Domestic Violence/Intimate Partner Violence
Pending Approvals

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Current Approvals

Registered Nurse 4.2 Contact Hours

Access Continuing Education, Inc. is approved as a provider of continuing nursing education by the Kentucky Board of Nursing through January 1, 2017. Approval number 6-0022.

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### Answer Sheet:
**Domestic Violence/Intimate Partner Violence**

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Access Continuing Education, Inc. is an approved provider (#6-0022) of nursing CE by the Kentucky Board of Nursing. The Kentucky Board of Nursing approval of an individual nursing continuing education provider does not constitute endorsement of program content. As per the Kentucky Board for Nursing approval process, the following course is awarded 4.2 contact hours (50 minutes=1 contact hour).

Nurses licensed prior to July 15, 1996 had a mandatory requirement to earn 3 hours of Kentucky Board of Nursing approved Domestic Violence continuing education (CE) before July 1, 1999. Any nurse licensed in Kentucky after July 15, 1996, has 3 years from the date of initial licensure to earn the one-time mandatory requirement for 3 hours of Domestic Violence CE.

According to the Kentucky Board of Nursing, compliance monitoring includes random audits that started in January, 2000. Nurses should retain certificates of attendance/completion indefinitely. Copies of CE certificates of completion should not be submitted to the Board unless requested to do so.

Authors

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Jean is a Licensed Clinical Social Worker (LICSW) and a practicing psychotherapist, living in the Berkshires. She has performed in various roles during her 20-year career as a professional helper including work as a domestic violence/sexual assault counselor, addictions therapist, clinical supervisor, case manager, as well as an outpatient clinician. Her work at the Elizabeth Freeman Center, in Pittsfield, a domestic violence and sexual assault services agency, centers on trauma work for survivors and providing clinical supervision to staff. The agency provides services to individuals and families experiencing domestic violence and sexual assault issues on a 24/7 hour basis each day of the year.

Jean is also employed at the Brien Center for Mental Health and Substance Abuse Services where she performs individual, couples, and family psychotherapy in the outpatient and addictions services departments. She also provides clinical supervision to staff and interns. Jean is a DBT Intensive Trained therapist and utilizes CBT, psychodynamic psychotherapy, anger management and DBT groups when working with clients.

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Silvia Y. Beaupre, MS, RN, NPP, APRN, BC has many years of experience as an educator and clinician. Providing online continuing education to multiple healthcare professionals has been her mission for many years. Ms. Beaupre’s teaching experience has been in staff development in multiple healthcare organizations, as well the education of nursing students at the associates, bachelors and graduate degree level. Ms. Beaupre provides workshops and didactic instruction in face to face educational programs to multiple professionals, as well as provides education consultation to select professional organizations.
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Goals:

The purpose of this educational activity is:

- To provide licensed professionals with current relevant information in order to identify and intervene in situations of IPV/DV; and
- To meet the mandatory training requirement for licensure in Kentucky.

Objectives

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

- Define domestic violence/intimate partner violence, particularly in the state of Kentucky.
- Discuss the statistics related to domestic violence/intimate partner violence.
- Describe the consequences of violence.
- Discuss the dynamics of abuse.
- 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 Kentucky 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, 2013).

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).

Estimates, generally considered very conservative, are that 1.3 million women are victims of IPV/DV (NCADV, 2007a). If one compares this estimate of women victims to the total number of females in the US (157 million in 2010), it is clear that the estimated number of 1.2 million women is quite low.

It's important for victims of IPV/DV to know they are not alone (USDHHS, 2008):

- 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, 2008). 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, health, law enforcement/legal) in the life of the individual, family, community and society 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.

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/intimate partner 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.

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.

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, also known as battering (CDC, 2013).

There are four main types of IPV/DV (CDC, 2013; 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, 2007):

- 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.

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, 2011).

Technology has become a quick and easy way for stalkers to monitor and harass their victims. More than one in four stalking victims reports that some form of cyberstalking was used against them, such as email (83 percent of all cyberstalking victims) or instant messaging (35 percent). Electronic monitoring of some kind is used to stalk one in 13 victims (Baum, et al., 2009).

One in five teen girls and one in ten younger teen girls (age 13 to 16) have electronically sent or posted nude or semi-nude photos or videos of themselves. Even more teen girls, 37 percent, have sent or posted sexually suggestive text, email or IM (instant messages) (NCPTUP and CG, 2008).

More than half of teen girls (51 percent) say pressure from a guy is a reason girls send sexy messages or images, while only 18 percent of teen boys say pressure from a girl is a reason. Twelve percent of teen girls who have sent sexually suggestive messages or images say they felt "pressured" to do so (NCPTUP & CG, 2008).

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.

**Commonwealth of Kentucky Definitions**

Kentucky defines **domestic violence and abuse** (KS §403.715 to 403.785) as:

*Physical injury, serious physical injury, sexual abuse, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, or assault between family members or members of an unmarried couple.*

**Family member** means a spouse, previous spouse, a parent, a child, a stepchild, or any other person related by consanguinity in the second degree. **Member of an unmarried couple** means each member of an unmarried couple who allegedly have a child in common, any children of that couple, or member of an unmarried couple who are living together or have previously lived together.

The state definition of domestic violence only includes persons who are currently living together or who lived together in the past unless they share a common child, regardless of sex. Kentucky is certified to
collect and report incident-based data, and law enforcement agencies submit data electronically to the Kentucky State Police.

Definition of adult (KRS 209.020(4) and KRS 209A.020):

A person eighteen (18) years or older, who because of mental or physical dysfunctioning, is unable to manage his own resources or carry out the activity of daily living or protect himself from neglect, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services; or

A person without regard to age who is the victim of abuse or neglect inflicted by a spouse.

Abuse means the infliction of physical injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. These acts, may include, but are not limited to:

- Forced sexual relations, including forced sex with others, animals or foreign objects;
- Unwanted fondling or touching;
- Physical assault, including pushing, kicking, hitting, slapping, punching, choking, strangling, pinching, burning, hair pulling, shoving, stabbing, shooting, beating, battering during pregnancy, striking with an object and complaints of pain as a result of the assault;
- Marks that are or have been observed on an adult that were allegedly inflicted by another individual;
- Rough handling, i.e. forced feeding, roughness when transferring individual from bed to chair, or during bathing, etc; and
- Inappropriate use of physical or chemical restraints.

Mental injury is the infliction of mental anguish caused by actions or verbal assaults against an adult's well being that may result in an adverse change in behavior in the adult. The abuse can be spontaneous, protracted or systematic efforts to debase the adult while instilling fear and may include, but are not limited to:

- Threats of violence against the adult, or others;
- Threats with a weapon(s), including objects used as a weapon;
- Forced isolation or imprisonment, unreasonable confinement;
- Destruction or threats to destroy property and/or pets;
- Forcing to perform degrading acts;
- Controlling activities such as sleep, eating habits, access to money or social relationships;
- Verbal assaults and attacks on the adult's self esteem, including name-calling, insulting, degrading remarks, custody threats or threats to abduct/abscond with the child(ren);
- Stalking; and
- Intimidation.

Neglect is defined as a situation in which an adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult.

Spouse/Partner neglect is the deprivation of services needed for health and welfare and may include, but is not limited to:

- Actively prohibiting the spouse/partner from obtaining needed medical care;
- Controlling the environment to the extent that it prohibits the spouse/partner from carrying out activities of daily living.
Self-neglect is a situation in which the adult is unable to perform or obtain goods or services that are necessary to maintain health or welfare. These may include, but are not limited to situations alleging that the adult's health or welfare has suffered or declined as a result of:

- Unmet personal or medical needs, such as bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, incorrect use of medication, lack of food or inadequate food;
- Refusing or being unable to access medical or mental health care/treatment;
- Living in an unsafe environment, such as fire/safety hazard, roach/rat/insect infested dwelling, condemned building;
- Living alone and in life-threatening conditions;
- Being unable to manage own resources;
- New onset of confusion and/or disorientation; or
- Attempts to commit suicide.

Caretaker neglect is the deprivation by a caretaker of services, which are needed to maintain health and welfare. The caretaker arrangement can be formal (i.e. contractual, institution) or informal (i.e. voluntary agreement with family member, friend). Caretaker neglect can be either "passive" (unintentional) or "active" (intentional) in nature as related to the provision of services (i.e. food, clothing, shelter, social contact, personal needs, medical care) and may include, but is not limited to:

- Lack of adequate food or health related services due to the caretaker's inadequate skills or knowledge;
- Abandonment or lack of supervision;
- Unmet personal or medical needs, such as bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, incorrect use of medication, lack of food or inadequate food;
- Withholding or deprivation of food, water or health services;
- Over medication or under medication;
- Forced isolation, unreasonable confinement;
- Not obtaining needed mental health or medical services or permitting unnecessary pain.

A caretaker is an individual or institution who has been entrusted with or who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult voluntarily or by contract, employment, legal duty, or agreement.

Exploitation means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources. Indicators of financial, material and sexual exploitation may include:

- Use of force or manipulation through misrepresentation, threats, or coercion;
- Deception, and may include but is not limited to:
  - Creating or reinforcing a false impression, including a false impression as to law, value, intention, or other state of mind;
  - Preventing another from acquiring information that would affect his or her judgment of a transaction; or
  - Failing to correct a false impression that the deceiver previously created or reinforced, or that the deceiver knows to be influencing another to whom the person stands in a fiduciary or confidential relationship;
- Isolation from friends, relatives or important information, such as screening phone calls, denying visitors, or intercepting mail:
  - Compelling physical or emotional dependency; and
  - Acquiescence of the alleged victim.
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

One in four women report that they have been physically assaulted or raped by an intimate partner. These crimes occur in both heterosexual and same-sex relationships.

As stated previously, the legal definitions related to IPV/DV vary from state to state, making compiling accurate statistics difficult. Additionally, 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.

National Statistics

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 (CDC, 2013; CDC, 2010; NCADV, 2007a; Gazmararian, et al., 2000; Tjaden & Thoennes, 2000b). .4 million

- Approximately 42.4 million women in the US have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- An estimated 1.3 million women are victims of physical assault by an intimate partner each year.
- One in 3 women have experienced physical violence by an intimate partner.
- One in 4 women (22.3%) have been the victim of severe physical violence by an intimate partner, while 1 in 7 men (14.0%) have experienced the same.
- Eighty-five percent of domestic violence victims are women.
- Historically, females have been most often victimized by someone they know.
• Females who are 20-24 years of age are at the greatest risk of nonfatal intimate partner violence.
• Most cases of IPV/DV are never reported to the police.
• Almost one-third of female homicide victims that are reported in police records are killed by an intimate partner.
• In 70-80% of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder.
• Weapons are involved in 19% of intimate partner violence.
• One in 6 women and 1 in 33 men have experienced an attempted or completed rape.
• Nearly 7.8 million women have been raped by an intimate partner at some point in their lives.
• Sexual assault or forced sex occurs in approximately 40-45% of battering relationships.
• 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.
• Each year, women experience about 4.8 million intimate partner related physical assaults and rapes.
• IPV/DV resulted in 1,544 deaths in 2004. Of these deaths, 25% were males and 75% were females.
• Between 4% and 8% of pregnant women are abused at least once during the pregnancy.
• 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.
• Young women and those below the poverty line are disproportionately victims of IPV/DV.

Statistics for Kentucky

Women in Kentucky are at risk for IPV/DV at levels that exceed national statistics. In 2005, the reported lifetime prevalence of intimate partner abuse in women nationally was 25.5%, for Kentucky women the lifetime prevalence was 36.6%. According to the Kentucky Cabinet for Health and Family Services (2005) the majority of IPV/DV victims in Kentucky reported multiple rather than single IPV episodes over 12 months; three-fourths (76.7%) of them experienced psychological stress or physical injuries (74.1%), and more than one-fourth (29.8%) of abused, injured women sought medical treatment or counseling.

Domestic violence includes any of the following crimes when committed by one family member/partner against another: homicide, kidnapping, sex offenses, stalking, assault, and terrorist threatening. The statistics have been compiled for the Fiscal Year of 2013 (FY’13), which is July 1, 2012 to June 30, 2013 (KSP, 2014).

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>2008</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Kentucky Adult Protection Reports Received by DSS in FY</td>
<td>54,701</td>
<td>69,675</td>
<td>72,377</td>
</tr>
<tr>
<td>Total Number of Resulting Allegations</td>
<td>31,247</td>
<td>35,174</td>
<td>35,810</td>
</tr>
<tr>
<td>Domestic Violence Allegations Investigated (Spouse, Ex-Spouse, Paramour) or Assessed Calls</td>
<td>19,193</td>
<td>19,705</td>
<td>19,816</td>
</tr>
<tr>
<td>Adult Abuse Allegations in Investigated or Assessed Calls (reports)</td>
<td></td>
<td>16,322</td>
<td>16,780</td>
</tr>
<tr>
<td>Percent of Total Adult Protection Allegations due to Domestic Violence</td>
<td>35%</td>
<td>54.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>Percent Increase of Domestic Violence Allegations from FY ’07</td>
<td>7.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Increase of Domestic Violence Allegations from FY ’12</td>
<td></td>
<td>12.6%</td>
<td></td>
</tr>
</tbody>
</table>

During Domestic Violence Counts, the National Census of Domestic Violence Services, held annually on September 17th, 15 out of 15, or 100%, of identified domestic violence programs in Kentucky participated. On that day 1,097 IPV/DV victims were served (NNEDV, 2013):
- 594 domestic violence victims found refuge in emergency shelters or transitional housing provided by local domestic violence programs.
- 503 adults and children received non-residential assistance and services, including individual counseling, legal advocacy, and children's support groups.
- 252 hotline calls were answered. Domestic violence hotlines are a lifeline for victims in danger, providing support, information, safety planning, and resources. In the 24-hour survey period, domestic violence programs answered more than 12 hotline calls every hour.
- 499 were educated in prevention and education trainings. On the survey day, 499 individuals in communities across Kentucky attended 16 training sessions provided by local domestic violence programs, gaining much needed information on domestic violence prevention and early intervention.

The Kentucky Domestic Violence Association (KDVA) reports that in fiscal year 2009 (July 1, 2008-June 30, 2009):

- Kentucky domestic violence programs received 32,669 crisis-related calls.
- Kentucky domestic violence programs sheltered 4,428 survivors and their dependent children.

The relationship of women victims to perpetrators, during fiscal year 2009 was:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>715</td>
</tr>
<tr>
<td>Ex-spouse</td>
<td>110</td>
</tr>
<tr>
<td>Unmarried w/child</td>
<td>426</td>
</tr>
<tr>
<td>Unmarried w/o child</td>
<td>749</td>
</tr>
<tr>
<td>Perpetrator unknown</td>
<td>147</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,147</strong></td>
</tr>
</tbody>
</table>

**Identifying Abuse**

Some signs of abuse are clear: physical injuries, repeated injuries, injuries that are explained in a manner unlikely to occur given the explanation, 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 does all the shopping in the home.

Jim has not allowed Rhoda to go to have the headaches evaluated. Besides work and the occasional family event, 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. There are clear signs to help in the identification of abuse. Consider IPV/DV when faced with the following (USDHHS, 2012):

- 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;
- Threatens to harm himself or herself when upset with you;
- Says things like, “If I can't have you then no one can.”
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, 2007). 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). Abused women are six to eight times more likely to use healthcare services than non-abused women (USDHHS, 2008). 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).

Indeed, 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 (CDC, 2013a; USDHHS, 2008).

- Bruises
- Knife wounds
- Pelvic pain
- Headaches
- Back pain
- Broken bones
- Gynecological disorders
  - Pelvic inflammatory disease
  - Sexual dysfunction
  - Sexually transmitted infections, including HIV/AIDS
  - Delayed prenatal care
  - Preterm delivery
  - Pregnancy difficulties like low birth weight babies and perinatal deaths
  - Unintended pregnancy
- Asthma
- Bladder/kidney infections
- Circulatory conditions
- Cardiovascular disease
- Fibromyalgia
- Irritable bowel syndrome
- Chronic pain syndromes
- Central nervous system disorders
- Joint disease
- Migraines/headaches
- Central nervous system disorders
- Gastrointestinal disorders
- 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 (CDC,2013a; USDHHS, 2008; Campbell et al., 2002):

- Depression
• Post-traumatic Stress Disorder (PTSD)
  o Emotional detachment
  o Sleep disturbances
  o Flashbacks
  o Replaying assault in mind

Due to the difficult symptoms of depression and PTSD (intrusive thoughts, nightmares, flashbacks, anxiety, hyper arousal, avoidance, etc.), some women may turn to drugs and alcohol to numb themselves against those symptoms.

Other mental health issues include (CDC, 2013a; USDHHS, 2008; Roberts, Klein, & Fisher, 2003; Coker et al., 2002; Heise & Garcia-Moreno, 2002):

• Anxiety
• Antisocial behavior
• Suicidal behavior
• Low self-esteem
• Antisocial behavior
• Inability to trust others, especially in intimate relationships
• Fear of intimacy
• Emotional detachment
• Sleep disturbances

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. 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. 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. High risk sexual behaviors can include:
  o Unprotected sex
  o Decreased condom use
  o Early sexual initiation
  o Choosing unhealthy sexual partners
  o Having multiple sex partners
  o Trading sex for food, money, or other items, either by choice or by force
  o Unwanted pregnancies

• Using or abusing harmful substances - A way of numbing oneself the trauma of an abusive life include:
  o Smoking cigarettes
  o Drinking alcohol
Social Consequences of Violence

Victims of IPV/DV sometimes face the following social consequences (CDC, 2013a; 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 stained 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, 2013a).
- 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 (NCADV, 2014; CDC, 2013a; 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 (NCADV, 2014; CDC, 2013a).
- Between 21-60% of victims of IPV lose their jobs due to reasons stemming from the abuse (NCADV, 2014).
- 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, 2013a).
- Between 2003 and 2008, 142 women were murdered in their workplace as a result of IPV. This amounts to 22% of workplace homicides among women (NCADV, 2014).

Risk Factors for IPV/DV

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, 2013b). Not everyone who is identified as "at risk" becomes involved in violence.

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, 2013b).

Risk factors for DV/IPV are similar for both the victimization and the perpetration of violence. Multiple factors influence the risk of DV/IPV (CDC, 2013b; Crandall, et al., 2004; Heise & Garcia-Moreno, 2002; Tjaden & Thoennes, 2000a).>
Individual Factors:
- Prior history of DV/IPV
- Being female
- Young age
- Low self-esteem
- Low income
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- High-risk sexual behavior
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Witnessing or experiencing violence as a child
- Being less educated/low academic achievement
- Unemployment
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Perpetrating psychological aggression
- 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
- 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
- Marital/relationship conflicts or fights, tension and other struggles
- Marital instability: divorces or separations
- 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 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)
Dynamics of Abuse

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.
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.
NONVIOLENCE

NEGOTIATION AND FAIRNESS
Seeking mutually satisfying resolutions to conflict • accepting change • being willing to compromise.

NON-THREATENING BEHAVIOR
Talking and acting so that she feels safe and comfortable expressing herself and doing things.

ECONOMIC PARTNERSHIP
Making money decisions together • making sure both partners benefit from financial arrangements.

RESPECT
Listening to her non-judgmentally • being emotionally affirming and understanding • valuing opinions.

SHARED RESPONSIBILITY
Mutually agreeing on a fair distribution of work • making family decisions together.

TRUST AND SUPPORT
Supporting her goals in life • respecting her right to her own feelings, friends, activities and opinions.

RESPONSIBLE PARENTING
Sharing parental responsibilities • being a positive non-violent role model for the children.

HONESTY AND ACCOUNTABILITY
Accepting responsibility for self • acknowledging past use of violence • admitting being wrong • communicating openly and truthfully.

DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org
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 (USDHHS, nd; 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;
- Other mental health conditions;
- Death of unborn and newborn babies
- Homicide, which is the second leading cause of traumatic death for pregnant women and mothers with newborns.

It is recommended that all pregnant women be screened for the presence of IPV/DV (Certain, et al., 2008; ACOG, 2006).

Children and IPV/DV

Children who have been exposed to DV/IPV are more likely than their peers to experience a wide range of difficulties (USDHHS, CWIG, 2009). These difficulties fall into three main categories:

**Behavioral, social and emotional problems.** Children in families experiencing DV/IPV are more likely than other children to exhibit aggressive and antisocial behavior or to be depressed and anxious. Researchers have found higher levels of:
- anger, hostility, oppositional behavior, and disobedience;
- fear and withdrawal;
- poor peer, sibling and social relationships; and
- low self-esteem

**Cognitive and attitudinal problems.** Children exposed to DV/IPV are more likely to experience difficulties in school and score lower on assessments of verbal, motor, and cognitive skills. Slower cognitive development, lack of conflict resolution skills, limited problem solving skills, pro-violence attitudes, and belief in rigid gender stereotypes and
male privilege are other issues identified in research.

**Long term problems.** Research indicates that males exposed to domestic violence as children are more likely to engage in domestic violence as adults; similarly, females are more likely to be victims. Higher levels of adult depression and trauma symptoms have been found.

Despite the findings of the research, not all children exposed to DV/IPV will experience such negative effects. Children’s risk levels and reactions to DV/IPV exist on a continuum; some children demonstrate enormous resiliency, while others show signs of significant maladaptive adjustment. Protective factors such as social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships, and a supportive relationship with an adult (especially a non-abusive parent), can help protect children from the adverse effects of exposure to DV/IPV.

Other factors that influence the impact of DV/IPV on children include (USDHHS, CWIG, 2009):

- **Nature of the violence.** Children who witness frequent and severe forms of violence or fail to observe their caretakers resolving conflict may undergo more distress than children who witness fewer incidences of physical violence and experience positive interactions between their caregivers.
- **Age of the child.** Younger children appear to exhibit higher levels of emotional and psychological distress than older children. Age-related difference might result from older children’s more fully developed cognitive abilities to understand the violence and select various coping strategies to alleviate upsetting symptoms.
- **Elapsed time since exposure.** Children often have heightened levels of anxiety and fear immediately after a violent event. Fewer observable effects are seen in children as time passes after the violent event.
- **Gender.** In general boys exhibit more externalized behaviors (e.g., aggression and acting out), while girls exhibit more internalized behaviors (e.g., withdrawal and depression).
- **Presence of child physical or sexual abuse.** Children who witness DV/IPV and are physically abused are at higher risk for emotional and psychological maladjustment than children who witness violence and are not abused themselves.

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**

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, 2011).

If you are meeting someone you don't know or don't know well, you can take steps to stay safe. Try to:

- Meet your date in a public place
- Tell a friend or family member your date’s name and where you are going
- Avoid parties where a lot of alcohol may be served
• Make sure you have a way to get home if you need to leave
• Have a cellphone handy in case you need to call for help

Date rape drugs are drugs that are sometimes put into a drink to prevent a person from being able to fight back during a rape. These drugs have no color, taste, or smell, so you would not know if someone put them in your drink. They also make it hard to remember what happened while you were under their influence.

If you go to a club, bar, or party, here are some steps to take to avoid date rape drugs:

• Don't accept drinks from other people.
• Keep your drink with you at all times, even when you go to the bathroom.
• Don't drink from punch bowls or other open containers.
• If you lose track of your drink, dump it out.

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, 2012).

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, 2012):

• 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, 2012).

**GHB**

**GHB**, short for gamma hydroxybutyric acid is also known as (USDHHS, 2012):

- 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, 2012):

- 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, 2012):

- 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
- Problems seeing
- Dizziness
- Confusion
- Stomach problems

Ketamine

Ketamine is also known as (USDHHS, 2012):

- Black Hole
- Bump
- Cat Valium
- Green
- Jet
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, 2012):

- 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**

<table>
<thead>
<tr>
<th>Case Study 6. Chris</th>
</tr>
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<tbody>
<tr>
<td>Chris met Paul at a friend’s house. He was very nice, very kind; not like others Chris had met. They began to date, and Paul was always so encouraging and supportive of Chris’s academic goals and family relationships. Everyone liked Paul. One night when they were out, Paul had too much to drink, and began to be insulting to Chris. Chris was hurt when leaving; the next day Paul called to apologize for his behavior. Things went well after that; they became a couple. One night Paul had too much to drink and in the midst of an argument he hit Chris. Pained, Chris asked why he would hit someone he said he loved. Paul said he didn’t know what came over him but needed Chris to stop talking. He apologized for his behavior, and became very loving, intimate. Paul hit Chris again; this time because Chris didn’t want to engage in sex. Hitting became a regular part of life for them both. Chris was beginning to realize that the relationship couldn’t continue. But then Paul was always sorry and was generous and kind; he gave many gifts, they went on vacations. Paul promised he would never hit again, and life went on. Chris had become friendly with another man at work over time and Paul became very jealous. He began calling Chris names and made accusations of prostitution and treachery. Life became unbearable for Chris. Paul would be abusive whenever he was not able to get his way. Paul found out that Chris was planning to leave him; he held...</td>
</tr>
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Chris hostage with a weapon for days, threatening many ways he would hide a body. One night, after drinking and another round of beating, Paul fell asleep and Chris escaped. Emotionally, it was very difficult for Chris to stay away from Paul but with professional help, was able to so. Chris had so much difficulty talking about these experiences; there was so much shame for loving someone who treated you so badly. As a male, Chris was afraid to tell his friends and family that he was in an abusive relationship with another man.

**IPV/DV in Same-Sex Relationships**

Generally, it is thought that the prevalence of IPV/DV among lesbians, gay men, bisexuals 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.)
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 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 can initiate the discussion.
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.

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

Medical Power and Control Wheel

Just as with the previously identified Power and Control Wheel identifying the dynamics of abuse in the IPV/DV, the Medical Power and Control Wheel identifies how healthcare providers contribute to the problems of IPV/DV for the victim. These include violating confidentiality; trivializing, minimizing or normalizing the abuse, blaming the victim, taking a patriarchal tone by telling the victim what she should do and not taking the victims safety needs seriously.
Management of IPV/DV in the Healthcare Setting

Identifying IPV/DV in healthcare is critical. Many professional organizations recommend routine screening for IPV/DV. Among them are 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.
Changes in healthcare funding have contributed to broadening screening for DV/IPV. The Affordable Care Act requires many insurance plans to provide coverage for certain recommended preventive health services which will help ensure that women can receive, without cost-sharing, a comprehensive set of recommended preventive health services, including screening and counseling for interpersonal and domestic violence (USDHHS, 2012).

Identifying current or past abusive and traumatic experiences can help prevent further abuse, lessen disability, and lead to improved health status. Because they are often trusted resources in their communities, health care providers are in a unique position to connect women who experience interpersonal and domestic violence with support (USDHHS, 2012).

Providers do not need to be experts on interpersonal and domestic violence to conduct screenings. Screening can occur during any visit with a primary care provider or as part of any other health care visit. Just as providers routinely screen patients for diabetes or high blood pressure and refer them to specialists as needed, providers can also screen for interpersonal and domestic violence and provide a referral to local domestic violence programs and services (USDHHS, 2012).

If a woman discloses abuse, the provider can provide brief counseling to:

1) Promote the patient’s immediate safety;
2) Discuss the possible relationship between current or previous interpersonal and domestic violence and the patient’s health concerns; and
3) Link the patient to support services and resources (USDHHS, 2012).

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. Upon 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.
Assessment

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 IPVDV 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.


Screening can also occur through simple verbal questioning. 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, 2014):

"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, 2014).

Screening should occur (ACOG, 2014):

- 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, 2014):

- 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;
  - 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, Kentucky Adult and Child Abuse Reporting Hot Line:(800) 752-6200; Kentucky Spouse Abuse Shelter Hot Line: (800) 544-2022 VINE: The National Victim Notification Network (800) 511-1670.

For the patient that discloses past history of IPV/DV victimization:

- "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?"

**Reporting IPV/DV**

Some states mandate the reporting of IPV/DV some authority such as the police. Only Kentucky requires reporting to the state Department for Community Based Services (DCBS), a statewide, county-based victim service agency. What this means is that in Kentucky mandatory reporting is actually the mandatory connecting of victims of IPV/DV with trained community ‘specialists’ who offer protection, information and advocacy in a safe, confidential manner.

State statutes also require all courts to provide 24-hour access to emergency protection orders. Violation of a protection order is a Class A misdemeanor. No contact orders are issued as a condition of release. Each court is also mandated to establish local protocols in domestic violence matters. The protocols must be submitted to the Kentucky Supreme Court for review.
Reporting of spouse and partner abuse from victims themselves, by the general public and by professionals has continued to increase over the years. The DCBS data identifies a concurrent increase in the reporting of domestic violence by professionals: law enforcement officers, physicians and other healthcare providers (Fritsch, 2002).

In a recent survey by the Domestic Violence Subcommittee of the Kentucky Medical Association (KMA) (Fritsch, 2002):

- 59% of physicians responding indicated that mandatory reporting needs to be in place, and
- 47% of physicians indicated they had reported spouse abuse.

**Who Must Report** (KRS 209.030)

Any person, including, but not limited to, physician, law enforcement officer, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

**Immunity** (KRS 209.05060)

Anyone acting upon reasonable cause in the making of a report in good faith shall have immunity from any civil or criminal liability. Neither the husband-wife nor the psychiatrist-patient privilege shall be a ground for refusing to report known or suspected adult abuse.

**Confidentiality** (KRS 209.140)

All information obtained by the Department for Social Services in the course of an investigation under this chapter shall not be divulged to anyone except:

- Persons suspected of abuse, neglect or exploitation, provided that in such cases names of informants shall be withheld unless otherwise ordered by the court;
- Persons within the cabinet with a legitimate interest or responsibility related to the case;
- Other medical, psychological, or social service agency, or law enforcement agency with a legitimate interest in the case;
- Those persons so authorized by court order; and
- The alleged abused or neglected person.

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 and elder abuse 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 and elder abuse should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV/DV.

**Investigation Process** (KRS 209.030)

Upon receipt of a report, the Department for Social Services is required to notify the appropriate law enforcement agency, conduct an investigation of the allegation and offer protective services to the victim. Adult protective services differ from child protective services in that they are voluntary and may be refused by the adult victim. Department personnel may enter any health facility or health services...
licensed by the cabinet at any reasonable time to carry out the investigation, and may enter private premises with the permission of the adult or the caretaker.

**Emergency Protective Services (KRS 209.100)**

A court may order protective services on an emergency basis if the court finds that the adult:

- Is in a state of abuse or neglect and an emergency exists;
- Is in need of protective services;
- Lacks the capacity to consent or refuse to consent to such services; and
- No person authorized by law or court order to give consent for the adult is available to consent to emergency protective services or such person refuses to give consent.

**Penalty (KRS 209.990)**

- Anyone knowingly or wantonly violating the provisions of KRS 209.030(2) shall be guilty of a Class B misdemeanor as designated in KRS 532.090. Each violation shall constitute a separate offense.
- Any caretaker who knowingly abuses or neglects an adult is guilty of a Class C felony.
- Any caretaker who wantonly abuses or neglects an adult is guilty of a Class D felony.
- Any caretaker who recklessly abuses or neglects an adult is guilty of a Class A misdemeanor.
- Any caretaker who knowingly exploits an adult, resulting in a total loss to the adult of more than three hundred dollars ($300) in financial or other resources, or both, is guilty of a Class C felony.
- Any caretaker who wantonly or recklessly exploits an adult, resulting in a total loss to the adult of more than three hundred dollars ($300) in financial or other resources, or both, is guilty of a Class D felony.
- Any caretaker who knowingly, wantonly, or recklessly exploits an adult, resulting in a total loss to the adult of three hundred dollars ($300) or less in financial or other resources, or both, is guilty of a Class A misdemeanor.

**Documentation and Follow-up**

**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 IPVDV 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".

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 ever 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 Kentucky 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

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 (NCADV, 2011).

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 (NCADV, 2011).

- Think about and make a list of safe people to contact.
- Memorize all important numbers.
Establish a "code word" or "sign" so that family, friends, teachers or co-workers know when to call for help.

Think about what you will say to your partner if he/she becomes violent.

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.

- 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 Office of Women's Health (USDHHS, 2011) 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.

| Identification for yourself and your children | 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

Figure 2. What to Bring With You When You Leave an Abuser
## Important personal papers
- 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
- car title, registration, and insurance information

## Funds
- cash
- credit cards
- ATM card
- checkbook and bankbook (with deposit slips)
- investment papers/records and account numbers

## Keys
- house
- car
- safety deposit box or post office box

## A way to communicate
- phone calling card
- cell phone
- address book

## Medications
- 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
- 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
- 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:
• 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 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, according to Forbes magazine, for the last decade, median earnings for women working full time, year-round have been just 77% of men's earnings. 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.

Kentucky Adult and Child Abuse Reporting Hot Line:

(800) 752-6200

Kentucky Spouse Abuse Shelter Hot Line:

(800) 544-2022

VINE: The National Victim Notification Network

(800) 511-1670

Kentucky Domestic Violence Association
P.O. Box 356 - Frankfort, KY 40602
502.209.KDVA (5382)
502.226.KDVA (5382)
Info@KDVA.org
www.kdva.org

There are seventeen domestic violence programs in Kentucky. The programs began as safe shelters for victims of domestic violence, but as understanding of the complex issues facing victims of domestic violence continues to grow, domestic violence programs are increasingly committed to providing strong client support services. In addition to providing a safe, secure environment for victims/survivors and their children, programs now also offer a variety of support services to residents and non-residents including:

- Legal/Court advocacy
- Case management
- Safety planning
- Support groups
- Individual counseling
- Housing assistance
- Job search
- Children's groups

Programs are also working with clients on resume writing, improving basic job skills, parenting, budgeting, and drug and alcohol issues.

The programs are also committed to preventing future domestic violence through public awareness and community education efforts. Domestic violence programs are working with schools, local professionals, and community groups to increase understanding of domestic violence issues.

1. **Purchase Area Development District**

   Includes the Western Kentucky counties of Ballard, Calloway, Carlisle, Fulton, McCracken, Graves, Marshall and Hickman; including the communities of Paducah, Murray, Mayfield and Benton.

   **Merryman House**
2. **Pennyrile Area Development District**

   Includes the Western Kentucky counties of Livingston, Crittendon, Lyon, Caldwell, Trigg, Hopkins, Christian, Muhlenberg and Todd; including the communities of Hopkinsville, Madisonville, Cadiz and Greenville.

   **Sanctuary, Inc.**

   Crisis Line: (800) 766-0000
   Business Line: (270) 885-4572 (3)

3. **Green River Area Development District**

   Includes the Western Kentucky counties of Union, Webster, Henderson, Daviess, McLean, Ohio and Hancock; including the communities of Henderson, Owensboro, Beaver Dam and Providence.

   **OASIS**

   Crisis Line: (800) 882-2873
   Business Line: (270) 685-0260

4. **Barren River Area Development District**

   Includes the South Central Kentucky counties of Logan, Butler, Warren, Simpson, Allen, Monroe, Barren, Metcalfe, Hart and Edmonson; including the communities of Bowling Green, Glasgow, Horse Cave and Russellville.

   **Barren River Area Safe Space, Inc.**

   Crisis Line: (800) 928-1183
   Business Line: (270) 781-9334

5. **Lincoln Trail Area Development District**

   Includes the West Central Kentucky counties of Breckenridge, Grayson, Hardin, Meade, Larue, Nelson, Washington and Marion counties; including the communities of Springfield, Lebanon, Bardstown and Elizabethtown.

   **Springhaven Inc.**

   Crisis Line: (800) 767-5838
   Business Line: (270) 765-4057

6. **KIPDA Area Development District**

   Includes the Louisville Metro Area counties of Trimble, Oldham, Shelby, Jefferson, Bullitt and Spencer; including the communities of Louisville, Shelbyville, Taylorsville and LaGrange.
7. **Northern Kentucky Area Development District**

Includes the Northern Kentucky counties of Carroll, Gallatin, Owen, Grant, Pendleton, Boone, Kenton and Campbell counties; including the communities of Carrollton, Warsaw, Owenton, Dry Ridge, Falmouth, Covington and Florence.

**Women's Crisis Center**

Crisis Line: (800) 928-3335 or (859) 491-3335

Business Line: (859) 655-2650

8. **Bluegrass Area Development District**

Includes the Central Kentucky counties of Franklin, Anderson, Mercer, Boyle, Lincoln, Garrard, Jessamine, Woodford, Scott, Fayette, Madison, Estill, Powell, Clark, Bourbon, Nicholas and Harrison counties; including the communities of Frankfort, Harrodsburg, Danville, Richmond, Lexington, Cynthiana, Paris and Winchester.

**Bluegrass Domestic Violence Program**

Crisis Line: (800) 544-2022

Business Line: (859) 233-0657

9. **Lake Cumberland Area Development District**

Includes the South Central Kentucky counties of Green, Taylor, Adair, Cumberland, Clinton, Russell, Casey, Pulaski, Wayne and McCreary; including the communities of Campbellsville, Columbia, Jamestown, Liberty and Somerset.

**Bethany House Abuse Shelter, Inc.**

Crisis Line: (800) 755-2017

Business Line: (606) 679-1553

10. **Cumberland Valley Area Development District**

Includes the South Eastern Kentucky counties of Rockcastle, Jackson, Laurel, Clay, Knox, Whitley, Bell and Harlan; including the communities of Mt. Vernon, McKee, London, Manchester, Williamsburg and Middlesboro.

**Family Life Abuse Center**

Crisis Line: (800) 755-5348

Business Line: (606) 256-9511 or (606) 256-2724
11. Kentucky River Area Development District

Includes the South Eastern Kentucky counties of Wolfe, Lee, Owsley, Breathitt, Knott, Letcher, Perry and Leslie; including the communities of Campton, Booneville, Jackson, Hyden, Hazard and Whitesburg.

LKLP Safe House

Crisis Line: (800) 928-3131

Business Line: (606) 439-1552

12. Big Sandy Area Development District

Includes the Eastern Kentucky counties of Magoffin, Johnson, Floyd, Martin and Pike; including the communities of Salyersburg, Prestonsburg, Paintsville and Pikeville.

Big Sandy Family Abuse Center

Crisis Line: (800) 649-6605

Business Line: (606) 285-9079

13. Gateway Area Development District

Includes the Eastern Kentucky counties of Montgomery, Bath, Menifee, Rowan and Morgan; including the communities of Mt. Sterling, Owingsville, Frenchburg, Morehead and West Liberty.

D.O.V.E.S.

Crisis Line: (800) 221-4361

Business Line: (606) 784-6880

14. Buffalo Trace Area Development District

Includes the North Eastern Kentucky counties of Bracken, Robertson, Mason, Fleming and Lewis; including the communities of Augusta, Maysville, Flemingsburg and Vanceburg.

Women's Crisis Center

Crisis Line: (800) 928-6708 or (606) 564-6708

Business Line: (859) 655-2650

15. FIVCO Area Development District

Includes the North Eastern Kentucky counties of Greenup, Boyd, Carter, Elliott and Lawrence; including the communities of Ashland, Catlettsburg and Grayson.

Safe Harbor, Inc.

Crisis Line: (800) 926-2150

Business Line: (606) 329-9304
Additional Shelter Programs in Kentucky

**Safe Place**, serving Pike County

Crisis Line: (800) 292-7840

Business Phone: (606) 437-9587

References


Domestic Violence/Intimate Partner Violence
Course Test

1. Intimate partner violence/domestic violence (IPV/DV) is best conceptualized as all of the following
   Except:
   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 Kentucky.
   d. Encompassing the various terms of: domestic violence, with beating, batterer, abuser, same sex partner abuse.

2. The four 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, stalking.
   d. None of the above.

3. The state of Kentucky defines domestic violence and abuse as:
   a. Physical injury, serious physical injury, sexual abuse, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, or assault between family members or members of an unmarried couple.
   b. Family member means a spouse, previous spouse, a parent, a child, a stepchild, or any other person related by consanguinity in the second degree. “Member of an unmarried couple” means each member of an unmarried couple which allegedly has a child in common, any children of that couple, or member of an unmarried couple who are living together or have previously lived together.
   c. The state definition of domestic violence only includes persons who are currently living together or who lived together in the past unless they share a common child.
   d. All of the above.

4. IPV/DV tends to be a chronic problem, particularly in Kentucky. While the national life-time prevalence rate of IPV/DV among women was 25.5%, or 1 in 4 women, the lifetime prevalence for IPV/DV among women in Kentucky is 36.6%, or 1 in 3 women.
   a. True
   b. False

5. In Kentucky, reports of IPV/DV are made to the Kentucky Department of Community Based Services (DCBS), insuring that services can be provided to those impacted by IPV/DV.
   a. True
   b. False

6. IPV/DV results in multiple consequences for victims, families and societies. Acute and chronic consequences for the victim include:
   a. Physical injuries and conditions.
   b. Emotional and psychological sequelae, which may lead to high-risk behavior.
   c. Social and economic consequences.
   d. All of the above.

7. Risk factors for IPV/DV victimization include all the following EXCEPT:
   a. Witnessing or experiencing violence as a child.
   b. Economic security.
   c. Weak community sanctions against IPV/DV such as police being unwilling to intervene.
   d. Dominance and control by one partner in the relationship.
8. According to information discussed in this course, assessment for IPV/DV should occur:
   a. Only with pregnant women at their first prenatal visit.
   b. Routinely regardless of the presence or absence of indicators of abuse.
   c. Whenever the patient discloses the violence.
   d. Only in the company of the alleged abuser.

9. 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?"

10. In the interventions discussed in this course, choose the best interventions to be used in situations of IPV/DV:
    a. Provide information by speaking to the alleged abuser, counseling him/her to refrain from abusing 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.

11. According to information provided in this course, there is no impact on children from witnessing IPV/DV, as long as they are not directly abused themselves.
    a. True
    b. False

12. Victims of IPV/DV often do not disclose their abuse to healthcare providers. Some of the most commonly cited reasons that patients do not disclose are fear of retaliation by the abuser; shame, humiliation and denial about the seriousness of the abuse; and concern about confidentiality, and law enforcement involvement.
    a. True
    b. False

13. Healthcare providers have said that they do not screen for IPV/DV for a variety of reasons. Among those reasons are all the following EXCEPT:
    a. They lack the training/education, resources and time.
    b. They do not feel that they can make a difference and feeling powerless to “fix” the situation, including having frustration with the patient’s unresponsiveness to advice.
    c. Fear of retaliation from the abuser.
    d. Fear of offending the patient.

14. As identified in this course, when a victim decides to leave the abuser, there is often an escalation of danger.
    a. True
    b. False

15. It is a requirement in Kentucky that physicians, law enforcement officers, nurses, social workers, coroner, medical examiner, employees of alternate care facilities, or caretakers, as well as Department of Social Services personnel must report any suspicion that an adult has suffered abuse, neglect or exploitation.
    a. True
    b. False