LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will have increased your understanding of the impact of domestic violence and the role of the healthcare professional in identifying and responding to patients presenting with known or suspected domestic violence signs and symptoms. Specific learning objectives include:

- Describe who is affected by domestic violence.
- Discuss the healthcare implications of domestic violence.
- List common risk factors and lethality issues.
- Identify the dynamics associated with the different types of domestic violence.
- Recognize the signs and symptoms of domestic violence.
- Discuss appropriate documentation in cases of suspected domestic violence.
- Describe actions to protect victims.

On September 14, 2015, 26-year-old Marilyn Stanley of Union, Kentucky, was brutally beaten and scalped by her ex-boyfriend and then attacked by a dog at his command. Before releasing her, the ex-boyfriend forced her to look in a mirror while he ridiculed her appearance. Marilyn, a young mother, lost most of her scalp as well as one of her ears during the attack (CNN, 2015).

This is but one example of recent domestic violence in the United States, where 1 in 3 women and 1 in 4 men are victims of domestic violence (Black et al., 2011). Viewed as a national public health problem, domestic violence is a crime in all 50 states. Other crimes that may be related to domestic violence include:

- Assault
- Threats
Endangerment  
Criminal coercion  
Kidnapping  
Unlawful imprisonment  
Sexual assault, rape  
Trespassing  
Harassment  
Stalking  
Manslaughter, murder

The term *domestic violence* refers to physical, verbal, psychological, sexual, or economic abuse (e.g., withholding money, lying about assets) used to exert power or control over someone or to prevent someone from making a free choice. According to the U.S. Department of Justice (2010), “This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.” Rape, incest, and dating violence are all considered to be forms of domestic violence.

### DOMESTIC VIOLENCE TERMINOLOGY

Various other terms are used to refer to domestic violence:

- **Intimate partner violence (IPV)** is a more specific term often used when referring to harm to a current or former partner or spouse.

- **Domestic abuse** is a term that highlights the nonphysical components of an abusive situation; these include psychological or emotional abuse, threatening, and stalking, as well as neglect or financial exploitation, particularly of older adult family members.

- **Family violence** is a term also used to describe abusive domestic situations because children in the family may be affected, either as witnesses of violence and/or as victims themselves.

### WHO IS AFFECTED BY DOMESTIC VIOLENCE?

Domestic violence may occur in the lives of persons of all ages, cultural/ethnic/religious groups, genders, and social classes. Intimate partner violence is one of the most common but least reported crimes, so it is impossible to know the actual incidence and prevalence. Feelings of shame, fear, and hopelessness often prevent victims from seeking protection and support. Many abused women do not report domestic violence to their physicians or to anyone else. However, the statistics available confirm that the problem is pervasive and alarming.
The economic impact of intimate partner or domestic violence that accompanies the personal and emotional impact is clear. This economic impact affects the victim, the employer, and the community. Research indicates that victims of domestic violence in the United States lose 8 million work days, or the equivalent of more than 32,000 full-time jobs, annually. Individuals may develop strained relationships with employers due to poor job performance, tardiness, and absenteeism (CDC, 2015).

**Domestic Violence among Women**

Victims of domestic violence are usually women and children. Perpetrators of domestic violence are generally, though not always, men. According to the Centers for Disease Control (CDC) and Prevention, more than 12 million women and men are victims of intimate partner violence over the course of a year. In 2007, IPV resulted in 2,340 deaths and accounted for 14% of all homicides. Of these deaths, 70% were females and 30% were males. Many victims do not report IPV to police, friends, health professionals, or family, so these statistics underestimate the problem (CDC, 2012).

**Teens and Dating Violence**

Teen dating violence is another form of IPV that is disturbingly common among high school students and can result in serious long-term and short-term effects. The nature of dating violence can be physical, emotional, or sexual. Dating violence can also include stalking and can take place in person or electronically.

As with adult victims of IPV, many teens do not report their victimization, but according to a 2013 survey, approximately 10% of high school students reported being physically victimized by a boyfriend or girlfriend and another 10% reported sexual victimization from an intimate partner (Kann et al., 2014).

A CDC survey discovered a relationship between adult victims of sexual or intimate partner violence and early exposure to some form of violence between the ages of 11 and 17. This relationship was identified in 23% of females and 14% of males who ever experienced rape, physical violence, or stalking as adults (CDC, 2016b).

Those who harm their dating partners are more likely to be depressed and more aggressive than their peers. Other characteristics of abusive dating partners include:

- Trauma symptoms (irritability, anxiety, anger, difficulty concentrating, or insomnia)
- Exposure to harsh parenting
- Exposure to inconsistent discipline
- Lack of parental supervision and warmth
- Belief that using dating violence is acceptable
- Alcohol use
• Behavioral problems in other areas
• Having a friend involved with dating violence (CDC, 2016b)

Consequences of teen dating violence may include:
• Depression and anxiety
• Tobacco, alcohol, and drug use
• Antisocial behaviors
• Thoughts about suicide
• Continued victimization in college (CDC, 2016b)

### Domestic Violence among Older Adults

Knowledge of elder abuse is thought to be about 20 years behind the fields of domestic violence and child abuse, and there is an urgent need for research on the topic (NCEA, 2016). Abuse of older adults may be missed by professionals who work with these patients because of a lack of training in detecting abuse. Abuse may go unreported by the victims themselves because they may be unable physically or cognitively to seek help, they do not want to get the abuser in trouble, or they fear retaliation.

Various studies on elder abuse present different findings, but the most common type of elder abuse is financial, followed by neglect, physical abuse, and sexual abuse.

According to the National Center for Elder Abuse, the most common physical findings of physical abuse among older adults include:

• Bruises
• Contusions
• Lacerations
• Dental problems
• Head injuries
• Fractures
• Pressure ulcers
• Chronic pain
• Sexually transmitted infections
• Poor nutrition
• Poor hydration
• Sleep problems
• Increased susceptibility to new illnesses
  (NCEA, 2016)

**Domestic Violence among Minority Racial and Ethnic Groups**

Domestic violence is a crime without cultural boundaries. It affects people from all walks of life regardless of race, religion, or economic class. The desire or ability to report the crime and access services may also be affected by the person’s culture. Therefore, it is essential for health professionals to consider cultural differences when working with immigrant and diverse communities in order to provide appropriate and sensitive services (NIJC, 2013).

Some cultures believe that the family is the only appropriate forum for dealing with domestic violence, and outside interference is not encouraged or accepted. Other ethnicities may even resist acknowledging that domestic violence exists as a problem. It can be challenging to assist victims who do not understand that help is available. Language barriers and lack of knowledge of legal rights or resources can also be an obstacle to seeking help.

A recent study demonstrated that the Asian population nationwide is less likely to access professional services and tends to use informal means of support such as family and friends. Asian victims seem to utilize formal help less than victims of other racial groups (Cho, 2012).

**Hispanics** now comprise 16% of the national population and are the largest ethnic minority in the United States. Studies show that although IPV occurs at a similar rate in this population as it does in other ethnic groups, these victims are less likely to report the abuse or seek help. Possible contributing factors are that the victims may not trust the police, fear deportation, feel shame or guilt, or have a history of child victimization. In addition, the victims may not understand what type of help is available or how to access services.

Complex issues of racism, in combination with sexism, may contribute to increased prevalence of domestic violence in the African American community. Black women are as much as three times more likely to die from domestic abuse as white women, making it one of the leading causes of death for black women between the ages of 15 and 35. Although the most important risk factor for femicide is prior domestic violence, men who murder their domestic partners are likely to be unemployed, and the unemployment rate is higher in African Americans than in other races (Sabri, 2014).

Black women also under-report domestic violence more than women from other communities (Ingram, 2017). One impediment to reporting domestic violence faced by black women is that they are less likely to trust potentially racially biased law enforcement agents and the legal system than are their white counterparts. African American communities may be more likely to rely on a faith-based social system and prefer to keep their problems private. In 2013, 92% of black, female homicide victims knew their killers, and 56% were wives, domestic partners, ex-wives, or girlfriends of the offenders (Violence Policy Center, 2015).
U VISA and T VISA

The U visa is a nonimmigrant visa that was created in 2000 with the passage of the Victims of Trafficking and Violence Protection Act (including the Battered Immigrant Women’s Protection Act). It is a unique visa for victims of crimes who have suffered substantial mental or physical abuse and are willing to assist law enforcement in the investigation or prosecution of the criminal case. It was developed with the intent to strengthen the ability of law enforcement to investigate and prosecute certain types of cases.

Victims who are granted a U visa are given temporary legal status and work eligibility in the United States for up to four years. This program helps law enforcement agencies assist many victims of crimes who would otherwise not be served.

The T visa is a similar plan in which qualifying victims of trafficking, along with approved family members, may reside in the U.S. for approximately four years if they comply with criminal justice system requests.


Domestic Violence and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex Persons

The national Violence Against Women Survey summarizes the second year of data collection from the National Intimate Partner and Sexual Violence Survey (Breiding et al., 2011), in which 21.5% of men and 35.4% of women who live with a same-sex partner reported intimate-partner physical violence in their lifetimes.

A Massachusetts survey reported a lifetime prevalence of domestic violence among 34.6% of transgender persons (Ard & Makadon, 2011). In 2012, the National Coalition of Anti-Violence Programs reported the highest yearly total of LGBTQI intimate partner homicides ever recorded.

Persons who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQI) do not often access services or report to the police. There are many reasons they do not seek help, such as:

- An LGBTQI victim may fear that the abuser will reveal his or her sexual orientation or biological gender to family, friends, or coworkers.
- Abusers may threaten to reveal an infected person’s positive HIV status to others or to transmit HIV to the victim if he or she is HIV negative.
- These individuals fear institutional discrimination and homophobic or transphobic care providers.
- A transgender person may not have undergone sexual reassignment surgery and may avoid a physical exam by a clinician that might include observation of his or her genitals.
Law enforcement authorities may not recognize same-sex individuals as intimate or domestic partners and may have a difficult time determining the primary abuser or that the assaultive behavior is actually a domestic crime. Access to services is severely limited by lack of shelters that serve male victims. Sensitivity to the needs of this group is paramount to effecting social change and helping victims receive needed assistance (Sanctuary for Families, 2014; NCAVP, 2012).

**Domestic Violence and the U.S. Military**

Military regulations require that all military officials report any suspicion of family violence to a Family Advocacy agent. Officials include commanders, first sergeants, supervisors, medical professionals, teachers, and police officers. If the abuser is a military member, the military justice system will be implemented. Family Advocacy conducts an investigation, intervenes, and provides treatment. They may substantiate the abuse, but if there is insufficient legal evidence, there may be no punishment for the abuser. There is no confidentiality in the military, as there is with civilian advocacy, and any pertinent statements that are made during interactions with Family Advocacy are recorded and passed on to the legal sector.

If there is sufficient legal evidence, the military justice system may reprimand the abuser or mandate extra training or counseling. Reprimands can be verbal or written. Written reprimands are recorded and can negatively affect the subject’s career. In many cases, the subject is required to be separated from his or her spouse and required to be housed in barracks, if available, until an investigation has been completed and the subject may be issued a no-contact order with the victim.

Military spouses may decide not to report the abuse for all of the same reasons that civilian victims do not report, and they may also hesitate because the accusation may negatively impact their spouse’s career. In fact, a military member who is a domestic abuser is 23% more likely to be discharged than a nonabuser, and if not discharged, is likely to be promoted more slowly than a nonabuser. The federal government provides limited financial protection (up to 36 months) to the abused spouse if the military member is discharged for the abuse of a spouse or dependent child (Powers, 2016).

**HEALTH EFFECTS OF DOMESTIC VIOLENCE**

Domestic violence has an enormous impact on the health of those who are affected as well as on the healthcare system.

The 2014 National Violence Against Women Survey summarizes the second year of data collection from the National Intimate Partner and Sexual Violence Survey. It found that 1 in 4 women and 1 in 7 men aged 18 and older in the United States experience severe physical violence by an intimate partner in their lifetime. Nearly 15% of women and 4% of men have been injured as a result of acts of domestic violence that included rape, physical violence, and/or stalking by an intimate partner in their lifetime (Breiding et al., 2011).
Injuries sustained during episodes of violence are only part of the damage to victims’ health. Physical and psychological abuse are related to other adverse effects, including complaints such as:

- Headaches
- Back pain
- Pelvic pain
- Gastrointestinal disorders
- Gynecological disorders
- Obstetrical problems
- Sexually transmitted infections
- Central nervous system disorders
- Heart or circulatory conditions

Intimate partner violence is also linked to mental health problems, including:

- Depression
- Anxiety
- Antisocial behavior
- Low self-esteem
- Inability to trust men
- Fear of intimacy
- Posttraumatic stress disorder
- Substance abuse
- Suicide
- Risky sexual activity
  (Dillon et al., 2013)

Although 77% of women suffer from a chronic health condition in their lifetimes, the percentage increases to 81% for women who have experienced domestic violence and 88% for women who have experienced sexual abuse (Verizon Foundation, 2013).

Chronic pain and depression have many causes other than IPV, but either symptom should alert healthcare professionals to ask about violence in the home or intimate partner relationships, both past and present. A key finding in the Verizon study was that only 20% of participants reported that healthcare professionals had queried them about violence in their lives.
When physicians and nurses did ask patients about abusive behaviors, the most commonly asked questions were, “Has anyone close to you made you feel afraid for your own safety?” and “Has your partner ever physically hurt you?” The survey results reported that younger women, ages 21 to 44, were most likely to be asked directly about abuse, as compared to women over 44 years of age, and that nearly two thirds of the women who had experienced abuse reported that they would have wanted their physician or nurse to have asked them about domestic violence (Verizon Foundation, 2013).

**HEALTH EFFECTS ON CHILDREN**

Children who are subjected to domestic violence develop problems such as attachment disorder, depression, anxiety, and oppositional defiance disorder. A violent environment will have the greatest adverse effects on the brains of the youngest children, even infants. This is because the developing brain of a child is highly sensitive, and the chronic state of fear and stress that these children experience prevents the brain from developing normally. Instead, the brain is influenced adversely by abnormal patterns of neurological activities and brain chemicals (Child Welfare Information Gateway, 2015).

The Adverse Childhood Experience (ACE) Study, published in 2009, investigated the association between childhood maltreatment and later-life health and well-being (CDC, 2009). The ACE Study findings suggest that child maltreatment experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. The more adverse childhood experiences that were experienced by an individual, the greater the risk of developing alcoholism, chronic obstructive pulmonary disease (COPD), depression, illicit drug use, intimate partner violence, sexually transmitted infections, criminality, and smoking. *(See also “First Impressions: Exposure to Violence and a Child’s Developing Brain,” listed in the “Resources” section at the end of this course.)*

**RISK FACTORS AND LETHALITY**

**Common Risk Factors**

The National Institutes of Health published a systematic review of risk factors for IPV (Capaldi et al., 2012). They include:

- Low self-esteem
- Age range in adolescence and young adulthood
- Unemployment and low income
- Minority group membership
• High levels of acculturation stress
• Financial and work-related stress
• Lack of parental support and/or monitoring in adolescents
• Adolescent involvement with aggressive peers
• Social isolation
• Conduct problems
• Depression and irritability
• Substance use
• Separation
• Low relationship satisfaction
• Childhood victimization
• Exposure to interparental violence
• Alcohol use

POVERTY

Although domestic violence is found in all walks of life, those who live in poverty face additional challenges. The CDC (2016c) lists poverty as a risk factor for intimate partner violence. Poverty damages health and well-being in countless ways; exposure to domestic violence is just one. When IPV and persistent poverty intersect, they limit coping options. Both poverty and IPV lead to stress, feelings of powerlessness, and social isolation, which combine to produce posttraumatic stress disorder, depression, and other emotional difficulties.

Such women face risks from the batterer and risks resulting from their poverty.

• Risks from the batterer include physical injury; threats and loss of security, housing, and income; and potential loss of their children.

• Risks from poverty include food insecurity, lack of access to health insurance and healthcare, possibly racism, unsafe neighborhoods, and poor schools for their children.

The double jeopardy of poverty and IPV challenges abused women and the healthcare and social service professionals responsible for protecting them. Intervening to stop the violence is only the first step. Issues of income, housing, and healthcare—both mental and physical—must also be addressed. For instance, research shows that domestic violence is a primary cause of homelessness for women and families. A study in Massachusetts showed that 63% of homeless women were survivors of IPV (NAEH, 2014).
FAMILY/CAREGIVER STRESS

Families stressed by illness, unemployment, alcohol, and/or drug use are more likely to experience violence. This is particularly true with elder abuse, especially if the older person is frail or mentally impaired, the caregiver is poorly prepared for the task, or needed resources are unavailable. Adult children who abuse their parents frequently suffer from mental and emotional disorders, alcoholism, drug addiction, and/or financial problems that make them dependent on the parents for support. These families respond to tension or conflict with violence because they have not learned any other way to respond.

PREGNANCY

IPV often begins or escalates during pregnancy, making pregnancy an especially dangerous time for women in abusive relationships. Any type of abuse during pregnancy increases the risk of health problems for the woman and the unborn child because a pregnant woman is particularly vulnerable both physically and emotionally. Trauma from physical abuse can cause a woman both acute injury and increase her risk for an obstetrical emergency, preterm birth, complications during labor, or miscarriage later in the pregnancy (NDVH, 2013).

The most recent data from the National Violent Death Reporting System revealed 94 counts of pregnancy-associated suicide and 139 counts of pregnancy-associated homicide in a multistate sample of the United States during the years 2003 to 2007. Intimate partner conflict was associated with 54.3% of the pregnancy-associated suicides and 45.3% of the pregnancy-associated homicides. These deaths confirm the need to evaluate IPV with pregnancy-associated violent death (Palladino, 2011).

Battering can lead to adverse effects on both the mother and the baby. The mother may experience high blood pressure or edema, vaginal bleeding, kidney or urinary tract infection, and posttraumatic stress disorder (Silverman et al., 2006). The stress of abuse may also cause pregnant women to continue such unhealthy habits as smoking and drug or alcohol use. Abused women are also at high risk for postpartum depression, which can interfere with breastfeeding and affect their relationships with their babies and other children as well as with other adults (Kendall-Tackett, 2007).

Miscarriage, low birth-weight, or other injury may occur in the developing fetus, and a study by Lannert and colleagues (2014) suggests that a fetus whose mother experiences violence can be affected by her elevated cortisol levels. Cortisol is a neurotoxin, and babies who have a high cortisol exposure in utero may develop nightmares, intolerance to noise and bright lights, and emotional problems later in life. In other words, a baby whose mother is a victim of domestic violence can suffer consequences of the abuse even before being born.

DISABILITY/IMPAIRMENT

According to research, women with a disability are more likely to experience IPV than those without a disability. In fact, 37.3% of women with a disability reported experiencing some form of IPV during their lifetime as compared to 20.6% of women without a disability (CDC, 2012).
Having a disability limits a woman’s options for escaping or resolving the abuse. For example, if an abusive partner withholds needed equipment, such as a wheelchair or assistance with dressing or getting out of bed, this prevents access to programs that could help end the abuse (Nosek, 2001). Unemployment further disadvantages women with disabilities, decreasing their chances of being able to break the cycle of violence (Smith, 2008).

Women living with HIV also can be at increased risk for IPV. According to the National Women’s Health Information Center, many women infected with HIV report emotional, physical, or sexual abuse at some time after their diagnosis.

**Risk of Lethality**

Without any sort of intervention, abuse tends to escalate. While not all abusers kill and there are no perfect predictors of time and place, research has revealed some patterns of escalation in domestic violence. The time of separation—when an abuse victim leaves the abuser and just afterward—presents the greatest threat to the abuser’s ability to maintain power and control.

Risk factors for domestic violence femicide or homicide include:

- Previous nonfatal strangulation (7 times higher)
- Separation from the abuser
- Pregnancy (3 times higher)
- Perpetrator substance or alcohol abuse (problem drinking is associated with a twofold increase of completed or attempted femicide)
- Access to firearms
- Use of firearms during previous incidents of domestic violence
- Perpetrator unemployment
  (Riviello, 2014)

**HOMICIDE-SUICIDE**

Incidents in which a family member kills a domestic partner or other family members and then kills himself are fortunately rare, but awareness of risk factors for lethality in a relationship is important.

According to data gathered by the CDC from 408 such homicide-suicide cases, 91% of the perpetrators were men and 88% used a gun. There was a history of intimate partner violence in 70% of the cases, although only 25% of prior domestic violence appeared in the arrest records. The point of separation was acknowledged as a vulnerable period, and risk factors for homicide-suicide were identified as:
• Prior domestic violence
• Access to a gun
• Threats with a weapon
• Stepchild in the home
• Estrangement
• Unemployment
• Poverty
• White, non-Hispanic male
• Possessively jealous
• Substance abuse
• Family stressors
  (Auchter, 2010)

ACCESS TO GUNS

Studies have demonstrated that the risk of homicide to a victim of domestic violence is five times higher when the abuser has access to a gun (Campbell et al., 2003) and that incidents of homicide are reduced when persons under a restraining order are prohibited from purchasing a firearm (Sorenson, 2006). Federal law prohibits individuals who have been convicted of domestic violence misdemeanors or are subject to domestic violence protective orders from possessing guns or ammunition.

In spite of the overwhelming evidence that access to firearms increases the risk of homicide in domestic violence cases and federal laws that disallow abusers to retain or purchase firearms and ammunition, some states do not prohibit convicted domestic violence abusers from possessing guns, nor does it require that they surrender firearms or ammunition or require that guns be removed even when they are discovered at the scene of a domestic violence incident.

WHAT DO THE DYNAMICS OF DOMESTIC VIOLENCE LOOK LIKE?

While domestic violence can manifest in a variety of manners and severity, the CDC recommends using a consistent definition in order to monitor trends over time (CDC, 2016a). There are four main types of domestic violence (also called intimate partner violence):

• Physical violence
• Sexual violence
• Psychological aggression
• Stalking
  (Breiding et al., 2015)
Research indicates that domestic violence occurs in a **three-phase cycle** (Walker, 2017):

1. A period of increasing tension, leading to verbal and physical abuse
2. Acute battering incident
3. A “honeymoon” period of calm and remorse in which the abuser is kind and loving and begs for forgiveness

When stress and conflict begin to build, the cruel cycle begins again. Over time, the first two phases grow longer and the honeymoon phase diminishes.

**Physical Violence**

Physical violence can be defined as “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.” Physical violence can also include coercing another person to perform those acts (Breiding et al., 2015).

**Sexual Violence**

There are five categories of sexual violence as identified by the CDC. These include:

- Rape or penetration of the victim. The definition includes attempted rape and penetration that is drug-facilitated or forced.
- Forcing the victim to penetrate another person. This act includes alcohol- or drug-facilitated incidents.
- Unwanted penetration of the victim by the use of nonphysical methods such as verbal pressure or abuse of authority.
- Unwanted sexual contact in which the perpetrator touches the victim or forces the victim to touch the perpetrator either directly or through the clothing without the victim's consent. The areas of the body involved in the definition include genitalia, buttocks, anus, groin, inner thigh, and breast.
- Unwanted noncontact sexual experiences, such as exposure to pornography, sexual harassment, filming or photography, and threats of sexual violence.
  (Breiding et al., 2015)
Psychological Aggression

Psychological aggression is defined by the CDC as “the use of verbal and nonverbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person” (Breiding et al., 2015). This form of abuse may include name-calling, humiliation, and control over finances, transportation, and access to family and friends.

It may also include reproductive coercion, such as deliberately exposing a partner to sexually transmitted infections (STIs); attempting to impregnate a partner against her will (by damaging condoms or throwing away her birth control pills, also called birth control sabotage); threats or acts of violence if the partner does not comply with the perpetrator’s wishes concerning the decision to terminate or continue a pregnancy; as well as threats or acts of violence if the partner refuses to have sex.

Psychological aggressors may exploit vulnerabilities of the victim, such as immigration status or disabilities, or present false information to the victim with the intent of causing victims to doubt their memories or perceptions.

Researchers report that psychological/emotional (nonphysical) violence may be more difficult to endure and have more lasting effects than physical violence, particularly in middle-aged and older women. This kind of abuse appears to be more effective in controlling the victim’s behavior than physical violence because it erodes self-esteem and increases uncertainty, hopelessness, and fear (Seff et al., 2008).

The “invisibility” of nonphysical abuse serves as a barrier to reporting the abuse. Victims fear that law enforcement officers would not recognize psychological or emotional violence as a crime. Victims have reported to researchers that, “[The police] want to see the bruises and the black eye and the teeth knocked out,” and “You have no proof of it. You have nothing to show, and you can’t have them arrested” (Seff et al., 2008).

Stalking and Cyberstalking

The U.S. Department of Justice (2016) identifies several types of unwanted “stalking” behaviors that would cause a reasonable person to experience fear. Examples of behaviors that are experienced by stalking victims include.

- Receiving unwanted phone calls
- Receiving unsolicited or unwanted letters or emails
- Being followed or spied on
- Having the stalker show up at places without a legitimate reason
- Having the stalker wait at places for the victim
- Receiving unwanted items, presents, or flowers
• Having information or rumors about the victim posted on the Internet, in a public place, or by word of mouth

Although these acts individually may not be criminal, collectively and repetitively they may cause a victim to fear for his or her safety or the safety of a family member. Women are disproportionately victimized by stalking, with a prevalence of 1 in 6 women experiencing stalking in their lifetime compared to 1 in 19 men (Breiding et al., 2011).

The explosion of digital technology—cellular phones, GPS systems, the Internet, and social networking sites such as Facebook and YouTube—is abused by some, resulting in cyberstalking, cyberbullying, harassment, sexting (sharing naked images of oneself or others), and dating abuse. Collectively, these activities are known as **digital abuse**, which is particularly pervasive among teens (Associated Press-MTV, 2009).

Half of people ages 14 to 24 reported experiencing digitally abusive behavior, and females were more likely to have been targeted than males. Nearly 1 in 4 young people currently in a dating relationship report that their dating partner checks up on them many times each day either online or by cell phone to see where they are, whom they are with, and what they are doing. Others report that their dating partners attempt to manipulate and control them by checking the text messages on their phone without permission, demanding their passwords, or demanding that they “unfriend” former dating partners on social networks.

Although there is no universally accepted definition of **cyberstalking**, the term is used here to refer to the use of the Internet, email, or other electronic communications devices to stalk another person. Cyberstalking has become an all-too-common means of harassment, particularly by spurned intimate partners. Even though cyberstalking does not involve physical contact with the perpetrator, it can constitute emotional and psychological abuse.

The Stalking Resource Center recommends that victims of cyberstalking:

• Trust your instincts.

• Call the police if there is immediate danger and explain why certain actions cause fear.

• Keep a record of each contact and save all emails, text messages, photos, and other communications.

• Connect with a local advocate to discuss options and a safety plan.

• Call the National Domestic Violence Hotline. (NRCVC, 2014)

(See “Resources” at the end of this course).
EFFECTS OF STALKING

Victims of stalking suffer from both short-term and long-term effects and are more likely than their nonvictim counterparts to experience:

- Posttraumatic stress disorder (PTSD)
- Asthma
- Diabetes
- Headache
- Chronic pain
- Difficulty sleeping
- Limited activity
- Poor physical health
- Poor mental health

(Black et al., 2011)

Stalking often precedes murder or attempted murder of women by their intimate partners (femicide). Researchers reported that 76% of women murdered by their former partners had been stalked by their partners in the year prior to their murder. Most women were stalked after the relationship had ended. More than half of femicide victims had reported the stalking to police before they were killed by their stalkers (McFarlane et al., 1999).

UNDERSTANDING PERPETRATORS AND VICTIMS

People outside of abusive relationships often wonder both why a perpetrator abuses and why a victim of abuse remains in such a relationship.

Why Perpetrators Abuse

Typically, abusers want power and control, and all their various behaviors are intended to achieve that end.

Although an abuser’s behavior may also arise from or be exacerbated by a mental illness, that is not usually the case; however, abusive behaviors may be complicated by substance abuse problems. Health professionals should be alert to any signs of these complicating factors when assessing high-risk individuals.
POWER AND CONTROL

A model developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, known as the Power and Control Wheel, depicts the most common abusive behaviors or tactics experienced by battered women. It is characterized by the pattern of actions that a male abuser uses to intentionally control or dominate his intimate partner. These actions fall under eight primary categories:

- Using coercion and threat
- Using intimidation
- Using emotional abuse
- Using isolation
- Minimizing, denying, and blaming
- Using children
- Using male privilege (potential socio-economic advantages for persons of male gender)
- Using economic abuse

(See also “Resources” at the end of this course.)


CASE

Anthony and Deborah met in their early twenties. Anthony’s source of income was an inheritance, and Deborah was completing a nursing program. After Deborah graduated, they married and Deborah began working at a local hospital. She was unhappy that she had to go to work and Anthony did not. When Deborah complained about the situation, Anthony spat on her and told her that his inheritance was only for him and that she needed to earn enough money to pay for her own support.

Deborah became pregnant and worked the night shift after the baby was born. Following the birth of a second child two years later, Deborah asked Anthony to get a job. He declined, arguing that he was taking care of the children and she could make more money than he could. Anthony did not allow Deborah access to either the checkbook or a credit card.

One morning, Deborah’s car was towed away because the car payments were in arrears. Anthony told her she would have to take the bus. When she again asked Anthony to get a job, he became angry, yelling and shoving and even throwing a chair at her during the argument. When Deborah told Anthony that she wanted a divorce, he threatened to take the children away forever. Deborah was ashamed to ask her friends or family for help and remained in the marriage for several more years until Anthony began to physically abuse the children.
Why Victims Stay

There are many reasons why victims stay in abusive relationships, and in any given relationship there may be numerous factors that form an interrelated web. These reasons fall into three broad categories: situational factors, emotional factors, and personal beliefs. It is important for healthcare professionals to understand the many reasons why victims remain in these relationships in order to provide appropriate treatment, assistance, and referrals.

SITUATIONAL FACTORS

- Economic dependence and inability to support herself and her children
- Fear of greater physical danger to herself and her children if they try to leave
- Fear of being hunted down and suffering a worse beating than before
- Fear of being killed if she leaves, often based on real threats by her partner
- Fear of emotional damage to the children
- Fear of losing custody of the children, often based on her partner's remarks
- Lack of alternative housing; nowhere else to go
- Lack of job skills or the inability to get a job
- Social isolation resulting in lack of support from family and friends
- Social isolation resulting in lack of information about her alternatives
- Lack of understanding from family, friends, police, ministers, etc.
- Negative responses from community, police, courts, social workers, etc.
- Fear of involvement in the court process, sometimes due to bad prior experiences
- Fear of the unknown (“Better the devil you know than the devil you don’t”)
- Fear and ambivalence over making formidable life changes
- “Acceptable violence,” in which the violence escalates slowly over time and numbs the victim so that she is unable to recognize a pattern of abuse
- Fear of losing ties to the community, including the children leaving their school, leaving behind friends and neighbors, losing contact with her “old life”
- Ties to her home and belongings
- Family pressure (“Mom always told you it wouldn’t work out,” or “You made your bed, now sleep in it”)
- Fear of her abuser doing something to “get” her (reporting her to welfare, calling her workplace, etc.)
• Inability to access resources due to language barriers, disability, homophobia, etc.
• Lack of time needed to plan and prepare to leave

EMOTIONAL FACTORS

• Insecurity about being alone or on her own; fear she can’t cope with home and children by herself
• Loyalty (“He’s sick; if he had a broken leg or cancer, I would stay. This is no different.”)
• Pity, feeling sorry for him
• Wanting to help (“If I stay, I can help him get better.”)
• Fear that he will commit suicide if she leaves, often based on her partner’s remarks
• Denial (“It’s really not that bad. Other people have it worse.”)
• Love, particularly when the abuser is quite loving and lovable when he is not being abusive
• Love, especially when remembering what he used to be like
• Guilt, believing that their problems are all her fault, often with the agreement of her partner
• Shame and humiliation in front of the community (“I don’t want anyone else to know.”)
• Unfounded optimism that the abuser will change
• Unfounded optimism that things will get better, despite all evidence to the contrary
• Learned helplessness, as a result of trying every possible method to change things without success, thereby coming to expect failure (also seen with prisoners of war, hostages, those in extreme poverty, etc.)
• False hope (“He’s starting to do things I’ve been asking for,” such as counseling, anger management, etc.)
• Feeling responsible, as though she only needs to meet some set of vague expectations in order to earn the abuser’s approval
• Insecurity over her potential independence and lack of emotional support
• Guilt about the failure of the marriage/relationship
• Demolished self-esteem (“Just like he says, I’m too fat, stupid, ugly, etc., to leave.”)
• Simple exhaustion, feeling too tired and worn out from the abuse to leave
PERSONAL BELIEFS

- Parenting: that the children need two parents (“A crazy father is better than none at all.”)
- Religious and family: pressure to keep the family together no matter what
- Duty (“I swore to stay married till death do us part.”)
- Responsibility: it is up to her to work things out and save the relationship
- Belief in the dream of growing up and living happily ever after
- Identity: being raised to feel that all women need a partner—even an abusive one—in order to be complete or accepted by society
- Violence: thinking all partners relate this way (often among women who experienced a violent childhood)
- Other religious and cultural beliefs
  (WRAP, 2007)

WHY ABUSED MEN STAY

While most victims of domestic violence are women, men are sometimes victims. Like women, men remain in these relationships for a variety of reasons.

The most frequent seem to be:

- Protecting their children: afraid to leave their children alone with the abuser, that they will never be allowed to see their children again, that the abuser will turn the children against them

- Assuming blame (guilt-prone): believe that they deserve the abusive treatment or that it is their fault; feel responsible or that they can and should do something to fix things

- Dependency (or fear of independence): feel mental, emotional, or financial dependence on the abuser

Source: Oregon Counseling, 2013.
ASSESSMENT, DOCUMENTATION, AND TREATMENT

Assessing for Signs and Symptoms

Every healthcare facility that serves women, children, and older adults needs to screen for potential domestic violence. This screening need not be lengthy. The screening can be part of the intake interview or included as part of the written history. Patients should have the opportunity to respond to the questions in a confidential setting outside the presence of the patient’s family, caregiver, or the person who brings the patient to the appointment.

Healthcare professionals should be alert for signs and symptoms that may be related to domestic violence:

- Delay in seeking care or missed appointments
- Vague or inconsistent explanations of injuries or nonspecific somatic complaints
- Depression, chronic pain, and social isolation
- Substance abuse and use of alcohol or drugs
- Signs of abuse in pregnant clients (because abuse often escalates during pregnancy)
- Lack of eye contact and/or an intimate partner who is reluctant to leave the woman alone with the healthcare professional
- Patient who is fearful, anxious, withdrawn, angry, nonresponsive, or afraid to talk openly
- Suicide attempts

DANGER ASSESSMENT INSTRUMENT

The Danger Assessment Instrument is an excellent tool and has been used for over 25 years by health professionals, law enforcement, and advocates. The tool consists of 20 questions that the client may respond to with yes/no answers. The various questions are weighted for risk factors associated with intimate partner homicide. Some of the risk factors include past death threats, partner’s employment status, and partner’s access to a gun. Culturally competent versions are now available to evaluate same-sex and immigrant relationships for lethality. The tool is available online for certified professionals to download after they have completed a brief online training and posttest.

(See “Resources” at the end of this course.)

Source: Messing et al., 2013; Campbell et al., 2009.
PHYSICAL EXAMINATION

During the physical examination, the clinician should:

- Look for injuries on many areas of the body, especially the face, throat, neck, chest, abdomen, and genitals.
- Note any bruises, burns, or wound patterns that resemble teeth marks, hand prints, belts, or cigarette tips.
- Note any pain or tenderness from touching.
- Be alert for puncture wounds, fractures and dislocations, scars on the vulva or rectum, or any unexplained vaginal or anal bleeding, particularly in older adults.
- Be aware that the patient may wear a glove or sock to conceal a scalded hand or foot.

Following an established procedure for examination will ensure that no critical information is overlooked:

1. Have the patient change into an exam gown that will allow all areas of the body to be examined.
2. Check for injuries.
3. Document physical findings in detail and include measurements, preferably using a report form specified for domestic violence exams.
4. Photograph injuries, including long-distance, mid-range, and close-up perspectives. Photograph each injury with and without a scale.
5. Conduct a mental status exam.
6. Use open, nonjudgmental questions regarding the mechanism of injury.
7. Do not cut clothing or discard any potential evidence. Collect, preserve, and maintain chain of custody. All evidence should be stored in paper bags. Wet evidence should be placed inside of a waterproof container and given to law enforcement for immediate processing. (CCFMTC, 2014)

NONPHYSICAL SIGNS

It is important to remember that many victims of domestic violence may show no physical signs of injury at all. Nonfatal strangulation, which can be a strong predictor of future homicide, may leave no marks. Sexual assault may result in no visible trauma. In fact, there may be no physical signs resulting from the top five predictors of lethality: threatening to use a weapon, threatening to kill the victim, constant jealousy, strangulation, and forced sex.
STRANGULATION

The most dangerous domestic violence offenders strangle their victims. The most violent rapists strangle their victims. We used to think all abusers were equal. They are not. Our research has now made clear that when a man puts his hands around a woman, he has just raised his hand and said, “I’m a killer.” They are more likely to kill police officers, to kill children, and to later kill their partners. So, when you hear, “He choked me,” now we know you are on the edge of homicide. (Gwinn, 2017)

Strangulation is one of the most lethal forms of domestic violence: unconsciousness may occur within 10 seconds and death within 4 minutes. Strangulation is also one of the best predictors for future homicide of victims of domestic violence. One study showed that “the odds of becoming an attempted homicide increased by about seven-fold for women who had been strangled by their partner” and that the risk of completed homicide increases to 800% (Glass et al., 2008).

Yet strangulation has been overlooked in the medical literature, and some states still do not adequately address this violence in their criminal statutes. As of January 1, 2017, 41 states have passed legislation that categorizes strangulation as a felony crime.

Many victims of strangulation do not seek medical attention because “they look fine.” When law enforcement officers respond to emergency calls, they may think the same, because in the majority of cases there are no visible signs.

While victims of strangulation may have no visible injuries, the lack of oxygen during the assault can cause serious trauma to the brain and lead to death days, or even weeks, later. Strangulation can have a devastating psychological effect on victims in addition to a potentially fatal outcome, including suicide. In some cases, injuries may be apparent. A strangulation victim may struggle violently, which could lead to neck injuries. Efforts to fight back may also lead to injury on the face or hands of the assailant. Victims of strangulation may also experience difficulty breathing, speaking, or swallowing; nausea; vomiting; light headedness; headache; and involuntary urination and/or defecation (TISP, 2014).

(See also “Resources” at the end of this course.)

ASSESSING FOR OTHER CONDITIONS

Women who show signs of physical abuse should also be screened for sexually transmitted infections (STIs), including chlamydia, human papilloma virus, gonorrhea, trichomoniasis, bacterial vaginitis, and syphilis. One study found that women who are in an abusive relationship are more likely to acquire STIs and have a higher prevalence of STI risk behaviors such as not
using condoms. The study suggests that clinicians should consider screening women who are in violent relationships for STIs (Hess et al., 2012).

Clients suffering from abuse may have complaints or injuries that include arthritis, irritable bowel syndrome, stomach ulcers, chronic pain, migraines, and eating disorders. Other closely associated complaints include insomnia, depression, posttraumatic stress disorder, panic disorder, and substance abuse.

**SCREENING AMONG ELDERS**

It is estimated that 10% of older persons experience abuse or neglect by their caregivers, but the majority of cases are never reported to authorities. Although it is unclear if screening for elder abuse mitigates the incidence, clinicians are encouraged to use validated screening tools such as the Elder Abuse Suspicion Index (EASI). If the clinician has concerns about the cognitive status of the patient, a two-step screening process may be used to evaluate the patient for dementia prior to screening for abuse.


**LACK OF SCREENING**

Even though many healthcare professionals are alert to signs of potential child abuse, too few screen for domestic violence among adults. A meta-analysis by Sprague and colleagues (2012) revealed that the three most common clinician barriers to screening for domestic violence include time constraints (82%), knowledge deficit (68%), and lack of resources and/or support staff (63%). One half of the providers articulated that they felt that such screening was an invasion of the clients’ privacy or that the questions might be perceived as offensive, and nearly 50% expressed the opinion that they did not believe such screening was part of their role as clinicians or that it was a priority over other urgent issues.

**Documenting Suspected Domestic Violence**

Accurate, thorough documentation of the patient’s injuries is essential in cases of suspected abuse because it can serve as objective, third-party evidence useful in legal proceedings. For example, medical records can help victims to obtain a restraining order or to qualify for public housing, welfare, health and life insurance, and immigration relief.

Recommendations for documentation of suspected domestic violence include:

- With the patient’s permission, photograph the injuries whenever possible.
- Using a body map, document the location, number, type, and characteristics of injuries.
• Record the patient’s own words about how the injuries occurred, using quotation marks or prefaced by “the patient states” or “the patient reports” to indicate information that came directly from the patient rather than a third party; do not paraphrase.

• Describe the patient’s demeanor (crying, angry, agitated, upset) as well as the patient’s appearance.

• Identify the person whom the patient reports as the abuser using the patient’s own words, such as “my boyfriend kicked me.”

• Include the time of day when the patient is examined and, if possible, how much time has elapsed since the injuries occurred, using the patient’s own words (for example, “The patient states, ‘My husband punched me last night.’”).

• Use legible handwriting (if not documenting in an electronic record). Poor handwriting on medical records can cause documentation to be deemed inadmissible as evidence.

• Do not include personal opinion or conclusions in the documentation. Biased remarks can be inadmissible in court. Instead, document facts objectively so that others may draw their own conclusions.

• Do not use the terms domestic violence, DV, or intimate partner violence in the documentation. These are legal terms and are for the court to decide.

• Do not use terms that have specific legal meanings such as “patient alleges.”

• Document any reporting process that was followed per local or state protocol. (Lentz, 2011)

Most states require healthcare professionals and others to report suspected domestic abuse to state or local authorities. All healthcare professionals should keep themselves informed of mandatory reporting requirement laws in their jurisdiction, as well as the current status of related statutes. Establish good communication with local law enforcement and judicial offices in order to stay abreast of any changes.

Treatment Plan

When assessment and examination are complete, the clinician reviews any therapeutic protocols with the patient and provides a supportive and encouraging environment in which the patient can seek help and get support. This includes:

• Providing appropriate diagnostic and therapeutic interventions in collaboration with other professionals

• Providing verbal and written information about domestic violence and legal options

• Providing a listing of relevant community resources
• Making any necessary referrals
• Initiating mandatory reporting procedures when required
• Discharging the patient to a safe environment

It is also critical to understand and implement the facility’s established safety protocols.

**SPOUSAL ABUSE AND DEMENTIA**

Healthcare workers may report spousal abuse to Adult Protective Services when a patient with dementia exhibits violent behavior, but if the violence is dementia-related and the client is receiving dementia care services, there may be nothing more that the APS worker can do. It may be prudent to attempt to have guns and other obvious weapons removed from the home or to notify the police.

There is a need for dementia care programs to develop policies for situations that involve clients who have histories of domestic violence. These policies should address how to assess future risk and what to do to ensure caregivers’ safety. Working with law enforcement to safeguard that violent elders with dementias are treated humanely is also important. Elder abuse is now being incorporated into domestic violence policies, and police are being instructed to use applicable domestic violence laws when responding to elder abuse cases.

Involving the police may result in more elders with dementias becoming incarcerated. Some people in the dementia care field are concerned that inappropriate actions (such as incarceration of a confused elder) may result from the interactions between law enforcement and Adult Protective Services. Cognitive decline is usually gradual, making it difficult to determine at which point people are no longer culpable for their actions. A response that is both fair and humane will require cooperation between law enforcement and adult protective services.


**CASE**

On July 19, 2012, 77-year-old Rosetta Rosa shot and killed her husband of 54 years because she said he was sexually abusing their granddaughter. The granddaughter was not present at the time of the shooting. For the next two days after killing him, Ms. Rosa continued to prepare meals for her husband. Ms. Rosa underwent a series of interviews with psychiatrists and was found to be incompetent to stand trial due to progressive and irreversible dementia. The murder charge was dismissed in August of 2013. While in court for the hearing, Ms. Rosa asked if her husband was present (Hefler, 2013).
CARING FOR VICTIMS OF ABUSE

Healthcare professionals can begin by believing any patient who indicates she or he is being abused. The patient has shown trust and courage to disclose the facts. Skillful, nonjudgmental interviewing can help build trust and establish a therapeutic relationship. Holtz and Furniss (1993) developed the following guidelines for care of an abused woman:

**ABCDES FRAMEWORK**

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<tr>
<td>A</td>
<td><strong>Assure</strong> the woman she is not alone. Isolation enforced by her abusive partner prevents her from understanding that others are in a similar situation and that healthcare professionals can help.</td>
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<td>B</td>
<td>Express the <strong>belief</strong> that violence against the woman is unacceptable in any situation and that it is not her fault.</td>
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<td>C</td>
<td>Ensure <strong>confidentiality</strong>. She may fear (justifiably) that the abuser will retaliate.</td>
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<tr>
<td>D</td>
<td><strong>Document</strong> the case thoroughly.</td>
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<tr>
<td>E</td>
<td><strong>Educate</strong> the woman about the cycle of violence, the likelihood of repeated violence, and her options for ending the abuse.</td>
</tr>
<tr>
<td>S</td>
<td><strong>Safety</strong>. Help the woman formulate a plan of action for either leaving or remaining safely in the relationship. Provide information about available resources, such as hotline and shelter numbers. Suggest she pack a quick getaway bag with personal items to be hidden or left with a trusted neighbor or friend. Recommend she have an extra set of car keys, house keys, money, and any legal documents needed for identification.</td>
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Healthcare agencies should maintain lists of local resources, including shelters and legal assistance. Be aware of the need to ask a victim if coming across such information is likely to upset the abuser. If at all possible, have available a concealable resource list for victims who need it.

**Helping the Children**

When leaving the home because of abuse, abuse victims with children should take their children with them to prevent them from being abused or held hostage by the abuser. Children living with an abuser need help in protecting themselves. Depending on their age, children can:

- Learn about the cycle of violence and when violence is most likely to occur
- Recognize the clues that suggest the abuser is getting upset
- Watch for signs of drinking or drug abuse by the abuser
- Avoid behaviors that may worsen the abuser’s stress
• Avoid areas of the house where violence usually occurs
• Leave the house when domestic violence starts
• Stay with a friend or relative

For example, a mother can have her children go to bed with their shoes on so they can escape at a moment’s notice if their alcoholic father becomes violent. She can train them to run to a trusted neighbor’s house and ask the neighbor to call the police.

Safety Plans

A safety plan is something that an abuse victim can begin working on at any time. In a safety plan, the individual develops personalized and practical steps, both physical and psychological, to take while in the relationship, when planning to leave, and after leaving. Details on the elements of a safety plan, along with forms that a victim can use to create a plan, are available online. Nurses and other healthcare professionals should keep such forms and/or information available with other resources for domestic abuse victims.

Healthcare professionals can also use the following questions to evaluate immediate safety issues:

• Where is the abuser now?
• Does the abuser know where the client is now?
• Has the abuser threatened to use weapons?
• Are weapons available to the abuser?
• Is the abuser intoxicated?
• Does the abuser have a criminal record?
• Are there children? Are they safe now?
• Are they being abused?
• Is the abuser verbally threatening the client?
• Is the abuser frightening relatives and friends?

(See “Resources” at the end of this course.)

Obtaining a Protective Order

A protective order is a document that is signed by a judge and directs a specific person to stay away from the person who is seeking the protection. Other restrictions covered by protective orders can include travel and gun ownership. In addition to protecting current and former abused
spouses and intimate partners, children and victims of stalking may benefit from protective orders.

There are two types of civil protective orders:

- Emergency protective order (EPO), which is an immediate temporary order
- Domestic violence order (DVO), which is a long-term order

CIVIL VERSUS CRIMINAL LAW

Protective orders are issued under the civil law system. When a victim asks the court for protection from the abuser, the victim is not asking the court to arrest that person for committing a crime. But if the abuser violates the civil court order of protection, he may then face legal consequences, including incarceration. In a civil case, the victim has the right to drop the charges or remove the protective order.

The criminal law system handles all cases that involve crimes such as assault, harassment, theft, etc. A criminal complaint involves the abuser being charged with a crime. In a criminal case, the district attorney is the one who can decide to drop the case and the victim does not have any control over whether or not the case continues (WomensLaw.org, 2008).

A MODEL PROTOCOL FOR ADDRESSING DOMESTIC VIOLENCE

It is critical in any clinical setting to develop protocols that assist and support staff when caring for victims of domestic violence. A protocol enables the staff to respond to domestic violence in a comprehensive and consistent manner. Any protocol should include screening, identification/assessment, treatment, documentation, safety planning, discharge planning, and referral. A protocol can be comprehensive or brief, but it should adequately provide the staff with a blueprint for preparing for and responding effectively and efficiently to patients experiencing domestic violence.

The minimal elements that should be included are:

1. **Definitions:** Include types of abuse and the persons who are covered by the protocol. Elder abuse and child abuse may be addressed separately.
2. **Principles:** Include the institution’s philosophy about and commitment to addressing domestic violence.
3. **Identification and assessment procedures:** Specify who is to do the assessment, screening tools and procedures, and how to ensure safety and confidentiality.
4. **Intervention procedures:** Include interviewing strategies, safety assessment and planning, and discharge instructions. Addendums should address educational materials.
5. **State reporting requirements:** Clarify the law. Include reporting procedures and forms as required. Define who is responsible for making the report.

6. **Confidentiality:** Clarify privacy laws and ensure that the disclosure of health information serves to improve the health and safety of the victim.

7. **Collection of evidence and photographs:** Include procedures for collection, storage, and release of evidence. Include procedures for taking photos and utilizing release forms.

8. **Medical record documentation:** Clarify what information is to be included in the medical record.

9. **Referral and follow-up:** Include instructions for resources, how to make referrals, domestic violence programs, and other community agencies. Update phone numbers regularly. Include instructions for victims to have at least one follow-up appointment.

10. **Staff education plan:** Describe ongoing training for all staff.

Source: Futures Without Violence, 2016

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**Prevention Efforts**

Prevention of domestic violence and early identification and treatment of victims eliminates much pain and suffering for survivors and benefits all healthcare systems in the long run.

Prevention is something everyone can participate in. Empowerment should be the guiding force behind victim advocacy and is something all healthcare professionals can promote. Remember to always:

- Respect confidentiality
- Believe and validate experiences
- Acknowledge injustice
- Respect autonomy
- Help plan for future safety

Communities also benefit from advocacy activities. Healthcare professionals may be able to do one or more of the following:

- Provide professional or community education about family violence
- Participate actively to develop and maintain community resources for prevention of domestic violence
- Participate actively to develop and maintain community resources for intervention in domestic violence situations
• Participate on a Domestic Violence Coordinating Council

CONCLUSION

Domestic violence in any form deprives those who are affected of their basic human rights. Children, who are the future of our society, are witnesses of this abuse and suffer irreparable damage from the exposure. Healthcare professionals can make a critical difference in ending this costly, destructive epidemic and interrupt the transmission of violence from generation to generation. By being alert to the possibility of domestic abuse in patients of every age, race, cultural, and socioeconomic group, nurses can identify, protect, and assist victims in resolving their situations.

To accomplish this goal, healthcare professionals must be present for their patients, learn to ask the right questions, and speak for those who are too afraid to ask for help. Nurses must put forth a coordinated effort with advocacy groups, community resources, and law enforcement in order to be effective change agents.

RESOURCES

Danger Assessment Instrument

Domestic Abuse Intervention Project Power and Control Wheel

First Impressions: Exposure to Violence and a Child’s Developing Brain (video)

National Domestic Violence Hotline
http://www.thenhotline.org
800-799-SAFE (800-799-7233)
800-787-3224 (TTY)

Nursing Network on Violence Against Women International
http://www.nnvawi.org/

Rape, Abuse, and Incest National Network (RAINN)
http://www.rainn.org
800-656-HOPE (4673)

Violence prevention (CDC)
https://www.cdc.gov/ViolencePrevention/

What is a safety plan?
http://www.thenhotline.org/help/path-to-safety/
REFERENCES


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TEST

[ Take the test online at wildirismedicaleducation.com ]

1. The actual incidence of domestic violence is impossible to know because:
   a. There are no domestic violence data collection systems in place.
   b. Authorities believe that most of the violence takes place outside the home.
   c. Shame, fear, and hopelessness prevent many victims from reporting the event.
   d. Governmental agencies have failed to share domestic violence statistics.

2. A male patient who describes a sexual assault by his male partner is reluctant to report the incident to the police. The clinician recognizes that the patient may fear:
   a. Learning his HIV/AIDS status.
   b. Revealing his sexual orientation to others.
   c. Remaining in an abusive relationship.
   d. Undergoing additional medical screening.

3. Domestic violence survivors often face ongoing health problems such as depression and:
   a. Reynaud’s disease.
   b. Polycystic ovarian syndrome.
   c. Headaches.
   d. Hiatal hernia.

4. A woman who lives in poverty and is a victim of domestic violence is more likely than other female victims to:
   a. Abandon her children in despair.
   b. Grow stronger through adversity.
   c. Report her abuse to state authorities.
   d. Experience homelessness.

5. A woman who has been battered begins making a plan to leave her abuser. The healthcare professional uses research-based education to inform the woman that her abuser is most likely to escalate the violence against her:
   a. During her planning phase of separating from the abuser.
   b. During the “honeymoon” phase after an act of violence.
   c. At the time of separating from the abuser.
   d. At the time of revealing her plan to another person.
6. Psychological aggression does not include:
   a. Calling a partner derogatory names that play on known insecurities
   b. Public or private humiliation of a partner
   c. Physically preventing the partner from making a phone call
   d. Control over the partner’s finances

7. The Stalking Resource Center recommends that victims of cyberstalking:
   a. Take action based on facts, not instincts.
   b. Call the police in cases of immediate danger and explain the cause for fear.
   c. Immediately delete all harassing emails or text messages to avoid suffering the emotional trauma of reading them.
   d. Wait until the stalker makes a physical threat to increase the likelihood that criminal charges can be filed.

8. Perpetrators of domestic violence are focused on gaining:
   a. Love.
   b. Power and control.
   c. Sexual favors.
   d. Monetary rewards.

9. A female patient reports weakness and loss of movement in her right arm relating to abusive trauma by her husband. When asked if she wants to report her husband’s action to law enforcement, the patient replies, “No, he might hurt himself if I do that.” The clinician categorizes the patient’s refusal to report as stemming from:
   a. A situational factor.
   b. An emotional factor.
   c. A personal belief.
   d. A health belief.

10. When performing the physical assessment of a patient with suspected domestic abuse, the clinician is especially alert for any:
    a. Muscle atrophy.
    b. Signs of poor hygiene.
    c. Pain or tenderness upon palpation.
    d. Untreated skin infection.
11. The clinician’s examination in cases of domestic violence includes:
   a. Documenting whether children were present because they are potential witnesses.
   b. Questioning the abuser to determine if his or her history matches the victim’s account.
   c. Asking the patient whether he or she precipitated the violent incident.
   d. Photographing any injured body parts from multiple perspectives.

12. Medical documentation for a patient who reports being a victim of domestic violence should include:
   a. Information about any injuries in the patient’s own words.
   b. The phrases “patient alleges” or “patient claims.”
   c. Conclusive terms such as assault, battery, or domestic violence.
   d. The clinician’s conclusions about the cause for the patient’s injuries.

13. When caring for a patient who reports abuse, the clinician’s action is to:
   a. Memorize the details of the abuse incident for later reporting to the authorities.
   b. Gently question the patient as to whether the violence may have been avoidable.
   c. Assure the patient that he or she is not alone.
   d. Urge the patient to immediately leave the abusive relationship.

14. When developing an evidence-based protocol for patients who are victims or perpetrators of domestic violence, the facility includes:
   a. Screening procedures.
   b. Examination fee schedules.
   c. A designated medical director.
   d. A mission statement.