Perceived Risk, Severity of Abuse, Expectations, and Needs of Women Experiencing Intimate Partner Violence

Karen S. Neill, PhD, RN, SANE-A1, and Teri Peterson, EdD2

ABSTRACT
This prospective, descriptive, correlational study examined perceived risk, severity of abuse, expectations, and needs of women experiencing intimate partner violence (IPV) with arrest of the offender occurring at the time of incident. This study builds on previous research completed on fear and expectations of female victims/survivors of IPV that come to the attention of police, to expand knowledge of women's experiences once they enter the criminal justice system and to create a comprehensive response to this recognized public health problem (Apsler, Cummins, & Carl, 2002). Forty-three women were interviewed regarding the incident, relationship, and experience. Most of the women in this study reported experiencing mild violence and varied forms of threats. There was a significant relationship between the experience of mild violence, serious violence, sexual violence, threats to victims, threats to objects, and others and nonverbal threats with fear of the offender. However, there were no significant correlations between levels of violence or threats with perceived risk of future physical abuse. As the criminal justice response to this crime has changed with the development of legislation and laws aimed at keeping women safe and holding offenders accountable, further research is needed to understand the experience of IPV victims and support an informed response. Forensic nurses are critical interdisciplinary team members in these efforts and play a significant role in providing expertise, sharing of knowledge, and application of evidence fostering victim-centered approaches to addressing IPV.

KEY WORDS:
abuse; domestic violence; intimate partner violence; offender; risk

Background
Intimate partner violence (IPV), also referred to as domestic violence, is a major health and social problem with significant impact on women. Defined as “physical, sexual, or psychological harm by a current or former spouse or partner,” IPV results in significant physical, reproductive, psychological, and economic consequences for victims (Centers for Disease Control & Prevention, 2013). IPV is a leading cause of injury in the United States with increased healthcare costs for women experiencing violence (Felblinger & Gates, 2008; Fishman, Bonomi, Anderson, Reid, & Rivara, 2010). Physical and/or sexual violence against women by an intimate partner is a universal phenomenon, which impacts 15%–71% of women internationally at some point in their lives (World Health Organization, 2013). Outcomes of IPV, past or present, can include increased risk for health disorders, depression, injury, and alcohol and drug abuse, among other impacts (Ambuel et al., 2011; CDC, 2013). IPV can also result in homicide or death (Sato-DiLorenzo & Sharps, 2007) in 2010 in the U.S., 38% of female murder victims were killed by a husband or boyfriend (National National Center for Victims of Crime, 2012).

Much of the research has focused on physical and sexual violence perpetrated by men against women. However, other forms of violence, such as psychological and
emotional abuse, have been recognized as having significant impact on the victim. These forms of violence include threats, social isolation, verbal harassment, controlling acts, and denial of basic resources, among others (CDC, 2010). These types of nonphysical violence have a devastating impact on the victim’s health and well-being and may place a woman at risk for physical abuse or more frequent violence if already in an abusive relationship. A single incident of any one type of violence toward a partner rarely occurs in isolation, and the negative health impact of cumulative abuse is well recognized (Outlaw, 2009; Scott-Storey, 2011). Emotional and psychological abuse is harder to identify than physical abuse, which more often comes to the attention of police (Klein, 2012). These different types of violence experienced by women in intimate partner relationships vary in frequency, severity, and form (CDC, 2010; Dienemann, Glass, Hanson, & Lunsford, 2007). There is a growing body of empirical research demonstrating varied forms of IPV, which can be differentiated in relation to partner dynamics, content of relationship, and consequences. Implications include a need to assess and improve response procedures and processes given different types of partner violence to develop interventions, standards, and practices that keep women safe and provide for offender treatment that protects those at risk for future violence (Cavanaugh & Gelles, 2005; Kelly & Johnson, 2008).

Women may seek assistance from law enforcement for IPV, or police may be contacted by an external party or other source concerned for the victim. Although a significant number of calls are made to police every year in the United States for IPV, many women experiencing violence do not contact police (Wolf, Uyen, Hobart, & Kernic, 2003). Public policy and laws have enhanced police response to IPV with an emphasis on the protection of victims and offender accountability. Police officers utilize varied tactics and decision factors when responding to a call involving interpersonal conflict, including coercive control approaches or noncoercive supportive approaches (Sun, 2006). An increasing number of police departments are adding lethality assessment to policy and protocol requiring officers to assess a victim’s risk of danger, death, or morbidity by the abuser at the time of response (Johnson, 2010; Klein, 2012). This is a recognized area of competency of forensic nursing practice and an opportunity for nurses to be involved in this process at some level (Markowitz, Pierce-Weeks, & Lewis-O’Connor, 2012). Current criminal justice and police response policies do not always consider input from the victim regarding his or her experience nor the impact of these policies on IPV outcomes for women. Decisions made by women experiencing IPV can be counterintuitive to providers and police who may question why women stay with abusive partners (Rhodes, Cerulli, Dichter, Kothari, & Barg, 2010). The criminal justice system has focused its intervention efforts primarily on the offender rather than the victim at risk for further abuse (Dichter & Rhodes, 2011).

Community and system level changes have occurred in response to IPV across the United States, particularly related to perpetrators or offenders (Hamberger, 2008). In the last decade, state legislatures enacted laws designed to enhance response to domestic violence offenders in an effort to reduce subsequent violence, increase victim safety, and hold offenders accountable, among other intentions (Dugan, 2003). Policies impacting response to IPV have been implemented to support improved outcomes for women, increase system accountability, and create a coordinated community effort (Javdani, Allen, Todd, & Anderson, 2011). Police officers are often first responders in an IPV situation and an entry point to the criminal justice system. Victims seek protection and safety intervention from law enforcement and expect to have the offender held accountable for his or her actions (Dichter & Rhodes, 2011).

A key criminal justice solution to domestic violence has been mandatory or pro-arrest policies, which require or encourage arrest of the perpetrator with resulting incarceration. Pro-arrest policies, sometimes referred to as preferred arrest, encourage officers to make an arrest given evidence that domestic violence has occurred. Mandatory arrest policies, however, require arrest of the perpetrator by police. Some states have laws that call for arrest of the offender based on police discretion (U.S. Department of Justice, 2008). These laws and resultant policies were created to standardize police response to domestic violence, remove or reduce police discretion in these cases, and alleviate victim pressure to initiate criminal charges. They have resulted in more IPV arrests and the proliferation of batterer intervention programs (Cerulli, Conner, & Weisman, 2004; Frye, Haviland, & Rajah, 2007; Hamberger, 2010). There is no consensus regarding the efficacy of these policies in the case of IPV, and some research illuminates unintended consequences such as dual arrest (Frye et al., 2007; Hamberger, 2008; Hovmand & Ford, 2009). Research has also found that these policies can have negative consequences on children, calling for a reformed IPV response sensitive to violence experienced by the victim and the impact on the family as a whole (Shields, 2008). Women can predict future violence with relative accuracy, although not perfectly, and understanding women’s assessment of risk in relation to violence being experienced is foundational to the development of services that meet the needs of victims (Harding & Helweg-Larsen, 2009). It is important to note that women may underestimate or fail to recognize risk. Concerns around risk perception and prevention efforts include the need for assessment of dangerousness, lethality and safety in IPV situations with advocates, health professionals, and criminal justice providers working together. These alliances
are critical to assertive safety planning and implementation of risk reduction strategies (Campbell, 2004). Engaging in interdisciplinary collaboration and outreach is a competency needed by health professionals for addressing exposure to violence and abuse. This includes being able to identify resources in the local, regional, and statewide community and building collaborative relationships that support a whole system response (Ambuel et al., 2011).

The purpose of this research was to explore perceived risk, severity of abuse, the relationship between perceived risk and severity of abuse, and the needs and expectations of women experiencing IPV, specifically in cases that have come to the attention of police and that resulted in the arrest of the offender. The researchers were interested in listening to women who had experienced violence and had entered the criminal justice system in an effort to add to the body of research regarding IPV response and so inform and aid in the continued development and provision of services that support safety; offender accountability; and a victim-centered, comprehensive system response.

Methods
This study followed a prospective, descriptive, correlational design, using a mixed methods approach. According to Brink and Wood (1998), a descriptive study provides descriptions of population characteristics. The correlational nature of this research consisted of the exploration of the correlations among the quantitative variables. Data were collected through a structured interview approach. The data collection instruments consisted of the Severity of Violence against Women Scale (SVAWS) in addition to a tool used to collect data on participant demographics, perceived risk, fear, likelihood of repeat occurrence of IPV, and concerning the current incident of IPV associated with the police contact. The primary focus was quantitative with an emphasis on the SVAWS subscales as well as the use of the additional tool, which included multiple-choice and open-ended questions. Qualitative data were collected from participants through four open-ended questions at the end of the interview.

The human subjects committee at the academic institution of the primary researcher approved this study. This research resulted from a collaboration of the academic researcher, the local police department, and a nonprofit victim service agency. The study took place in a rural state, with domestic violence offenses occurring in a county defined by the U.S. Census Bureau as an urbanized area with a population of 83,800 people (U.S. Census Bureau, 2010).

A potential risk for participants in the study included emotional feelings, anxiety, or other responses to participation in the interview. The collaborating victim service organization had in place a 24-hour hotline, and this number was provided to all participants as a primary resource should questions or problems arise as a result of participation in the study. Counseling services were available and offered free-of-charge for victims of violence through the participating victim service organization. No adverse outcomes were reported by any participant during the course of the research investigation.

Sample
The sample was a nonprobability purposive sample. The participants in the sample consisted of adult women whose experiences of IPV had come to the attention of police and had resulted in the arrest of a household member, intimate partner, or spouse for misdemeanor domestic violence as defined by the Idaho state statute. The police department from which the sample was identified had a pro-arrest policy in place during the time of data collection. This policy defined domestic violence as criminal conduct and emphasized enforcement of criminal law related to domestic violence, protection of the victim, and arrest of the party whom an officer had probable cause to believe was the primary assailant in the incident. Misdemeanor domestic assault (domestic violence) under Idaho state statute 18–918, “Crimes and Punishments Assault and Battery,” involves a situation in which a household member commits an assault against another household member that does not result in traumatic injury. A household member is defined as (1) a person who is a spouse, former spouse, or a person with whom the other household member has a child in common or (2) a person with whom a person is cohabitating, regardless of marital status, or people who hold themselves out to be husband and wife. Use of physical force that results in the infliction of traumatic injury or presence of a wound, external or internal, minor or serious, is a felony charge based on state statute and was not included in our research (Idaho Legislature, n.d).

The city police department’s victim witness coordinator (VWC) attempted to make contact with women whose partner or spouse had been arrested for domestic violence as part of her position responsibilities. The VWC asked these women about participation in the study and secured initial informed consent. Once the victim expressed willingness to participate, the VWC provided its contact information to the primary researcher who then attempted to make contact with the victim a minimum of 7 days after the incident and within 5 weeks of offender arrest. After establishing informed consent with each participant, the researcher informed participants that an incentive for participation would be provided: a $10.00 Wal-Mart shopping card. During the time in which the research was conducted, 106 women were asked to participate in the study, and 31 women declined. Of the 75 women who expressed an initial willingness to participate, 43 consented to an interview with the primary researcher.
Data Collection
Data were collected over a 21-month period. Initially, interviews were conducted in a private office of the victim service organization collaborating in the research. This proved to be difficult for the initial two participants because of problems with childcare and transportation. A decision was made by the primary researcher to conduct interviews on the telephone to decrease burden on participants. The following 41 interviews were conducted on the telephone by the primary researcher. The human subjects committee of the academic institution of the primary researcher approved this change in methods.

Instruments
Data were collected using two instruments: the SVAWS and a second questionnaire used in similar research. The SVAWS is a recognized instrument designed to measure IPV victimization and perpetration (Thompson, Basile, Hertz, & Sitterle, 2006). The SVAWS, developed by Marshall (1992), was used for the measurement of the severity of violence experienced by the subjects. The 46-item scale includes subscales for measuring physical violence; threats; and mild, minor, moderate, and serious violence. Marshall developed the instrument to target women reporting abuse experienced with an intimate partner in the previous year. Established internal consistency ranged from .89 to .96 for community women, and evidence of construct validity has been established (Thompson et al., 2006).

With permission of the primary author, the researcher adapted and used an additional interview instrument (questionnaire) from a published study focused on fear, expectations, and differences among women who had come to the attention of police (Apsler, Cummins, & Carl, 2002). The instrument included demographic questions followed by 28 multiple-choice questions regarding relationship; current and past abuse experience; knowledge and utilization of resources; response received by police; and perceived risk, fear, needs, and expectations. Using the adapted tool provided an opportunity to build on previous research and further describe the victimization and response experience of women who come to the attention of police. No reliability or validity information had been reported for the interview instrument in the primary study.

The interview tool included questions designed to collect qualitative data by asking participants to respond to inquiry regarding needs based on a coordinated community response effort by police, advocates, and nurses or other healthcare professionals. Three specific questions were designed to obtain information from the victim regarding the need for services from each of the following: law enforcement, nurse (or other health professionals), or advocate at the time of incident up to the time of interview. An additional question allowed for an open-ended response from the victim regarding her experience on the date of the incident on which offender was arrested and incarcerated and/or to ask questions of the researcher at the conclusion of the interview. Responses from each victim were transcribed by the researcher at the time of interview.

Data Analysis
Data from the adapted questionnaire were initially entered into an Excel spreadsheet and subsequently read into IBM SPSS (Release 19, 2010). All statistical analyses were performed using IBM SPSS. Frequencies and percentages were calculated for the demographic and other categorical questions.

Subscales for the SVAWS were calculated, and Cronbach’s alphas and descriptive statistics (means and standard deviations) were reported for each of the subscales. The overall physical violence subscale showed strong internal consistency reliability with a Cronbach’s alpha of .906. The mild, moderate, serious, and sexual violence subscales also had good Cronbach’s alphas (.939, .856, .750, and .868, respectively). Only the minor violence scale did not show adequate internal consistency with an alpha of .485. The threats to objects or others subscale (alpha = .752), threats to victim (alpha = .735), and nonverbal threats (alpha = .846) all showed good internal consistency reliability. In addition to the questions associated with the subscales constructed in the original use of the SVAWS, the researchers identified questions within the SVAWS related to other types of violence: threats directed to the victim, nonverbal threats, threats to objects or others, and sexual violence. These additional subscales were analyzed for internal consistency using Cronbach’s alpha. The items chosen for each subscale were based on the construct being estimated. Given the theoretical relationship within the construct and good internal consistency reliability, these scales were included in the analyses.

To assess the relationship between perceived risk, fear, and SVAWS subscales, Spearman’s rank correlation coefficients were calculated. Mann–Whitney U tests were computed to compare those who were married and those not married, those who were working and those not working, and those who had children and those who did not have children on the SVAWS subscales. Nonparametric statistics were chosen because of violations of normality and the ordinal nature of the perceived risk and fear.

Qualitative data were limited based on the four questions asked of the participants at the conclusion of the interview. These questions provided an opportunity for expression of needs by victims related to specific system responders in a domestic violence situation. Several areas of need were identified, and one concern expressed by a participant was particularly noted—a concern regarding police response and potential impact on her child. A
formal qualitative methodology was not used in the analysis of qualitative data obtained in the interview process given intent and design of the study.

Results

Demographics

Forty-three participants were interviewed for this study. One victim chose not to continue in the data collection process and did not complete the SVAWS. The participants in this study ranged in age from 18 to 56 years with an average age of 31 years and a standard deviation of 8.6 years. The victims were predominately White (n = 33, 79%), with some Hispanic (n = 5, 12%), whereas the remainder indicated either an ethnicity of other or did not state their ethnicity. Of those who reported a combined annual household income, 39 (31%) indicated an annual income of less than $10,000, whereas nine (23%) indicated more than $40,000. Of the participants who responded to the employment questions, 20 (48%) indicated that they did not work, whereas 16 (38%) indicated that they worked full time, and seven (17%) indicated that they worked part time. Most of the women had been in the relationship 5 years or less (n = 30, 70%). In response to the question regarding marital status, 12 (28%) reported being single but cohabitating, 10 (44%) reported being married to the offender, 10 (23%) reported being divorced, and one reported being separated. Most (n = 38, 91%) of the participants indicated having children residing in the home.

Descriptive Statistics Concerning Incident and Perceived Risk

For most women in the study, this was the first arrest of the household member, partner, or spouse for domestic violence (n = 26, 62%). Over half of the women (n = 25, 58%) reported that they had contacted police in the current incidence. Most of the women wanted the officer(s) to remove the offender and keep him away until he calmed down (n = 27, 66%) or remove the offender and keep him away forever (n = 11, 27%). Half of the women wanted the officer arrested (n = 21, 50%), whereas the other half reported they did not want this outcome (n = 21, 50%). Most of the women felt that the police officers were very helpful (n = 28, 65%), with over half of the women reporting that they would contact police again in the future if a similar incident occurred (n = 27, 64%).

Past physical abuse by the offender was reported by 24 (57%) participants, whereas 18 (43%) reported no experience with previous physical violence from this offender. In response to a yes/no question about risk for further physical abuse, only 11 (26%) of the participants felt that they were at risk. However, 16 participants responded to the ordinal scale indicating level of risk of future physical abuse. Fully half of these (n = 8, 50%) rated their risk as moderate or higher for further physical abuse. Of all the participants, only 24 felt they were at risk for future verbal abuse.

Verbal abuse from their partner or spouse was reported by 31 (73%) participants. Of the 28 respondents who rated their risk of future verbal abuse, 22 (70%) indicated moderate risk to very high risk.

Forty-one participants responded to the question concerning fear of the offender. More than half (n = 24, 59%) indicated they were “not at all afraid” of the offender, and a fifth of the respondents (n = 8, 20%) indicated that they were “very afraid” of the offender.

SVAWS Subscales and Relationships

The means and standard deviations for the seven subscales are presented in Table 1. The minor violence scale was not used because of its low internal consistency as measured by Cronbach’s alpha. The means on the subscales ranged from 1.3 to 2.5 on a scale of 1 (never) to 4 (many times), indicating that the levels of violence and threats ranged from between never and once to between once and a few times. Serious and sexual violence had the lowest means, whereas mild violence and nonverbal threats had the highest means.

No relationships were found between age, income, whether the woman worked, and whether children were in the home and the SVAWS subscales. However, there was a statistically significant (p = 0.048) higher incidence of sexual violence in married (M = 1.5, SD = 0.7) versus unmarried participants (M = 1.2, SD = 0.43).

Spearman’s rank correlation coefficients with their observed significance levels are presented in Table 2. None of the SVAWS subscales were significantly correlated with perceived risk of physical abuse. There was a statistically significant moderate positive correlation between nonverbal threats and risk of verbal abuse. Thus, the higher the participant scored on the nonverbal threat subscale, the higher the reported risk of verbal abuse. All the subscales except moderate violence had a statistically

| TABLE 1. Means and Standard Deviations of SVAWS |
|-----------------|--------|--------|
| Scale            | M     | SD    | N    |
| Physical violence (overall) | 1.6   | 0.5   | 42   |
| Threats (overall) | 2.0   | 0.6   | 42   |
| Mild violence    | 2.5   | 1.0   | 42   |
| Moderate violence| 1.5   | 0.8   | 42   |
| Serious violence | 1.3   | 0.4   | 42   |
| Sexual violence  | 1.3   | 0.6   | 42   |
| Threats to victim| 1.4   | 0.5   | 42   |
| Threats to objects or others | 1.9   | 0.9   | 42   |
| Nonverbal threats | 2.3   | 0.8   | 42   |

Note: SVAWS = Severity of Violence against Women Scale.
significant moderate positive correlation with fear of offender. Therefore, the higher the participant scored on the subscales of mild violence, serious violence, sexual violence, threats to victims, threats to objects and others, and nonverbal threats, the higher the self-reported fear of offender.

**Qualitative Findings**

At the conclusion of the interview process, the participants were asked the four open-ended questions. Two broad areas related to need were expressed by the participants, and these included: (a) needs relative to response by law enforcement officials and (b) needs related to health professional intervention, particularly access to and cost of healthcare services.

Needs related to law enforcement response were exemplified in these comments made by victims of IPV:

Need more clarity. Don’t know what happens once they [partner or spouse] are arrested. Need more information about what’s going to happen.

I want to know what to do next.

Give me reassurance that he will remain incarcerated.

Bothered me. Son was there. Explanations [by police] in front of my child. [Child] didn’t understand why police were saying [offender] was being arrested because of what he did to mommy. Talking [police] about reasons why arrest was occurring. Freaked son out quite a bit. I didn’t agree with that. Need to remember that children are there and are listening.

The need for access to healthcare services and cost concerns were exemplified by the following quotes:

Need a clinic for domestic violence victims so you don’t have to worry about being seen by a doctor because you can’t afford it. I don’t have health insurance—only reason I didn’t go to the hospital. I can’t afford medical bills.

Would have been helpful to have someone talk to me about going to the hospital even though I couldn’t pay [pause] all I could think of was money.

Counseling is a wonderful thing, then you are thinking oh my god, how am I going to pay rent. Huge factor in why women go back to their abuser and stay.

The participants did not identify specific needs in relation to advocacy services provided. In these cases and in this jurisdiction, advocates from the local victim service agency respond to the scene. After the scene is secured, the victim is asked by law enforcement if he or she would like to speak to an advocate. If the victim chooses to do so,
the advocate will spend time with the victim in crisis intervention and provide resources and information as needed to support safety.

Discussion

IPV continues to be a significant problem worldwide with measurable and multifaceted impacts on women. However, little research has been conducted on factors associated with perceived risk (Harding & Helweg-Larsen, 2009). Policy initiatives designed to hold offenders accountable and support victim safety require careful evaluation of outcomes that support the needs and expectations of women while responding effectively to this criminal offense. This study did not show a relationship between perceived risk and severity of violence as measured by the SVAWS. Thus, there is a noted disconnection among the women in this study in understanding violence and risk in cases of IPV. This needs to be taken into account in designing response protocols on the part of law enforcement, advocacy, and health professionals in particular. In addition, the qualitative responses further support the need for incorporating the concerns of women in the implementation of response policies and procedures. Input from women whose partners are arrested for IPV is important to the design of a comprehensive system response that supports a victim’s decision-making process while supporting safety, building awareness of the scope of IPV, and implementing services that are caring and victim centered.

Most of the women in the study had experienced domestic violence in a short-term relationship. Most of the women had children residing in the home, which is concerning as studies have shown that domestic violence has a significant impact on children who witness this crime (Lee, Kolomer, & Thomsen, 2012). The previously cited quote from a victim regarding statements made by the police in front of a child during the offender’s arrest illustrate this point further. In addition, women expressed a desire for low-cost counseling; access to mental health intervention is a significant problem as IPV results in mental health sequelae that significantly impacts both short- and long-term health outcomes (Sato-DiLorenzo & Sharps, 2007). IPV victims need to understand the many different types of risk associated with IPV, including the risk of reassault, danger, and lethality (homicide or a significant morbidity outcome) as well as the many factors that support safety (Campbell, 2004).

Women can provide valuable insight into the experience of IPV and can share information that supports an effective system approach. Most of the women in this study reported experiencing mild violence and varied types of threat, which correlated with fear of the offender. Interestingly, the level of violence experienced was not correlated with perceived risk of physical abuse. IPV remains a leading cause of physical injury to women (Felbinger & Gates, 2008; Fishman et al., 2010). These findings may indicate a lack of victim awareness and knowledge of what constitutes IPV, risk factors associated with recidivism, and effects on self and family. Qualitative findings indicate a need for access to healthcare services and economic concerns consistent with previous research on social service needs of IPV survivors (Dichter & Rhoades, 2011).

Women’s perceptions as a valuable predictor of risk for further IPV and lethality has led to the implementation of danger assessments in many police jurisdictions as a component of response, which provide valuable information in IPV cases (Connor-Smith, Henning, Moore, & Holdford, 2011). Research has shown that safety planning with victims is important and best carried out in partnership with advocates who provide services beyond the date of incident (Campbell, 2004). In that domestic violence is a multifaceted phenomenon and encompasses varied behaviors from situational events to a pattern of coercion and control (Zosky, 2011), a carefully coordinated response and assessment is necessary. Consistent with the research by Apsler et al. (2002), a range of victims come to the attention of police, and more needs to be known about the victims who vary in their fear of the abuser and expectation of future violence. Studies have found that a coordinated community response to domestic violence can support and inform policy initiatives to hold offenders accountable and improve victim safety.

Limitations

Limitations include a small sample size, which limits generalizability of the findings. Telephone interviews may impact the responses of women regarding their experiences with IPV; in-person interviews offer an enhanced opportunity to build trust through eye contact, nonverbal communication, and a caring presence that may influence willingness to report details of the experience. Lack of established reliability of the adapted data collection instrument used as a component of the interview process is a noted limitation.

Implications for Clinical Forensic Nursing Practice

Forensic nurses can play a key role in a coordinated community response to IPV within a scope of practice that includes management and prevention of intentional and unintentional injuries in collaboration with social, criminal justice, healthcare, and other systems (International Association of Forensic Nurses, American Nurses Association, 2009). Becoming actively involved in the IPV response process in partnership with police and advocacy service agencies provides an opportunity for forensic nurses
to support safety through education of the victim, contribute expertise to the development of policy and protocol, inform responders regarding initial assessment and healthcare intervention, and be involved in prevention strategies. Coordination of IPV response should be formalized, with policies and procedures across systems that clearly define the roles and responsibilities of the interdisciplinary team and emphasize meeting the needs of IPV victims (Pennington-Zoellner, 2009). Forensic nurses can develop expanded competencies that support an individualized, victim-centered response to IPV across systems and promote safety and improved outcomes for the victim. Competencies have been established at several levels including system, institutional, and learner for health professionals addressing exposure to violence and abuse (Ambuel et al., 2011). The International Association of Forensic Nurses has developed guidelines for forensic nurse education in IPV to support development of expertise in this area of practice (Markowitz et al., 2012). Forensic nurses can work to expand expertise in IPV given that this has been recognized as a significant social and public health problem. Furthermore, forensic nurses can develop important relationships with law enforcement and victim service agencies that foster linkages across health, human, social, and criminal justice systems to improve IPV response. Beyond the realm of direct involvement in individual cases, forensic nurses can help shape policy and legislation that supports effective response, offender accountability, and the safety of victims. Given the scope of practice and unique skill set of the forensic nurse, opportunities to build partnerships, connect with key responders, and link with community-based resources for victims and their families offer a strong promise for the development of effective services across systems that are informed in part by those who experience this crime.

Acknowledgments

The authors would like to thank Dana Katona and Becky Rodriguez, victim/witness coordinators in the participating police department, for collaboration in the planning and implementation of the research endeavor. The authors would also like to thank Sarah O’Banion, LSW, Advocate Program Director of Family Services Alliance, for collaboration in completing this research. The authors would like to thank collaborating individuals and organizations for their commitment to excellence and caring in providing services to women experiencing violence.

References