



**Domestic Violence/Intimate Partner
Violence: Applying Best Practice
Guidelines**

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**Answer Sheet: Domestic Violence/Intimate Partner Violence:
Applying Best Practice Guidelines**

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Objectives

Upon completion of this course, the learner will be able to:

- Define intimate partner violence/domestic violence, particularly in the state of Florida.
- Discuss the statistics related to intimate partner violence/domestic violence.
- Describe the consequences of violence.
- Identify risk factors related to being a victim of violence and for being a perpetrator of violence.
- Describe how to initiate the topic of intimate partner violence/domestic violence with your patients.
- Discuss interventions identified in the Best Practice Guidelines described in this course.
- Identify resources in Florida related to intimate partner violence/domestic violence.

Introduction

Case Study 1. Roseanne

Roseanne is rushing to get ready for work. She finishes helping 3 year old Matthew get dressed and gives him some breakfast. She grabs the baby from her crib and a shooting pain stabs her in the right shoulder. With the pain comes the memory of last night. Roseanne's husband Jack got home late last night-he had been drinking and he was in a foul mood. He finally went to bed-but not before berating Roseanne, as usual, and slapping and punching her multiple times. She has bruises on her face that her makeup can barely hide. She touches up her makeup one last time before dropping off both Matthew and the baby with her mother.

Her mother knows that it's been difficult for Roseanne, but she doesn't know how bad it's gotten. Since Roseanne was pregnant with 5 month old Tara, she has been punched, kicked and sexually victimized repeatedly by her husband. It has become a routine part of her life. While driving to work, Roseanne starts crying. She tries to reapply some more makeup to cover the bruises as she rushes onto the unit. Roseanne is a neonatal nurse.

Roseanne is like so many American women; she is the victim of intimate partner violence/domestic violence (IPV/DV). IPV/DV is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or significant other, or current or former dating partner. Intimate partners may be heterosexual or of the same sex; sexual intimacy is not a requirement in this definition (CDC, 2011).

IPV/DV is widespread in the US-indeed it is rampant worldwide. According to the National Coalition Against Domestic Violence (NCADV), **one in four women report that they have been physically assaulted or raped by an intimate partner** (NCADV, 2007).

According to the CDC (2011), each year, women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults.

It's important for victims of IPV/DV to know they are not alone (USDHHS, 2011a):

- Nearly 25 percent of U.S. women have been raped or physically assaulted by an intimate partner at some point in their lives;
- More than 1 million women are stalked by partners each year;
- Physical and psychological abuse is connected to chronic health problems such as gastrointestinal disorders, chronic pain syndrome, depression and suicidal behavior;
- Abused women are six to eight times more likely to use healthcare services than non-abused women.

Unfortunately, when victims seek medical care, healthcare providers often do not screen for and identify IPV/DV. Some studies have shown that approximately 70 to 81 percent of survivors of abuse want their healthcare professionals to ask them about domestic abuse during their appointments (USDHHS, 2011a). The purpose of this course is to assist healthcare providers to intervene more effectively in identifying and treating victims of IPV/DV.

Conceptualizing IPV/DV as a public health issue helps one to recognize that this issue impacts multiple domains (relational, financial, education, employment, law enforcement/legal) in the life of the individual, family, community and social in general. Healthcare providers have long supported the conceptualization of IPV/DV as a public health issue through:

- Identifying the problem (definitions, frequency, prevalence, injuries, death),
- Identifying risk factors and protective factors,
- Developing and testing strategies (such as the use of best practice and evidence-based guidelines), and
- Assuring widespread adoption of the strategies.

The purpose of this course is to provide healthcare providers with current information about IPV/DV, in order to support greater identification and intervention of IPV/DV in the healthcare setting.

For the purposes of this course the term intimate partner violence/domestic violence (IPV/DV) will be used. The course will also use the pronouns "she" and "her" in relation to victims of IPV/DV and "he" or "him" for perpetrators. The learner is reminded that although statistically more women are abused by men, this violence can also occur at the hands of women towards their male partners, and among same-gender partners.

Defining the Problem

Domestic violence is a broad term that indicates violence in close or intimate interpersonal relationships. This violence is known by many names: intimate partner violence, wife abuse, wife battering, spousal abuse, woman abuse, etc. Some define the term domestic violence even broader to include child abuse, elder abuse, or any close interpersonal relationship. Put simply it is when one person purposely causes either physical or mental harm to another when they are in a close personal relationship. These crimes occur in both heterosexual and same-sex relationships.

The Family Violence Prevention Fund (FVPPF) defines Intimate Partner Violence (IPV) as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (Healthy People, 2010).

Because the definition of intimate partner violence/domestic violence (IPV/DV) varies from agency to agency, state to state, obtaining accurate statistics is also difficult. A consistent definition is needed to monitor the incidence of IPV/DV and examine trends over time. It helps determine the magnitude of IPV/DV and compare the problem across jurisdictions. A consistent definition also helps researchers measure risk and protective factors for victimization in a uniform manner. This ultimately informs prevention and intervention efforts (CDC, 2010).

It is also important to remember that abuse rarely occurs in just one form; more frequently forms of abuse occur in combinations. A woman who is physically abused is also likely isolated and controlled by her partner; a woman who is abused sexually may also be stalked and emotionally abused.

IPV/DV is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden & Thoennes, 2000a). It occurs on a continuum, ranging from one assault that may or may not significantly impact the victim, to chronic, repeated abuse which is also known as battering (CDC, 2010).

There are four main types of IPV/DV (CDC, 2011; CDC, 2010; Saltzman, et al., 2002):

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and use of restraints or one's body, size, or strength against another person.

Sexual violence is divided into three categories:

1. Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
2. Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and

3. Abusive sexual contact.

Threats of physical or sexual violence use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence.

Stalking is often included among the types of IPV/DV, either as a separate category, or it is including under psychological/emotional violence.

Stalking is a pattern of repeated, unwanted attention, harassment, and contact. It is a course of conduct that can include (NCVC, nd):

- Following or laying in wait for the victim
- Repeated unwanted, intrusive, and frightening communications from the perpetrator by phone, mail, and/or e-mail
- Damaging the victim's property
- Making direct or indirect threats to harm the victim, the victim's children, relatives, friends, or pets
- Repeatedly sending the victim unwanted gifts
- Harassment through the Internet, known as cyberstalking, online stalking, or Internet stalking
- Securing personal information about the victim by: accessing public records (land records, phone listings, driver or voter registration), using Internet search services, hiring private investigators, contacting friends, family, work, or neighbors, going through the victim's garbage, following the victim, etc.

Stalking generally refers to repeated behavior that causes victims to feel a high level of fear (Tjaden & Thoennes, 2000a). Stalking can be very traumatic and cause emotional stress. Victims of stalking may have nightmares; feel out of control; have trouble sleeping, eating, and concentrating; or feel vulnerable or depressed. Stalking can also cause financial stress if the victim loses time from work or can't go to work (USDHHS, 2011a).

One out of every 12 women has been stalked at some time in her life. The majority of stalking victims are between 18 and 39 years old. The most common type of stalking is by a person in a former personal or romantic relationship, like an ex-husband; only a small number of women are stalked by strangers (USDHHS, 2011a).

Statistics about IPV/DV vary because of differences in how different data sources define IPV/DV and collect data. For example, some definitions include stalking and psychological abuse, and others consider only physical and sexual violence. Legal definitions vary from state to state. Data on IPV/DV usually come from police, clinical settings, nongovernmental organizations, and survey research.

Definition of Domestic Violence in the State of Florida

The State of Florida, in Florida Statute Section 741.28, defines domestic violence as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.

The relationship between those involved in the violence must be that of (NCVC,nd):

- Spouses;
- Former spouses;
- Persons related by blood or marriage;
- Persons who are presently residing together as if a family or who have resided together in the past as if a family;
- Persons who are parents of a child in common, regardless of whether they have been married;
- With the exception of persons who have a child in common, the family or household members must be currently residing, or have in the past resided, together in the same single dwelling unit.

Florida Statutes can be accessed through the official website of the Florida Legislature: Online Sunshine at

<http://www.leg.state.fl.us/Welcome/index.cfm?CFID=92809846&CFTOKEN=53386739>.

Case Study 2. Rita

Rita is a 29 year old woman, who works as an administrative assistant at her county's office building. She has an 8 year old son Toby, the product of a 10 year relationship with her ex-boyfriend, Cliff. Cliff has problems with cocaine and this is why Rita and Cliff are no longer together; she had finally had enough of his abuse.

When they lived together Cliff would be little Rita for the slightest "infraction"; he did this in the presence of her family, the few friends they had left and out in public. Cliff would criticize whatever she did; he would call her "stupid" and "fat". Rita had learned to keep her head down and not do anything to further irritate Cliff. But when they were alone, that was the worst time. Cliff wouldn't just embarrass her; he degraded her, calling her filthy, terrible names in front of their son, Toby. Cliff would beat Rita so badly that she could not go to work, out of shame and pain. Toby would often try to intervene when his father would beat his mother, but Cliff would always scream at him to stay out of it. Rita had felt like she was barely alive. She just wanted Cliff to go away, but she had always been too scared of him to take any action. She had hoped he would find another girlfriend and leave. But she couldn't wait; three days ago she took Toby and went to live with her sister.

Statistics

Statistics about IPV/DV vary widely for a number of reasons. It is estimated that cases of IPV/DV are highly underreported, so that the statistics do not reflect the actual occurrence. Additionally, the numbers vary widely because of differences between states on the definition of IPV/DV, differences in how other data sources define IPV/DV and variations in how data is collected.

IPV/DV is one of the most chronically underreported crimes (NCADV, 2007). Only approximately one-quarter of all physical assaults, one-fifth of all rapes, and one-half of all stalkings perpetrated against females by intimate partners are reported to the police (NCADV, 2007). Even fewer IPV/DV incidents against men are reported. The reported data greatly underestimates the true magnitude of the problem.

The following represents **national** information on the occurrence of IPV/DV. In many cases, the severity of the IPV/DV behaviors is not known and because of the differences in the definitions of IPV/DV and how statistics are gathered, there are discrepancies in the statistics.

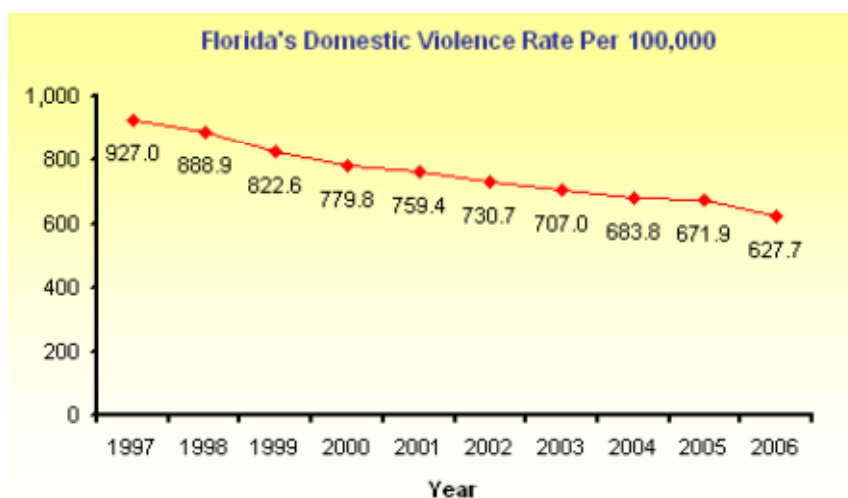
- An estimated 1.3 million women are victims of physical assault by an intimate partner each year (NCADV, 2007a).
- 85% of domestic violence victims are women (NCADV, 2007a).
- Historically, females have been most often victimized by someone they knew (NCADV, 2007a).
- Females who are 20-24 years of age are at the greatest risk of nonfatal intimate partner violence (NCADV, 2007a).
- Most cases of IPV/DV are never reported to the police (NCADV, 2007a).
- Almost one-third of female homicide victims that are reported in police records are killed by an intimate partner (NCADV, 2007a).
- In 70-80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder (NCADV, 2007a).
- One in 6 women and 1 in 33 men have experienced an attempted or completed rape (NCADV, 2007a).
- Nearly 7.8 million women have been raped by an intimate partner at some point in their lives (NCADV, 2007a).
- Sexual assault or forced sex occurs in approximately 40-45% of battering relationships (NCADV, 2007a).
- 1 in 12 women and 1 in 45 men have been stalked in their lifetime (NCADV, 2007a)
- 81% of women stalked by a current or former intimate partner are also physically assaulted by that partner; 31% are also sexually assaulted by that partner (NCADV, 2007a).
- Each year, women experience about 4.8 million intimate partner related physical assaults and rapes (CDC, 2011).
- IPV resulted in 2,340 deaths in 2007. Of these deaths, 70% were females and 30% were males (CDC, 2011).
- Men are the victims of about 2.9 million intimate partner related physical assaults (CDC, 2011). Between 4% and 8% of pregnant women are abused at least once during the pregnancy (Gazmararian, et al., 2000).

- Prevalence of IPV/DV varies among race. Among the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women, and Hispanic women (Tjaden & Thoennes, 2000b).
- Young women and those below the poverty line are disproportionately victims of IPV/DV (Tjaden & Thoennes, 2000b).
- The medical care, mental health services, and lost productivity (e.g., time away from work) cost of IPV was an estimated \$5.8 billion in 1995. Updated to 2003 dollars, that's more than \$8.3 billion (CDC, 2011).

Statistics specifically for **Florida** include (FDLE, 2011):

- In 2010, there were 113,378 reported domestic violence incidents (FDLE, 2011). This number is less than the 116,547 reported domestic violence incidents in 2009 (FDLE, 2011).
- Females were the victims in 85% of domestic violence homicides in 2007 (NCADV, n.d.).
- Of the 116,547 reports, there were 210 deaths, which included 191 cases of murder, which was 17 fewer than in 2009; and 19 cases of manslaughter (FDLE, 2011).
- Miami Dade county had the highest number of deaths in 2007 with 23 cases of homicide related to IPV/DV, followed by Pinellas and Broward counties with 15 homicides each (FDLE, 2008).
- The most common charge in domestic violence cases was for simple assault; there were 89,435 cases of simple assault and 18,299 cases of aggravated assault (FDLE, 2011).
- 24% of all aggravated assaults in 2007 were domestic violence related (NCADV, n.d.).
- There were 954 cases of forcible rape among domestic violence incidents in 2010; 270 cases of forcible sodomy and 846 cases of forcible fondling (FDLE, 2011).
- In 2010 there were 392 cases of simple stalking and 214 cases of aggravated stalking (FDLE, 2011).
- In 2010 there were 2,758 cases of threats/intimidation (FDLE, 2011).
- Of the victims of domestic violence, 27,785 were the spouse of the abuser, 33,894 victims cohabited with the abuser, and 9,017 were the children of the abused (FDLE, 2008);
- Of the reported cases, 66% of the offenses were committed by a spouse, co-habitant, or girlfriend/boyfriend (NCADV, n.d.).

Figure 1. **National Coalition Against Domestic Violence: Florida's Rate 1997-2006**



Overall, the rate of domestic violence in Florida has declined since 1997 (see Figure 1), reflecting the national trend of slowly declining rates of IPV/DV. While that indicates an improvement, the suffering for those who continue to be abused persists.

Identifying Abuse

Some signs of abuse are clear: physical injuries, repeated injuries, injuries that are explained in a manner unlikely to occur, bilateral injuries, injuries that appear in a pattern left by the object used in the assault. In addition to the physical injuries, there are behavioral indicators that IPV/DV may be occurring.

Case Study 3. Rhoda

Rhoda and Jim have been married for 38 years. Rhoda has been suffering from severe headaches for about 10 years. At a recent holiday dinner, Rhoda's niece Hannah notices, once again, how Jim always accuses Rhoda of flirting with one of her 4 brothers-in-law. Inevitably, at every family get together, after a few drinks, Jim starts this behavior. Hannah has always liked her aunt Rhoda, despite not seeing her very often, and her shy, self-effacing manner. But Jim has always been jealous. Hannah knows that he also doesn't allow Rhoda to spend much money. She turns over her paycheck to him and he gives her a small allowance. That is all she's allowed to spend. Jim has not allowed Rhoda to have the headaches evaluated. Jim does all the shopping in the home. Besides work and the occasional family occasion, Rhoda doesn't really get out much. Hannah is curious and asks Rhoda if she's ok. Rhoda begins to cry and tells Hannah that Jim has been physically abusing her ever since he started drinking-about 10 years ago-after Jim had been laid off from his high level management position with a Fortune 500 company. That was about the same time that her headaches started.

Hannah offers to take Rhoda to see her primary care provider, a nurse practitioner, for her headaches. When the NP screens for IPV/DV, this time, Rhoda admits to the abuse.

Sometimes it is hard to identify an abusive relationship, or to admit to it, if suspicions arise. There are clear signs to help in the identification of abuse. Consider IPV/DV when faced with the following (USDHHS, 2011a):

- Monitoring how the partner spends all of her time;
- Criticism of even little things;
- Constant accusations of unfaithfulness;
- Prevention or discouragement of partner seeing friends or family, or going to work or school;
- Anger when drinking alcohol or using drugs;
- Controls how any money is spent;
- Controls the use of needed medicines;
- Humiliates the partner in front of others;
- Destroys property or things that the partner cares about;
- Threatens to hurt the partner, the children, or pets, or does cause hurt (by hitting, beating, pushing, shoving, punching, slapping, kicking, or biting);
- Uses or threatens to use a weapon against the partner;
- Forces sex against the partner's will;
- Blames the partner for his/her own violent outbursts.

Consequence of Violence

In the past it was a common belief that domestic violence/intimate partner violence was a family problem. Over the decades, public opinions and laws have changed that make domestic violence a crime. However, in addition to the criminal aspect, domestic violence is also a public health problem. Because of its alarming frequency, its significant impact on the individual, the family, the community, IPV/DV is a serious problem that is common in our society. Violence by an intimate partner is linked to both immediate and long-term health, social, and economic consequences. Factors at all levels-individual, relationship, community, and societal-contribute to the perpetration of IPV/DV.

Preventing IPV/DV requires a clear understanding of those factors, coordinated resources, and empowering and initiating change in individuals, families, and society (CDC, 2007).

Case Study 4. Jenna

Jenna is 34 years old; she has 5 children, only 2 of her children have the same father. Her children have been in and out of foster homes for years, mainly because of neglect. Jenna has an addiction to crack cocaine and crystal methamphetamine. Jenna's current boyfriend is a dealer of methamphetamine. When he uses methamphetamine, he becomes verbally, physically and sexually abusive to Jenna. But in order to get meth for herself, she tolerates his behavior. Jenna's last boyfriend is currently in prison for drug offenses. He was also abusive to her. The father of 2 of her children is also in prison, for aggravated assault of Jenna and her oldest child, who is hearing impaired and in special education as a result of head trauma sustained during that beating. Jenna grew up watching her father beat her mother and enduring sexual abuse at the hands of 2 different uncles for most of her childhood.

Jenna's never held a job more than 2 weeks; she has a great deal of anxiety that often comes out as anger and irritability, making it difficult for her to get along with coworkers. Jenna is on welfare. Her children have a variety of difficulties. In addition to special education services, her children see several other specialists. They include mental health and behavioral specialists; several of her children take psychotropic medications. Two of the children have had psychiatric hospitalizations. The family continues to have an open case with the Florida Department of Children and Families. A social worker comes out to visit Jenna every few weeks. Jenna wishes they would all just leave her alone.

Each year, women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults (CDC, 2011). These assaults result in injuries that lead to over 73,000 hospitalizations and 1,500 deaths. In addition to the physical injuries domestic violence causes, it is also a major risk factor for mental health disorders. For example, one study found that 61 percent of women diagnosed with depression had also experienced domestic violence—a rate two times that of the general population (Kass-Bartlemes, 2004).

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (CDC, 2008a; Johnson & Leone, 2005). Women who are victims of abuse suffer long-term consequences such as poor health status; decreased quality of life and high use of healthcare services (CDC, 2008a; Campbell et al., 2002). Research indicates that women who experience IPV are at increased risk for a wide range of medical and psychologic morbidities, including headaches, chronic pain, gastrointestinal and gynecologic symptoms, depression and anxiety, and acute and chronic injuries (Rivera, et al, 2007). Abused women are six to eight times more likely to use health care services than nonabused women (USDHHS, 2011a). However, often those who have been abused do not present to emergency departments or primary or urgent care offices with overt trauma or injury, despite their significant injuries. Less than one-fifth of victims reporting an injury from intimate partner violence sought medical treatment following the injury (NCADV, 2007a).

The higher utilization of healthcare services does not end with the cessation of IPV/DV. Rivera, et al. (2007) found that women who ever had experienced IPV/DV had approximately 50% higher usage of emergency department (ED) visits, twofold higher for mental health visits, and sixfold higher for use of alcohol or drug services than women who had no history of IPV/DV. The number of visits for primary and specialty care and pharmacy use was 14% to 21% higher in women with IPV/DV, ever compared to those with no history of IPV/DV. Rates of use were highest during the period of IPV and decreased after cessation of IPV. Nevertheless, even 5 years after the cessation of IPV/DV, women with a prior history of IPV/DV still had significantly higher use rates for all types of services except inpatient hospital care.

Among physicians who treat patients who are victims of abuse, success in treatment was not viewed as disclosure of the abuse, but rather success was seen as the development of a longitudinal trust relationship. That was necessary before women will admit that their injuries, often discovered during care for some other healthcare problem, are a result of IPV/DV (Campbell, et. al, 2002).

Physical Consequences of Violence

Physical and psychological abuse is connected to chronic health problems such as gastrointestinal disorders, chronic pain syndrome, depression, and suicidal behavior (USDHHS, 2011a; Bonomi, et al., 2009; CDC, 2008a).

- Bruises
- Knife wounds
- Pelvic pain
- Headaches
- Back pain
- Broken bones
- Gynecological disorders
- Pregnancy difficulties like low birth weight babies and perinatal deaths
- Sexually transmitted diseases including HIV/AIDS
- Degenerative joint disease
- Trauma related joint disorders
- Central nervous system disorders
- Gastrointestinal disorders
- Symptoms of post-traumatic stress disorder:
 - Emotional detachment
 - Sleep disturbances
 - Flashbacks
 - Replaying assault in mind
- Heart or circulatory conditions

Psychological Consequences of Violence

Physical violence is typically accompanied by emotional or psychological abuse (Tjaden & Thoennes 2000a). IPV/DV, whether sexual, physical, or psychological, can lead to various psychological consequences for victims. The most common forms of mental health disorder arising from IPV/DV are (USDHHS, 2011a; Bonomi, et al., 2009; CDC, 2008a; Roberts, Klein, & Fisher, 2003; Coker et al., 2002; Heise & Garcia-Moreno, 2002):

- Depression
- Post-traumatic Stress Disorder
- Substance Abuse Disorders

Other mental health issues include (Bonomi, et al., 2009, CDC, 2008a; USDHHS, 2011a):

- Suicidal behavior
- Anxiety
- Low self-esteem
- Antisocial behavior
- Inability to trust
- Fear of intimacy
- Family and social problems
- Tobacco use

Intimate partner violence results in more than **18.5 million mental health care visits** each year (NCADV, 2007a).

Unhealthy/Risky Behaviors Related to Violence

Women with a history of IPV/DV are more likely to display behaviors that present further health risks. These behaviors may be a result of force by the abuser, an inability to negotiate for protection due to limited power within the relationship, a means of numbing oneself, already feeling that there is no point in trying to be healthy within the context of abuse, and perhaps an attempt to seek help from healthcare providers through the overuse of health services.

IPV/DV is associated with a variety of negative health behaviors (CDC, 2008a):

- Engaging in high-risk sexual behavior - This can be the result of force on the part of the abuser. But it is important to remember that abused persons are not generally able to negotiate safer sex practices, which can keep them safe from blood borne pathogens and other sexually transmitted diseases. Since the perpetrator is motivated by power and control, women who are abused by their partners do not generally have enough power in their relationships to insure their own safety from their abusers in many ways, including safety during sex. Some of the high risk sexual behaviors can include:
 - Unprotected sex
 - Decreased condom use
 - Early sexual initiation
 - Choosing unhealthy sexual partners
 - Having multiple sex partners
 - Trading sex for food, money, or other items, either by choice or by force
 - Unwanted pregnancies
- Using or abusing harmful substances - A way of numbing oneself the trauma of an abusive life include:
 - Smoking cigarettes
 - Drinking alcohol
 - Driving after drinking alcohol
 - Using drugs
- Unhealthy diet-related behaviors:
 - Fasting
 - Vomiting
 - Abusing diet pills
 - Overeating

Overuse or underuse of health services

Social Consequences of Violence

Victims of IPV/DV sometimes face the following social consequences (CDC, 2011; Plichta, 2004; Heise & Garcia-Moreno 2002):

- Isolation from social networks, including family, friends, work and/or school
- Restricted access to services
- Strained relationships with healthcare providers
- Poor work performance or strained relationships with employers

Economic Consequences of Violence

- Costs of IPV/DV against women in 1995 exceed an estimated \$5.8 billion. These costs include nearly \$4.1 billion in the direct costs of medical and mental health care and nearly \$1.8 billion in the indirect costs of lost productivity. This is generally considered an underestimate because the costs associated with the criminal justice system were not included (CDC, 2008a).
- When updated to 2003 dollars, IPV/DV costs exceed \$8.3 billion, which includes \$460 million for rape, \$6.2 billion for physical assault, \$461 million for stalking, and \$1.2 billion in the value of lost lives (CDC, 2008a; Max et al., 2004).
- Victims of severe IPV/DV lose nearly 8 million days of paid work-the equivalent of more than 32,000 full-time jobs-and almost 5.6 million days of household productivity each year (CDC, 2008a).
- Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children's lives threatened) are more likely to have been unemployed in the past, have health problems, and be receiving public assistance (CDC, 2008a).

Risk Factors for Victimization and Perpetration

Risk factors are associated with a greater likelihood of IPV/DV victimization or perpetration. Risk factors are not necessarily direct causes of IPV/DV, but are contributing factors to IPV/DV (CDC, 2008a). Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for IPV/DV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV/DV perpetration and victimization (CDC, 2008a).

The public health approach aims to moderate and mediate those contributing factors that are preventable, and to increase protective factors, which reduce risk of victimization and perpetration (CDC, 2008a).

A combination of individual, relational, community, and societal factors contribute to the risk of being a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various points of prevention intervention (CDC, 2008a).

Risk Factors for Victimization

Multiple factors influence the risk of victimization (CDC, 2008a; Crandall, et al., 2004; Heise & Garcia-Moreno, 2002; Tjaden & Thoennes, 2000a)

Individual Factors

- Prior history of DV/IPV
- Being female

- Low self-esteem
- Young age
- Depression
- Heavy alcohol and drug use
- High-risk sexual behavior
- Witnessing or experiencing violence as a child
- Being less educated
- Unemployment
- For men, having a different ethnicity from their partner's
- For women, having a greater education level than their partner's
- For women, being American Indian/Alaska Native or African American
- For women, having a verbally abusive, jealous, or possessive partner

Relationship Factors

- Couples with income, educational, or job status disparities
- Dominance and control of the relationship by one partner

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital-lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
- Weak community sanctions against DV/IPV (e.g., police unwilling to intervene)

Societal Factors

- Patriarchal gender norms (e.g., women should stay at home, not enter workforce, should be submissive)

Risk Factors for Perpetration of Violence

Multiple factors influence the risk of perpetrating IPV/DV (CDC, 2008a; Garcia-Moreno, 2002; Tjaden & Thoennes, 2000a):

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Involvement in aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Personality disorders
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Economic stress
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)

- Desire for power and control in relationships
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child

Relationship Factors

- Marital conflict-fights, tension, and other struggles
- Marital instability-divorces and separations
- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

Community Factors

- Poverty and associated factors (e.g., overcrowding)
- Low social capital-lack of institutions, relationships, and norms that shape that community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)

Societal Factors

- Patriarchal gender norms (e.g., women should stay at home, not enter workforce, should be submissive to their male relatives, men support the family and make decisions, etc.)

Dynamics of Abuse

According to the National Coalition Against Domestic Violence (NCADV, nd c),

“Battering is a pattern of behavior used to establish power and control over another person with whom an intimate relationship is or has been shared through fear and intimidation, often including the threat or use of violence. Battering happens when one person believes that they are entitled to control another.”

A significant component of dynamics of IPV/DV is the power and control the perpetrator has over the victim. The Power and Control wheel was developed by the Duluth Violence Prevention Program. It came from the work of battered women in Duluth, Iowa who had been abused by their male partners and were attending women's education groups sponsored by the women's shelter. The Wheel used in the curriculum is for men who have used violence against their female partners. The Duluth Project recognizes that there are women who use violence against men, and that there are men and women in same-sex relationships who use violence, this wheel is meant specifically to illustrate men's abusive behaviors toward women.

IPV/DV relationships are highly unequal relationships. The Power and Control Wheel identifies how the perpetrator utilizes a number of strategies to gain and maintain power and control over

the victim. The perpetrator uses power and control to problem solve, make decisions and exert his own will on the victim.

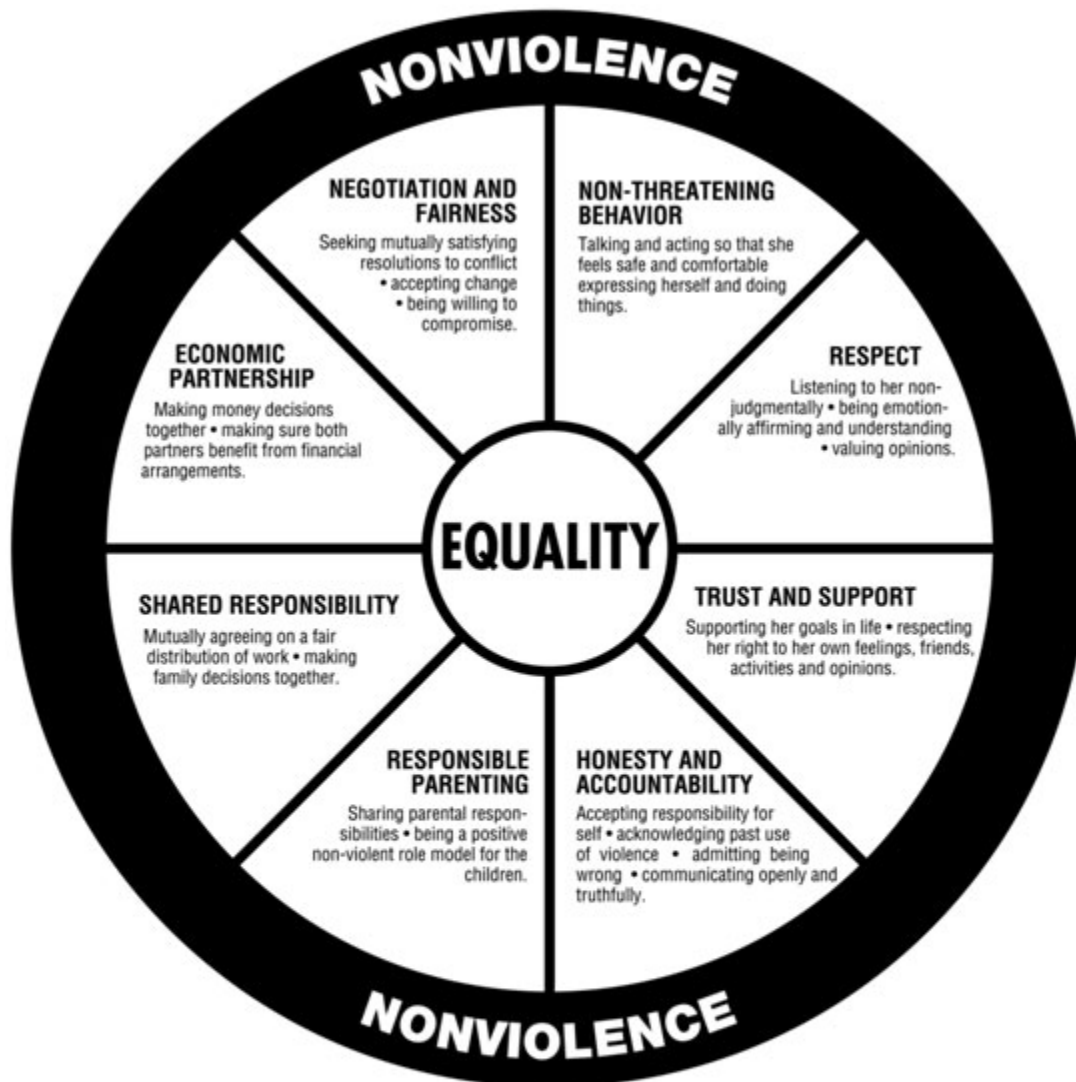


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Some men feel remorse and guilt after an episode of violent behavior and become loving and caring. This behavior can give the woman hope and allows her to stay in the relationship until the next episode. This perpetuates the cycle (Saddock & Saddock, 2004).

Treatment in IPV/DV relationships aims to equalize the power in the relationship and stop the violence against victims.



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Select Populations and IPV/DV

Pregnancy and IPV/DV

Pregnancy can be a vulnerable time for victims of IPV/DV. Fifty to 70 % of women who were abused prior to pregnancy are also abused during pregnancy. Among pregnant teens, 26% reported that they were abused by their boyfriends during pregnancy; almost half reported that the abuse began or intensified prior to the pregnancy (NCADV, nd,b). Murder is the second leading cause of injury-related death for pregnant women (31%), after car accidents (NCADV, nd.b).

According to The Family Violence Prevention Fund (2004a), 15.9 percent of pregnant women are victims of IPV/DV; among adolescents, the rate of victimization rises to 21.7 percent.

The consequences for women who were victimized during pregnancy, as well as their infants, include (NCADV, nd,b; Jasinski, 2004; Gazmarian, et al., 2000):

- Late entry into prenatal care;
- Low birth weight babies;
- Anemia;
- Infections;
- Premature labor;
- Unhealthy maternal behaviors (such as smoking, drinking, drug use, etc.);
- Fetal trauma;
- Sexually transmitted diseases, including HIV-1;
- Urinary tract-infections;
- Substance abuse;
- Depression;
- Post-partum depression; and
- Other mental health conditions.

It is recommended that all pregnant women be screened for the presence of IPV/DV (ACOG, 2011, COINN, 2010; Certain, et al., 2008).

Children and IPV/DV

According to the Family Violence Prevention Fund (2004a) the estimates of the numbers of children who are exposed to intimate partner violence vary greatly, from 3.3 million to ten million children per year. The number varies depending on the specific definitions of witnessing violence, the source of interview and the age of child included in the survey. In 30-60% of homes where IPV/DV is occurring, children are also being abused.

According to the National Coalition Against Domestic Violence (nd) witnessing violence between one's parents or caretakers is the strongest risk factor of transmitting violent behavior from one generation to the next. Boys who witness IPV/DV are *twice as likely* to abuse their own partners and children when they become adults.

There are many studies that have identified the negative impact of IPV/DV on children (FVPPF, 2004a). Generally, children under five, and adolescents have the highest incidence of being victimized.

Post traumatic stress disorder is a response that children have to IPV/DV, particularly in situations of chronic violence. One study reported that exposure to IPV/DV, without having directly been abused, was enough to cause significant symptoms in 85% of children (FVPPF, 2004a).

Behavioral and physical problems can result from witnessing IPV/DV. These include (FVPPF, 2004a):

- Violence towards peers;
- Academic and social problems at school;
- Drug and alcohol abuse;
- Truancy;
- Running away from home;
- Sexual assault of other children;
- Prostitution;
- Hypervigilance;
- Poor concentration and distractibility;
- Chronic somatic complaints;
- Depression;
- Anxiety;
- Sleep difficulties;
- Attempted suicide.

In homes where IPV/DV occurs, children learn that violence is a method of problem solving in interpersonal relationships. They also learn that in “loving” relationships, violence is a given.

Dating Violence/Date Rape Drugs

Dating violence is when one person purposely causes physical or psychological harm to another person they are dating, including sexual assault, physical abuse, and psychological/emotional abuse. It is a serious crime that occurs in both casual and serious relationships, and in both heterosexual and same-sex relationships. Sometimes, a victim might unknowingly be given alcohol or so called "date rape" drugs (USDHHS, 20011).

These are drugs that are sometimes used to assist a sexual assault. Sexual assault is any type of sexual activity that a person does not agree to. It can include inappropriate touching, vaginal, anal or oral penetration, sexual intercourse, rape, and attempted rape. The drugs often have no color, smell, or taste and are easily added to flavored drinks without the victim's knowledge. These drugs can cause the victim to be weak, confused, lose consciousness. Because of these effects, victims may be physically helpless, unable to refuse sex, and may not remember what happened while drugged. Date rape drugs are used on both females and males. The victim is then left to deal with the trauma of the sexual assault and the uncertainty surrounding the

specifics of the crime. Unfortunately, most cases of dating violence are not reported to the police (USDHHS, 20011; USDHHS, 2008a).

These drugs also are known as "club drugs" because they tend to be used at dance clubs, concerts, and raves. There are at least three common date rape drugs (USDHHS, 2008a):

- GHB (gamma hydroxybutyric acid)
- Rohypnol (flunitrazepam)
- Ketamine (ketamine hydrochloride)

Case Study 5. Tiffany

Tiffany is 20 year old college student. Last year at a dorm party (where Tiffany knew almost all of the people who attended the party) she awoke in a friend's room, under a pile of coats with no clothes on. She doesn't remember at all what happened that night, except when she awoke, there were others sleeping in the room on the floor and her genital area was sore, wet and sticky. She got dressed and ran back to her own room to find her best friend and roommate. Tiffany cried with her roommate and together they called the police. The police officers brought her to the emergency room. In talking with the nurse in the emergency department, Tiffany learned that she had probably been victimized through the use of so-called "date rape drugs".

Since that night, Tiffany has had a number of emotional responses; some of them very distressing. She started therapy because of difficulty with trust. She knew all the people at the party; someone she knew had drugged her and raped her; she just was so depressed when she thought about it.

The term "date rape" is widely used. But most experts prefer the term "drug-facilitated sexual assault." These drugs also are used to help people commit other crimes, like robbery and physical assault. The term "date rape" also can be misleading because the person who commits the crime might not be dating the victim. Rather, it could be an acquaintance or stranger (USDHHS, 2008a).

GHB

GHB, short for gamma hydroxybutyric acid is also known as (USDHHS, 2008b):

- Bedtime Scoop
- Cherry Meth
- Easy Lay
- Energy Drink
- G
- Gamma 10

- Georgia Home Boy
- G-Juice
- Gook
- Goop
- Great Hormones
- Grievous Bodily Harm (GBH)
- Liquid E
- Liquid Ecstasy
- Liquid X
- PM
- Salt Water
- Soap
- Somatomax
- Vita-G

GHB takes effect in about 15 minutes and can last 3 or 4 hours. It is very potent, so overdose is not uncommon. Most GHB is made by people in home or street labs making it difficult to know exactly what is in it or what symptoms it can cause. Generally, GHB can cause the following (USDHHS, 2008a):

- Relaxation
- Drowsiness
- Dizziness
- Nausea
- Problems seeing
- Unconsciousness (black out)
- Seizures
- Can't remember what happened while drugged
- Problems breathing
- Tremors
- Sweating
- Vomiting
- Slow heart rate
- Dream-like feeling
- Coma
- Death

Rohypnol

Rohypnol is the trade name for flunitrazepam. Abuse of two similar drugs appears to have replaced Rohypnol abuse in some parts of the United States. These are: clonazepam (marketed as Klonopin in the U.S. and Rivotril in Mexico) and alprazolam (marketed as Xanax). Rohypnol is also known as:

- Circles
- Forget Pill

- LA Rochas
- Lunch Money
- Mexican Valium
- Mind Erasers
- Poor Man's Quaalude
- R-2
- Rib
- Roach
- Roach-2
- Roches
- Roofies
- Roopies
- Rope
- Rophies
- Ruffies
- Trip-and-Fall
- Whiteys

The effects of Rohypnol can be felt within 30 minutes of being drugged and can last for several hours. Rohypnol can cause the following (USDHHS, 2008a):

- Can't remember what happened while drugged
- Lower blood pressure
- Sleepiness
- Muscle relaxation or loss of muscle control
- Drunk feeling
- Nausea
- Problems talking
- Difficulty with motor movements
- Loss of consciousness
- Confusion
- Vision problems
- Dizziness
- Confusion
- Death

Ketamine

Ketamine is also known as (USDHHS, 2008a):

- Black Hole
- Bump
- Cat Valium
- Green

- Jet
- K
- K-Hole
- Kit Kat
- Psychedelic Heroin
- Purple
- Special K
- Super Acid

Ketamine is very fast-acting. The victim might be aware of what is happening, but be unable to move. Because it also causes memory problems, the victim might not be able to remember what happened while drugged. Ketamine can cause the following (USDHHS, 2008a):

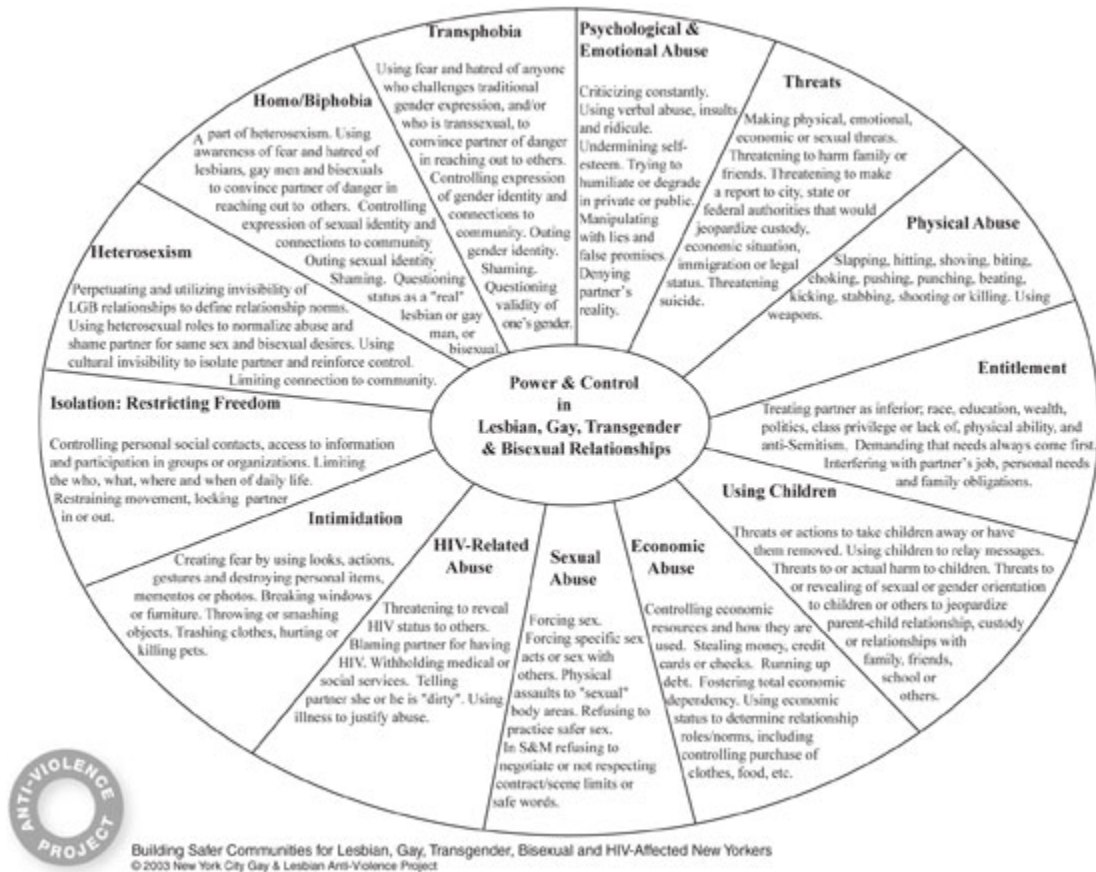
- Distorted perceptions of sight and sound
- Lost sense of time and identity
- Out of body experiences
- Feeling out of control
- Impaired motor function
- Problems breathing
- Convulsions
- Vomiting
- Memory problems
- Dream-like feeling
- Numbness
- Loss of coordination
- Aggressive or violent behavior
- Slurred speech
- High blood pressure
- Depression

IPV/DV in Same-Sex Relationships

Generally, it is thought that the prevalence of IPV/DV among lesbians, gay men, bi-sexuals and transgendered individuals (LGBT) is roughly the same as for heterosexual women. However, given that accurate statistics for heterosexual IPV/DV is difficult to obtain and interpret, it is even more difficult with same-sex partners because of the additional layer of secrecy that being homosexual may require for many LGBT persons. Thus, the learner should keep in mind that the numbers are likely to be much higher than reported. Additionally, for a host of reasons, including heterosexism and transphobia, there is relatively little scientific research that has been done on the topic of LGBT IPV/DV (NCAVP, 2008).

There were 3,319 reported incidents of intimate partner violence affecting lesbians, gay men, bisexuals and transgendered individuals (LGBT) individuals in 2007. This was a decrease (-13%) over the 3,839 incidents reported by National Coalition of Anti Violence Project (NCAVP) members in 2006 (NCAVP, 2008). (Note: The NCAVP is comprised of 16 organizations, representing 14 regions in the US, who participated in developing this report, submitting statistical data for 2007 and/or written summaries, narratives, or other information. Those regions include Tucson, AZ; San Francisco, CA; Los Angeles, CA; Colorado; Chicago, IL;

Boston, MA; Kansas City, MO; New York, NY; Columbus, OH; Philadelphia, PA; Houston, TX; Virginia; Seattle, WA; and Milwaukee, WI.)



(New York Anti-Violence Project, email to webmaster@apv.org, 2009)

Barriers to addressing LGBT intimate partner violence (both for service providers and survivors) include (NCADV, n.d.a):

- The belief that domestic violence does not occur in LGBT relationships and/or is a gender based issue;
- Societal anti-LGBT bias (homophobia, biphobia and transphobia);
- Lack of appropriate training regarding LGBT domestic violence for service providers;
- A fear that airing of the problems among the LGBT population will take away from progress toward equality or fuel anti-LGBT bias.
- Domestic violence shelters are typically female only, thus transgender people may not be allowed entrance into shelters or emergency facilities due to their gender/genital/legal status.

Barriers to Identification of Intimate Partner Violence/Domestic Violence

The literature is full of references that victims are reluctant to disclose IPV/DV to healthcare providers and that healthcare providers are reluctant to ask patients about IPV/DV. Most commonly cited reasons that patients do not disclose is:

- Fear of retaliation by the abuser;
- Shame, humiliation and denial about the seriousness of the abuse; and
- Concern about confidentiality, especially related to law enforcement involvement.

In cases when injuries and health problems are apparent and well documented, healthcare providers often do not ask about IPV/DV or intervene on behalf of their patients who experience it. One study found that only 6 percent of physicians ask their patients about possible IPV/DV, yet 88 percent admitted that they knew they had female patients who had been abused. Another study indicated that 48 percent of women supported routine screening of all women, with 86 percent stating it would make it easier to get help (Kass-Bartlesme, 2004).

Healthcare providers have said that they do not screen for IPV/DV because (Darrow, et al, 2007; Tjaden, P. & Thoennes, N., 2002; Borowsky, I.W., Ireland, M., 2002; Elliott, L., Nerney, M., Jones, T., et al., 2002; Gerbert, et. al., 1999):

- They lack the necessary training and education, time, tools, and support resources, and
- Fear of offending the patient;
- Frustration with the lack of change in the patient's situation or frustrations with the patient's unresponsiveness to advice;
- They do not feel they can make a difference;
- Feelings of powerlessness to "fix" the situation; and
- Their sense of loss of control over the patient's decision making.

An AHRQ-funded survey found that many primary care clinicians, nurses, physician assistants, and medical assistants lack confidence in their ability to manage and care for victims of IPV/DV (Sugg, et. al., 1999):

- Only 22 percent had attended any educational program on IPV/DV within the previous year;
- Over 25 percent of physicians and nearly 50 percent of nurses, physician assistants, and medical assistants stated that they were not at all confident in asking their patients about physical abuse;
- Less than 20 percent of clinicians asked about IPV/DV when treating their patients for high-risk conditions such as injuries, depression or anxiety, chronic pelvic pain, headache, and irritable bowel syndrome;
- Only 23 percent of physicians, nurses, physician assistants, and medical assistants believed they had strategies that could assist victims of IPV/DV.

A recent study of emergency department nurses (Darrow, et al., 2007) identified the following barriers to screening patients for IPV/DV:

- Language difference;
- Lack of training in how to deal with abuse; and
- Time issues affected their ability to adequately screen patients.

For information regarding the specific studies referred to above, go to <http://www.ahrq.gov/research/domviolria/domviolria.htm#more>.

An additional factor for nurses in the identification of IPV/DV, is that so many nurses are victims of intimate partner violence. Furniss (1999) reported that 38% of obstetric nurses are or have been the victims of domestic violence. She reported on a study by Janssen, et al.,(1998) that:

- 38% of the nurses completing the survey said they had experienced abuse;
- 27.3% said that their partners try to control them;
- 26.9% said they suffer emotional abuse;
- 22.7% are afraid of their partners;
- 14.6% have been battered;
- 8.1% have experienced sexual abuse.

Darrow, et al., (2007) also identified personal or family history of abuse as a factor why nurses do not screen for IPV/DV.

Best Practice Guidelines for Domestic Violence/Intimate Partner Violence

With the current focus on evidence-based practice, the Agency for Healthcare Research and Quality (AHRQ) reported that the U.S. Preventive Services Task Force (USPSTF) did not find enough evidence to recommend for or against routine screening for IPV/DV among the general population. However, the USPSTF reinforced the necessity for healthcare providers to be able to identify the signs and symptoms of IPV/DV, document the evidence, provide treatment for victims, and refer victims to counseling and social agencies that can provide assistance (Kass-Bartlesme, 2004).

Identifying IPV/DV in healthcare is critical. Many professional organizations recommend routine screening for IPV/DV. Among them are (Horner, 2005): the American Association of Colleges of Nursing, the American Nurses Association, the American Academy of Pediatrics (AAP), American College of Nurse Midwives, and National Association of Pediatric Nurse Practitioners.

A focus on outcomes in healthcare has helped to fuel the work of identifying best practice guidelines or evidence-based practice. Through the work of a panel of content experts, research review and literature review have helped to shape these guidelines. This process has yielded best practice guidelines for a number of different illnesses and conditions (see Resource section of this course for more information on these guidelines).

The federal government's National Guideline Clearinghouse, identifies guidelines for intervention in IPV/DV. They list The Family Violence Prevention Fund's 2004 publication of *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*. The full reference appears in the Reference section of this course; the full guidelines can be retrieved from the Family Violence Prevention website at <http://endabuse.org/programs/display.php3?DocID=206>. These guidelines will be referred to as the Guidelines during this course.

These Guidelines offer a variety of healthcare professionals, working in a variety of healthcare settings, the ability to address IPV/DV. Responses to intimate partner victims are most efficient and effective when coordinated in a multi-disciplinary manner and in collaboration with IPV/DV advocates so that no single provider is responsible for the entire intervention.

In order to effectively be able to identify and respond to IPV/DV, healthcare providers must have information and training on the subject. They need to be able to feel comfortable asking a

patient about IPV/DV and they need to feel as though they have something to offer the patient, once IPV/DV is disclosed.

Training sessions funded by AHRQ improved primary care providers' confidence in asking and treating victims of domestic violence. Providers who participated in the training increased their screening for domestic violence from 3.5 percent prior to the training program to 20.5 percent after training. In their research, after completion of the training sessions, participants stated they (Kass-Bartlesme, 2004):

- Felt less fear of offending patients by asking about domestic violence.
- Had less fear for their own safety.
- Asked patients more often about possible domestic violence.
- Offered strategies to abusers to seek help.
- Provided strategies so victims could change their situation.
- Had better access to information on managing domestic violence.
- Had methods to ask abusers about domestic violence while minimizing the risk to the victims.

Using a public health model, that has been effective in treating other conditions and illnesses (for example, smoking cessation, drinking and driving campaigns, immunizations, etc.), it is the routine inquiry and assessment that can identify IPV/DV. Making routine inquiry and assessment of IPV/DV a routine part of healthcare history and examination, reinforces the role of healthcare providers in IPV/DV and gives the patient information about where to receive assistance if she chooses. Even if patients choose not to disclose the abuse, they know that the healthcare provider can be approached about the subject in the future.

The Guidelines recommend that all adolescent and adult patients are routinely assessed for IPV/DV. These women want help. Some studies have shown that approximately 70 to 81 percent of survivors of abuse want their health care professionals to ask them about domestic abuse during their appointments (USDHHS, 2008). Patients should be asked about current and lifetime exposure to IPV/DV victimization. Direct questions about physical, emotional and sexual abuse should be asked. Due to the long term consequences of IPV/DV on health, the Guidelines recommend integrating assessment for current and lifetime exposure into routine care. They acknowledge that in some settings lifetime exposure assessment may be limited due to time constraints, such as emergency departments or urgent care facilities.

Inquiry for past and present IPV/DV should occur:

- As part of the routine health history (e.g. social history/review of systems);
- As part of the standard health assessment (or at every encounter in urgent care);
- During every new patient encounter;
- During periodic comprehensive health visits (assess for current IPV/DV victimization only);
- During a visit for a new chief complaint (assess for current IPV/DV victimization only);
- At every new intimate relationship (assess for current IPV/DV victimization only);
- When signs and symptoms raise concerns or at other times at the provider's discretion.

Assessment for IPV/DV should be:

- Conducted routinely, regardless of the presence or absence of indicators of abuse;

- Conducted verbally as part of a face-to-face health care encounter;
- Included in written or computer based health questionnaires;
- Direct and nonjudgmental using language that is culturally/linguistically appropriate;
- Conducted in private: no friends, relatives (except children under 3) or caregivers should be present;
- Confidential: prior to inquiry, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality;
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends or family socially.

The goals of the assessment are to:

- Create a supportive environment in which the patient can discuss the abuse;
- Enable the provider to gather information about health problems associated with the abuse; and
- Assess the immediate and long-term health and safety needs for the patient in order to develop and implement a response.

The timing of assessment is important:

- Initial assessment should occur immediately after disclosure;
- Repeat and/or expanded assessments should occur during follow-up appointments;
- At least one follow-up appointment (or referral) should be offered after disclosure of current or past abuse with health care provider, social worker or DV advocate.

Case Study 1. Roseanne (continued)

Today at work, Roseanne is caring for a baby in the neonatal intensive care whose mother has only come to the NICU for 2 hours in the past week. Roseanne watches the mom; she recognizes the bruises on her face, not quite covered up by makeup. She appears anxious and is tearful. Roseanne knows just how she feels-but she cannot bring herself to ask the mom about her experience. Roseanne decides to talk with her supervisor; she admits that she suspects IPV/DV in the family of the baby she is caring for. She then begins to cry and tells her supervisor that she recognizes the abuse because it looks so much like her own situation.

Roseanne requests that the supervisor intervene on behalf of the mom and screen for IPV/DV, because Roseanne is unable to do so. Roseanne's supervisor offers her support to Roseanne both for the patient and for Roseanne herself. She talks with Roseanne about safety planning, refers her to the Employee Assistance Program at work and offers emotional support as well. Roseanne recognizes that she has to make a change, but she isn't sure what to do.

According to the American College of Obstetricians and Gynecologists (ACOG), IPV/DV screening, which they recommend should be conducted on ALL patients, can be conducted by making the following statement and asking these three simple questions (ACOG, 2011).

"Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence:

1. Within the past year -- or since you have been pregnant -- have you been hit, slapped, kicked or otherwise physically hurt by someone?
2. Are you in a relationship with a person who threatens or physically hurts you?
3. Has anyone forced you to have sexual activities that made you feel uncomfortable?"

Pregnant women should be screened throughout the pregnancy because some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy (ACOG, 2011).

Screening should occur (ACOG, 2011):

- At the first prenatal visit
- At least once per trimester, and
- At the postpartum checkup.

ACOG also suggests that screening should occur for women who are not pregnant (ACOG, 2011):

- At routine ob-gyn visits;
- Family planning visits;
- Preconception visits.

If the patient says "no":

- Respect the patient's response;
- Let the patient know that you are available should the situation ever change;
- Assess again at previously recommended intervals;
- If patient says "no" but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms.

Interventions will vary based on the severity of the abuse, the patient's decisions about what s/he wants for assistance at that time and if the abuse is happening currently. It is important to let the patient know that you will help regardless of whether s/he decides to stay in or leave the abusive relationship. It is also important for the healthcare provider to NOT impose her or his own values onto the patient. Since the patient is already suffering from the abuse of control and power, the healthcare provider should support the patient to make her/his own decisions and not further exert power over the patient by making decisions for her/him.

For the patient who discloses current abuse, assessment should include at a minimum an **assessment of immediate safety**:

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Have there been threats or direct abuse of the children (if s/he has children)?"
- "Are you afraid your life may be in danger?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"
- "Has your partner used weapons, alcohol or drugs?"
- "Has your partner ever held you or your children against your will?"
- "Does your partner ever watch you closely, follow you or stalk you?"
- "Has your partner ever threatened to kill you, him/herself or your children?"

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment.

Assess the impact of the IPV (past or present) on the patient's health. There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these healthcare risks and assess:

- How the (current or past) IPV/DV victimization affects the presenting health issue
- "Does your partner control you access to healthcare or how you care for yourself?"
- How the (current or past) IPV/DV victimization relates to other associated health issues

Assessment of the pattern and history of current abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"
- "Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?"
- "Have other family members, children or pets been hurt by your partner?"
- "Does your partner control your activities, money or children?"

For all patients who disclose current abuse, providers should:

- **Provide validation:**
 - Listen non-judgmentally;
 - "I am concerned for your safety (and the safety of your children)";
 - "You are not alone and help is available";
 - "You don't deserve the abuse and it is not your fault";
 - "Stopping the abuse is the responsibility of your partner not you". "
- **Provide information:**
 - "Domestic violence is common and happens in all kinds of relationships";
 - "Violence tends to continue and often becomes more frequent and severe";
 - "Abuse can impact your health in many ways";

- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones".
- **Respond to safety issues:**
 - Offer the patient a brochure about safety planning and go over it with her/him (see Appendix D for a sample safety plan);
 - Review ideas about keeping information private and safe from the abuser;
 - Offer the patient immediate and private access to an advocate in person or via phone;
 - Offer to have a provider or advocate discuss safety then or at a later appointment;
 - If the patient wants immediate police assistance, offer to place the call;
 - Reinforce the patient's autonomy in making decisions regarding her/his safety;
 - If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained.
 - Make referrals to local resources:
 - Describe any advocacy and support systems within the health care setting
 - Refer patient to advocacy and support services within the community
 - Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or lesbian, gay, transgender or bisexual clients)
 - Offer a choice of available referrals including on-site advocates, social workers, local IPV/DV resources or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224 and local **Florida Domestic Violence Hotline at 1-800-500-1119**.

For the patient who discloses past history of IPV/DV victimization, obtain the answers to the following, to help direct recommendations for referral:

- "When did the abuse occur?"
- "Do you feel you are still at risk?"
- "Are you in contact with your ex-partner?" "Do you share children or custody?"
- "How do you think the abuse has affected you emotionally and physically?"

Confidentiality

Inappropriate disclosure of health information may violate patient/provider confidentiality, including the federal Healthcare Insurance Portability Act (HIPAA). As important, the inappropriate disclosure of suspected IPV/DV can threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV/DV should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV/DV.

Reporting Laws in Florida

Florida mandates that reports are made for the treatment of gunshot wounds. Florida statute requires **that physicians, nurses and employees or hospitals, clinics, nursing homes and sanitariums must report treating any person sustaining a gunshot wound, or life-threatening injury indicating an act of violence, or receiving a request for such treatment.** Reports are to be made to the sheriff's department or the police department. Failing to report is a 1st degree misdemeanor and is punishable by up to a \$1,000 fine and up to one year in prison.

Florida law also mandates the reporting of child abuse or neglect and elder abuse or abuse of the disabled.

Documentation

Documentation is critical, both for the protection of the patient and of the healthcare provider. Document relevant history, including:

- Chief complaint or history of present illness.
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.
- For current IPV/DV victims, document a summary of past and current abuse including:
 - Social history, including relationship to abuser and abusers name if possible;
 - Patient's statement about what happened, not what lead up to the abuse (e.g. "boyfriend John Smith hit me in the face" not "patient arguing over money");
 - Include the date, time, and location of incidents where possible;
 - Patients appearance and demeanor (e.g. "tearful, shirt ripped" not "distraught");
 - Any objects or weapons used in an assault (e.g. knife, iron, closed or open fist);
 - Patients accounts of any threats made or other psychological abuse;
- Names or descriptions of any witnesses to the abuse.

Document results of physical examination:

- Findings related to IPV/DV, neurological, gynecological, mental status exam if indicated; " If there are injuries, (present or past) describe type, color, texture, size, and location;
- Use a body map and/or photographs to supplement written description;
- Obtain a consent form prior to photographing patient. Include a label and date.

Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse Document results of assessment, intervention and referral:
- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide and health impact of IPV/DV; " Document referrals made and options discussed;
- Document follow-up arrangements.

If patient does not disclose IPV/DV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse;
- If you suspect abuse, document your reasons for concerns: i.e. "physical findings are not congruent with history or description," "patient presents with indications of abuse".

Follow-up

At least one follow-up appointment (or referral) with a healthcare provider, social worker or IPV/DV advocate should be offered after disclosure of current or past abuse:

- "If you like, we can set up a follow-up appointment (or referral) to discuss this further";
- "Is there a number or address that is safe to use to contact you?";
- "Are there days/hours when we can reach you alone?";
- "Is it safe for us to make an appointment reminder call?".

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV/DV;
- Communicate concern and assess both safety and coping or survival strategies:
 - "I am still concerned for your health and safety"
 - "Have you sought counseling, a support group or other assistance?"
 - "Has there been any escalation in the severity or frequency of the abuse?"
 - "Have you developed or used a safety plan?"
 - "Told any family or friends about the abuse?"
 - "Have you talked with your children about the abuse and what to do to stay safe?"
 - Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.).

RADAR

A simple method for remembering the basics of the Guidelines is to use the RADAR method of inquiry and assessment for IPV/DV. RADAR is a mnemonic: R=Routinely screen female patients; A=Ask direct questions; D=Document your findings; A=Assess patient safety; R=Review options and referrals.

Figure 1. RADAR Intervention Method

R = Routinely Screen Female Patients

Although many women who are victims of IPV/DV will not volunteer any information, they will discuss it if asked simple, direct questions in a nonjudgmental way and in a confidential setting. Interview the patient alone.

A = Ask Direct Questions

- "Because violence is so common in many women's lives, I've begun to ask about it routinely."

- "Are you in a relationship in which you have been physically hurt or threatened?" If no, "Have you even been?"
- "Have you ever been hit, kicked or punched by your partner?"
- "Do you feel safe at home?"
- "I notice you have a number of bruises; did someone do this to you?"
- **If the patient answers "yes":** Encourage her to talk about it: "Would you like to talk about what has happened to you?" "How do you feel about it?" "What would you like to do about this?"

Listen nonjudgmentally. This serves both to begin the healing process for the woman and to give you an idea of what kind of referrals she may need. Often a battered woman believes her abuser's negative messages about her. She may feel responsible, ashamed, inadequate and afraid she will be judged by you.

- Validate her experience. **Make sure she knows she is not alone.** Millions of women of every age, race, and religion face abuse, and many women find it extremely difficult to deal with the violence. Emphasize that when she wants help, it is available. Let her know that domestic violence tends to get worse and become more frequent with time and that it rarely goes away on its own. "You are not alone." "You do not deserve to be treated this way." "Help is available to you."

Tell her the abuse is not her fault. Explain that physical violence in a relationship is never acceptable. There's no excuse for it - not alcohol or drugs, financial pressure, depression, jealousy or any behavior of hers. "No one has to live with violence." "You are not to blame." "What happened to you is a crime."

- If the patient answers "no", or will not discuss the topic: Be aware for any clinical signs that may indicate abuse: injury to the head, neck, torso, breasts, abdomen or genitals; bilateral or multiple injuries; delay between onset of injury and seeking treatment; explanation by the patient which is inconsistent with the type of injury; any injury during pregnancy, especially to abdomen or breasts; prior history of trauma; chronic pain symptoms for which no etiology is apparent; psychological distress such as depression, suicidal ideation, anxiety and/or sleep disorders; a partner who seems overly protective or who will not leave the woman's side.

If any one of these clinical signs are present, ask more specific questions. Make sure she is alone. "It looks as though someone may have hurt you. Can you tell me how it happened?" "Sometimes when people feel the way you do, it may be because they are being hurt at home. Is this happening to you?"

D = Document Your Findings

Record a description of the abuse as she has described it to you. Use statements such as "the patient states she was . . ." "If she give the specific name of the

assailant, sue it in your record. "She says her boyfriend John Smith struck her . . ."
Record all pertinent physical findings. Use a body map to supplement the written record. Offer to photograph injuries. When serious injury or sexual abuse is detected, preserve all physical evidence. Document an opinion if the injuries were inconsistent with the patient's explanation.

A = Assess Patient Safety

Before she leaves the medical setting, find out if she is afraid to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Have there been threats to her children? Is there a gun present?

R = Review Options and Referrals

If the patient is in imminent danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity of a private phone to make a call. If she does not need immediate assistance, offer information about hotlines and resources in the community. (Resources for Domestic Violence in Florida can be found in the "Resource" section near the end of this course).

Remember that it may be dangerous for the woman to have these in her possession. Do not insist that she take them. Make a follow-up appointment to see her or some other method of checking in.

Safety Planning

Safety planning is an important intervention for the healthcare provider. The Safety Plan included in the Guidelines appears in [Appendix D](#) of this course.

Creating a Safety Plan

Those who are at risk of violence need to have a plan to respond to the abuse in a safe manner, often called a Safety Plan. The plan should list steps to take if a partner becomes violent or abusive. It should also include teaching children how to call 9-1-1 for help. Women who experience dating violence or other forms of abuse also need a safety plan (SAMHSA, 2003).

Safety During a Violent Incident

You don't have control over your partner's violent actions. However, you *can* control how you prepare for your safety and the safety of your children (SAMHSA, 2003).

- If you think an argument may become violent, stay out of rooms that may contain possible weapons. This would include the kitchen, bathroom, and garage. Try to go to a room with an exit.
- Practice getting out safely. Which doors, windows, stairwells, and elevators will you use?

- Keep your purse and car keys close by and always keep an extra car key hidden in a safe place.
- You may need to tell a neighbor to call the police if they hear suspicious noise coming from your home. This may be difficult for you to reveal, but it is a very important step. Have a code word that will alert them to call the police. Make sure your children also know the code word and how to call 9-1-1.

Safety If You Are Planning To Leave

Some women decide that the best safety plan is to leave. Because the abuser often becomes more violent when he suspects his partner is leaving (it represents a loss of control), it is important to prepare carefully (SAMHSA, 2003).

- Leave money, an extra set of keys, an extra set of clothes, and copies of important papers (see list below) with someone you trust at least several days before you plan to leave.
- If you don't already have one, open a bank account in your name only.
- Determine who might be able to loan you money or give you a place to stay.
- Keep change for phone calls since credit cards or calling cards will show up on phone bills.

Checklist for Leaving an Abuser

The National Women's Health Information Center (USDHHS-NWHIC, 2009; SAMHSA, 2003) provides the following list of helpful items to get together when planning on leaving an abusive situation. Keep these items in a safe place until ready to leave, or if sudden departure is needed. If there are children in the home, take them. And take the pets too, if possible.

Figure 3. What to Bring With You When You Leave an Abuser	
Identification for yourself and your children	<ul style="list-style-type: none"> • birth certificates • social security cards (or numbers written on paper if you can't find the cards) • driver's license • photo identification or passports • welfare identification/documents • immigration documents, green card, visa
Important personal papers	<ul style="list-style-type: none"> • marriage certificate • divorce papers • custody orders • legal protection or restraining orders • Insurance forms and information • health insurance papers and medical cards • medical records for all family members including children's immunization records • children's school records • work permits • immigration papers • rental agreement/lease or house deed

	<ul style="list-style-type: none"> • car title, registration, and insurance information
Funds	<ul style="list-style-type: none"> • cash • credit cards • ATM card • checkbook and bankbook (with deposit slips) • investment papers/records and account numbers
Keys	<ul style="list-style-type: none"> • house • car • safety deposit box or post office box
A way to communicate	<ul style="list-style-type: none"> • phone calling card • cell phone • address book
Medications	<ul style="list-style-type: none"> • at least 1 month's supply for all medicines you and your children are taking, as well as a copy of the prescriptions
A way to get by	<ul style="list-style-type: none"> • jewelry or small objects you can sell, if you run out of money or stop having access to your accounts
Things to help you cope	<ul style="list-style-type: none"> • pictures • keepsakes • children's small toys or books • clothing

Safety In Your Own Residence

When you make the decision to end an abusive relationship and you plan to stay in your residence, you will need to take other precautions. You may need to obtain a protective order or peace order, both of which are court documents that provide relief to women who are experiencing abuse. Your local District court and/or local domestic violence agency can help you with this. All protective orders order an abuser to stop threatening or committing abuse. They also require an abuser to end all contact with the victim. However, a protective order does

not guarantee your safety. In addition, there are other precautions you should take (SAMHSA, 2003):

- Change the locks on all doors and windows, and install or improve security to include better outside lighting.
- Purchase rope/chain ladders to permit escape from a second story window, if it becomes necessary.
- Talk to all childcare providers and schools about who has permission to pick up the children.
- Use your community domestic violence resources for legal advice.
- Cover the mailbox with brightly colored paper to make it easier for the police to find the house if you live in a rural area where only the mailbox can be seen from the street.
- Keep the protective or peace order with you at all times.
- Tell your neighbors or landlord that your partner no longer lives with you and ask them to call the police if they see him at your home.

Case Study #4. Rita (Continued)

Since Rita and Toby moved in with her sister, Cliff has been calling her repeatedly on her cell phone and threatening her. He's been to the house several times, pounding on the doors, trying to get into the house.

She went to the police department to file an Order of Protection against Cliff, including limiting his ability to contact her by phone, mail or come anywhere near her and her son at her sister's house, at work or at Toby's school. She talked with her boss at work and provided a photo of Cliff, so that the receptionist will call the police if Cliff comes into the building. None of this has stopped Cliff. Yesterday when she went to the grocery store, Cliff was waiting in the parking lot; he grabbed her arm and tried to make her get into his car. She screamed and tried to get away from him. Cliff only let go and left in his car when 2 men came over (they happened to be off duty police officers) and asked if she was ok.

Today, Rita's boss called her to let her know that Cliff had been seen walking outside the building and that the police had been called; Cliff left before they arrived. Her coworkers have answered several calls from Cliff, telling him that Rita is unable to come to the phone. Rita is shaken and scared, wondering when this was going to end.

Conclusion

Domestic violence, intimate partner violence, wife abuse, battering, and spousal abuse...whatever you call it, it's a crime and it is a serious public health issue for individuals, families and societies. Because our patriarchal society continues to view women as "less than", the value of women in our society, while having made great gains over the last 50 years, continues the perspective that men have more worth than do women. For example, in 2007, women who were full-time wage and salary workers had median weekly earnings of \$614, or about 80 percent of the \$766 median for their male counterparts. This ratio has grown since 1979 (the first year for which comparable earnings data are available), when women earned

about 62 percent as much as men (BLS, 2008). While this is an improvement, much still needs to be done to combat the perception that one gender has more value than the other.

Healthcare providers can help alleviate both the immediate suffering and significant long-term impact of IPV/DV by engaging in training such as this course, screening for IPV/DV, identifying IPV/DV when it occurs and providing sound, best-practice interventions. Remember that those who are victims of IPV/DV are counting on healthcare providers to introduce the topic.

Appendix A. Important Phone Numbers

If you are in immediate danger, call 911

Florida Domestic Violence Hotline at 1-800-500-1119

National Domestic Violence Hotline at 1-800-799-SAFE (7233)

National Sexual Assault Hotline at 1-800-656-4673

To print this information out so you can post it or keep it handy [click here](#).

Appendix B. If You are Being Stalked

Take these steps (USDHHS, 2009; NCVS, ND):

- If you are in immediate danger, find a safe place to go, like a police station, friend's house, domestic violence shelter, or a public area. If you can't get out of danger, but can get to a phone, call 911.
- If you think you could be in danger, get a restraining order. A restraining order requires the stalker to stay away from you and not contact you. Talk to a victim advocate or attorney in your area to see how to get a restraining order and if an arrest can be made if the stalker violates the order.
- File a complaint with the police. Tell them about all threats.
- Write down every incident that happens. Include the time, date, and other important information.
 - Vary routines, including changing routes to work, school, the grocery store, and other places regularly frequented. Limit time spent alone and try to shop at different stores and visit different bank branches.
 - When out of the house or work environment, try not to travel alone and try to stay in public areas.
 - Keep videotapes, audiotapes, answering machine/voicemail messages, photos of property damage, and letters.
- Contact support systems to help you, including domestic violence and rape crisis hotlines, domestic violence shelters, the district attorney's office, police, counseling services, and support groups. Make sure to also keep these numbers handy, just in case you need them.

- Tell important people about the stalking problem, including the police, your employer, and family, friends, and neighbors. Show a picture of the stalker
- Trust your instincts. If you're somewhere that doesn't feel safe, either find ways to make it safer, or leave.

Appendix C. Protecting Yourself from Date Rape Drugs

Protection from Date Rape Drugs

Protect yourself from being a victim (USDHHS, 2008a):

- Don't accept drinks from other people.
- Open containers yourself.
- Keep your drink with you at all times, even when you go to the bathroom.
- Don't share drinks.
- Don't drink from punch bowls or other large, common, open containers. They may already have drugs in them.
- Don't drink anything that tastes or smells strange. Sometimes, GHB tastes salty.
- Have a non-drinking friend with you to make sure nothing happens.
- If you realize you left your drink unattended, pour it out.
- If you feel drunk and haven't drunk any alcohol — or, if you feel like the effects of drinking alcohol are stronger than usual — get help right away.

If you think that you have been drugged and raped (USDHHS, 2008a):

- It is often hard to tell; most victims don't remember being drugged or assaulted. The victim might not be aware of the attack until 8 or 12 hours after it occurred. These drugs also leave the body very quickly. Once a victim gets help, there might be no proof that drugs were involved in the attack. But there are some signs that you might have been drugged:
- You feel drunk and haven't drunk any alcohol — or, you feel like the effects of drinking alcohol are stronger than usual.
- You wake up feeling very hung over and disoriented or having no memory of a period of time.
- You remember having a drink, but cannot recall anything after that.
- You find that your clothes are torn or not on right.
- You feel like you had sex, but you cannot remember it.
- Get medical care right away. Call 911 or have a trusted friend take you to a hospital emergency room. Don't urinate, douche, bathe, brush your teeth, wash your hands, change clothes, or eat or drink before you go. These things may give evidence of the rape. The hospital will use a "rape kit" to collect evidence.
- Call the police from the hospital. Tell the police exactly what you remember. Be honest about all your activities. Remember, nothing you did — including drinking alcohol or doing drugs — can justify rape.
- Ask the hospital to take a urine (pee) sample that can be used to test for date rape drugs. The drugs leave your system quickly. Rohypnol stays in the body for several hours, and can be detected in the urine up to 72 hours after taking it. GHB leaves the body in 12 hours. Don't urinate before going to the hospital.

- Don't pick up or clean up where you think the assault might have occurred. There could be evidence left behind — such as on a drinking glass or bed sheets.
- Get counseling and treatment. Feelings of shame, guilt, fear, and shock are normal. A counselor can help you work through these emotions and begin the healing process. Calling a crisis center or a hotline is a good place to start. One national hotline is the **National Sexual Assault Hotline at 1-800-656-HOPE** .

Appendix D. Safety Plan (NCADV, 2005; FVPF, 2004)

Safety Plan	
Safety during a violent incident	<p>I can use some or all of the following strategies:</p> <p>A. If I have/decide to leave my home, I will go to _____.</p> <p>B. I can tell _____ about the violence and request they call the police if they hear suspicious noises coming from my house.</p> <p>C. I can teach my children how to use the telephone to contact the police.</p> <p>D. I will use _____ as my code word so someone can call for help.</p> <p>E. I can keep my purse/car keys ready at _____ in order to leave quickly.</p> <p>F. I can avoid rooms that have no exits, such as bathrooms, or rooms with weapons, such as kitchens.</p> <p>G. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.</p>

Safety when preparing to leave	<p>I can use some or all of the following safety strategies:</p> <ul style="list-style-type: none"> A. I will keep copies of important documents, keys, clothes and money at _____. B. I will open a savings account by _____ to increase my independence. C. Other things that increase my independence include: _____ D. I can keep change for my phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill will show my partner those numbers that I called after I left. E. I will check with _____ and my advocate _____ to see who would be able to let me stay with them or lend me some money. F. If I plan to leave, I won't tell my abuser in advance face to face, but I will call or leave a note from a safe place.
Safety in my own residence	<p>Safety measures I can use include:</p> <ul style="list-style-type: none"> A. I can change the locks on my doors and windows as soon as possible. B. I can replace wooden doors with steel/metal doors. C. I can install additional locks, window bars, poles to wedge against doors, and electronic systems, etc. D. I can install motion lights outside. E. I will teach my children how to make a collect call to _____ if my partner takes the children. F. I will tell people who take care of my children that my partner is not permitted to pick up my children. G. I can inform _____ that my partner no longer resides with me and they should call the police if he is observed near my residence.
Safety with a protection	<p>The following are steps that help the enforcement of my protection order:</p>

order	<p>A. Always carry a certified copy with me and keep a photocopy.</p> <p>B. I will give my protection order to police departments in the community where I work and live.</p> <p>C. I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.</p>
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Appendix E. Discharge Instructions (FVPPF, 2004)

If you are currently being abused...

Are you here as a result of someone hitting or threatening you—a spouse, boyfriend, lover, relative or someone you know? Have you been sexually abused by someone you know? As you read this, you may be feeling confused, frightened, sad, angry or ashamed. **You are not alone!** Unfortunately, what happened to you is very common. Domestic violence does not go away on its own. It tends to get worse and more frequent with time. There are people who can help you. If you want to begin talking about the problem, need a safe place to stay or want legal advice—call one of the agencies listed on the back of this instruction sheet today.

While still at the healthcare provider's office...

- Think about whether it is safe to return home. If not, call one of the resources listed on the back of this instruction sheet or stay with a friend or relative.
- You have received instructions on caring for your injuries and taking medications prescribed. Remember, if you have received tranquilizers they may help you rest but they won't solve the problem of battering.
- Battering is a crime and you have the right to legal intervention. You should consider calling the police for assistance (see information on back of this sheet). You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- Ask the doctor or nurse to take photos of your injuries to become part of your medical record.

When you get home...

- Develop an "exit plan" in advance for you and your children. Know exactly where you could go even in the middle of the night—and how to get there.
- Pack an "overnight bag" in case you have to leave home in a hurry. Either hide it yourself or give it to a friend to keep for you.
- Pack toilet articles, medications, an extra set of keys to the house and car, an extra set of clothing for you and your children, and a toy for each child.
- Have extra cash, loose change for phone calls, checkbook, or savings account book hidden or with a friend.
- Pack important papers and financial records (the originals or copies), such as social security cards, birth certificates, green cards, passports, work authorization and any other immigration documents, voter registration cards, medical cards and records, drivers license, rent receipts, title to the car and proof of insurance, etc.
- Notify your neighbors if you think it is safe.

Resources

Florida Coalition Against Domestic Violence

425 Office Plaza Drive
Tallahassee, FL 32301
Phone: (850) 425-2749
Fax (850) 425-3091
Web: www.fcadv.org

FCADV, works towards ending domestic violence through public awareness, policy development, creation of standards, provision of funding, and support for Florida's domestic violence centers. Serving Florida's 42 domestic violence centers, operates Florida's toll-free domestic violence hotline (1-800-500-1119), maintains a resource library, and develops posters, brochures, safety plans, and other resources.

For a listing of Florida's domestic violence centers, go to their website at:
<http://www.fcadv.org/centers.php>.

An Abuse, Rape, and Domestic Violence Aid and Resource Collection (AARDVARC)

<http://www.aardvarc.org/about.shtml>

This is a Florida-based non-profit organization dedicated to combating family and relationship violence, sexual violence and child abuse. The organization was formed in 1996 and incorporated in 2001 by former victims of relationship and family violence for the purposes of assisting others to find resources, receive guidance, and enjoy the support and empathy of others who have "been there, done that". From victims to advocates - volunteer have left their abusive situations and have gone on to run battered women's shelters, to work as police officers, 911 dispatchers, victim advocates, or counselors.

*******AARDVARC** maintains a listing of Florida domestic violence advocacy and support contacts. To access this listing, go to <http://www.aardvarc.org/dv/states/fldv.shtml>. *****

Address Confidentiality

1-800-500-1119 Florida has an address confidentiality program that allows victims to relocate and maintain address confidentiality through a "mail drop box" administered by the Attorney Generals Office. The program issues an ID card to participants that allows them to have a new social security and driver's license without attachment to their previous numbers. It also allows them to maintain address confidentiality with schools, work, utility companies etc. For more information call the number above.

Florida Council Against Sexual Violence

The Florida Council Against Sexual Violence (FCASV) is a statewide nonprofit organization committed to victims and survivors of sexual violence and the sexual assault crisis programs who serve them. Website: <http://www.fcasv.org/index.htm>.

National Domestic Violence Hotline 24 hours

1-800-799-SAFE (7233)
1-800-787-3224 (TTY)

Links individuals to help in their area using a nationwide database that includes detailed information on DV shelters, other emergency shelters, legal advocacy and assistance programs, and social service programs. website: www.ndvh.org

Rape Abuse & Incest National Network (RAINN) 24 hours

1-800-656-HOPE will automatically transfer the caller to the nearest rape crisis center, anywhere in the nation.

It can be used as a last resort if people cannot find a DV shelter.

635-B Pennsylvania Ave SE
Washington, DC 20003
Phone: (800) 656-HOPE (4673) ext. 3
Fax: (202) 544-3556
E-mail: rainnmail@aol.com
Website: www.rainn.org

Local Domestic Violence Hotlines Numbers are listed in the front of your telephone book.

For the list of State Domestic Violence or Sexual Assault Coalitions visit:
www.ojp.usdoj.gov/vawo/state.htm

National Center for Victims of Crime

National Center for Victims of Crime
2000 M Street, NW Suite 480
Washington, DC 20036
1-800-FYI-CALL
www.ncvc.org

If a community or system based victim service provider cannot offer suitable advice and assistance, they should still be able to make referrals to organizations that can help. If they are not able to do so please call the National Center for Victims of Crime at 1-800-FYI-CALL.

Domestic Violence Organizations

Family Violence Prevention Fund (FVPPF) is a national non-profit organization that focuses on domestic violence education, prevention and public policy reform. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (415) 252-8900 TTY: (800) 595-4889 fax: (415) 252-8991 e-mail: fund@endabuse.org website: www.endabuse.org

National Coalition Against Domestic Violence (NCADV) is dedicated to the empowerment of battered women and their children and is committed to the elimination of personal and societal

violence in the lives of battered women and their children. PO Box 18749, Denver, CO 80218 phone: (303) 839-1852 fax: (303) 831-9251 website: www.ncadv.org

Pennsylvania Coalition Against Domestic Violence and National Resource Center (PCADV) is a private, nonprofit membership organization and is dedicated to ending domestic violence and helping battered women and their children reestablish physical, social, and economic dignity. 6400 Flank Drive, Suite 1300, Harrisburg, PA 17112 phone: (800) 932-4632 fax: (717) 671-8149 website: www.pcadv.org

The National Network to End Domestic Violence (NNEDV) is a membership and advocacy organization of state domestic violence coalitions, allied organizations and supportive individuals and is a leading voice among domestic violence advocates in public policy. 660 Pennsylvania Ave., SE, Suite 303, Washington D.C. phone: (202) 543-5566 email: nnedv@bellatlantic.net website: www.nnedv.org

Sacred Circle: The National Resource Center to End Violence Against Native Women is dedicated to the actions that promote the sovereignty and safety of native women. 722 St. Joseph St., Rapid City, SD 57701 phone: (605) 341-2050 (877) RED ROAD (733-7623)

Asian & Pacific Islander Institute on Domestic Violence strives to eliminate domestic violence in Asian and Pacific Islander communities by increasing awareness about the extent and depth of the problem making culturally specific issues visible; strengthening community models of prevention and intervention; identifying and expanding resources; informing and promoting research and policy; and deepening understanding and analysis of the issues surrounding violence against women. 942 Market Street, Suite 200, San Francisco, CA 94102 phone: (415) 954-9964 fax: (415) 954-9999 website: www.apiahf.org

Institute on Domestic Violence in the African American Community provides an interdisciplinary vehicle and forum by which scholars, practitioners, and observers of family violence within the African American community will have the continual opportunity to articulate their perspectives on family violence through research findings, the examination of service delivery and intervention mechanisms, and the identification of appropriate and effective responses to prevent/reduce family violence in the African American community. 290 Peters Hall 1404 Gortner Avenue, St. Paul, MN 55108-6142 phone: (877) NIDVAAC (643-8222) fax: (612) 624-9201 website: www.dvinstitute.org

National Latino Alliance for the Elimination of Domestic Violence is a network of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understand, sustain dialogue, and generate solutions to move toward the elimination of domestic violence in Latino communities, with an understanding of the sacredness of all relations and communities. P.O. Box 322086, Fort Washington, New York, NY 10032 phone: (800) 342-9903 fax: (800) 216-2404 website: www.dvalianza.org

Clinical Materials for the Healthcare Setting

The National Health Resource Center on Domestic Violence a project of the FVPPF, provides support to thousands of health care professionals, policy makers and domestic violence advocates through its four main program areas: model training strategies, practical tools, technical assistance, and public policy.

383 Rhode Island St.
, Suite 304
, San Francisco, CA 94103-5133
P phone: (888) Rx-ABUSE TTY: (800) 595-4889
Fax: (415) 252-8991 Ee-mail: health@endabuse.org
website: www.endabuse.org/health

California Medical Training Center trains medical professionals to effectively identify, evaluate and treat victims of child abuse and neglect, sexual assault, domestic violence, and elder and dependent adult abuse and offers comprehensive domestic violence curriculum targeted for a continuum of learners.

3300 Stockton Boulevard
Sacramento, CA 95820
E-mail: mtc@ucdmc.ucdavis.edu
Website: www.calmtc.org

Websites of Interest for Adolescents

The Empower Program works with youth to end the culture of violence. 1312 8th Street, Washington, DC 20001 phone: (202) 882-2800 fax: (202) 234-1901 e-mail: empower@empowered.org website: www.empowered.org

Girls Incorporated National Resource Center is a national youth organization dedicated to inspiring all girls to be strong, smart and bold. 441 West Michigan Street, Indianapolis, IN 46202 phone: (317) 634-7546 fax: (317) 634-3024 e-mail: girlsinc@girls-inc.org website: www.girlsinc.org

Youth Resource website created for GLBTQ youth to promote sexual health website: www.youthresource.com

Lesbian, Gay, Transgendered, Bisexual, Queer (LGBTQ)

Community United Against Violence (CUAV) is a 20-year old multicultural organization working to end violence against and within lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities. The Love & Justice Project aims to lead the discussion on positive communication skills, consensual sexuality, partnership decision making and naming abusive behavior in LGBTQ youth relationships by building bridges and community resources between LGBTQ youth and elders. 973 Market St., #500, San Francisco, CA 94103 phone: (415) 777-5500 fax: (415) 777-5565 24 Hr. Support Line: (415) 333-HELP (4357) e-mail: cuav@aol.com website: www.cuav.org

Parents, Families, and Friends of Lesbians and Gays (PFLAG) is a national organization that promotes the health and well-being of gay, lesbian, bisexual and transgendered persons, their families and friends. Their web site provides users with information on local chapters, advocacy and support information and other resources that support the family and friends of gays and lesbians. 1726 M Street, NW, Suite 400, Washington, DC 20036 phone: (202) 467-8180 fax: (202) 467-8194 e-mail: info@pflag.org website: www.pflag.org

Gay Men's Domestic Violence Project is a grassroots, non-profit organization in Boston providing community education and direct services for clients. GMDVP offers shelter, guidance,

and resources to allow gay, bisexual, and transgender men in crisis to remove themselves from violent situations and relationships GMDVP, PMB 131, 955 Mass Ave. Cambridge, MA 02139 fax: (617) 354-6072 phone: (617) 354-6056 crisis: (800) 832-1901 toll-free: (800) 832-1901 website: www.gmdvp.org

Network for Battered Lesbians and Bisexual Women was formed to address battering in lesbian, bisexual women's, and transgender communities. POB 6011 Boston, MA 02114 phone/TTY: (617) 695-0877 hotline/TTY: (617) 423-7233 website: <http://www.thenetworklared.org/english/network/about.html>.

The Northwest Network provides support and advocacy for bisexual, transgender, lesbian and gay survivors of abuse and dating violence. P.O. Box 20398, Seattle, Washington 98102 phone: (206) 568-7777 TTY: (206) 517-9670 website: www.nwnetwork.org

The Survivor Project expanding access to sex/gender variant survivors of domestic violence. P.O. Box 40664, Portland, Oregon 97240 phone: (503) 288-3191 email: info@survivorproject.org website: www.survivorproject.org

Anti-Violence Project serves LGTB & HIV-positive and others affected by violence. 240 West 35th St., Suite 200, New York, NY 10001 24-hour bi-lingual Hotline: (212) 714-1141 TTY: (212) 714-1134 website: www.avp.org

LAMBDA GLBT community services. P.O. Box 31321, El Paso, TX 79931 phone: (208) 246-2292 fax: (208) 246-2292 email: info@lambda.org website: www.lambda.org/dv97.htm

Websites of Interest for Male Victims of Domestic and Sexual Violence

Menweb information for battered men on how to cope and the steps they should take, as well as other resources. website: <http://www.batteredmen.com/>

National Organization on Male Sexual Victimization committed to prevention, treatment & elimination of all forms of sexual victimization of boys and men website: <http://www.malesurvivor.org/>

Teen Pregnancy

American College of Obstetricians and Gynecologists (ACOG) has a membership of 40,000 physicians and is the nation's leading group of professionals providing health care for women. ACOG's website provides adolescent sexual assault assessment tools as well as other teen pregnancy materials. To request free copies of their educational bulletins, call: (202) 638-5577 or e-mail: violence@acog.org ACOG, 409 12th Street, SW, PO Box 96920 Washington, DC 20024 phone: (202) 863-2487 fax: (202) 484-3917 e-mail: adolhlth@acog.org website: www.acog.org

Rape Abuse & Incest National Network (RAINN) (see "Hotlines") Sexual Assault Resource Service (SARS) is designed for nursing professionals involved in providing evaluations of sexually abused victims. SARS' website provides information and technical assistance to individuals and institutions interested in developing new SANE-SART programs or improving existing ones. website: www.sane-sart.com

Animal Cruelty and Family Violence

The Humane Society of the United States, through its First Strike campaign, is dedicated to raising public and professional awareness about the connection between animal cruelty and family violence. 2100 L Street, NW, Washington, DC 20037 phone: (301) 258-3076; toll-free (888) 213-0956 fax (301) 258-3074 e-mail: firststrike@hsus.org; website: www.hsus.org/firststrike

Other Websites of Interest

American Academy of Pediatrics: www.aap.org

American College of Emergency Physicians: www.acep.org

American College of Nurse Midwives: www.acnm.org

American College of Obstetricians and Gynecologists: www.acog.org

American Medical Association: www.ama-assn.org

American Medical Women's Association: www.amwa-doc.org

American Psychological Association: www.apa.org

Association of Traumatic Stress Specialists: <http://www.atss-hq.com>

Child Witness to Violence Project at Boston Medical Center:
www.childwitnessstoviolence.org

International Association of Forensic Nurses: www.forensicnurse.org

Nursing Network to End Violence Against Women International: www.nnvawi.org

National Sexual Violence Resource Center: <http://www.nsvrc.org/>

Physicians for a Violence-Free Society: www.nnvawi.org

Society of Academic Emergency Medicine: www.saem.org

Trafficking Information and Referral Hotline at 1.888.3737.888.

This hotline will help you determine if you have encountered victims of human trafficking, will identify local resources available in your community to help victims, and will help you coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives. For more information on human trafficking visit www.acf.hhs.gov/trafficking.

National Guideline Clearinghouse

The National Guideline Clearinghouse (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents. NGC is an initiative of the Agency for

Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]).

The NGC mission is to provide physicians, nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use. Website: www.guidelines.gov.

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Domestic Violence/Intimate Partner Violence: Applying Best Practice Guidelines Test

***If you have downloaded the course off the Internet and wish to submit your test online you must return to our website (www.accesscontinuingeducation.com) to do so.**

1. Intimate partner violence/domestic violence (IPV/DV) is best conceptualized as:
 - a. A public health problem, impacting large numbers of the population.
 - b. A family problem, best dealt with within the family.
 - c. A reportable crime in Florida regardless of whether or not a weapon was used in the abuse.
 - d. All of the above.

2. The 4 main types of IPV/DV, according to Saltzman and colleagues, are:
 - a. Stalking, psychological violence; neglect and physical violence.
 - b. Physical violence, sexual violence; stalking; and emotional violence.
 - c. Physical violence; sexual violence; threats of physical and sexual violence; emotional and psychological violence.
 - d. None of the above.

3. The State of Florida defines domestic violence as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.
 - a. True.
 - b. False.

4. In Florida Statutes, the relationship between the those involved in the violence must be that of:
 - a. A spouse or ex-spouse.
 - b. Relatives by blood or marriage who currently live together or who lived together in the past.
 - c. Anyone who lives or has lived together in the same dwelling as a family unit, or anyone who together have had a child, with or without having lived together.
 - d. All of the above.

5. IPV/DV trends in Florida are similar to national statistics. According to information provided in this course, the incidence of IPV/DV has greatly increased in the past several years.
- True.
 - False.
6. Conservative estimates are that nearly 25% of US women have been raped or physically assaulted by an intimate partner at some point in their lives. That is a lifetime prevalence of 1 in 4!
- True.
 - False.
7. IPV/DV results in multiple consequences for victims, families and societies. Acute and chronic consequences for the victim include:
- Physical injuries and conditions.
 - Emotional and psychological sequelae, which may lead to high-risk behavior.
 - Social and economic consequences.
 - All of the above.
8. Risk factors for IPV/DV victimization include all the following EXCEPT:
- Witnessing or experiencing violence as a child.
 - Economic security.
 - Weak community sanctions against IPV/DV such as police being unwilling to intervene.
 - Dominance and control by one partner in the relationship.
9. According to the best-practice guidelines discussed in this course, assessment for IPV/DV should occur:
- Only with pregnant women at their first prenatal visit.
 - Routinely regardless of the presence or absence of indicators of abuse.
 - Whenever the patient discloses the violence.
 - Only in the company of the alleged abuser.

10. In the RADAR method discussed in this course, healthcare providers can initiate the subject of IPV/DV by asking any of the following EXCEPT:
 - a. "Because violence is so common in many women's lives, I've begun to ask about it routinely."
 - b. "You're not the victim of violence at home, are you?"
 - c. "Are you in a relationship in which you have been physically hurt or threatened?"
 - d. "Have you ever been hit, kicked or punched by your partner?"

11. Utilizing the guidelines discussed in this course, choose the best interventions to be used in situations of IPV/DV:
 - a. Provide information as well as the means to achieve safety for the victim.
 - b. Encourage the victim to leave the abuser immediately.
 - c. Provide validation; provide information; respond to safety issues; and make referrals for further intervention or follow-up.
 - d. Remind the victim that she/he plays a part in perpetuating the abuse.

12. The Florida Domestic Violence Hotline number is 1-800-500-1119.
 - a. True.
 - b. False.