

CHAPTER 86

Family and Sexual Violence: Nursing and U.S. Policy

“If the numbers we see in domestic violence were applied to terrorism or gang violence, the entire country would be up in arms, and it would be the lead story on the news every night.”

Rep. Mark Green, Wisconsin

Our society is steeped in violence. In the most recent national statistics, more than 26 per 1000 people aged 12 years or older will be the victims of a violent crime (Truman, Langton, & Planty, 2013). Most of our violence prevention strategies prepare potential victims to ward off violent attacks from strangers; yet, someone known to the victim perpetrates most violence against women, children, and older adults. The intimate nature of this violence, often perpetrated behind closed doors, has made these forms of violence less visible. However, the toll of violence on individuals and societies is substantial. The World Health Organization has framed violence as a significant public health problem (Truman, Langton, & Planty, 2013). A public health approach suggests an interdisciplinary, science-based approach with an emphasis on prevention. Effective strategies draw on resources in many fields, including nursing, medicine, criminal justice, epidemiology, and other social scientists.

The purpose of this chapter is to provide an overview of state, federal, and health sector policies regarding violence against women in the United States, briefly discuss policies related to violence against children and older adults, and outline the resulting implications for nurses and directions for future work.

INTIMATE PARTNER AND SEXUAL VIOLENCE AGAINST WOMEN

Intimate partner violence (IPV) is physical, sexual, or psychological harm inflicted by a current or former partner (same sex or not) or a current or former spouse (Black et al., 2011). Almost one third of American women experience being hit, slapped, or pushed by an intimate partner, and nearly a quarter will experience serious forms of IPV during their lifetimes. Additionally, nearly one in five women will experience a completed or attempted rape in their lifetimes. Men experience IPV and rape as well, although at far lower rates than do women. About a quarter of men will experience IPV (about 12% serious forms of violence) and nearly 1.5% a completed or attempted rape. Although more than half of women reporting rape report that the assailant was an intimate partner and 40% that the assailant was an acquaintance, men report that half of rapes were by acquaintances and 15% by strangers; the number raped by an intimate partner was too small to estimate.

The health effects of IPV and sexual violence are substantial and cost as much as \$8.3 billion in health care and mental health services for victims (Max et al., 2004). Violence is associated with a wide range of health problems, including chronic pain recurring central nervous system symptoms, vaginal and sexually transmitted infections and other gynecological symptoms, and diagnosed gastrointestinal symptoms and disorders (Black et al., 2011). Mental health symptoms include depression.

anxiety, posttraumatic stress disorder, and alcohol and drug use (Black et al., 2011; Campbell, 2002).

STATE LAWS REGARDING INTIMATE PARTNER AND SEXUAL VIOLENCE

State laws address a number of issues important for nurses to understand. Most often, crime of IPV and sexual violence are addressed through state laws. Most, although not all, states have laws specifically providing enhanced penalties for assault and battery that occurs between intimate partners. (It worth noting that most laws refer to domestic violence or family abuse rather than IPV.) For example, at least 23 states have some form of mandatory arrest for IPV (Hirschel, 2008). Research findings are mixed on whether mandatory arrest laws reduce reassault (Felson, Ackerman, & Gallagher, 2005; Hirschel et al., 2007), although findings from at least one study suggest that the overwhelming majority of victims support mandatory arrest laws (Barata & Schneider, 2004). Additionally, states may have enhanced penalties, such as escalating third offenses to felonies.

Until 1975, all states provided what is called the marital rape exemption under which it was legally impossible to commit rape against one's wife. Beginning in the mid-1970s, based in part on nursing research, these laws began to change (Campbell & Alford, 1989). Although all states now recognize marital rape as a crime, in some states it is still treated differently from rape by a nonspouse (Prachar, 2010).

Nonlethal strangulation of women is a significant but often overlooked threat to public safety. Most (80%) strangulations of women are committed by intimate partners (Shields et al., 2010). They can result in significant physical health problems for victims (Taliaferro et al., 2009) and substantially increase risk of later lethal violence (Glass et al., 2008). These cases can be difficult to charge and prosecute commensurate with the severity of the crime (Laughon, Glass, & Worrell, 2009); therefore, a growing number of states have strengthened laws related to strangulation.

All states provide for civil protective orders in cases where victims have a reasonable fear of

violence from an assailant (Carroll, 2007). States vary widely, however, in who is eligible to obtain an order and how the orders are obtained. For example, in some states minors or dating partners may not be able to obtain orders of protection. Most states provide for civil protection orders against assailants who are accused of sexual assault, but the procedures may be different from those for protective orders against intimate partners. Studies of the effectiveness of these orders are mixed (Logan & Walker, 2009; Prachar, 2010).

In addition to these criminal justice remedies, state laws may address other issues related to IPV and sexual violence. As of 2010, 26 states had established intimate partner fatality review teams (Durborow et al., 2010). Fatality review teams use a multidisciplinary, public health approach to reviewing fatalities and identifying risk factors (Websdale, 1999). A handful of states require health care providers to report domestic violence against competent adults. It is important to understand that in most states, IPV and sexual assault are not mandatory reports unless there are other factors present.

FEDERAL LAWS RELATED TO INTIMATE PARTNER AND SEXUAL VIOLENCE

There are two significant federal laws that address violence against women. The Family Violence Prevention and Services Act was first authorized in 1984. It was most recently authorized through 2015 (Public Law [PL] 111-320 42 U.S.C. 10401, et seq.). It is the primary federal funding source for domestic violence shelters and service programs in the United States. It also funds the work of state coalitions on domestic violence, community-based violence prevention efforts, and a number of smaller training and assistance programs.

The Violence against Women Act (VAWA) was first authorized in 1994 (Title IV, sec. 40001-40703 of the Violent Crime Control and Law Enforcement Act of 1994, HR 3355, signed as PL 103-322). As states began creating the protective order and criminal statutes discussed earlier, the limitations of this patchwork of remedies became apparent.

The VAWA was therefore created to address the gaps in state laws; create federal laws against domestic violence, including protection for immigrant women and enhanced gun control provisions; and fund a variety of violence-related training and other local programs (Valente et al., 2009). The law originally included a provision making crime motivated by gender a civil rights offense. This provision was, however, found unconstitutional in 2000 (*Brzonkala v. Morrison*, 2000).

The VAWA represented a significant turning point in public policy related to violence against women. Previously, women who received a protective order might find that violations that occurred in other states could not be enforced. The full faith and credit provision of the VAWA requires that protective orders be recognized and enforced across jurisdictional, state, and tribal boundaries within the United States. Likewise, by creating federal crimes of domestic violence and stalking, criminal acts that cross jurisdictional boundaries can now be more easily charged and prosecuted. Under the VAWA, it is illegal for individuals subject to certain types of protective orders or convicted of even misdemeanor domestic violence offenses to possess a firearm. Given that risk of intimate partner homicide increases dramatically when firearms are available to the assailant, this represents an important safeguard for women (Campbell et al., 2003). The VAWA addressed the significant hardships faced by both legal and illegal immigrant women experiencing abuse from their partners. The VAWA additionally funds a wide range of victim advocacy and training programs, with the goal of ensuring that victims of violence receive consistent, competent services in all communities.

Each subsequent renewal of the VAWA has strengthened these provisions. The latest renewal in 2013 expanded its definitions to explicitly include gay, lesbian, and transgender victims; expanded the safeguards available to women assaulted in tribal territories; expanded housing provisions to prohibit discrimination against victims of IPV in all forms of subsidized public housing; strengthened protections for immigrant women; and, for the first time, specifically addressed violence on college campuses (Violence against Women Act, 2013).

HEALTH POLICIES RELATED TO INTIMATE PARTNER AND SEXUAL VIOLENCE

As discussed earlier, the health consequences of violence are significant for women. Additionally, women who have experienced violence have significantly higher health care costs than women without a victimization history (Bonomi et al., 2009; National Center for Injury Prevention and Control, 2003). There is now a consensus that these health care settings offer a unique opportunity to identify and support women living with the effects of violence (Family Violence Prevention Fund, 2002; World Health Organization [WHO], 2013). The U.S. Preventative Services Taskforce recommends "clinicians screen women of childbearing age for IPV such as domestic violence, and provide or refer women who screen positive to intervention services." The Institute of Medicine identified screening and brief counseling for interpersonal violence as an essential and evidence-based practice necessary to ensure the well-being of women (National Research Council, 2011). A wide variety of medical and nursing professional organizations also recommend routine screening for violence (Amar et al., 2013). Significant evidence now exists for safety planning strategies to prevent homicide for women in abusive relationships. The Danger Assessment Instrument, for example, has been shown to have good predictive value and can assist women with making a realistic appraisal of their likelihood of experiencing lethal violence (Campbell, Webster, & Glass, 2008). Health care institutions should also have the appropriate capacity to provide care to women in the acute period after a physical or sexual assault (WHO, 2013).

Nurses and other health professionals have a role to play in community responses to violence. Many localities have created sexual assault response teams. These interdisciplinary teams work to ensure consistent, trauma-informed, and effective care for victims of sexual assault. Despite scant research on the effectiveness of these teams, they are a promising practice (Greenson & Campbell, 2013). Likewise, intimate partner/domestic violence fatality review teams review cases of intimate partner homicide with a public health approach. As with sexual assault

response teams, there are little data on the effectiveness of these teams that have also been labeled a promising practice (Wilson & Websdale, 2006).

CHILD MALTREATMENT

Child maltreatment includes physical, sexual, and emotional abuse, as well as neglect. Actual prevalence of maltreatment is unknown, but there are more than 3 million referrals for more than 6 million children to child protective agencies annually, with nearly a quarter of these cases substantiated. An estimated 1570 children nationally died from abuse or neglect in 2011 (Administration on Children, Youth, and Families Children's Bureau, 2011; U.S. Government Accountability Office, 2011), a number that is believed to be undercounted. The estimated annual cost of child abuse and neglect in the United States for 2008 was \$124 billion (Fang et al. 2012). Child maltreatment results in lifelong adverse physical and mental health consequences such as posttraumatic stress disorder, increased risk of chronic disease, lasting impacts or disability from physical injury, and reduced health-related quality of life (Corso et al. 2008).

STATE AND FEDERAL POLICIES RELATED TO CHILD MALTREATMENT

Because minors are considered to need additional protection as a result of their age, states not only have laws making the acts of abuse and neglect criminal offenses but also have laws requiring that certain adults must report suspected maltreatment to appropriate authorities. In some states, all adults are mandated reporters. In most states, specific professionals, teachers, health care professionals, social workers, law enforcement personnel, and others are mandated reporters (Child Welfare Information Gateway, 2011). At the federal level, the Child Abuse Prevention and Treatment Act (CAPTA) provides funding to states to support prevention, assessment, investigation, prosecution, and treatment activities related to child maltreatment and funding for research activities (Child Welfare Information Gateway, 2011, 2013).

HEALTH POLICIES RELATED TO CHILD MALTREATMENT

Children's Advocacy Centers coordinate investigation and intervention services for maltreated children by bringing together social work, legal, health care, and other professionals and agencies in a multidisciplinary team to create a child-focused approach to child abuse cases. Home visitation is another strategy that shows promise for improving child health and preventing child maltreatment (Avellar & Supplee, 2013).

OLDER ADULT MALTREATMENT

Best estimates indicate that 1 to 2 million Americans over the age of 65 years are abused, neglected, or exploited, most often by caregivers (National Center on Elder Abuse, 2005). Precise numbers are not available, attributable to differences in definitions of abuse, lack of a comprehensive national data system, and different state system reporting and data collection. Further, only a small fraction of abuse comes to the attention of Adult Protective Services (Dong & Simon, 2011). The U.S. aging population is rapidly increasing with projections for individuals 65 years and older to increase from 40.2 million in 2010 to 54.8 million in 2020 and to 72.1 million in 2030 (Dong & Simon, 2011). Legislation has been effective in bringing about reform.

STATE AND FEDERAL LEGISLATION RELATED TO OLDER ADULT MALTREATMENT

As with child maltreatment, state laws provide for criminal charges related to the abuse of older adults (the definition of which varies from state to state, but may be as young as 55 years of age). Most (but not all) states define certain individuals as mandated reporters of abuse of older adults as well. At the federal level, the Older American Act of 2006 developed and maintains the National Center on Elder Abuse, which provides funding for prevention activities, research, data collection, and long-term planning for elder justice. The Elder Justice Act (EJA) of 2010, which was part of the Patient

Protection and Affordable Care Act (2010), is the first comprehensive strategy to address older adult abuse, neglect, and exploitation. It is important to note that the authorized funding has not been appropriated at this time and that the EJA is set to expire in 2014. Funding for older adult maltreatment is significantly less than for other types of violence and a national database has yet to be established.

HEALTH CARE POLICIES RELATED TO OLDER ADULT MALTREATMENT

Recent efforts have focused on using the primary care setting to identify and respond to older adult abuse (Perel-Levin, 2008). Case management strategies can be effective in providing consistency in monitoring of adult patient and caregiver behavior (Choi & Mayer, 2000). Research on effective intervention strategies in this area lags behind that of other areas of violence and is an area where nursing can make an impact.

OPPORTUNITY FOR NURSING

Nurses have the skills and education to take a leadership role in addressing violence and abuse on multiple levels, as providers, researchers, policy analysts, educators, and advocates. Efforts to address violence against children, women, and older adults have met with impressive successes over the past decades. These forms of violence, seen as largely justifiable and perhaps even necessary in the past, are now recognized as both crimes and important public health problems. The evidence base for interventions to prevent these forms of violence, end them when they start, and mitigate the related health consequences is growing. It is clear, however, that we still have important gaps in our understanding of both effective violence interventions and policies. Although we work to address these gaps in knowledge, we can continue to move forward on numerous fronts. Educators should ensure that curriculums at all levels include content on violence and abuse. Given the high rates and significant health effects of violence, all nurses

should have basic clinical knowledge of how to assess for, competently respond to, and appropriately refer all patients with a history of violence or abuse. Nurses can serve as powerful advocates for victims of violence, ensuring that state and federal laws meet the highest standards.

Violence and crime unite two powerful systems, health care and criminal justice, and involve multiple professionals including physicians, nurses, social services, police, lawyers, and judges. Prevention and intervention strategies require efforts at the individual, community, institutional, and public policy levels. Nurses can have a significant voice in ensuring the best possible prevention and advocacy services at the local, state, and federal levels. Nursing research and the testimony of nurses has been foundational for federal and state laws and resulting public policy related to violence.

DISCUSSION QUESTIONS

1. Consider the differences in the treatment of violence across states and what federal provisions might be advantageous to address the discrepancies.
2. How might nursing research help to fill the gaps in the knowledge?
3. It is apparent in the chapter that different strategies exist for violence against women, child maltreatment, and older adult abuse. Could the same strategies work across populations and abuse types? What might be the advantages/disadvantages to having similar strategies?

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ONLINE RESOURCES

Child Welfare Information Gateway
www.childwelfare.gov
 Futures without Violence
www.futureswithoutviolence.org
 National Center on Elder Abuse
www.ncea.aoa.gov
 Rape, Abuse, and Incest National Network
www.rainn.org

