

Intimate Partner Violence

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Approved by the AWHONN Board of Directors, June 2001. Revised and reaffirmed as "Mandatory Reporting of Intimate Partner Violence," December 2007. Revised and reaffirmed as "Intimate Partner Violence," January 2015.

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Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other policies that require nurses to report the results of screening for intimate partner violence (IPV) to law enforcement or other regulatory agencies without the consent of the woman who experiences the IPV. Nurses and other health care professionals, however, should become familiar with laws on mandatory reporting in their states and comply as applicable.

Women should be universally screened for IPV in private, safe settings where health care is provided. Nurses are ideally positioned to screen for IPV for the purpose of initiating a referral for services and support when applicable. To protect the woman's safety, AWHONN supports policies that require a woman's consent before reporting occurs.

Background

Intimate partner violence, sometimes called domestic violence, is a serious, preventable public health problem. The term *intimate partner violence* is used to describe physical, sexual, or psychological harm done to an individual by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples (Centers for Disease Control and Prevention [CDC], 2014). Although IPV can occur against men, 85% of all IPV is directed toward women and perpetrated by male partners (Roark, 2010). It is estimated that more than one in three women in the United States have experienced rape, physical violence, or stalking by intimate partners in their lifetimes (Black et al., 2011). The true prevalence of IPV is difficult to determine because many survivors do not disclose their experiences.

Current and past experiences with IPV can have profound effects on women's physical and emotional health. In addition to the often visible injuries such as cuts, bruises, scratches, welts, and broken bones, researchers suggest that victims are

more likely to experience chronic medical conditions, including but not limited to irritable bowel syndrome, sexually transmitted infections, ulcers, eating disorders, arthritis, alcohol addiction and substance abuse, vaginal and urinary tract infections, depression, posttraumatic stress disorder, speech and language disorders, unintended pregnancies, and pregnancy complications. The longer the violence continues, the more serious the effects (Dudgeon & Evanson, 2014; Moats, Frederick, Edwards, & Files, 2014; Roark, 2010; Simmons & Scotese Baxter, 2010).

Intimate partner violence affects women of every age, race, ethnicity, and socioeconomic group. While all women are at some risk for IPV, specific populations are at greater risk or may have unique challenges in accessing IPV treatment and services. For example, pregnant women, especially those with unplanned pregnancies, are more likely to experience IPV than women who are not pregnant. Table 1 provides additional examples of special populations.

Screening Recommendations

Due to the numerous deleterious effects that IPV can have on physical and mental health, most experts agree that women should be screened for IPV. However specific recommendations vary based on age, health status, and frequency of screenings. Universal screening, which AWHONN supports, involves a standard assessment for all women, regardless of their age, reason for seeking medical care, health status, or history of IPV.

The Affordable Care Act addresses the issue of IPV in several important ways. First, it prohibits health insurance companies from denying coverage to survivors of IPV. Before this protection was in place, some states allowed insurers to deny coverage to survivors of IPV based on its classification as a pre-existing condition. Additionally, the law requires all new and non-grandfathered health insurance plans to cover screening and assessment for IPV at no cost.

Table 1: Special Populations at Risk for Intimate Partner Violence (IPV)

While IPV universally affects women, certain populations are at greater risk of experiencing IPV or may have specific challenges in accessing treatment and services. Access to affordable and acceptable health care services is a basic human right (AWHONN, 2008), and AWHONN supports programs that work to eliminate the barriers noted herein.

- *Pregnant Women.* Pregnant women, especially those who have unplanned pregnancies, are more likely to experience IPV than women who are not pregnant. A history of IPV can increase the risk of complications in pregnancy including low weight gain, anemia, infections, bleeding, maternal depression, and suicide attempts (Roark, 2010).
 - *Low-Income Women.* IPV is more prevalent in poor families than in middle- and high-income families. Poor women are less likely to have insurance or access to certain services, may be more isolated, are less likely to have the education and job experience necessary to be self-sufficient, and may stay in violent relationships for longer periods of time as a result (Hetling & Zhang, 2010).
 - *Rural Women.* Prevalence rates of IPV are roughly the same in rural in non-rural areas of the country. However, rural survivors face distinct barriers in obtaining help. The numbers of shelters, social services, and health care services are often limited in rural areas. Access to limited resources is further exacerbated by lack of public transportation and great geographic distances. Maintaining confidentiality in rural areas is another challenge, as rural health care providers and/or law enforcement agents may personally know or be related to the survivor or the perpetrator. Additionally, compared with urban women, rural women have reported greater barriers to obtaining protective orders and more violations of orders occur (Dudgeon & Evanson, 2014).
 - *Older Women.* Despite comparable rates of abuse among younger and older women, older women are often overlooked as victims of IPV and are not screened as often as their younger counterparts. Older women may be more likely to endure IPV for longer periods of time and are at risk for more sexual health consequences due to their possible lack of knowledge of safe sex practices, including how to appropriately use a condom or negotiate its use (Simmons & Scotese Baxter, 2010).
 - *American Indian and Alaska Native (AI/AN) Women Residing on Reservations.* AI/AN women have the greatest rates of IPV compared to all other groups. It is estimated that AI/AN women are 2.5 times more likely to be raped than other women; one in three AI/AN women will become the victim of rape or attempted rape in her lifetime (Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008; Perry, 2004). Furthermore, AI women residing on reservations are at increased risk for IPV and are more likely to be injured than women of any other ethnicity. Further, when they do report IPV, AI women face more legal barriers than other women.
 - *Veterans/Military Women.* Epidemiological data indicate a particular prevalence of IPV in military women and veterans (Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013). Cumulative trauma exposure may increase their risk for IPV, and complex symptom presentation may create additional screening barriers (Iverson et al., 2013). IPV is known to exacerbate mental health symptoms such as PTSD and substance abuse that are more common in female veteran patients (Iverson et al., 2013).
 - *Immigrant Women.* Language differences between health care providers and the women they serve may compromise efforts to screen for IPV. In some circumstances, the woman's translator may also be her abuser. For undocumented women, a lack of knowledge about the legal system and fear of deportation may further compound this effect.
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Mandatory Reporting Requirements

Some states have laws that require nurses and other health care professionals report incidents of IPV to law enforcement or other regulatory bodies. Many mandatory reporting laws for IPV are modeled on child abuse laws that reasonably assume that the child is unable to make an informed decision about self-protection. Abused women, as competent adults, should have the opportunity to determine their risk of additional violence and make their own decisions about their futures and their relationships with the abusers. Nurses play a

pivotal role in guiding and supporting women to make optimal decisions.

Mandatory reporting requirements threaten the confidentiality inherent in the relationship between health care professionals and their patients and may deter women from seeking needed medical attention or discussing abuse. Proponents of mandatory reporting of IPV claim that these requirements would ensure a process to hold offenders accountable, provide an improved tracking mechanism for IPV, and ultimately prevent

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