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Quality of Life among Women Who Exposed to Violence: Adult women Versus Old Women

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Abstract: Background: *Violence against women can have a myriad of devastating consequences on women's short and long-term health and wellbeing. Along with the immediate physical and emotional impacts of violence, women's overall quality of life adversely affected over an entire lifetime, which can, in turn influence their participation and engagement in various aspects of life and society.* ***Aim:*** *This study aimed to examine the quality of life among women who exposed to violence* ***Research questions:***
1-What are the different types of violence among studied women?
2-Does the types of violence affect the age groups of studied women differently?
3-Is there is a relationship between quality of life and age group of women?
Methods: *descriptive correlational design was used. The study was carried on 120 women who attending the outpatient clinics at EL Menoufia university hospital and Shebin Elkoum Teaching Hospital. Women aged less than 60 years (women aged 20 years and above) and women aged more than 60 years (women from 60 years and above). Data was collected using four instruments: 1-Structured interview schedule 2- Violence against women checklist 3-Consequences violence on women health structured interview questionnaire 4-WHO Quality of life.* ***Results:*** *More than half of the women aged less than 60 years and only 25% of them aged more than 60 years suffered from violence with a statistically significant difference. Moreover, a statistically significant difference was found between violence and quality of life domains in women aged less than 60 years and women aged more than 60 years.* ***Conclusion:*** *The women aged less than 60 years were suffered from violence more than women aged more than 60 years and the quality of life of women who did not suffer from violence is better than women who did. Moreover, women aged more than 60 years have a good perception on rating their quality of life and more satisfied with their health more than women aged less than 60 years.* ***Recommendations:*** *Increasing women's awareness of her issues, problems and legal rights through holding conferences and seminars in mass media. In addition, training programs for wives' and husbands about the effective communication skills, stress management techniques and problems solving skills.*
Keywords: *Quality of life, Violence, Adult women, Old women.*

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I. Introduction

The issue of violence against women has become a universal case due to its human, social and health dimensions. It is a multidimensional, multi-objective and multi-consequence case [1].

It is considered a major public health problems and violations of women's human rights. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"[2]. Historically, women aged less than 60 years are often recognized as victims of domestic violence. However, older women aged less than 60 years are affected too by domestic violence. Because abuse later in life often goes underreported or unrecognized. Nurses and all health care personal must be aware of the resources and interventions specific to serving the unique needs of the women aged more than 60 years[3].

Violence against women passes through her life cycle. In first phase at the beginning of her life that is pre-birth she suffers from sex-selective abortion, at infancy she suffers from female infanticide i.e. physical, sexual and psychological abuse, at girlhood child marriage, incest, child prostitution and pornography, at adolescence and women aged less than 60 years-hood go out with and courtship violence [4]. Furthermore, domestic violence against older women is a serious concern, which has been understudied in the literature. Consequently, older battered women are considered the silence victims. women aged more than 60 years forced suicide or homicide for any reasons i.e. sexual, physical and psychological abuse may occur. Efforts to address this issue are affected by the lack of community awareness, resources and education [3,4].

Violence is a serious public health problem that is increasingly affecting health and well-being of millions of women and families throughout the world [5]. Globally, at least one woman in every three has been physically or sexually abused by a family member or an acquaintance at some time in their lives. Moreover, violence against women has been shrouded in a culture of silence. Reliable statistics are hard to come by as violence is under reported because of shame, stigma and fear of retribution[6]. The prevalence rates vary from 0.8% to 29.3% across Europe and overall 28.1% of older women had experienced some kind of violence or abuse[7]. A WHO multi-country study found that between 15–71% of women reported experiencing physical and/or sexual violence by an intimate partner at some point in their lives[8]. Risk factors for being a perpetrator include low education, past exposure to child maltreatment or witnessing violence between parents, harmful use of alcohol, attitudes accepting of violence and gender inequality. In addition, poverty, low economic status, social status, norms, employment and the tradition of the society are considered as risk factors to violence [4].

Similar to other women around the world, Egyptian women suffer from varying types and degrees of physical and psychological violence. Violence against women in Egypt is an integral part of the issues and problems suffered by the society, being a traditional society where various forms of norms and practices entrench a culture of discrimination against women, their inferiority and degradation, thus subjecting them continuously to various forms of violence. Perhaps the worst form of violence is that related to honor crimes, severe beating, early marriage, sexual abuse, marital rape, while other harmful practices include sale of brides, marriage of children, and preferential treatment of males[9]. Women over the age of 55 who are abused are more invisible than the women aged less than 60 years battered woman because of ageism and cultural norms for their generation. In addition, she is more likely to treat like a child, not as a competent woman aged less than 60 years. The older abused woman may be afraid to speak up because she fears declining health, losing property, rejection by friends or family, losing her caregiver, what people will say, or feeling responsible for the person who is abusing her[10].The Egypt Demographic and Health Survey (2008) [11] illustrated that 50% of married, widowed and divorced women have subjected to some form of physical violence since the age of fifteen. Moreover, the National Council for Women produced a report titled "A Study on Violence against Women in Egypt: Summary of Findings" (2009)[12] that pointed to prevalent social violence against women, which is more difficult to monitor compared to domestic violence. Among the most common types of this violence are rape and sexual assault that not reported in most cases, due to the social stigma of the raped woman.

There is a growing interest in the quality of life of women. It is an issue that has not been sufficiently researched yet. Health related quality of life (HRQOL) is a general term that describes the overall impact of a disease, illness, or condition on the health and well-being of the affected individual. HRQOL can describe an individual 's health and well-being in term of symptoms and functioning or it can reflect how an individual value, a particular state of health, meaning how much they like or dislike being in that particular state of health and well-being. This value –focused measure of HRQOL is termed "preference – based" because it measures an individual's preference for a health state, as opposed to an individual's description of the state. HRQOL also refers to the physical and mental domains of health, which seen as distinct areas that are influenced by a person's experiences, beliefs, expectation and perception[13,14]. Moreover, violence against women is not acceptable and has a negative impact on health and wellbeing of the women. It occurs in one or more of the following ways: physical abuse, sexual abuse, emotional abuse and financial abuse[10]. Violence against ladies will have a myriad of devastating consequences on women's short and long-run health and welfare. at the side of the immediate physical and emotional impacts of violence, women's overall quality of life will adversely have an effect on over a complete lifespan, which can, in turn, influence their participation and engagement in numerous aspects of life and society. These consequences to the individual women, along with the violent act itself, can have ripple effects on society as a whole [15]. For instance, employers may experience lost productivity and output from their employees, while women's informal support networks, such as families and friends, may need to alter their daily activities to assist victims. This is in addition to the broader societal costs associated with delivering and maintaining health care, social and justice-related services to victims of violent crime, as well as the costs related to the criminal justice response to accused persons [16].

Nurses and other health care professionals have responded to the problem of domestic violence by engaging in increasingly sophisticated research, designing prevention and intervention programs and advocating for social change. However, much of the research and services have focused almost on women aged less than 60-years. This article compares women aged more than 60 years with women aged less than 60 years in order to recognize the magnitude of the problem as well as its impact. Accordingly, the current article compares incidence, type of violence, violence source, demographic characteristics, quality of life, effect of violence on women health status, and the relationship between violence and quality of life among women aged less than 60 years and women aged more than 60 years.

Aim of the study:
This study aimed to examine the quality of life among women who exposed to violence

Research questions:
1-What are the different types of violence among studied women?
2-Does the types of violence affect the age groups of studied women differently?
3-Is there is a relationship between quality of life and age group of women?

Materials
Design: This was a descriptive co relational study.
Settings: This study was carried out in El- Menoufia main University Hospital and Shebin El-kom Teaching hospital, Egypt.
Subjects: The study subjects comprised of 120 women who attending the study setting. The subjects selected according to the following criteria: women aged 20 and women aged more than 60 years, able to communicate and accept to participate in the study. The sample size was calculated based on the most important variables in this study (violence). Egypt Demographic and Health Survey (2008)[11] revealed that a third of women aged less than 60 years are abused and a study done by Darwish et al. (2008)[17] revealed that the prevalence of violence among women was 36.87%. In addition, the prevalence of overall violence among women aged more than 60 years was 28.1% according to a multicultural survey done by Luoma et al., (2011)[7] and 29% in another study done by Grunfeld et al., (1996)[18]. By using the website www.Dssresearch.com accessed on 17 December 2012 to calculate the sample size, and the choice average percentage value for sample 1 (women aged less than 60 years) was 35 and the average percentage value for sample 2 (women aged more than 60 years) was 28 using a two tailed significance test with a power of 80% and alpha error level of 5.0%. Based on these parameters the required sample size was 57 women, and added 5% because of defaulter, so the sample was 60 women for each group.

Instruments of the study: -
The following Instruments were used for data collection.
Instruments I: structured interview schedule. The researchers based on relevant literature developed this instrument. It included data such as age, residence, marital status, occupation, level of education, income& its source, living with, presence of disease, type of associated disease, type of medication taken, suffering from violence and who is the perpetrator **for** women aged less than 60 years and women aged more than 60 years.
Instrument II: Violence against Women Checklist. This instrument developed by the researchers based on relevant literature review[19-21] to assess violence against women. It consisted of questions related to economic violence, physical violence, psychological violence and sexual violence against women. It included 30 items on Arabic language. Scoring of the items was made using a 3-point Likert scale, a zero (0) scored for the items which indicated never done, one (1) means sometimes done and two (2) means always done. The total score for economic violence was 10, physical violence was 20, psychological violence was 20 and for sexual violence were 10. The higher score indicates a greater level of violence against women.
Instrument III: - Consequences of violence on women health structured interview Questionnaire: The researchers developed this instrument based on relevant literature review[19-21] to assess impact of violence on women health. It consisted of questions to assess the impact of violence on women physical health status (10 items) and on women psychological health status (13 items). Scoring of the items was made using a zero (0) score for the response with not present and score one (1) for the response with yes present. The higher score indicates a negative impact on women health status.
Instrument IV: - WHO Quality of life-bref (WHOQOL-BREF). Instrument was developed by the World Health organization in (1997)[22] and was updated in 2014 and translated into Arabic and tested for its validity and reliability by Ahmed 2008 [23]. The reliability was assured by Spearman's correlation coefficient r = 0.884. It was used to assess the individual’s perceptions in the context of their culture and value systems, and their personal goals, standards and concerns. The WHOQOL-Bref produces a profile with four domain scores and two individually scored items about an individual’s overall perception of quality of life and health. It contains 26 questions. Scoring of the items was made using a 5-pointlikert scale ranged from one (1) to five (5). The four domain scores are scaled in a positive direction with higher scores indicating a higher quality of life.
Methods:
The study was executed according to the following steps:

Procedure for Data Collection: -
1-Duration of time in data collection: The researcher started the data collection from March 10, 2016 and ended on September 2016. Data collection schedule start from 10 am to 1pm.

2- An official letter was issued to the manager of El-Menoufia University hospitals and Shebin Elkoum Teaching Hospital to obtain his approval in order to collect the necessary data.
3-Instruments development: The instruments for data collection were developed after reviewing the related literature then tested for content validity. Study instruments I, II, III were tested for content validity by a jury of five peers from related specialties. The necessary modifications were done accordingly. The reliability was assured by spearman's correlation coefficient r = 0.962 for instrument II and r = 0.866 for instrument III.
4-Verbal consent was obtained from the study subjects after explaining the purpose of the study.
5-Privacy of the subjects and confidentiality of the collected data was assured throughout the study. Study subjects were informed about their rights to withdrawn from the study at any time.
6-Each subject was interviewed individually by the researcher to collect the necessary data using instrument I (Socio-demographic , clinical data of the women aged less than 60 years and women aged more than 60 years and women structured interview schedule), instrument II (Violence assessment structured interview schedule), instrument III (impact of violence on women health) and instrument IV (WHOQOL-BREF). Assessment of every subject was carried out by the researcher in the outpatient clinics
7-A pilot study was carried out on a sample of 10 women from the previously mentioned setting who were excluded from the sample before starting the data collection to test the feasibility of the study and applicability of the tools and the necessary modifications were done accordingly.

Statistical analysis:

Data were analyzed using the Statistical Package of Social Science (SPSS) software version 16.0. The 0.05 level was used as the cut off value for statistical significance and the following statistical measures were used: descriptive statistics (count & percentage, minimum-maximum and median, mean &standard deviation) and analytical statistics (Pearson’s chi square test, Monte Carlo Exact test and Fisher Exact test, t-test & Mann-Whitney test).

II. Results

Table I shows distribution of the studied women according to their socio-demographic characteristics. It was observed that, more than half (53.3%) of the adult women and 60% of the elderly women live in urban area. Regarding social status, 80% of the adult women were married and nearly two third of the elderly were married and the difference between two groups was statistically significant. More than fifty percent of the young women had med education and 45% of the elderly women were illiterate followed by 38.3% had med education. The difference was statistically significant. The majority (95%) of the elderly women were housewife and 60% for the adult women. The difference was statistically significant. Moreover, there
is a statistically significant difference between the adult and elderly women in relation to income, income source and living with (P=0.00).

Table (1): Socio-demographic characteristics of the adult and elderly women

Items	Women aged less than 60 years (Adult Women)		Women aged more than 60 years (Elderly)		X^2 (P)
	N= (60)	%	N= (60)	%	
Age:					
20-	18	30.0	0	0.0	24.287
30-	21	46.7	0	0.0	(0.000)
45-	14	23.3	0	0.0	
60-	0	0.0	57	95.0	
75+	0	0.0	3	5.0	
Residence					
Rural	28	46.7	24	40.0	0.543
Urban	32	53.3	36	60.0	(0.461)
Social status					
Single	6	10.0	1	1.7	
Married	48	80.0	38	63.3	18.294
Widow	4	6.7	21	35.0	(0.000)* ^
Divorced	2	3.3	0	0.0	
Educational level					
Illiterate	4	6.7	27	45.0	
Read &write	7	11.7	3	5.0	23.329
Med education	36	60.0	23	38.3	(0.000)*
University	13	21.7	7	11.7	
Occupation					
Employee	22	36.7	2	3.3	21.742
Housewife	36	60.0	57	95.0	(0.000)* ^
Worker	2	3.3	1	1.7	

Income Enough Not enough Enough and save	 18 38 4	 30.0 63.3 6.7	 55 5 0	 91.7 8.3 0.0	 48.079 (0.000)* ^
Income source Work Pension Son help Husband	 29 3 5 23	 48.3 5.0 8.3 38.3	 2 40 0 18	 3.3 66.7 0.0 30.0	 60.963 (0.000)*^
Living with Alone Family	 2 58	 3.3 96.7	 13 47	 21.7 78.3	 9.219 (0.002)*

*significant at p≤ ^ P value based on Monte Carlo exact probability

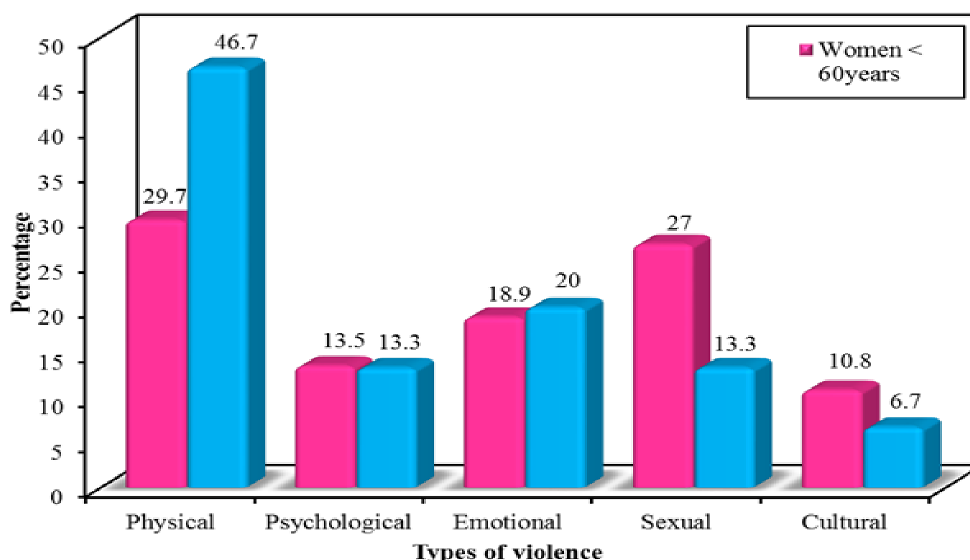
Table 2 shows distribution of the studied women according to their medical history. It was observed from the table that, more than three quarter (76.7%) of the adult women did not suffer from any disease while 90% of the elderly women suffer from diseases and the difference between two groups was statistically significant. Cardiac disease and diabetes were prevalent among elderly women (50%) and 42.8% of the adult women complain from diabetes mellitus. In relation to the current medications taken, it was observed that 50% of the adult women and 45% of the elderly women take antihypertensive medication.

Table (2): Distribution of the studied women according to their medical history

Items	Women aged less than 60 years(Adult)		Women aged more than 60 years(Elderly)		X^2 (P)
	N= (60)	%	N= (60)	%	
Suffer from disease Yes No	 14 46	 23.3 76.7	 54 6	 90.0 10.0	 54.299 (0.000)*
Diseases # Cardiac Gastrointestinal Respiratory Renal Diabetes mellitus Others	N= 14 3 2 2 0 6 5	 21.4 14.3 14.3 0.0 42.8 35.7	N=54 27 1 7 6 27 1	 50.0 1.8 12.9 11.1 50.0 1.8	 25.6 (0.000)* FET (1.00) 3.003 (0.083) 6.316 (0.012)* 18.433 (0.000)* FET (0.207)
Medication taken Antihypertensive Hypoglycemic Analgesics	 7 6 1	 50.0 42.9 7.1	 27 26 7	 45.0 43.3 11.7	 5.060 (0.472) ^

\# Not mutually exclusive FET=Fisher Exact Test
*significant at p≤0.05 ^ P value based on Monte Carlo exact probability

Figure (1) different types of violence among studied women.



FET=Fisher Exact Test (two tails)

Figure 1 highlights the prevalence of different types of violence among the studied adult and elderly women. The highest prevalence is physical violence with nearly one-third (29.7%) of the studied sample followed by sexual violence with 27% prevalence. The lowest prevalence of violence is cultural which is reported by one tenth of studied sample (6.7%). Approximately half (46.7%) of the elderly report physical violence followed by emotional violence (20%), while approximately one third of adults report physical violence followed by sexual violence (27%). The difference between two groups was not statistically significant (P>0.05 for each).

Figure (2): Distribution of the studied women according to presence of violence among women

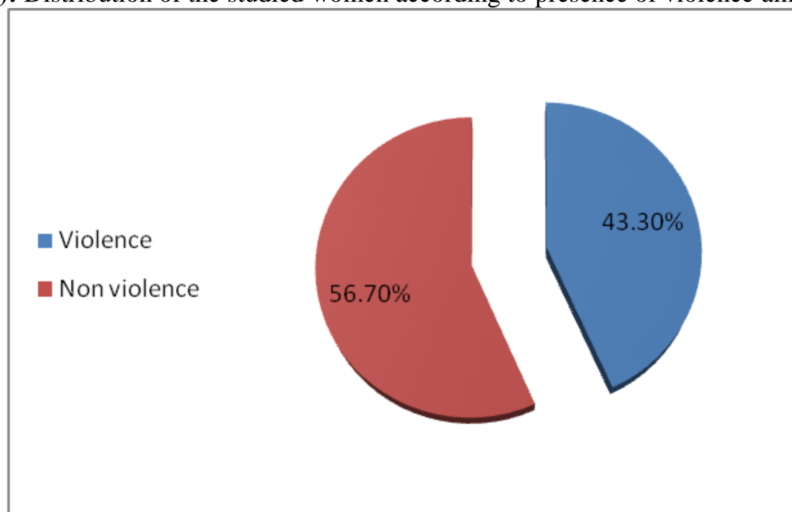


Figure 2 shows distribution of the studied subject according to presence of violence among women. It was observed that, more than half (56.70%) of the adult women and only 43.30% of the elderly women suffered from violence. The difference between the two groups was statistically significant (P=0.000).

Table 3 shows distribution of the studied women according to their quality of life domains (QOL). It appears that, the adult women have a high mean total score of physical health and social relationship domains than elderly women and the difference between the two groups was statistically significant (P=0.00 and P=0.01 respectively). Moreover, the elderly women have a high mean total score regarding psychological and environment domains than adult women but the difference between the two groups was not statistically significant.

Table (3): Distribution of the studied women according to their quality of life domains (QOL)

Items	Women aged less than 60 years	Women aged 60 years and over	t-test (P)
	Mean ±SD	Mean ±SD	
Physical health	60.716±17.557	45.616±16.283	4.885 (0.000)*
Psychological	47.633±19.994	49.566±18.404	0.551 (0.583)
Social relationships	62.367±16.479	54.917±17.718	2.385 (0.019)*
Environment	51.550±21.363	52.783±18.989	0.334 (0.739)

*significant at p≤0.05

Table 4 shows the distribution of the adult and women aged more than 60 years according to their overall perception of health and quality of life (QOL). It appears that, nearly two thirds of the elderly women (65%) have a good perception of QOL rather than adult women (56.6%). The difference between the two groups was not statistically significant. Also, more than three quarter of the elderly women (81.7%) reported more satisfaction with their health than adult women (70.0%) and the difference between the two groups was statistically significant (P=0.006).

Table (4): Distribution of quality of life (QOL) among studied women according to their overall perception of health.

Items	Women aged less than 60 years		Women aged 60 years and over		X^2 (P)
	N= (60)	%	N= (60)	%	
Rating own QOL					
Very poor	6	10.0	2	3.3	
Poor	5	8.3	5	8.3	3.693
Neither poor nor good	15	25.0	14	23.3	(0.449)
Good	34	56.6	39	65.0	
Satisfaction with own health					
Very dissatisfied	5	8.3	0	0.0	
Dissatisfied	2	3.3	2	3.3	14.598
Neither satisfied nor dissatisfied	11	18.3	9	15.0	(0.006)*
Satisfied	42	70.0	49	81.7	

*significant at p≤0.0

Table 5 shows that a statistically significant difference was found between the adult and elderly women regarding the effect of violence on their psychological health (P=0.003**).**

Table (5): Effect of violence on the health of the studied women

Items	Women aged less than 60 years	Women aged 60 years and over	Mann-Whitney (U)Test (P)
	(Min-Max) Median	(Min-Max) Median	
Effect on physical health	(n=30)	(n=6)	62.500
	(1.0-14.0) 3.0	(1.0 -8.0) 2.5	(0.233)
Effect on psychological health	(n=14)	(n=11)	25.000
	(1.0 -5.0) 2.0	(2.0 -7.0) 5.0	(0.003)*

*significant at p≤0.0

Table 6 shows the relation between quality of life domains and violence among adult and elderly women. Regarding violence and non-violence among adult women, it was observed that the total mean score of QOL domains is high in the adult women who do not suffer from violence. Therefore, a statistically significant difference was found. Moreover, the elderly women who do not suffer from violence have a high mean total score of QOL domains. The difference between elderly women who reported violence and non-violence was statistically significant.

Table (6): Relationship between quality of life domains and the presence of violence among women

Items	Women aged less than 60 years		Women aged 60 years and over	
	Violence (n=37)	Non violence (n=23)	Violence (n=15)	Non violence (n=45)
	Mean ±SD	Mean ±SD	Mean ±SD	Mean ±SD
Physical health	59.16±14.31	63.22±21.93	35.2±14.64	49.09±15.43
t-test (p)	0.868(0.389)		3.057(0.003)*	
Psychological	40.89±18.08	58.48±18.39	30.47±12.49	55.93±15.45
t-test (p)	3.640(0.001)*		5.776(0.000)*	
Social relationships	56.89±17.19	71.17±10.64	37.87±18.00	60.6±13.63
t-test (p)	3.575(0.001)*		5.151(0.000)*	
Environment	44.35±20.16	63.13±18.19	35.13±16.63	58.67±15.93
t-test (p)	3.638(0.001)*		4.901(0.000)*	

*significant at p≤0.05

Table 7 shows the relation between socio-demographic characteristics, presence of disease and violence among women. It was observed that, a statistically significant difference was found between residence, income and the presence of violence among adult women group. While, a statistically significant difference was found between social status, educational level, income, income source and the presence of violence among elderly women group.

Table (7): Relationship between socio-demographic characteristics, presence of disease and violence against women

Items	Women aged less than 60 years				Women aged 60 years and over			
	Violence (n=37)		Non violence (n=23)		Violence (n=15)		Non violence (n=45)	
	No	%	No	%	No	%	No	%
Residence								
Rural	13	35.1	15	65.2	9	60.0	15	33.3
Urban	24	64.9	8	34.8	6	40.0	30	66.7
Test of significance	P = 0.023*				P = 0.068			
Social status								
Single	4	10.8	2	8.7	1	6.7	0	0.0
Married	30	81.1	18	78.3	6	40.0	32	71.1
Widow	1	2.7	3	13.0	8	53.3	13	28.9
Divorced	2	5.4	0	0.0	0	0.0	0	0.0
Test of significance	P = 0.309				P = 0.036*			
Educational level								
Illiterate	3	8.1	1	4.3	10	66.7	17	37.8
Read &write	5	13.5	2	8.7	3	20.0	0	0.0
Med education	20	54.1	16	69.6	2	13.3	21	46.7
University	9	24.3	4	17.4	0	0.0	7	15.5
Test of significance	P = 0.690				P = 0.001*			
Occupation								
Employee	11	29.7	11	47.8	1	6.7	1	2.2
Housewife	24	64.9	12	52.2	14	93.3	43	95.6
Worker	2	5.4	0	0.0	0	0.0	1	2.2
Test of significance	P = 0.236				P = 0.605			
Income								
Enough	7	18.9	11	47.8	11	73.3	44	97.8
Not enough	28	75.7	10	43.5	4	26.7	1	2.2
Enough and save	2	5.4	2	8.7	0	0.0	0	0.0
Test of significance	P = 0.039*				P = 0.003*			
Income source								
Work	18	48.6	11	47.8	1	6.7	1	2.2
Pension	1	2.7	2	8.7	14	93.3	26	57.8
Children help	5	13.5	0	0.0	0	0.0	18	40.0
Husband	13	35.1	10	43.5	0	0.0	0	0.0
Test of significance	P = 0.223				P = 0.012*			
Living with								
Alone	2	5.4	0	0.0	7	46.7	6	13.3
Family	35	94.6	23	100.0	8	53.3	39	86.7
Test of significance	P = 0.257				P = 0.007*			
Suffering from disease								
Yes (14)	7	18.9	7	30.4	13	86.7	41	91.1
No (46)	30	81.1	16	69.6	2	13.3	4	8.9
Test of significance	P = 0.305				P = 0.619			

*significant at p≤0.

III. Discussion

Quality of life among women who exposed to violence became a key issue and early research on the relationship between violence against women and their health in the developing countries contributed to a deeper awareness of the problem and the adverse health outcomes associated with it [24]. It is the most pervasive yet under-recognized human rights violation in the world. Sometimes, it was assumed that adult women mainly experience violence, and that older women's experiences could be put under the category of "elder abuse". This reflects a societal predisposition to homogenize older people by not considering individual differences, including gender. It also indicates a general disrespect of older people and older women, which is present in many societies throughout the world[25].Although there are many similarities in the circumstances of older adult women victims, some of the differences that exist are large enough to warrant closer examination. Below we will discuss these differences as well as similarities. Before discussing the implications of the findings, it is important to note that many women refused to participate in the study. Women who otherwise refused participation were older than those who consented women aged less than 60 years age. Moreover, we did not formally assess reasons for refusals, anecdotally; older women were less likely to perceive a need for screening for violence. They did not discuss the incident (violence) and considered that nobody could do anything or take an action about it.

The current study showed that, slightly less than fifty percent of women aged less than 60 years (women aged from thirty to less than forty-five years old (reproductive age)). The same percentage was represented at a study carried out in Egypt by Morsy et al., (2013)[26] about "effect of partner abuse on the quality of life of married women". While most of the studied women aged more than 60 years (women aged 60 years to less than 75 years). In addition, more than three quarter of the women aged less than 60 years do not suffer from any disease while ninety percent of the women who aged more than 60 years suffer from diseases and the difference between the two groups were statistically significant. This result could be related to increase prevalence of the diseases that increased with age because aging process is associated with multiple structural and functional changes and alterations in all body systems. Moreover, the present study revealed that women aged more than 60 years suffer from violence and had more chronic diseases than women aged less than 60 years. Therefore, the difference was not statistically significant. This reflects that women aged more than 60 years could become a victim of violence more than women aged less than 60 years related to physical frailty, compromised mental health status, social factors (such as poverty, isolation, lack of support), retirement or general societal conditions and trends[7].

Regarding relationship between socio-demographic characteristics, presence of disease and violence against women, it was observed that, violence was common among women aged less than 60 years, married women who live in urban area, with med education with not enough income and who live with her family. The difference was statistically significant regarding residence and income. While violence was common among widow women aged more than 60 years who live in rural area, illiterate, who live with her family and suffer from multiple diseases. Therefore, a statistically significant relation was found regarding social status, level of education, income, living with and income source. While, a study done by Morsy et al., (2013)[26] revealed that, there were statistically significant relationships found between mean total score of women abuse and their residence, level of education, occupation, husbands' education, occupation and family income.

Regarding distribution of the studied subjects according to presence of violence among women the results revealed that, the women aged less than 60 years suffered from violence. In the current study more than the women aged more than 60 years did. In addition, the women aged less than 60 years reported violence from husband more than the women aged more than 60 years. Women who reported violence from sons and daughters more than women aged less than 60-years women do. This result is congruent with the result of Luoma et al., (2011)[7]. This result had interpreted by; older women may experience even more barriers to disclosure than women aged less than 60 years. Therefore, women more reluctant to report violence. Beside that, some older women become widow (have no husband) and the older women who has sons they have new women in their life (wife) and have a new family that need more of income and responsibilities. On the other hand, these new women may prevent fund from her husband to his mother (mother in law) this clear other source of violence from daughter in law to mother in law and vice versa and this is common in Egypt especially with large families who live in the same house. The daughter in law may become a victim because of suffering from all types of violence at the same place such as physical type not only from her husband but also from his mother, father, sister and also his brother. Furthermore, when a man's ability to be the breadwinner is challenged by the working women. It directly causes spousal violence against women. The loss of this title is detrimental to the mental health of husbands and it is difficult for men to realize the economic dependence of their wives. It goes against the norm of male dominance and female dependence, which in turn can cause the men to react violently while regaining control over their relationship [27].

Violence is a profound health problem that saps women's energy, compromises their physical and mental health and erodes their self-esteem [28].On examining types of violence against women, the present study revealed that the most common type of violence among women aged less than 60 years and women aged more than 60 years was psychological violence followed by economic violence, physical violence and sexual violence. The difference between the two groups was statistically significant in relation to physical and economic types of violence. This result is in accordance with a study carried out by Sinha (2013)[29], Abd El Maqsoud et al., (2011)[30] and Hussein (2012)[5]who reported that psychological violence was the highest prevalent of violence against women. Cook J et al., (2011)[19] recorded that, women over 55 years reported less lifetime exposure to physical and sexual assaults. Moreover, this result is not in same line of Ogrodnik (2008)[24] who reported that, financial victimization is the most common form of violence that older persons are likely to face. This may be related to older women typically live longer than older men, financial victimization for older women may have profound and long-term impacts on their quality of life. Moreover, women aged less than 60 years suffer from other types of violence such as work and gender violence more than older women. This result also revealed that economic violence (subtract from salary) and psychological violence (prevent the victim to present in conferences or workshops or obtain some licenses that alter with advancement); the source of this types of violence is the head of department or director of work that affect negatively the women quality of life. Morsy et al., (2013)[26] found the same result.

Concerning effect of violence on women health, the present study showed that, violence has a negative impact on women physical and psychological health status. The women aged less than 60 years has more physical health problems than psychological and the opposite was found among women aged more than 60 years. A statistically significant difference was found between the two groups in relation to the effect of violence on psychological health status. This result is consistent with a result of Moraes et al., (2012)[28] and Abd Elwahed et al., (2011)[6]. Therefore, the assumption that both subjective and symbolic dimensions of violence should recognized with their signifiers and representations, to avoid its trivialization and naturalization. These characterized as a subtle form of domination, becoming an obstacle to the recognition of violence. Thus, one must understand the phenomenon of violence in its various nuances, not only what is visible and apparent, but also what is felt and understood subjectively and presents itself in a subtle way not revealed [31].

Violence may have both short- and long-term negative health consequences for survivors even after the abuse has ended. These effects can manifest as poor health status, poor quality of life and high use of health care services[32]. The current study showed that; the women aged more than 60 years have a good perception on rating their QOL and more satisfied with their health rather than women aged less than 60 years. Women aged less than 60 years had a high mean total score in social relationships and physical health status of QOL domains more than women aged more than 60 years. The difference between the two groups was statistically significant. In relation to violence in overall terms, the present study revealed that, women aged less than 60 years and women aged more than 60 years suffer from violence and had a lower mean total score of quality of life than who do not. The difference was statistically significant. This is in accordance with the results of Luoma et al., (2011)[7]and Leung et al., (2005) [33]and not consistent with the result of Klevens et al., (2012)[34], who reported that no significant differences in the QOL health component. A number of studies suggest a strong correlation between violence victimization and mental health concerns.[32] Also, the present study revealed that; psychological domain was the most affected by violence among women aged less than 60 years and women aged more than 60 years. This in the same line of Costa et al., (2015)[35]andWittenberg et al., (2007)[13] who reported that psychological health was the most severely affected domain. Therefore, psychological and emotional health plays an important role in the overall health related quality of life of abused women.

Because abused women in Egypt do not typically talk to doctors or other health care providers about their beatings, additional interventions have been recommended to involve all health care providers in combating domestic violence against women. These include adding a module on domestic violence in medical education and training curriculum, develop a culturally appropriate screening tool to help health care providers assess risks for each female patient, modify the national health information system (NHIS) to include systematic data collection on domestic violence and its consequences for women's health, develop referral systems and inform the medical personnel of these mechanisms[11] .Finally, we can say that, violence against women is an important neglected public health problem in the Egyptian community that needs multidisciplinary approach to understand its causes and plan an effective preventive measures as well as manage its consequences. For instance, employers may experience low productivity and output from their employees, while women's informal support networks such as families and friends may need to alter their daily activities to assist victims. Therefore, the healthcare providers especially the nurse can play a crucial role in addressing and treating victims of violence. Moreover, additional data are needed to truly have a base of information with which to evaluate the services needed for those women across the different age groups.

IV. Conclusion and Recommendations

Violence was common among women aged less than 60 years and has a negative impact on their physical and psychological health status. The women aged less than 60 years has more physical health problems than psychological and the opposite was found among women aged more than 60 years. The most common type of violence among women aged less than 60 years and women aged more than 60 years was psychological violence. Moreover, both women aged less than 60 years and women aged more than 60 years who suffer from violence had a lower mean total score of quality of life than those who do not. Therefore, the difference was statistically significant. In addition, the women aged more than 60 years have a good perception on rating their QOL and more satisfied with their health than women aged less than 60 years.

V. Recommendations

1. Increase women's awareness of her issues, problems and legal rights through holding conferences and seminars in the mass media.
2. The government should established a violence service system to help the victims as well as a violence agencies or programs in order to maximize their role in providing support, safety, care and advocacy for the older women victims and women aged less than 60-years.

3. Training programs for wives and husbands about the effective communication skills, integrated workshops about stress management techniques and problems solving skills, as well as educational programs about successful intimacy partner relationships should be provided.

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