# Violence Against Women

## Contemporary Examination of Intimate Partner Violence

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## Contemporary Examination of Intimate Partner Violence

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# Foreword

Intimate partner violence (IPV) is an entirely stoppable yet crippling epidemic in the United States and around the globe. The 2010 National Intimate Partner and Sexual Violence Survey (NISVS) from the Centers for Disease Control and Prevention report that more than 1 in 3 women and 1 in 4 men experience rape, physical violence, and/or stalking by an intimate partner in their lifetime. Moreover, the majority of both men and women experiencing IPV do so for the first time before the age of 25.[1] Many require medical and other healthcare related encounters. A study by Bonomi and colleagues found significantly higher healthcare costs for physically abused women, and greater utilization of services in emergency, hospital outpatient, primary care, pharmacy, and specialty services departments.[2] Reviewing all homicides in the US between 1980 and 2008, nearly 1 in 5 victims was killed by an intimate partner; in 2008, 45% of all female victims were killed by an intimate partner, a rate far higher than their male counterparts.[3]

IPV exists within small towns and big cities, wealthy communities and poor; on military installations, and on high school and college campuses across the nation. It would be difficult to find any community not impacted by IPV. Legislation related to IPV has improved drastically over the years. Every state has some form of anti-stalking law on the books, and as of 1993 all states and the military criminalize rape of a spouse. The Victims of Crimes Act (VOCA) as well as the Violence Against Women Act (VAWA) have done much to assist victims of crimes in meaningful ways. Felony strangulation laws have become increasingly common—a majority of states now have them—making it easier to hold offenders accountable for a frequently used and potentially lethal form of violence. However, jurisdictions differ widely in the ways they approach the investigation and prosecution of crimes related to IPV, be it in definition, level of criminal offense, or types of available punishment upon successful prosecution. Regardless, criminal justice professionals and colleagues in allied professions, including healthcare and victim advocacy, will certainly come into contact with victims of abuse. Understanding the broad spectrum of ways in which IPV can manifest itself and the ripple effect it can have on the lives of victims and their families is critical.

Violence Against Women: A Contemporary Examination of Intimate Partner Violence is a one-stop reference book. It is relevant for victim advocates, social workers, law enforcement professionals, prosecutors, judges, healthcare workers, and any other professional who desires a well-rounded understanding of the implications and impact of IPV. This book systematically examines all aspects of IPV and contains detailed and well-resourced chapters on broad issues, such as risk assessment, healthcare implications and investigation, as well as more focused examinations of IPV within specific communities. I am not aware of a more comprehensive look at IPV than Violence Against Women: A Contemporary Examination of Intimate Partner Violence. The authors, contributors, and editors are to be commended for its excellence.

**Sasha N. Rutizer**
Senior Attorney
National District Attorneys Association

1. *Black MC, Basile KC, Breiding MJ, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.*
2. *Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. Health Serv Res. 2009;44(3):1052-1067.*
3. *Cooper A, Smith EL. Homicide Trends in the United States, 1980-2008. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2011.*

# Foreword

Over the last several decades we have come to realize that exposures to violence is in fact a major social determinant of health. Some great visionaries of our country 'got' violence way before most. One visionary was Dr. Martin Luther King, he stated:

"Violence as a way of achieving racial justice is both impractical and immoral. It is impractical because it is a descending spiral ending in destruction for all. The old law of an eye for an eye leaves everybody blind. It is immoral because it seeks to humiliate the opponent rather than win his understanding; it seeks to annihilate rather than to convert. Violence is immoral because it thrives on hatred rather than love. It destroys community and makes brotherhood impossible. It leaves society in a monologue rather than a dialogue. Violence ends by defeating itself. It creates bitterness in the survivors and brutality in the destroyers." I believe Dr. King captured the devastating effects of violence like no other before or since.

Globally, Gender Based Violence (GBV) affects millions of women (and some men). Over the last 4 decades much evidence has evolved on the health consequences of GBV, and a major focus this decade is exploring interventions and health outcomes. We know that GBV is deeply rooted in socio-political factors, inequality, racism, sexism, and poverty. Addressing these route causes is vital and inherent to preventing and intervening in cases of GBV. Our success will best be measured by the acceptance of zero tolerance for violence across our Nation and the World.

Health care professionals are in a unique and privileged position to prevent and intervene when caring for patients exposed to violence. A Trauma and Patient Informed theoretical framework offers the best opportunity to engage patients. This scholarly written book illuminates the impact of violence on individuals and provides information that is applicable to practice and policy. Worthy of note is the breath and depth of the authors- representing medicine, nursing, lawyers, researchers, academics, and advocates. Their unique and combined contributions are complimentary to each other and provide a wealth of information.

I am confident this book will serve as a beacon for those providing services to victims of GBV. I commend each and every author as surely the parts of this book equal the whole. I also want to acknowledge the patients we serve- it is an honor and a privilege to be in a position of working with them- I know I am a better provider and person for having had this opportunity in my career. In solidarity- Annie Lewis-O'Connor

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# Preface

Significant advances have been made in understanding violence and developing effective prevention and treatment methods. However, addressing interpersonal violence effectively demands involvement from many players, from healthcare professionals, victims, perpetrators, families, educators, community leaders, law enforcement officials, legislators, faith-based organizations, and the media.

Intimate partner violence (IPV) is manifested by four types of behaviors: physical violence, sexual violence, threats of physical or sexual violence, and emotional abuse.

Oftentimes, psychological and emotional violence is the beginning of a continuum of behaviors that commence with relational tensing progressing to emotional mistreatment, escalating to battering, and further progress to violence. This book was compiled from well known worldwide experts in violence and abuse and is intended to be used as a reference and handbook for hospital providers, the law enforcement team, media, educators, and legislators.

Intimate partner violence is the most common cause of nonfatal injury to women.

The Center for Disease Prevention and Control reports that about 4.8 million women experienced physical assault or rape related to IPV in 2009, while 2.9 million men experienced IPV. The related death rate in women is 78%, while in men it is only 22%. Within the United States, one in three female homicides is a result of intimate partner violence, while only one in twenty male homicides is a result of IPV. Clearly, intimate partner violence is a problem that needs to be eradicated, and this is possible through partnerships between educators, health care professionals, law enforcement, and the media using the best assessments and treatments. It is our hope that you will find this book helpful in your fight against intimate partner violence.

**Karyn Holt, RN, CNM**

# Contents in Brief

# Chapter 1

# Risk and Protective Factors for Intimate Partner Violence

Heidi Stöckl, PhD
Charlotte Watts, PhD

## Key Points

1. Studying the risk and protective factors for intimate partner violence (IPV) will help in understanding the causes of IPV, and inform interventions to address and prevent its occurrence.
2. There was a high correlation between alcohol abuse by a violent partner and experiencing intimate partner violence.
3. Exposure to abuse during childhood was cited in most studies as a risk factor for IPV, both for perpetrators and women who experience IPV. This may be because children model the behavior of their parents.
4. IPV is correlated with having a low income, high levels of unemployment, and poor education. In some areas, studies found that abuse was more prevalent in relationships where the female partner earned more or was better educated than the male partner.
5. Other factors, such as race, rigid gender roles, permissive attitudes towards violence, infidelity, unmarried cohabitation, and number of children have been identified as possible risk factors for IPV.

## Introduction

Intimate partner violence is one of the most widespread human rights violations and a public health problem in need of urgent attention. This chapter provides an overview of factors associated with an increase or decrease in women's likelihood of experiencing IPV, which is important both to understanding pathways leading to IPV and to informing interventions to prevent and address its occurrence.

This chapter presents the findings of detailed reviews based on current global evidence of factors associated with IPV in different settings. This evidence comes from multi-country studies; single-country population-based analyses; and previous reviews. This chapter focuses primarily on factors supported by strong evidence from most multi-country and individual population-based studies. Theoretical explanations for these risk factors are discussed alongside the evidence.

## Methodology

The sources used in this review consist of 4 multi-country studies, 9 risk and protective factor analyses from African countries, 15 analyses from Asia and Australia, 11 analyses from Europe and North America, and 4 analyses from Latin America.

The 4 multi-country studies that explored risk factors for IPV each used comparable survey data from more than 1 country and more than 1 continent. These studies are: (1) the WHO Multi-Country Study, consisting of population-based surveys in 15 rural and urban sites in 10 countries[1] and surveying 24 097 women across all sites; (2) an analysis of 10 countries of the Demographic and Health Surveys, (referred to as DHS analysis),[2] that surveyed 7000 to 23 000 women per country; (3) the World Safe Study, a collection of small population-based surveys of 3975 women in different sites in four different countries[3]; and (4) a macro analysis by Kaya and Cook of more than 50 countries, using different survey estimates.[4]

In addition to evidence from multi-country studies, risk and protective factor analyses of population-based surveys from individual countries across the world are also used if they identified factors that put women at risk for IPV, while controlling for the effect of other known risk factors. The 9 African studies under review include an analysis of 8 Southern African countries,[5] as well as individual studies from Egypt,[6] Ethiopia,[7,8] Lesotho,[9] South Africa,[10] Uganda,[11,12] and Zambia.[13] The 15 analyses from Asia and Australia used in this chapter include studies from Australia,[14] Bangladesh,[15,16,17] China,[18] India,[19-23] Iran,[24] Mongolia,[25] Philippines,[26] Thailand,[27] and Vietnam.[28] European and North American studies under consideration consist of nationally representative studies from Canada,[29] Denmark,[30] Germany,[31] Norway,[32] the UK,[33] and the US,[34,35] as well as population-based studies of capital or major cities in Albania,[36] Greece,[37] Spain,[38] and Turkey.[39] Population-based studies from Haiti,[40] Mexico,[41] Nicaragua,[42] and Peru[43] provided insight into the risk factors for IPV in Latin America.

Three important methodological issues have to be considered when interpreting the risk and protective factors for IPV described in this chapter: reverse causality, their probabilistic nature, and the influence of third variables. The issue of reverse causality acknowledges that studies investigating risk factors for IPV using cross-sectional data are often unable to distinguish if certain associations are outcomes or causes of IPV. The terms "risk" and "protective factors" are therefore only used loosely in this chapter, because the cited evidence mainly draws on cross-sectional studies. Furthermore, the outlined risk and protective factors are probabilistic and not deterministic, which means that a person with a specific risk factor is more likely to experience IPV than a person who does not share that risk factor, but not that every person with a specific risk factor necessarily experiences IPV. The influence of third-factor variables cannot be ignored, and may impact the risk factors in the results, being as it suggests that the correlation between IPV and a risk factor may be due to their association with an unmeasured and unknown third factor.

## Results

The review of risk and protective factors in these studies showed strong evidence for associations between women's experiences of IPV and alcohol abuse, childhood experiences of violence, and issues of women's empowerment. The reviewed studies also gave substantial support to the identification of certain other risk factors, such as attitudes towards violence and gender, male abusers with multiple partners, non-marital cohabitation, low-quality relationships, several children, and social and geographic disadvantages. Each risk factor is discussed below along with an outline of its supporting evidence and theoretical grounding.

### Alcohol Abuse

Both the WHO Multi-Country Study[1] and the DHS analysis[2] found in all sites that women who reported experiencing IPV were more likely to report alcohol abuse by their partners. The World Safe Study found similar results in all sites, but El-Sheik Zayed and Santa Rosa.[3] The WHO Multi-Country Study further showed that the

# Chapter 2

# Assessing for Intimate Partner Violence

Amy Carney, NP, PhD, FAAFS

## Key Points

1. A large number of cases of intimate partner violence go undetected by health care professionals, often due to lack of training. Clinicians often also find it difficult to broach the subject of IPV with patients.
2. Intimate partner violence is prevalent among both men and women in the US and globally. Some studies have shown that in up to 50% of cases, men are the victims of IPV.
3. Early indicators of intimate partner violence perpetration include substance abuse and childhood exposure to abuse.
4. Re-victimization is a serious risk for those who have experienced IPV. Women are more at risk immediately following separation from their partner. A study has shown that in about two-thirds of cases, women are able to accurately predict their risk for repeat abuse.
5. Questionnaires and other assessment tools are available for clinicians to guide assessment of IPV. In 2006, the Centers for Disease Control and Prevention published a list of over 20 such tools.

## Introduction

Intimate partner violence occurs across all cultural and socioeconomic levels and age brackets; it is both global and local. Assessing for possible interpersonal violence can be intimidating for even the most seasoned professional, but knowing what questions to ask and when can make the difference in getting the best care for a victim of violence. The diversity in types of violence and type of aggressor make assessing for intimate partner violence (IPV) challenging. This chapter will address assessment for interpersonal violence, examine behavioral indicators of violence in personal relationships, and offer suggestions on reaching out to victims of interpersonal violence.

## Background and Scope of IPV

A large number of cases of IPV go undetected and unreported by clinicians and other professionals. Barriers include lack of education on what to look for and how to convey those findings to the appropriate agency. Experiencing discomfort while asking a possible victim of violence questions, is a hurdle for many.[1] Another difficulty is understanding what constitutes "screening" and what is meant by "assessment." While screening someone for IPV might include general questions at a routine visit, identification of possible signs of abuse warrant a thorough assessment. Knowing these signs and their consequences can aid in asking sensitive and relevant questions, evaluating the victim's physical and emotional needs, and moving them to a place of safety.[2]

It is evident that intimate partner violence is a serious problem in the United States. The National Center for Injury Prevention and Control at the Centers for Disease Control has stated that each year more than 12 million women and men are victims of rape, physical violence, and stalking. In 2007, IPV resulted in 2340 deaths, most of whom were female. The number of cases is estimated to be much higher as IPV often goes unreported for fear of not being believed or fear that law enforcement cannot help.[3] The impact of IPV can also be seen globally: the World Health Organization (WHO) reported in a study of over 24 000 women in 10 countries with both urban and rural settings that up to 71% reported physical and sexual abuse by a partner.[4] Costs for mental health services, medical treatment, and lost productivity associated with IPV continue to rise. The ability to detect and assess for IPV is necessary for both the immediate safety of the victim of violence and to prevent future recurrence.

Many organizations, including the American Nurses Association (ANA) and the American Medical Association (AMA), have taken strong stands in the fight against intimate partner violence. In 'Social Causes and Health Care' the ANA says, "There is a critical need for attention to and increased awareness of the problems of violence against women by all healthcare providers in order to reduce immediate and long term physical and psychological injuries associated with this crime."[5] The AMA notes that "Interpersonal violence and abuse were once thought to primarily affect specific high-risk patient populations, but it is now understood that all patients may be at risk."[6] The Academy on Violence and Abuse has developed a set of interdisciplinary competencies arranged in three levels of responsibility: health system competencies, institutional competencies for academic institutions and training programs, and individual learner competencies. The authors note that these are meant to be a common starting point for both professional societies and academic institutions in various disciplines to develop specific criteria concerning the skills, knowledge and attitudes needed to deal with violence and abuse.[7]

Multiple approaches to assessment can be found in the literature on IPV. In 2006, the California Department of Health Services issued the paper California Statewide Policy Recommendations for the Prevention of Violence Against Women. This document detailed an approach to IPV that advocated making violence against women a community responsibility rather than a "woman's problem." By approaching IPV as a human rights issue, a wider range of approaches can be used, broadening the focus from solely the victim to a public health basis across multiple fields and inter-disciplinary groups. Recommendations included a state-wide campaign to shift social norms to reflect that violence against women is not tolerated in this society; to articulate violence against women as a threat to public safety; to establish programs in school to support a violence-free society; and to identify and institute core competencies and resources across disciplines to sustain identification, prevention, and intervention on violence against women and girls. Assessment needs to be addressed as a coordinated effort across the spectrum of services with education and training for all levels of staff as well as lay people who may be the first to see signs of abuse.[8]

Violence against men by female partners is receiving more attention since it was first noted in the 1970s (see **Table 2-1**). Studies have indicated that at least 12% of men are the targets of physical aggression from female partners, with many being victims of severe violence. Population-based studies show up to 50% of victims of interpersonal violence are men. Psychological aggression, such as being threatened, being sworn at, or being insulted, affects a large percentage of men. While men are more likely to use more violent means of aggression, such as physically restraining or strangling their

**Table 2-1. Interpersonal Violence Legislation: A Brief Timeline**

| | |
|---|---|
| **1874** | The New York Society for the Prevention of Cruelty to Children is founded: world's first child protection agency |
| **1909** | First White House Conference on the Care of Dependent Children |
| **1911** | First Family Court created in Buffalo, New York |
| **1919** | 19th Amendment to the U.S. Constitution is passed, giving American women the right to vote. |
| **1940s** | In response to World War II, women move out of the home and into the workforce. |
| **1960s-1970s** | The Feminist Movement grows and takes shape, giving rise to the Battered Women's Movement. |
| **1965** | Congress begins passing laws prohibiting discrimination against women in the workplace and requiring equal pay for equal work. |
| **1981** | Duluth, Minnesota: the Duluth Model: The Duluth Domestic Abuse Intervention Project becomes the first multi-disciplinary program designed to address the issue of domestic violence. |
| **1990** | Stalking identified as a crime |
| **1994** | Congress passes the Violence Against Women Act. |
| **2000** | Congress re-authorizes the Violence Against Women Act. |
| **2002** | The Institute of Medicine issues the report *Confronting Chronic Neglect* citing the lack of adequate training of health care professionals who it states have an ethical responsibility to recognize and address exposure to abuse in patients. |
| **2005** | The Violence Against Women Act again re-authorized by Congress |
| **2011** | The Family Violence Prevention Fund, founded in 1980, changes its name to Futures Without Violence. |

partners, no gender differences were shown when the perpetrator slapped, punched, or stabbed the victim. Injury rates were also consistent for abrasions, broken bones, and broken teeth. Social service and criminal justice agencies are often unsure how to proceed when the victim is male.[9] One of the problems in assessing the prevalence of male victims includes men being unwilling to admit they are being abused and to seek professional help. In some cases, men who reported being physically assaulted were arrested or threatened with arrest, in effect blaming the victim.[10] Further complicating the assessment picture is the unfortunate fact that, although there are multiple tools for assessment of violence, most have been developed and tested for evaluation of violence against women and only with heterosexual samples.[11]

# Chapter 3

# Risk Assessment in Intimate Partner Violence

Catherine Mortiere, PhD

## Key Points

1. The high prevalence of intimate partner violence (IPV) underlines the need for a valid and systematic means of evaluating domestic violence cases. It is critical that we identify those cases most likely to escalate, ultimately to lethality.
2. The Danger Assessment (DA) tool is an effective tool used to assess the level of danger being experienced in IPV. This instrument has been revised since its original development. There are various other screening tools that are also viewed as effective.
3. Risk assessment is performed by many people in the justice, advocacy, and healthcare sectors, including law enforcement officers, probation officers, parole officers, psychiatrists and psychologists, social workers, and emergency room employees. Competent risk assessment requires education and training, although many who perform risk assessments lack such training.
4. The use of standard assessment instruments in combination with clinical interviewing is necessary for optimal risk assessment.
5. Law enforcement officers have adapted the DA for a more rapid response in domestic violence situations they encounter. This tool is known as the Lethality Assessment (LA).

## Introduction

The United States Department of Justice's Bureau of Justice Statistics (BJS) reported that between 2001 and 2005, females were more likely than males to experience nonfatal intimate partner violence (IPV).[1] The annual average was 510 970 incidents for non-fatal female victims of IPV. This represented 22% of the total non-fatal, violent victimizations against females. During the same period, there was an average of 104 820 male victims of IPV, representing 4% of total non-fatal, violent victimization. Of the victims, 96% of females were victimized by their male partners and 82% of males by their female partners. Thirty percent of all female homicides (femicides) committed by intimate partners, as reported by BJS.[1] From 2001 to 2005 the number of these homicides remained relatively constant, with statistics for 2005 showing 1100 murdered females. Male intimate partner homicides were relatively low at 5%. What is no surprise is the rate of male IPV which goes unreported. The BJS study indicated that 40% of male and 22% of female victims stated that their reason for not reporting the violence was "private" or "a personal matter." These statistics emphasize the need for valid, systematic means of evaluating domestic violence cases and identifying those most likely to escalate, ultimately to lethality.

Using a combination of research-based standardized instruments and clinical judgment, experts attempt to predict a level of risk in IPV. In order to prevent IPV, risk assessments

are performed in a variety of settings. Professionals, including police, probation and parole officers, healthcare providers and emergency room staff, social workers, judges, and shelter workers, estimate the level of risk that an abuser will commit further acts of violence against a partner. In some settings this may be done through a brief screening process, such as when a police officer responds to a domestic disturbance call and asks key questions before deciding how to proceed. In other settings, experts in the area of risk assessment conduct comprehensive risk analyses. This is accomplished by lengthy interviewing, careful administration of risk assessment instruments, and reviewing documentation before offering an opinion as to a particular level of risk, within a reasonable degree of medical or psychological certainty. Determining the level of risk may also dictate what course of action is appropriate, for example that discharge to the community is or is not consistent with the safety and protection of the public, that treatment is necessary, or that supervision is mandatory.

In IPV murder cases, most victims had contact with agencies that may have been able to predict and prevent those tragedies.[2] When taking a retrospective look at cases, professionals often are able to see some kind of a sign that was ignored, not seen in context, or misunderstood at the time. There are also times when the victims themselves refuse to be persuaded to take action in order to escape a dangerous situation.

Inherent in risk assessment is a profound responsibility. If one underestimates the level of dangerousness of an IPV perpetrator, it is possible that a victim may be hurt, or possibly killed. On the other hand, if one errs too much on the side of caution, the rights of accused perpetrators may be violated and a false-positive may also have an adverse effect on the family. Furthermore, a disproportionate response may make a victim reluctant to seek help in the future. Many times, victims of IPV fail to realize the level of danger in their situation. Through the process of interviewing in risk assessment, victims may be able to view their situation more clearly, and possibly become convinced that they need to leave their home or relationship and seek shelter.[3,4]

It is a matter of tremendous importance that professionals perform risk assessments with great care. The choice of risk assessment instruments with the highest degree of validity and reliability is vital to accurately identifying high-risk offenders. Furthermore, researchers must continue to study and refine the process of risk assessment, in order to improve its predictability.

## History of Assessing for Risk of Violence in IPV

Public attitudes towards IPV have changed drastically over the past few decades. In the past, domestic violence was viewed as a family problem. Police responding to calls for help from victims often hesitated to make an arrest, even when there was evidence of abuse. The only risk assessment performed was the result of the subjective judgment of a police officer or social worker responding to the scene. He or she would decide whether or not the abuse warranted arrest, or if the abuser was likely to hurt the victim again.

In 1986, nurse and researcher Jacquelyn Campbell, working with battered women, shelter workers, police, and psychologists, developed the Danger Assessment (DA), to help determine the likelihood that a woman will be killed by her intimate partner.[5] Since that time, the DA has been revised, and several other risk assessment instruments have been developed by other researchers. That was one of the first research projects that actually had an impact on educating the public, mostly the victims of IPV, about the seriousness of this issue.

Among the factors contributing to the evolution of both public attitudes and the official response to IPV was the OJ Simpson murder trial in 1994. Nicole Brown Simpson was

found murdered in her home, along with her friend Ronald Goldman. Several times prior to the murder, Nicole had told both friends and police that she believed her ex-husband, former football star OJ Simpson, would kill her. Her sister had even taken pictures of bruises she allegedly incurred during beatings by her husband. Although at trial Simpson was acquitted, the case drew public attention to the fact that domestic violence is a serious crime, not merely a family problem.

The Simpson case also served as a turning point for police response to domestic violence calls. Since that time, police officers' discretionary assessment has been restricted when responding to domestic violence scenes. Previously, an officer would assess the risk of IPV, and decide whether or not to arrest the accused perpetrator, often asking the aggressor to leave the home for a cooling-off period. After the Simpson trial, it became standard practice for police to arrest perpetrators of domestic violence even if the victim recants her or his story or asks the police not to make an arrest. Prosecutors will charge the perpetrator even if the victim changes her (or his) story or does not wish to prosecute.[6]

The response to IPV has changed in a number of areas since the early 1990s, including the criminal justice system, social services, and health care. Law enforcement and officers of the court now receive training in domestic violence, special domestic violence courts have been set up to hear IPV cases, and hospital emergency departments routinely screen patients for IPV. The prevalence of this form of violence has necessitated some sort of triage, especially in the criminal justice system, and this need has driven the development of risk assessment tools specific to this problem. Although the combination of scores on a risk assessment instrument, in addition to clinicians' judgment, yield a more accurate evaluation of risk than was possible twenty years ago, risk assessment remains an inexact science.

Victims of IPV often have the information experts need to formulate a risk profile, such as specific things the perpetrator has said and done in the past that led to previous violence, indications of the perpetrator's current state of mind and things the perpetrator has said or done which may be threatening in the present, but the victims are not always able or willing to access or provide such information. There are psychological reasons why a victim of IPV may or may not have the ability to communicate this information to appropriate parties, including trauma, shock, fear, denial, privacy concerns, and resistance to outside help. Therefore, one of the most important tools used in risk analysis is sound clinical interviewing; in other words, asking the questions that take into account a victim's limitations. This requires skill and experience in getting the information necessary to form an opinion on the risk of violence.

## Who Performs Risk Assessment?

As outlined in **Table 3-1**, a variety of people in different roles and settings are put in the position of performing some type of assessment for risk of violence. Competent risk assessment requires specialized expertise combining the use of standardized instruments with clinical interviews and information gathered from collateral sources. Unfortunately, not everyone who performs risk assessment has been adequately trained to do so. In particular, the proper and proficient use of standardized instruments in risk analysis requires education and training. A layman cannot be expected to fill out a questionnaire or administer a psychological test and to reach an expert, clinical opinion on level of risk. Scores from these sources are meant to guide experts along with clinical interviewing and information from collateral sources. Adequate training is required in order to reach level of expertise similar to an expert professional.

**Table 3-1. Assessors and Calls for Assessment**

| Who performs risk assessment? | When is risk assessment performed? |
|---|---|
| **Law enforcement officers** | When responding to reports of domestic violence, officers must decide what course of action is appropriate, taking into account their departmental policies, once they have assessed the level of risk for violence from information available at the scene. |
| **Probation officers** | When designating terms of probation, such as where probation will be served and what restrictions will be placed on the defendant with whom the perpetrator will be allowed contact duration of probation and boundaries of reporting. |
| **Parole officers** | When supervising incarcerated offenders released prior to serving their full sentences. |
| **Psychologists and psychiatrists** | When determining whether someone poses a risk to him- or herself or others. This is standard throughout the United States when committing a person to in-patient psychiatric treatment and in some states when an offender is soon to be released to the community. |
| **Social workers** | When monitoring troubled families. Monitoring by social workers can be mandated by courts and Child Protective Services. |
| **Shelter workers** | When a woman living in a shelter considers going home or integrating back into a relationship with her aggressor. Shelter employees assume responsibility to discuss risk factors with those willing to re-join their families or move back into the family home. |
| **Colleges and other educational settings** | When a student exhibits threatening or violent behavior |
| **Emergency room employees** | When treating victims for injuries sustained in domestic conflicts. Where a minor or other incapacitated person is involved, a determination must be made whether or not there is further risk for harm, and if the health care workers perceive a risk, they must report it to legal authorities. |

*(continued)*

# Chapter 4

# General Indicators of IPV in Women's Health

Karyn E. Holt, PhD, RN, CNM
Margit B. Gerardi, PhD, RN, WHNP

## Key Points:

1. Intimate partner violence is a serious public health problem, concerning all of us and affecting many of us, which is preventable.
2. The goal is to stop IPV before it begins. This chapter identifies numerous identifiers and risk factors to assist.
3. Identify physical, emotional, and psychological violence and their impact on relationships.
4. Recognize risk factors for and consequences of IPV in women.
5. Identify evidence-based screening tools in use as medical screening.

## Introduction

Intimate partner violence manifests as four types of behaviors: physical violence, sexual violence, threats of physical or sexual violence, and emotional abuse. The Centers for Disease Control and Prevention (CDC)[1] uses the following definitions for these behaviors, and, in an effort to standardize definitions, this chapter will use those CDC definitions:

— *Physical violence* is the intentional use of physical force with the potential for causing death, disability, injury, or harm.

— *Sexual violence* is defined as a deliberate or threatened action or behavior of sexual aggression directed toward a person by another individual with an intention to control, humiliate, or harm. Threats of physical or sexual violence use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.[1]

— *Psychological/emotional violence* involves trauma to the victim caused by acts, threats of acts, or coercive tactics.[1]

Oftentimes, psychological or emotional violence is the beginning of a continuum of behaviors that commence with relational tensing progressing to emotional mistreatment, escalating to battering, and further progressing to violence. The absence of caring and respectful partner behaviors is just as powerful in creating an emotionally abusive experience as openly abusive behaviors.[2] Emotional abuse is a dynamic event, encompassing multiple culminations, secondary physical and mental health symptoms, and quality of life issues that extended well beyond the immediate abuse experience. Cooley-Strickland et al[2] found that those who have experienced or witnessed IPV are more likely rather than reject to accept IPV, because of its familiarity.[2]

Those who provide health care services in hospital and outpatient settings commonly see women in their practices who have experienced or are currently experiencing intimate partner violence (IPV). The World Health Organization (WHO) Multi-Country Study of Women's Health and Domestic Violence Against Women reports a lifetime prevalence of IPV in the United States of 25-60%.[3,4] The Department of Justice[5] estimates there are 960 000 to 3 million incidents of violence per year including physical abuse from husbands or boyfriends to violence against current or former spouses, boyfriends, and girlfriends. Intimate partner violence crosses socioeconomic strata, ethnic groups, and opposite as well as same-sex relationships. It occurs in every culture, race, and nation, regardless of economic and social status, education, or religious preference. According to Gunter,[6] IPV is the most common cause of nonfatal injury to women.

The CDC reports that about 4.8 million women experienced physical assault or rape related to IPV in 2009, while only 2.9 million men experienced IPV.[4] Intimate partner homicide victims are 78% female and only 22% male.[5] Puzone et al[7] reports that in the US, 1 in 3 female homicides are a result of intimate partner violence, while only 1 in 20 male homicides are a result of intimate partner violence. Oregon reports that between 1997 and 2001, 50% of in-state female homicides (151) were murdered by intimate partners, whereas only 4% of in-state male homicides were murdered by intimate partners between 1997 and 2001.[8] Homicides are the second leading cause of death in 15-24 year olds and the third leading cause of death in 25-34 year olds in the United States.[1] Women aged 20-24 are at highest risk for nonfatal intimate partner violence.[9,10] While these figures are significant, it is even more alarming to realize these rates may be underestimated, as many victims do not report incidences of IPV to the police, to family, or even to health care providers.[4]

Stalking is often included among types of IPV. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property."[11,12] In the United States 503 485 women are stalked annually by intimate partners.[4] IPV takes many forms and familiarity with each one is necessary in order to identify and assess the violence and assist the victims.

Both women and men suffer and perpetrate IPV; however, 85% of victims of IPV are women, while men make up the other 15% of victims.[5] Women who perpetrate violence as teens or young adults often have childhood experiences of violence. DiNapoli[13] notes that for some girls, the strongest predictor of committing future violence is their experience of past victimization and violence. In essence, victimized girls may perpetuate the cycle of abuse. When women engage in IPV, it often occurs as a reciprocal event in an argument or self-protection in the context of victimization.[14] Furthermore, Kelly and Johnson[15] note female IPV usually manifests in ***situational couple violence*** versus ***coercive controlling violence*** more commonly exhibited by male abusers. This chapter will address women as victims of IPV, not as perpetrators.

## Practitioner Impact on IPV

Health care practitioners, such as nurses, nurse practitioners, physicians' assistants, and physicians, specifically providing care to women can make a difference through early assessment of and intervention on behalf of patients and families affected by intimate partner violence. Often a woman's only visit for health services may be for her yearly well-woman examination and periodic screening. These visits offer opportunities for assessment and individualized discussion about IPV; however, almost half of the victims of intimate partner femicide

were seen in health care settings in the year preceding their death[16] but went undetected as victims of abuse. Two hundred and ninety women in prenatal health care clinics were asked if they were assessed for IPV at their last prenatal visit and they unanimously reported they had not been assessed. Within this group, 36% had been battered with slaps, kicks, punches, and choking.[17] Health care providers need to increase their comfort level with assessment of IPV and their ability to safely advise and appropriately refer in such situations.

IPV assessment can be defined as assessing clients for harm or risk for harm in their intimate relationships.[18] Health care practitioners must be vigilant, ready to pick up on both subtle and overt cues of victimization, and take advantage of identification and assessment instruments to help target those in need. Two common tools for assessment and intervention easily incorporated into clinic visits are the RACE tool for identification and assessment and Campbell's Danger Assessment.[19]

## Theoretical Framework

The ***socio-ecological model*** offers health care practitioners and others a means to see the "gestalt" when considering important individual aspects that influence violence in the lives of women and their families (see **Figure 4-1**). The Centers for Disease Control (CDC) and many other organizations and individuals have adopted the socio-ecological model as the framework to understand and target interventions toward preventing violence in the United States.[20,21] The framework consists of multiple, interacting levels to understand the relationship between violence and potential prevention strategies.[22]

The first level of the socio-ecological model is personal or individual risk factors for violence, including an individual's unique psychological characteristics; physical factors, such as age, income, education, and substance abuse; and immediate physical setting, such as one's home (see **Figure 4-1**).[21] The second level examines close relationships that may also increase the risk for becoming either a perpetrator or a victim of IPV. These relationships may be with close friends, partners, or family members. Prevention strategies would be aimed at mentoring and peer prevention programs. The third level identifies neighborhoods, schools, or workplaces, locations where social relationships occur outside of family and close friendships. This could include interaction with health care, education, and social service providers.[23] Societal norms, strategies, and policies are affected at this level of impact. The fourth and last level is the societal level. Looking with a broader perspective, societal factors can create a climate that either repels or encourages intimate partner violence. Other factors evaluated at this level include educational, health, economic, and societal policies.

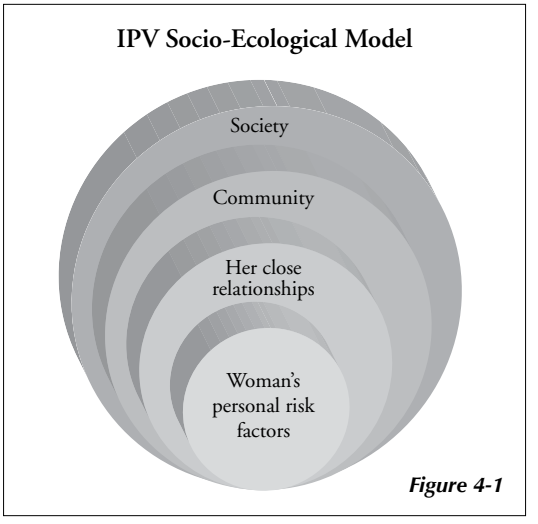


***Figure 4-1.*** *Gerardi model of intimate partner violence (adapted from Bronfenbrenner's Ecological Systems Theory).*

## Personal Risk Factors for Intimate Partner Violence

Many women in a partner relationship can be at risk for intimate partner violence, as the above statistics reveal. Risk factors for IPV are multifactorial. Although risk factors have been segregated into categories in this chapter, it is important to remember that factors from one level influence on all remaining levels in this conceptualization. When risk increases in one part of a woman's life, it can impact frequency and severity of intimate partner violence.

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