure to violence and prolonged psychological stress can produce sustained physiological changes involving the hypothalamic-pituitary-adrenal axis, autonomic nervous system, and immune system (Das & Zhang, 2025; SAMHSA, 2014). Dysregulation of these systems has been associated with persistent inflammation, altered immune function, and increased symptom severity across a range of chronic illnesses (Das & Zhang, 2025). Although these biological pathways have not been extensively investigated among women living with episodic disabilities who experience intimate partner violence, they provide a possible explanation for how chronic trauma may contribute to worsening fatigue, pain, cognitive dysfunction, psychological distress, and disease activity.

In addition to these biological mechanisms, intimate partner violence may influence disease outcomes through behavioural and social pathways. Women experiencing ongoing violence may encounter substantial challenges in managing chronic illness, including reduced adherence to medications, difficulty attending healthcare appointments, disrupted sleep, poor nutrition, limited physical activity, and decreased engagement in recommended self-management strategies (Manouchehri et al., 2022; Pol-Patil et al., 2023). Control by intimate partners may further interfere with women's ability to access healthcare, obtain medications, maintain employment, or seek support from family, friends, or community organizations (Brownridge, 2006; Nosek et al., 2001; Saxton et al., 2001). Collectively, these factors may contribute to increased healthcare utilization, reduced functional capacity, worsening psychological well-

being, and diminished quality of life. Conversely, increasing disease severity or symptom exacerbations may heighten dependence on intimate partners and reduce opportunities to leave abusive relationships, suggesting a potentially reciprocal relationship between episodic disability and intimate partner violence.

Although the available evidence consistently demonstrates associations between intimate partner violence and poorer health outcomes, the predominantly cross-sectional designs of existing studies limit conclusions regarding causality (Campos-Tinajero et al., 2024; Etemadifar et al., 2025; Manouchehri et al., 2022; Ponce-Santillán et al., 2025). It remains unclear whether intimate partner violence contributes directly to worsening disease activity, whether greater disease severity increases vulnerability to abuse, or whether these relationships are bidirectional and influenced by broader social and structural determinants of health. Longitudinal research is therefore needed to examine how intimate partner violence may influence disease onset, progression, relapse rates, and long-term functional outcomes, as well as how fluctuations in disease severity may, in turn, affect vulnerability to intimate partner violence.

Taken together, these findings reinforce the importance of recognizing intimate partner violence as more than a social issue occurring alongside chronic illness. Rather, intimate partner violence should be understood as a significant factor that may shape disease experiences, health behaviours, healthcare utilization, and long-term outcomes among women living with episodic disabilities. Comprehensive chronic disease management should therefore incorporate routine consideration of intimate partner violence alongside traditional medical assessment to support more holistic, trauma- and violence- informed, and person-centred care.

The Gap Between Identification, Documentation, and Response

The findings of this review demonstrate considerable variation in approaches to the identification of intimate partner violence, particularly regarding routine universal screening versus case-finding strategies alongside gaps in documentation and healthcare response. Collectively, these findings suggest that identifying intimate partner violence involves more than asking about violence, and that effective recognition depends on coordinated clinical, organizational, and system level supports.

At the clinical level, provider barriers contribute to inconsistent identification. Although clinicians generally report positive attitudes toward screening for intimate partner violence, implementation remains inconsistent and is hindered by time constraints, provider ambiguity, lack of privacy, insufficient training, and lack of formal referral pathways (Alhusen et al., 2023; Anyango et al., 2025; Lu et al., 2024; Lutz et al., 2023; Melhado et al., 2024; Sutherland et al., 2020). These barriers suggest that providers recognize the importance of addressing intimate partner violence but often lack the confidence, resources, or organizational supports necessary to respond effectively.

The lack of consensus regarding intimate partner identification reflects an ongoing debate within the broader literature about the most effective strategies for recognizing women experiencing violence while minimizing potential harms and ensuring appropriate follow-up care. Variability in definitions, screening tools, reporting practices, and clinical guidelines, and contributes to inconsistent prevalence estimates and considerable variability in clinical practice (Alhusen et al., 2023; Anyango et al., 2025; Lu et al., 2024; Lutz et al., 2023; Melhado et al., 2024; Sutherland et al., 2020). This results in inconsistent opportunities for identification across healthcare settings. Differences among international guidelines further illustrates this uncertainty. The WHO recommends a case-finding approach, suggesting healthcare providers

inquire about intimate partner violence when clinical indicators or concerns are present rather than implementing universal screening (WHO, 2013). Similarly, the Canadian Task Force on Preventative Health (CTFPHC) recommends against routine screening for women who do not present with signs or asymptomatic of abuse, citing insufficient evidence that universal screening improves health outcomes (CTFPHC, 2013). In contrast, the United States Preventative Services Task Force (USPSTF) recommends screening for intimate partner violence in women of childbearing age when systems are in place to ensure accurate diagnosis, effective interventions and appropriate follow-up (USPSTF, 2025). Although the broader debate regarding universal screening remains unresolved, the findings of this review suggest that existing approaches may not adequately address the needs of women living with episodic disabilities. As discussed, symptom overlap, diagnostic overshadowing, fluctuating functional status, psychological abuse, and disability-related dependence may obscure traditional indicators of violence, making reliance on visible injuries or overt disclosure not feasible for this population. Approaches based solely on case-finding may fail to identify women whose experiences of intimate partner violence remain concealed within routine disease management. Conversely, universal screening implemented without adequate provider training, referral pathways, or organizational supports may have limited effectiveness and fail to produce meaningful improvements in outcomes.

Beyond variation in screening approaches, an important finding of this review was the discrepancy observed in several studies between women's self-reported experiences of intimate partner violence and the documentation within records (Freedman et al., 2024; Nesbitt et al., 2026). This gap suggests that opportunities to identify and respond to intimate partner violence are being missed despite frequent interactions with providers. While disclosure represents an important first step, recognition of violence does not consistently translate into documentation,

intervention, or referral, highlighting important limitations within healthcare responses. Inconsistent or absent documentation may reflect uncertainty about what should be recorded, concerns regarding patient confidentiality and safety, time pressures, or the absence of standardized documentation protocols for example. Incomplete documentation can disrupt continuity of care, limit communication between providers, and reduce opportunities for ongoing assessment and follow-up, while failure to document intimate partner violence contributes to the continued invisibility of violence.

These findings suggest that healthcare systems may not be adequately prepared to respond when intimate partner violence is identified. Effective responses require more than screening alone as they depend upon infrastructure that supports safe disclosure, standardized documentation, trauma- and violence- informed care, interdisciplinary collaboration, and timely referral. In the absence of these supports, disclosure may not result in meaningful intervention and can potentially leave women without the assistance they need despite having engaged with healthcare services.

These findings suggest that greater clarity is needed regarding approaches to intimate partner violence identification. Rather than viewing universal screening and case finding as competing strategies, evidence-informed approaches should integrate trauma- and violence-informed assessment while ensuring that providers have the knowledge, confidence, referral networks, and organizational supports necessary to respond safely and effectively when intimate partner violence is identified. However, knowledge alone is insufficient to change practice without targeted educational interventions and standardized approaches that increase knowledge and build clinical competence in addressing intimate partner violence, increasing opportunities for early intervention. At the same time, identification of intimate partner violence represents

only one component of comprehensive care. Organizations must ensure that providers have access to clear clinical guidelines, ongoing education, standardized documentation processes, private environments for assessment, and established referral networks that facilitate coordinated responses to violence. Without these system-level supports, opportunities for intervention may continue to be missed, even when women disclose their experiences. Future research and implementation practices should therefore focus on the development and validation of standardized, sensitive, and disability informed intimate partner violence screening tools, alongside the design and evaluation of targeted interventions, integrated care pathways, and multidisciplinary approaches.

Implications for Nurse Practitioner Practice

Finally, provider-focused research is critically needed, particularly within the Canadian context and among Nurse Practitioners. However, there is significant lack of research specifically examining Nurse Practitioners knowledge, attitudes, and practice related to intimate partner violence in women with episodic disabilities. This gap is particularly important given the increasing central role of Nurse Practitioners in primary care and chronic disease management as discussed earlier.

As autonomous healthcare providers, Nurse Practitioners are well positioned to provide comprehensive, person-centered care that extends beyond the assessment and management of disease symptoms to include the broader social, psychological, and environmental factors influencing health (CNA, 2010; CNO, 2023; CNO, 2024). Such an approach is particularly important for women living with episodic disabilities, whose experiences of intimate partner violence may remain concealed within routine chronic disease management unless providers intentionally consider the broader context in which symptoms occur.

One of the greatest strengths of Nurse Practitioner practice is the continuity of care afforded through longitudinal relationships (CNA, 2010; CNO, 2023; CNO, 2024). Women living with episodic disabilities frequently require ongoing assessment, monitoring, medication management, and support over extended periods, creating repeated opportunities for Nurse Practitioners to develop trust, establish rapport, and recognize subtle changes in health, functioning, or social circumstances. Unlike episodic encounters, these ongoing relationships allow disclosure of intimate partner violence to occur over time as trust develops, recognizing that women may not feel safe or ready to disclose violence during initial consultations.

The holistic philosophy underpinning Nurse Practitioner practice further positions this group to recognize the complex interplay between episodic disability, trauma, and the social determinants of health. This holistic philosophy recognizes that comprehensive assessment extends beyond evaluation of disease activity and includes factors such as but not limited to, psychological well-being, relationships, financial security, housing stability, social support, functional status, and experiences of violence. Using this holistic approach may improve recognition of women while supporting collaborative decision-making, autonomy, and individualized care planning.

Despite these opportunities, the review also identified barriers that may limit Nurse Practitioners ability to identify and respond to intimate partner violence effectively as discussed in previous sections. Addressing these barriers will require investment in Nurse Practitioners education, continuing professional development, standardized clinical guidance, and accessible referral pathways that support comprehensive responses to violence within primary care settings (Woroch & McNamara, 2021). Strengthening these supports may enhance Nurse Practitioners

confidence and competence while promoting more consistent, equitable, and trauma- and violence- informed care for women living with episodic disabilities.

Nurse Practitioners may be uniquely positioned to identify and respond to intimate partner violence because of their ongoing therapeutic relationships, holistic approach to assessment, and central role in episodic and chronic disease management. By integrating trauma- and violence-informed care, person-centered assessment, and consideration of the social determinants of health into routine practice, Nurse Practitioners have the potential to improve recognition of intimate partner violence, facilitate earlier intervention, and support women living with episodic disabilities in ways that promote both health and safety.

Conclusion

This scoping review synthesized the current evidence regarding intimate partner violence among women living with episodic disabilities to better understand the intersection of these two health issues and identify gaps in knowledge that may inform future research, policy, education, and healthcare practice. Although the available evidence remains limited, the findings consistently demonstrate that women living with episodic disabilities experience disproportionately high rates of intimate partner violence and face unique challenges in the recognition, disclosure, and management of abuse. The fluctuating and often invisible nature of episodic disabilities, combined with symptom overlap between chronic illness and trauma, creates circumstances in which intimate partner violence may remain concealed despite frequent interactions with healthcare providers.

Importantly, this review demonstrates that vulnerability to intimate partner violence cannot be understood through a biomedical lens alone. Rather, women's experiences are shaped by the interaction of gender, disability, social isolation, financial dependence, stigma,

discrimination, and broader structural inequities. Applying an intersectionality framework highlighted that these overlapping systems of disadvantage influence not only women's risk of experiencing violence but also their ability to disclose abuse, access healthcare and community supports, and safely leave abusive relationships. Consequently, improving health outcomes for women living with episodic disabilities requires healthcare approaches that acknowledge both the clinical manifestations of disease and the broader social determinants that influence safety and well-being.

This review also identified important gaps within healthcare systems that extend beyond the identification of intimate partner violence. The findings suggest that effective care requires more than asking women about abuse and that healthcare providers must be supported by trauma- and violence-informed education, standardized clinical guidance, clear documentation processes, multidisciplinary collaboration, and accbessible referral pathways that facilitate safe and coordinated responses when violence is identified. Without these organizational and system-level supports, opportunities for meaningful intervention may continue to be missed even when women disclose their experiences.

For Nurse Practitioners, these findings have particular significance. As autonomous primary care providers who frequently establish long-term therapeutic relationships with patients, they a group uniquely positioned to recognize changes in physical, psychological, and social functioning that may indicate underlying intimate partner violence. Integrating trauma- and violence-informed care into routine chronic disease management, while considering the influence of disability-related dependence, coercive control, and broader social determinants of health, may improve earlier recognition, strengthen therapeutic relationships, and facilitate timely intervention and referral. In doing so, Nurse Practitioners have an important opportunity

to address not only disease management but also the broader conditions that influence women's health, safety, and quality of life.

Finally, this review highlights the substantial need for future research. The current evidence base remains scarce, with limited literature examining fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, and systemic lupus erythematosus. More literature was found on multiple sclerosis, which may have been influenced by the supervisor's expertise in this area. Even still, with global problem of multiple sclerosis and the pervasiveness of the disease in Canada, more focus needs to be applied to this issue. Future research should prioritize these understudied populations while evaluating disability-informed approaches to intimate partner violence identification, trauma- and violence- informed interventions, integrated models of care, and long-term health outcomes. Expanding this evidence base will be essential to informing clinical guidelines, strengthening healthcare policy, and improving the quality and consistency of care provided to women living with episodic disabilities.

Ultimately, this thesis contributes to a growing body of literature recognizing intimate partner violence as both a significant public health issue and a critical determinant of health for women living with episodic disabilities. By synthesizing the existing evidence and identifying key knowledge gaps, this review provides an important foundation for advancing research and informing healthcare practice. Improving recognition of intimate partner violence within this population has the potential not only to enhance clinical care but also to promote health equity, reduce preventable suffering, and support safer, more comprehensive, and person-centred care for women living with episodic disabilities.

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Appendix A

Characteristics of Studies

Author (Year)	Country	Condition	Design	Sample	Key Findings
Campos-Tinajero et al. (2024)	Mexico	Systemic lupus erythematosus	Quantitative	Women with SLE	IPV associated with poorer quality of life and increased disease activity
Etemadifar et al. (2025)	Iran	Multiple sclerosis	Cross-sectional	Women with MS	High prevalence of psychological, physical, and sexual IPV
Freedman et al. (2024)	Canada	Multiple sclerosis	Narrative review	Women with MS	Under-identification of IPV in clinical settings
Manouchehri et al. (2022)	Iran	Multiple sclerosis	Cross-sectional	Women with MS	Psychological abuse most common
Michaelson (2024)	Canada	Multiple Sclerosis	Personal reflection	Women with MS	Barriers to disclosure, accessing services, and receiving support.
Nesbitt et al. (2026)	Australia	Multiple sclerosis	Narrative review	Women with MS	Gap between patient disclosure and clinical documentation
Pol-Patil et al. (2023)	Unites States	Multiple Sclerosis	Qualitative	Women	Structural barriers influence help-seeking
Ponce-Santillán et al. (2025)	Mexico	Pregnant/postpartum with systemic lupus erythematosus and rheumatoid arthritis	Quantitative	Women with SLE and RA	Pregnancy associated with increased IPV prevalence

Appendix B

Characteristics of grey literature

Author (Year)	Organization	Country	Publication Types	Primary Contribution
Das & Zhang	Professional resource	International	Scholarly book chapter	Reviews evidence on the psychoneuroimmunological mechanisms linking intimate partner violence with immune dysregulation and autoimmune disease, providing biological context for the relationship between trauma and episodic disabilities.
Horne & Ford (2024)	Community resource	United Kingdom	Podcast	Dependence and social isolation increased vulnerability
Venkatachalam (2024)	Professional resource	United Kingdom	Clinical guidance	Recommendations for trauma- and violence-informed care

Appendix C

Distribution of Episodic Disabilities

