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The Role of Violence Against Women Act in Addressing Intimate Partner Violence: A Public Health Issue

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Abstract

Intimate partner violence (IPV) is defined as violence committed by a current or former boyfriend or girlfriend, spouse or ex-spouse. Each year, 1.3 to 5.3 million women in the United States experience IPV. The large number of individuals affected, the enormous healthcare costs, and the need for a multidisciplinary approach make IPV an important healthcare issue. The Violence Against Women Act (VAWA) addresses domestic violence, dating violence, sexual assault, and stalking. It emphasizes development of coordinated community care among law enforcement, prosecutors, victim services, and attorneys. VAWA was not reauthorized in 2012 because it lacked bipartisan support. VAWA 2013 contains much needed new provisions for Native Americans; lesbian, gay, bisexual, transgender, gay, and queer (LGBTQ) individuals; and victims of human trafficking but does not address the large amount of intimate partner violence in America's immigrant population. There are important remaining issues regarding intimate partner violence that need to be addressed by future legislation. This review examines the role of legislation and addresses proposals for helping victims of IPV.

Introduction

Intimate partner violence (IPV) is defined as violence committed by a current or former boyfriend, girlfriend, spouse, or ex-spouse. The definition of intimate partner violence endorsed by the World Health Organization is behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behavior.[1,2] Sexual/reproductive coercion is coercion by male partners to make female partners pregnant or to discontinue current pregnancy. Birth control sabotage is partner interference with contraception.[3] Although intimate partner violence affects both men and women, more women experience IPV, and most studies and interventions focus on female populations.[4] Accordingly, this paper will focus on intimate partner violence against women in the United States, with an emphasis on legislation related to this topic. This paper will focus on the Violence Against Women Act (VAWA) first introduced in 1994 and how it shapes the federal response to violence against women—in particular, the response to intimate partner violence. VAWA addresses domestic violence, dating violence, sexual assault, stalking, and human trafficking. The reauthorization process of VAWA every 5 years gives policymakers, special interest groups, and the general public time to reflect about the current need for legislation.

Background Information on Intimate Partner Violence

Each year, 1.3 to 5.3 million women in the United States experience IPV.[4] The 2010 National Intimate Partner and Sexual Violence Survey (NVAWS)[5] indicates that over a lifetime, 30% of women experience physical violence, 9% are raped, 17% experience sexual violence other than rape, and 48% experience psychological aggression. NVAWS reports that nearly 3 in 10 women have experienced stalking, rape, and/or physical violence by an intimate partner.[5] The loss of life attributed to IPV is alarming. According to Federal Bureau of Investigation's *Uniform Crime Reports Supplementary Homicide Reports*, 1,026 women were killed by an intimate partner in 2011.[6] Younger women and minorities are more likely to experience IPV.[5] Lifetime prevalence of rape, physical violence, and/or stalking is highest in those who self-identify as multiracial.[5] Native Americans are victims of rape or sexual assault at more than double the rate of other racial groups.[7,8]

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Individuals affected by IPV have pain, suffering, and loss of quality of life.[5] Victims of IPV may have posttraumatic stress disorder symptoms, injuries, and missed work/school days.[5] Many studies have shown greater prevalence of physical health problems, depression, substance abuse, and suicide attempts in abused women compared with women who are not abused.[9–13] IPV during pregnancy is associated with pregnancy complications (inadequate weight gain, bleeding, and infections) and poor pregnancy outcomes (preterm delivery, low birth weight, and neonatal death).[14] IPV also has many lasting effects on the children of IPV victims. Between 45% and 70% of children who are exposed to domestic violence are also victims of physical abuse.[15] The American Psychological Association reported that "a child exposed to the father abusing the mother is at the strongest risk for transmitting violent behavior from one generation to the next."[16]

IPV is a significant financial burden on our economy. According to the NVAWS study,[5] IPV victims in the United States lose a total of nearly 8.0 million days of paid work annually the equivalent of more than 32,000 full-time jobs. Expenditures for IPV include healthcare crisis intervention services housing services, victim's advocate services, and legal services.[5] Published cost estimates of IPV in the United States range from $1.7 billion to $10 billion annually, but these numbers are believed to underestimate the true economic impact of this type of violence.[17] Rivara et al.[18] studied 1,546 women who reported IPV in their lifetime and found that adjusted total healthcare costs were 19% higher in women with a history of IPV compared with women without IPV. This translated to extra expenditure of $19.3 million healthcare dollars due to IPV per 100,000 women in the United States.

IPV affects many aspects of a victim's life and health as well as the lives and health of her children. Not only is a victim's medical and mental health impacted, her reproductive and economic freedom are impacted as well. The global impact of this issue makes it imperative to examine the pivotal role of legislation in this area.

The Violence Against Women Act

The United States passed the federal law The Violence Against Women Act of 1994 (Title IV, sec. 40001-40703 of the Violent Crime Control and Law Enforcement Act of 1994) on September 13, 1994. VAWA's origins were from the collective effort of the battered women's movement, law enforcement agencies, sexual assault advocates, the courts, and attorneys who urged Congress to create legislation that protects women from intimate partner violence.

The VAWA act created the Department's Office on Violence Against Women to support a permanent federal response to violence against women. The 1994 act provided $1.6 billion over 6 years toward investigation and prosecution of violent crimes against women and imposed automatic and mandatory restitution for those convicted. Through the STOP (Services Training Officers and Prosecutors) Formula Grant Program, from 1995 to 2000, an excess of $440 million was awarded to support 9,000 projects that address intimate partner violence.

The VAWA act addresses domestic violence, dating violence, sexual assault, and stalking. It emphasizes development of coordinated community care among law enforcement, prosecutors, victim services, and attorneys. It funds support groups and battered women houses and shelters, in addition to supporting the training of personnel who provide services to victims of IPV. VAWA also makes IPV a federal crime when state lines are crossed. VAWA provides grants to states for programs that prevent violence against women or provide services for victims of violence. VAWA currently provides support for work with tribes and tribal organizations to end domestic violence, dating violence, sexual assault, and stalking against Native American women. VAWA also changed the criminal and civil justice system by doubling federal penalties for repeat sex offenders.[19] Since passage of VAWA in 1994, every state has enacted laws making stalking a crime and each state strengthened criminal rape statutes.

Impact of VAWA

After passage of VAWA, the rate of intimate partner violence against females declined 53% between 1993 and 2008, from 9.4 victimizations per 1,000 females aged 12 years or older to 4.3 victimizations per 1,000, according to the Bureau of Justice Statistics.[20] Rates of violence against males declined 54%, from 1.8 per 1,000 aged 12 years or older to 0.8 per 1,000.[20] The number of victims of intimate partner violence declined, from approximately 2.1 million victimizations in 1994 to around 907,000 in 2010.[21] Between 1993 and 2007, the number of intimate partner homicides of females decreased 26%, and the number of intimate partner homicides of males decreased 36%.[20] A report at the University of Kentucky found that there is a 51% increase in reporting of IPV after mandatory arrest laws of VAWA went into effect, and that there is 63% decrease of nonfatal violence and 24% decrease in fatal violence.[22] A survey of women in a shelter found that 85% were supportive of mandatory arrest policies, and the women surveyed were more likely to feel that mandatory arrest policies reduced the burden of responsibility for survivors (77%), rather than disempowering them (18%) (Fig. 1).[23]

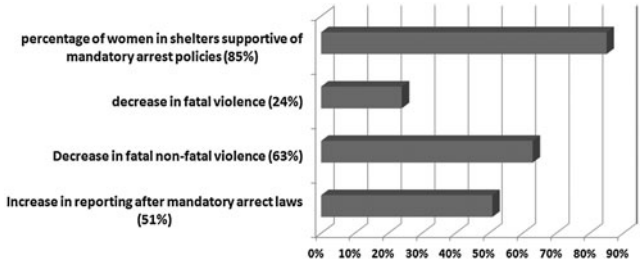

FIG. 1. Impact of the Violence Against Women Act. Figure created from data collected at University of Kentucky Center for Research on Violence Against Women, 2011.

Reauthorization of VAWA

VAWA needs to be reauthorized every 5 years. VAWA was reauthorized by Congress in 2000, and again in December 2005. In 2012, VAWA did not have bipartisan support. The House and the Senate passed their own version of the bill but these bills were not reconciled by the end of the 112th Congress. At that time, Republicans objected to extending the act's protections to same-sex couples and expanding the number of temporary visas for illegal immigrants who are victims of domestic violence.[24]

On February 12, 2013, the Senate passed a new VAWA bill with a roll call (yea or nay) vote of 78 to 22, which added the following amendments: provisions targeting human trafficking, provisions ensuring that child victims of sex trafficking are eligible for grant assistance, provisions for lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, and provisions for Native Americans living on reservations. Provisions to provide expanded resources for undocumented immigrant victims of intimate partner violence, although included in the Senate's proposed bill in 2012, was not included in the 2013 bill.

New Provisions in the Reauthorization of VAWA 2013

Protection for Native Americans

An University of Oklahoma study[25] of 422 Native Americans women in Oklahoma found that 82% of study women had experienced physical or sexual intimate partner violence in their lifetime, with 66% reporting severe physical partner violence (defined as kicking, choking, using an assault weapon, etc.).[25] This study had similar findings to previous studies[26–32] that found higher rates of IPV among Native American women compared with the general U.S. population of women. On some reservations, Native American women are murdered at more than 10 times the national average.[7] One in three of these violent victimizations against Native American women were committed by an acquaintance—this one in three proportion is similar to the national trend, but the total victimizations against Native American women is 10 times higher.[8]

Before passage of VAWA 2013, previous VAWA legislation did not include provisions for Native American women if they were victim of violence committed by non-Native Americans. The new VAWA 2013 was amended to contain provisions overturn the rulings of the Supreme Court case Oliphant vs. Squamish Indian Tribe of 1978 and allow for prosecution in tribal courts of domestic violence or dating violence committed against Native Americans by non-Native Americans.[7]

Protection of same sex couples

LGBTQ individuals face domestic violence at the same rates as other members of the community: 25%–33%.[33] A 2010 Centers for Disease Control and Prevention survey found that the prevalence of intimate partner violence was higher in some LGBTQ relationships than in their heterosexual counterparts: 61% of bisexual women and 44% of lesbian women reported intimate partner violence versus 35% of heterosexual women. Meanwhile, 26% of gay men and 37% of bisexual men reported being assaulted or stalked by a partner, compared with 29% of heterosexual men.[34] The 2000 U.S. census identified almost 600,000 households headed by same-sex couples, spread across 99% of the nation's counties,[35] yet previously, VAWA legislation has not included provisions for LGBTQ individuals. Many services that were created for IPV through VAWA have not been accessible for LGBTQ individuals. A 2011 survey found that "nearly 85% of service providers who worked with LGBTQ clients had clients who reported that they were turned away or denied services because of their sexual orientation and/or gender identity."[33] In a 2010 report, nearly half of LGBTQ survivors (both males and females) were turned away from domestic violence shelters. More than "55% of LGBTQ survivors (both males and females) were denied orders of protection and only 7% of all victims reported violence to the police."[36]

VAWA 2013 creates services for LGBTQ victims of IPV and creates legislation about their rights. The act explicitly includes LGBTQ victims in two key VAWA grant programs. VAWA now contains a nondiscrimination clause that prohibits LGBTQ individuals from being turned away from shelters or other VAWA funded programs on the basis of sexual orientation or gender identity.

Protection of victims of human trafficking

According to the Trafficking Victims Protection Act of 2000,[37] an estimated 50,000 people are trafficked into the United States each year. Women and children are disproportionately trafficked because many women and children lack access to education and are affected by chronic unemployment and discrimination in their countries of origin.[37] In many instances, women are lured into networks with false promises but are then given poor living conditions, unfair wages, and are subjected to exploitation. Victims of trafficking are sometimes subjected to the same type of abuse as victims of intimate partner violence: physical and sexual violence, financial control, threats, intimidation, and restriction on freedom of movement.[38] In the United States, runaway and homeless children are highly susceptible for being domestically trafficked for sexual exploitation.[39] The new VAWA amendments would reauthorize appropriations for the Trafficking Victims Protection Act.

Still Needed: Protection for Immigrant Victims of IPV

The reauthorized VAWA 2013 includes legislation for many marginalized groups that have been forgotten in the past, including legislation for LGBTQ individuals, Native Americans, and victims of human trafficking. It expands protection for immigrant women by adding stalking to the list of crimes covered by U Visas. However, VAWA 2013 did not expand the number of U Visas or increase the government's research interest in violence in the immigrant communities. According to the Migration Policy Institute,[40] immigrant women comprise 18.9 million, or 12%, of total women in the United States. Because national studies have not been done to investigate IPV in immigrant communities, the number of immigrant IPV victims is unknown.

Violence against women is found in immigrant populations and is intensified by some characteristics unique to immigrant

populations. In one study, 48% of Latinas reported that their partner's violence against them had increased since they immigrated to the United States.[41]A survey of immigrant Korean women to the United States found that 60% had been battered by their husbands.[41] Immigrant women victims of IPV may feel isolated because of language, economic, and social barriers. Also, some women come from male-dominated cultures where IPV does not carry the same legal and cultural consequences as it does for Americans. Some immigrant women may not think services exist for them or do not know how to access these services.

Nava et al.[42] found that the level of acculturation of an immigrant woman who is exposed to IPV may influence her physical safety, her willingness to seek help and her mental anguish over the situation. Women from minority populations are at higher risk for experiencing mental health problems from IPV than the general U.S. population. According to a study by Rodriguez et al.,[43] 51% of pregnant Latina survivors

Table 1. Proposals for Helping Victims of Intimate Partner Violence

Recommendations	*Work by existing organizations*
Prevention	
• Policymakers and funders should fund initiatives to increase public awareness about intimate partner violence. • Policymakers and funders should support early intervention and prevention programs for at risk children. • Healthcare workers should distribute information (written in their patient's native languages) about intimate partner violence (IPV) and resources for help. The information should include information about recognizing the warning signs of abusive behavior.	• The external peer review panel convened by the Centers for Disease Control and Prevention (CDC)'s Injury Center emphasized the need to increase awareness of sexual violence in the eyes of the general public.[47] • Since the early 2000s, the Department of Violence Department has identified a need for programmatic efforts on prevention of sexual violence perpetration (created EMPOWER program).[47] • The American College of Obstetrics and Gynecology Committee Opinion No. 518 advocates that medical community can play a vital role in identifying women who are experiencing IPV through screening, offering ongoing support and reviewing available prevention and referral services.[48]
Interventions	
• Healthcare workers should screen individuals for IPV. If a victim of IPV is identified, healthcare providers should refer this individual to local domestic violence services. • Domestic violence services/social workers should be able to inform the victim of her legal rights and can help immigrants with U Visa applications. • Healthcare workers should screen for IPV in the LGBTQ patients and understand how patters of IPV are different for these patients. • Healthcare workers should provide low-cost mental health services to those affected by IPV. • More innovative ideas are needed to find ways to encourage immigrant victims of IPV to seek help. • Healthcare workers should urge passage of legislation for undocumented immigrants including expansion of U Visas for victims of IPV.	• The U.S. Preventative Task force recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services.[49] • Ard et al.[50] reported the burden of IPV in the lesbian, gay, bisexual, transgender, gay, and queer (LGBTQ) community and outlined steps clinicians can take to address IPV in LGBTQ patients. • Rodriguez et al. investigates IPV and Barriers to Mental Health Care for ethnically Diverse Population of Women. This group found that there understanding these barriers can help inform the development of more effective strategies for health care practice and policy.[51] • Human Rights Watch organization endorses the expansion of U Visas.[52]
Research	
• The Department of Justice Bureau of Justice Statistics should increase research on immigrant IPV so that it can provide detailed statistics of IPV by immigrant group. By knowing the scale of the problem, the government can allocate appropriate resources to address immigrant IPV. • Critical analysis should be conducted about how VAWA 2013 changes the programs funded by VAWA and how it impacts victims of IPV. • Healthcare workers can contribute to more research about the prevalence of IPV in marginalized communities such as in the LGBTQ community and small ethnic communities. • Policymakers and funders should support research on intimate partner violence in immigrant communities to identify unique stressors that contribute to immigrant IPV. • Policymakers should support research on eliminating barriers for immigrant IPV victims to access mental/healthcare services.	• The National Intimate Partner and Sexual Violence Survey (NISVS) describes the prevalence and characteristics of sexual violence, stalking, and IPV.[47] • VAWA 2013 changes to Office on Violence Against Women – Administered Grant programs can be found at www.ovw.usdoj.gov/docs/vawa-2013-sum.pdf[53] • The Robert Wood Johnson Foundation investigates IPV in immigrant and refugee communities in the United States, and makes recommendations for funders, service providers, and policymakers. The document *Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices, and Recommendations* was published March 2009.[54]

of IPV, most of which were not U.S. citizens, experienced depression, which is much higher than the 14% rate of depression among pregnant white women survivors of IPV.

Immigrant victims of IPV may choose not to tell authorities of their abuse because of fear of deportation or changes in their immigration status if they separate from their abuser. In one study by Raj et al.,[44] the odds of reporting IPV (23% of the sample) were higher for immigrant women who reported that their partners refused to change their immigration status (odds ratio [OR] 7.8; confidence interval [CI] 1.4) or threaten them with deportation (OR 23.0, CI 4.5) and for those on spousal dependent visas (OR 2.8, CI 1.1) than they were for other immigrant women.

In 1994, VAWA created special routes to immigration status for certain battered noncitizens who were spouses of U.S. citizens or permanent residents. U visas give victims of certain crimes of domestic abuse temporary legal status and work eligibility in the United States for up to 4 years. On November 30, 2011, Senator Patrick Leahy introduced legislation that would expand the annual number of U visas issued from 10,000 to 15,000 per year for a limited period and would expand the definition of abuse under the U visa provisions to include stalking. Leahy's bill was rejected by the House in 2012.[45] This year the Senate did not include U Visa expansion proposals in the VAWA 2013 bill.

Discussion

Legislation such as VAWA address IPV from prevention, victim services, and prosecution standpoints. It is important for healthcare professionals to understand the current legislation and to advocate for expanding legislative policy to include care for previously ignored groups. Healthcare workers are the front line in the battle to identify victims of intimate partner violence and refer them to organizations that can help these individuals. As observers, healthcare workers can identify unique needs of individuals affected by IPV and advocate for policy changes on behalf of these individuals. When intimate partner violence occurs in any group—particularly in marginalized populations—it burdens society as a whole. This year VAWA 2013 expands resources for victims of human trafficking, LGBTQ victims, and Native Americans. As America has a growing immigrant population, it is important to investigate cultural driving factors in immigrant IPV and to create culturally sensitive programs to address these factors. There is a huge gap between the number of minorities who have experienced IPV and the number of these individuals who have sought treatment for IPV.[43] Clinicians need to be aware of the patient's cultural perceptions about IPV and their willingness to access mental health services.[43]

There is still room for improvement in the future for VAWA legislation to increase resources for undocumented women, just as it has for other marginalized groups (Table 1). This quote by Senator Patty Murray (Washington State) effectively summarizes the issue: "Expanding coverage for domestic violence should never have been controversial. Where a person lives, who they love, or what their citizenship status may be should not determine whether or not their perpetrators are brought to justice."[46]

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