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.

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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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Foreword

Violence against women is pervasive. A pregnant woman in Pakistan is stoned to death by her family as an "honor killing," 2 girls in India are raped and hung, nearly 300 girls in Nigeria are kidnapped—all are recent examples of egregious, violent acts based on historic, cultural, social, and religious norms of gender inequality. Violence against women is a tragedy of personal, interpersonal, societal, generational, and global proportions, inflicting a vast impact, both economic and moral. Widely recognized as a fundamental human rights violation, this type of violence affects as many as 35% of women worldwide, many of whom experience the highest risk in their own home.[1]

As a newly minted emergency medicine physician in 1980, I had solidified my desire to be on the front lines in caring for people from diverse walks of life. I was prepared to render care and relieve suffering from a variety of health concerns, including forms of inflicted violence. I was given the unique privilege to provide medical direction for what was then known as the Rape Crisis Program at Saint Luke's Hospital in Kansas City, Missouri. Established in 1974, this was the first private sexual assault program in the country.[2-4] I did not realize at the time, but I was embarking on a career-altering shift into the emotionally-charged realm of combatting violence against women and helping to establish a new specialty: clinical forensic medicine. This specialty applies medical forensic knowledge to living patients.[5,6] William Smock, MD, MS, FACEP, FAAEM was the first to complete a clinical forensic medicine fellowship in the United States.[7]

The concept that violence is a public health issue, which we in the health care professions have a responsibility to address, has yet to be fully adopted. After the leading causes of death shifted mid-century from infectious diseases to violence, the Centers for Disease Control and Prevention (CDC) established the Violence Epidemiology Branch and the Division of Injury Epidemiology and Control. In 1985, one of my mentors, US Surgeon General C. Everett Koop, MD, articulated the challenge:[8]

> Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, [we] . . . have deferred to the criminal justice system. Over the years we have tacitly and, I believe, mistakenly agreed that violence was the exclusive province of the police, the courts, and the penal system. To be sure, those agents of public safety and justice have served us well. But when we ask them to concentrate more on the prevention of violence and to provide additional service for victims, we may begin to burden the criminal justice system beyond reason. At that point, the professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue and one that profoundly affects the public health.[9]

Historically, criminal justice professionals have borne the responsibility "to protect the public" and serve the community, primarily by removing from society persons who demonstrate violent behavior, typically after they have committed a crime. Now, doctors, nurses, and social service professionals realize that we also bear a responsibility: "to prevent harm to the public" from violent behavior or disease by implementing interventions that reduce or eliminate risk factors and increase protection. This distinction suggests a profound shift not only in roles and responsibilities but in models and tools for addressing violence. The public health approach is collaborative; it engages criminal justice, health care, education, and social services. Moreover, this approach is grounded in data. This data encompasses a 360-degree view of all types and severity levels of violence, eg, minor trauma, psychological violence, threats of violence, and neglect or deprivation. Historically, in most areas, the collection of violence-related injury data is segregated and reflects a mere tip of the injury iceberg. Victims of violence that results in fatal injury present through the criminal justice system. Victims of significant violence, both fatal and non-fatal, enter the health care system through the

doors of emergency departments. The health care data, although rich regarding types of injury and circumstances, usually captures little information about perpetrators, which is necessary for prevention strategies. The emerging sub-specialty of clinical forensic medicine integrates the public health model with criminal justice practices. As emergency departments implement forensic medicine concepts, the increased use of injury surveillance tools will provide victim-perpetrator relationship insight and will yield more accurate epidemiologic data surrounding these events.

The World Health Organization[10] defines violence as "[t]he intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, physiological harm, mal-development, or deprivation." Based on this definition, a typology has developed, dividing the concept of violence into 3 categories: self-directed, interpersonal, or collective.[11] Interpersonal violence, that is, violence that involves the family or community, is sub-classified into child, intimate partner, and elderly. The CDC defines the distinct sub-category of intimate partner violence (IPV) as "physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy."[12]

IPV affects both females and males; however, most IPV is directed against women, affecting 1.3 to 5.3 million women annually in the United States.[13] The 2010 National Intimate Partner and Sexual Violence Survey found that over their lifetimes, 24.3% of women experience severe physical violence by an intimate partner; 18.3% are raped, with 9.4% being raped by an intimate partner; nearly 17% experience non-rape sexual violence by an intimate partner; and 48% experience psychological aggression by an intimate partner.[14] The highest prevalence of physical violence, rape, and stalking occurs among multiracial groups, and Native Americans experience sexual assault and rape at a rate more than double that of other racial groups.[15] These behaviors also tend to be generational. Forty-five percent to 70% of children exposed to domestic violence become physical abuse victims,[16] and the strongest risk factor for parental violence toward children is childhood exposure to a father who abuses the child's mother.[17]

The year 2014 marks the 20-year anniversary of the Violence Against Women Act (VAWA). This landmark legislation mandates the collaboration between the criminal justice system and health care that Dr. Koop championed decades ago. Between 1993, when the VAWA was first authorized, and 2008, the rate of IPV decreased by 53%. New provisions of the VAWA 2013 now address violence against Native American women, after an Oklahoma study found that 82.7% of their 422 subjects had experienced IPV or physical violence in their lifetime.[18] Indeed, the murder rate on some reservations is more than 10 times the national average.[19] The VAWA also addresses lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues, being as studies find that nearly 44% of lesbian women and 61% of bisexual women report IPV, compared to 35% of women who identify as heterosexual.[20]

Offering a comprehensive review, this book seeks to sharpen the reader's focus on and understanding of violence against women and illuminate the multifaceted issues of IPV. The target audiences are health care professionals, law enforcement officials, advocacy personnel, those teaching at the university level, and those beginning their journey into this domain. The authors and contributors—physicians, nurses, district attorneys and lawyers, professors, psychiatric researchers, and domestic violence program directors and board members—are subject matter experts, sharing their considerable knowledge from diverse disciplines. The content is well-organized. The initial chapters discuss IPV assessment, risk factors, effects on women's health, and risk reduction. Subsequent

chapters examine criminal justice aspects, including orders of protection; aspects of prosecution; and promising practices to decrease the incidences of IPV, including safety planning. The closing chapters explore specific areas of IPV, such as strangulation, stalking, sex-related homicide, child maltreatment, pregnancy, LGBTQ, and military aspects. Each chapter begins with well-referenced key points, and the text incorporates multiple tables, graphs, and figures to visually convey key concepts, some of which are also explored through case studies.

This excellent book reflects in its construct the public health collaborative model that Dr. Koop envisioned. Similarly, Saint Luke's Hospital has become one of the first programs to expand this model beyond sexual assault to address general trauma, domestic violence, and child and elder abuse.

In an increasingly global society, we in the health care professions have a moral obligation to break the cycle of violence against women whenever and wherever it occurs; to bring to bear those tools that fundamentally change the way in which women are viewed, valued, and treated; and to embrace the energies and benefits that women bring to humanity. Those of you who are engaged and dedicated to this work are to be commended, and you will find this book a powerful tool and an essential resource to carry with you as you face the challenges ahead in decreasing the incidence and prevalence of IPV in the US and throughout the world.

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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.

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