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Contact Hours: **2**

Domestic Violence Education

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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 to address potential learning gaps include:

- Identify the different types of domestic violence.
- Describe who is affected by domestic violence.
- Discuss the healthcare implications and adverse effects of domestic violence.
- List common risk factors, lethality issues, and dynamics of abuse.
- Recognize the signs and symptoms of domestic violence.
- Discuss appropriate documentation and reporting in cases of suspected domestic violence.
- Identify community resources and victim services and protections.
- Explain a model protocol that addresses domestic violence.

INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC), 1 in 4 women and 1 in 7 men in the United States will experience serious physical violence from a domestic partner over their lifetime, and sometimes it will result in death. In the United States, 1 in 6 victims of homicide are killed by a domestic partner, and nearly half of female victims of homicide are killed by a current or former intimate partner (CDC, 2019a). Viewed as a national public health problem, domestic violence is a crime in all 50 states.

Domestic violence, which is believed to be underreported, affects not only victims but also their families and communities through a ripple effect. Victims of this crime experience diminished quality of life, decreased productivity, and negative health consequences. An estimated lifetime economic cost to society of \$3.6 trillion is attributed to domestic violence (CDC, 2019a).

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. 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. The related term *intimate partner violence* (IPV) describes violence committed by a current or former partner.

TYPES AND DYNAMICS OF DOMESTIC VIOLENCE

While domestic violence can manifest in a variety of manners and severity, the CDC (2019b) has identified **four types of domestic violence** (or intimate partner violence). These may occur separately or together.

- **Physical violence:** An attempt to injure or actually injuring a partner by kicking, hitting, or using a type of physical force.
- **Sexual violence:** An attempt to force a partner or actually forcing a partner to participate in any type of sex act or sexual event when the partner does not or cannot consent to the act or event.
- **Stalking:** Repeated and undesired attention or contact from a partner that results in fear or concern for the victim. This concern may be for the safety of the victim or someone to whom the victim feels close.
- **Psychological harm or aggression:** The use of any type of communication that is intended to cause psychological (emotional) harm to a person or to exercise control over that person.

These types of violence are perpetrated by a current or former partner or spouse and can occur among couples of all genders. The definition of intimate partner violence does not require sexual intimacy (CDC, 2018).

FINANCIAL ABUSE

Although the CDC does not list financial abuse as a separate form of domestic violence, this crime is frequently implemented by an abuser in an attempt to control and exert power over an intimate partner. Financial abuse can take many forms, such as not allowing a person full access to bank accounts, hiding assets, incurring debt, ruining a person's credit, or interfering with a person's employment or education.



Research indicates that domestic violence occurs in a **three-phase cycle**:

1. A period of increasing tension, leading to verbal and physical abuse
2. An 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 (Walker, 2017).

Physical Violence

The CDC defines physical violence more specifically to include “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, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one’s body, size, or strength against another person.” Coercing another person to commit any of those acts also constitutes physical violence (Breiding, 2015).

Sexual Violence

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

- Rape or penetration of the victim. This includes attempted rape or penetration that is drug-facilitated or forced.
- Forcing the victim to penetrate another person. This act also 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 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.

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 their safety or the safety of a family member.

RESPONDING TO CYBERSTALKING

Recommended actions for victims of cyberstalking include:

- Send the person one clear, written warning not to contact you again.
- If they contact you again after you have told them not to, do not respond.
- Print out copies of evidence, such as emails or screenshots of your phone. Keep a record of the stalking and any contact with police.



- Report the stalker to the authority in charge of the site or service where the stalker contacted you. For example, if someone is stalking you through Facebook, report them to Facebook.
- If the stalking continues, get help from the police. You also can contact a domestic violence shelter and the National Center for Victims of Crime Helpline for support and suggestions.
- Consider blocking messages from the harasser.
- Change your email address or screen name.
- Never post online profiles or messages with details that someone could use to identify or locate you (such as your age, sex, address, workplace, phone number, school, or places you often visit).

(DHHS, 2018)

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. It 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 victims of such abuse do not report domestic violence to their physicians or to anyone else. However, the statistics available confirm that the problem is pervasive and alarming.

Domestic Violence among Women

Victims of domestic violence are usually women and children. Perpetrators of domestic violence are generally, though not always, men. Nearly one in six homicide victims in the United States is killed by an intimate partner, and nearly half of female homicide victims are killed by a current or former male intimate partner. Many victims do not report IPV to police, friends, health professionals, or family, so these statistics underestimate the problem (CDC, 2019).

IPV AND PREGNANCY

Intimate partner violence (IPV) is considered to be a serious health concern and leading cause of traumatic death for pregnant women. The nexus of intimate partner violence and pregnancy is two-fold. The pregnancy may be a result of sexual assault or reproductive coercion, resulting in a disturbing situation for both mother and child. Secondly, if the abuse begins during pregnancy, it usually extends throughout the gestation and continues after the child is born (Hrelic, 2019).



IPV during pregnancy occurs in approximately 325,000 women each year. The prevalence of reported violence includes 30% emotional abuse, 15% physical abuse, and 8% sexual abuse. The psychological effects of abuse contribute to stress, depression, and substance abuse, which can also adversely affect the fetus. Prenatal care affords an excellent opportunity for screening and violence prevention (Huecker, 2019).

Teens and Dating Violence

Teen dating violence is another form of intimate partner violence that is disturbingly common among high school students and can result in serious short- and long-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. According to one survey in which teens reported various types of victimization, psychological abuse was most common (over 60%). Teens also reported substantial rates of sexual abuse (18%) and physical abuse (18%). The study found that only 12% of the youth who were surveyed reported perpetrating physical and/or sexual abuse (Taylor, 2016).

Teens 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, 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)

Domestic Violence among Older Adults

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. Elder abuse may also take the form of emotional abuse, abandonment, or self-neglect.



Domestic Violence among 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 to 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).

People in some cultures may believe that the family is the only appropriate forum for dealing with domestic violence, and outside interference is not encouraged or accepted. Some groups resist acknowledging that domestic violence exists as a problem. It can be challenging to assist victims who do not understand their legal rights or who are unaware that resources and legal assistance are available.

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. 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 (Violence Policy Center, 2019).

Language barriers, along with social isolation and cultural intolerance, can prevent people from seeking help and reporting abuse. It is important that service providers receive training and assistance in improving language access so that trauma survivors can safely report abuse and receive services (Vera Institute of Justice, 2016).

U VISA and T VISA

The U visa is a unique visa for undocumented 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 similar and addresses victims of trafficking. These victims, along with approved family members, may reside in the United States for approximately four years if they comply with criminal justice system requests (U.S. DHS, 2016).

The number of petitioners for the U visa has diminished from a total of 58,991 in 2018 to 47,225 in 2019 (U.S. CIS, 2020). This decrease in applications is attributed to Immigration



and Customs Enforcement (ICE) Directive 11005.1, which allows ICE to deport pending U visa applicants at their discretion (U.S. ICE, 2019).

Domestic Violence and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex Persons (LGBTQ+)

Intimate partner violence in LGBTQ+ relationships is not unlike that which occurs in heterosexual relationships. One partner exhibits a pattern of abusive behavior in an effort to control and intimidate the other. The prevalence is difficult to quantify because crime reports may list the persons as roommates, and not all LGBTQ+ survivors disclose their sexual orientation or gender identification when reporting IPV. Some reports state the rate of IPV as comparable to the rate in heterosexual relationships (Yale University, 2020).

Persons who identify as LGBTQ+ face unique barriers to accessing services or reporting to the police:

- A LGBTQ+ victim may fear that the abuser will reveal their 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 their genitals.
- LGBTQ+ communities are small, which makes maintaining privacy more difficult.
- LGBTQ+ individuals may not want to report for fear of perpetuating negative stereotypes.

(Yale University, 2020)

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 domestic violence shelters that serve male and transgender victims. Sensitivity to the needs of these individuals is paramount to effecting social change and helping victims receive needed assistance.



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 is implemented. Family Advocacy personnel conduct an investigation, intervene, and provide 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 are recorded and can negatively affect the subject's career. In many cases, the subject is required to be separated from their spouse and required to be housed in barracks 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. 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).

EFFECTS OF DOMESTIC VIOLENCE

Domestic violence has an enormous impact on the health and well-being of those who are affected as well as on the healthcare system. Injuries sustained during episodes of violence are only part of the damage to victims' health. Physical and psychological abuse are related to other **adverse health effects**, including both vague and specific 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
- Asthma
- Diabetes
- Fibromyalgia
- High blood pressure
- Chronic pain

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

- Depression
- Anxiety
- Fatigue
- Restlessness
- Decreased appetite
- Insomnia
- Panic attacks
- Posttraumatic stress disorder (PTSD)
(Huecker, 2019)

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)

The effects of any type of **stalking** can be severe. Victims of stalking can become depressed, hypervigilant, experience sleep problems, and develop PTSD. Victims may cope by taking time off work, changing jobs or schools, and relocating to avoid the stalker (Dardis, 2018).

The **economic impact** that accompanies the personal and emotional effects are severe. Researchers estimate the lifetime cost of domestic violence is at \$103,767 per female victim and \$23,414 per male victim, which totals nearly \$3.6 trillion over victims' lifetimes based on a population of 43 million U.S. adults with victimization history (Peterson, 2018).



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 (CWIG, 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

Categories of Risk Factors for Abusers

The CDC identifies four risk factor categories for abusers: individual, relationship, community, and societal. Not everyone who experiences these risk factors becomes an abuser. Identification and understanding of risk factors can lead to prevention.

INDIVIDUAL RISK FACTORS

- Low self-esteem
- Low income
- Low academic achievement/low verbal communication ability
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression and suicide attempts
- Anger and hostility
- Lack of nonviolent social problem-solving skills



- Antisocial personality traits and conduct problems
- Poor behavioral control/impulsiveness
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships
- Hostility toward women
- Attitudes accepting or justifying IPV
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- Witnessing IPV between parents as a child
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child
- Unplanned pregnancy

RELATIONSHIP RISK FACTORS

- Marital conflict/fights, tension, other struggles
- Jealousy, possessiveness, negative emotions within an intimate relationship
- Marital instability, divorces, separations
- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions
- Association with antisocial and aggressive peers
- Parents with less than a high school education
- Social isolation/lack of social support

COMMUNITY RISK FACTORS

- Poverty and associated factors (e.g., overcrowding, high unemployment rates)
- Low social capital; lack of institutions, relationships, and norms that shape a community's social interactions



- Poor neighborhood support and cohesion
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence)
- High alcohol outlet density

SOCIETAL RISK FACTORS

- Traditional gender norms and gender inequality (e.g., belief that women should stay at home, not enter workforce, and be submissive; belief that men should support the family and make the decisions)
- Cultural norms that support aggression toward others
- Societal income inequality
- Weak health, educational, economic, and social policies/laws (CDC, 2019)

Common Risk Factors

POVERTY

Although domestic violence is found in all walks of life, those who live in poverty face additional challenges. The CDC (2019) 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 violence and poverty intersect, they limit coping options. Both poverty and violence lead to stress, feelings of powerlessness, and social isolation, which combine to produce posttraumatic stress disorder, depression, and other emotional difficulties.

Victims who are experiencing poverty face risks that are related to poverty as well as risks from their abuser.

- Risks from the abuser 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, possible racism, unsafe neighborhoods, and poor schools for their children.

The double jeopardy of poverty and violence challenges victims 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 example, in 2019, approximately 48,000 beds were set aside for survivors of domestic violence in the United States on any single night (National Alliance to End Homelessness, 2020).



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.

DISABILITY/IMPAIRMENT

People with disabilities are more likely to experience abuse than those without disabilities. In one study, intimate partners were determined to have committed 27% of the violent crimes experienced by women with disabilities and 1.1% of men with disabilities. Police response to reports of violence is lower among victims of disabilities (77%) than among people without disabilities (90%). A survey by the Spectrum Institute Disability and Abuse Project reported that 70% of the participants with disabilities experienced abuse and that perpetrators were arrested in only 10% of the cases. Barriers to accessing services further impact people with disabilities who are experiencing IPV (NCADV, 2018).

In addition to physical and psychological abuse, unwanted sexual contact, and intimidation, people with disabilities may also experience the following types of abuse:

- Neglect
- Withholding medications
- Physically harming service animals
- Isolating victims
- Depriving victims of necessary physical accommodations
- Withholding or destroying assistive devices such as wheelchairs
- Financial exploitation
(NCADV, 2018)

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 **homicide by a male perpetrator** include:

- Access to a firearm (five times higher)



- Previous threats with a weapon
- Previous nonfatal strangulation (seven times higher)
- Previous rape of the victim
- Previous threats to harm the victim
- Previous stalking of the victim
(Spencer, 2018)

HOMICIDE-SUICIDE

Incidents in which a family member kills a domestic partner or other family members and then dies by suicide are rare and account for 4.8% of suicides, but in the context of intimate partner homicide, they represent 27% to 32% of homicides. Homicide followed by suicide is a common behavior in male perpetrators but not in females (Smucker, 2018).

INTIMATE PARTNER VIOLENCE AND GUNS

Nearly one million women currently living have either been shot or shot at by an intimate partner. A 2018 survey of the National Domestic Violence Hotline found over 33% of calls to involve reports of being threatened with a gun. An analysis of mass shootings indicates that 54% of the shooters shot an intimate partner or family member (Sorenson, 2018; Logan, 2018; Everytown for Gun Safety, 2018).

GUN LAWS AND DOMESTIC VIOLENCE

Federal law prohibits purchase and possession of firearms and ammunition by people who have been convicted in any court of a “misdemeanor crime of domestic violence” and/or who are subject to certain domestic violence protective orders. A conviction for a misdemeanor crime of domestic violence represents the third most frequent reason for denial of an application to purchase a firearm by the FBI, after a felony conviction and an outstanding arrest warrant.

Many states have adopted laws that fill gaps in federal law by more comprehensively restricting access to firearms and ammunition by domestic abusers. Examples of state laws include:

- Prohibiting domestic violence misdemeanants not covered by federal law from buying or possessing guns and/or ammunition
- Authorizing or requiring surrender of guns and/or ammunition after conviction of a domestic violence misdemeanor or when a protective order is issued
- Requiring reporting domestic violence offender identities to databases used for firearm purchaser background checks



- Authorizing or requiring courts to prohibit abusers subject to protective orders from buying or possessing firearms
- Prohibiting some abusive dating partners from gaining access to firearms, effectively closing the federal “boyfriend loophole”
- Prohibiting purchase and possession of firearms by people convicted of a misdemeanor crime of stalking
- Allowing law enforcement officers to remove firearms when they arrive at the scene of a domestic violence incident

(Giffords Law Center, 2018)

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 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

The iconic model known as the Power and Control Wheel was developed by the Domestic Abuse Intervention Project (2017) in Duluth, Minnesota, to depict the most common abusive behaviors or tactics experienced by victims of domestic violence. It is characterized by the pattern of actions that an abuser uses to intentionally control or dominate the intimate partner. These actions fall under eight primary categories:

- Using coercion and threats
- 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.)

WHY VICTIMS STAY

Victims who stay with an abuser are often judged by others who do not understand the complex problems these victims may face. To better understand these challenges, domestic violence researchers evaluated hundreds of posts from victims on social media and identified eight reasons that victims stay in abusive relationships. The researchers also concluded that victims fear being judged by others and are more likely to respond positively to concern and compassion than to criticism and pressure.

- **Distorted thoughts:** Victims who are controlled and hurt become traumatized, resulting in confusion and self-blame.
- **Damaged self-worth:** Victims believe that they are worthless and deserve the abuse as a result of being treated badly.
- **Fear:** The threat of physical or emotional harm is traumatic and debilitating.
- **Wanting to be a “savior”:** Some victims want to help their partners, continue to love them, and hope that they will change for the better.
- **Children:** Some victims sacrifice themselves to keep their children safe or express that they do not want their children to grow up without the other parent.
- **Family expectations and experience:** Past experiences can distort the victim’s opinion of themselves or healthy relationships. Others feel pressured to remain in the relationship because of family values or religious beliefs.
- **Financial constraints:** Many victims report an inability to provide for their children alone and that they cannot maintain employment because of abuse. Others suffer from financial abuse.
- **Isolation:** Abusers can separate victims from family and friends either physically or through emotional abuse.

(Cravens, 2015)



ASSESSMENT, DOCUMENTATION, AND REPORTING

Assessing for Signs and Symptoms

Every healthcare facility should screen patients routinely for potential domestic violence. 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 any person who is accompanying them.

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 patient alone with the healthcare professional
- Patient who is fearful, anxious, withdrawn, angry, nonresponsive, or afraid to talk openly
- Suicide attempts

According to the National Center for Elder Abuse (2020), the most common physical findings of physical abuse **among older adults** include:

- Bruises, black eyes
- Contusions, welts, rope marks, or signs of being restrained
- Lacerations, wounds, punctures
- Dental problems, broken eyeglasses
- Head injuries, internal bleeding
- Fractures, sprains, dislocations
- Pressure ulcers, untreated injuries
- Chronic pain
- Sexually transmitted infections
- Poor nutrition/poor hydration
- Over or under-use of medications
- Sleep problems, sudden change of behavior



- Report of being hit
- Caregiver not allowing visitors to see the elder alone

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, revised in 2019, 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 post-test (Alliance for Hope, 2019). (See "Resources" at the end of this course.)

PHYSICAL EXAMINATION

Following an established procedure to examine patients who may be victims of abuse will ensure that no critical information is overlooked. In some clinical settings, the best option may be to escort the patient to the emergency department to conduct an exam.

During the physical examination, the clinician:

1. Has the patient change into an exam gown that will allow all areas of the body to be examined
2. Checks for injuries over the entire body and especially the face, throat, neck, chest, abdomen, and genitals
3. Notes patterned injuries such as bruises that resemble teeth marks, hand prints, belts, or cords; observes burns that are consistent with cigarette tips
4. Notes any pain or tenderness on palpation
5. Documents physical findings in detail and includes measurements, preferably using a report form specified for domestic violence exams
6. Photographs injuries, including long-distance, mid-range, and close-up perspectives; photographs each injury with and without a scale
7. Conducts a mental status exam
8. In patients who report strangulation, considers the use of imaging to rule out life-threatening injuries
9. Uses open, nonjudgmental questions regarding the mechanism of injury



10. **Does not** cut clothing or discard any potential evidence; always collects, preserves, and maintains chain of custody; stores all evidence in paper bags, with wet evidence placed inside a waterproof container and given to law enforcement for immediate processing (CCFMTC, 2014; TISP, 2019)

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 is 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

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 was long-overlooked in the medical literature, and some states still do not adequately address this violence in their criminal statutes. As of January 2020, South Carolina, Ohio, Washington, DC, and Maryland have not passed legislation that categorizes strangulation as a felony crime (Austermuhle, 2020).

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 death by 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, 2020). (See also “Resources” at the end of this course.)

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 obtain a restraining order or 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 (e.g., crying, angry, agitated, upset) as well as the patient’s appearance.
- Identify the person whom the patient reports as the abuser and document the patient’s own words in quotes (e.g., “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 (e.g., “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. 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 determine.
- Do not use other terms that have specific legal meanings (e.g., “patient alleges”).
- Document any reporting process that was followed per local or state protocol.
(Lentz, 2011)

A documentation form for mandated reporters, although not required, is helpful to prompt the clinician to include all of the necessary information. A documentation form for that purpose may be provided by individual institutions.

Reporting Domestic Violence

Most states have laws pertaining to reporting suspected domestic abuse that healthcare professionals may encounter in the course of patient interactions. Reporting is typically required for suspected domestic violence and abuse involving children under 18 years of age (child abuse) or adults 18 years of age or older who are unable to protect themselves due to a disability (dependent adult abuse).



Conversely, **in cases involving competent adults**, healthcare professionals may be required to obtain informed consent before making a report. Otherwise, they may be prohibited to make a report in cases where the victim does not wish a report to be made. Such provisions allow adult victims to maintain control over their own lives and may make them more likely to ask for help and receive the information they need to stay safe (Currens, 2017).

Healthcare professionals may also be required by law in some states to assist victims by offering educational materials and contact information so that they may connect with local resources. This may include referrals to shelters or for legal assistance and information such as how to obtain a protective order. Since there may be a concern for a negative response if an abuser discovers educational materials and/or referral lists, it is recommended to provide a resource list in a discrete format (such as concealed in a small item that fits into a pocket or purse) for victims who may need it.

Laws pertaining to reporting domestic violence and abuse usually specify both legal consequences and legal protections for healthcare professionals who make a report. Typically, anyone acting upon reasonable cause or in good faith in making a report is given immunity from any civil or criminal liability. However, anyone knowingly or wantonly violating reporting laws, such as intentionally failing to make a required report or making a false report with malice, can be held criminally liable.

All healthcare professionals should keep themselves informed of mandatory reporting requirement laws in their jurisdiction as well as the current status of related statutes. Good communication with local law enforcement and judicial offices is helpful in order to stay abreast of any changes.

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.

TIPS FOR RESPONDING TO VICTIMS

- Listen and believe.
- Do not investigate if it is not your job to do so.
- Determine if reporting is required by law.
- Make the report immediately if required by law or requested by the victim.
- Respond in the safest way possible for the victim/safety planning/referrals.



- Identify resources for the victim and yourself.
- Continue to interact with the victim as normally as possible and provide support.
- Remember that reporting is often a beginning, not an end; victims often need more support and advocacy after a report is made.

CASE

A nurse in a busy OB/GYN practice notices multiple bruises in various stages of healing on her patient's legs during a routine prenatal visit. The nurse asks the patient what happened to her legs, and the patient states that her husband kicked her. The patient states she does not want to press charges. The nurse gives the patient a resource pamphlet on domestic violence, educates her about domestic violence services, and assures the patient that she does not have to go through this alone. Finally, the nurse asks the patient if she would like some privacy to call the helpline before leaving the office.

DOMESTIC VIOLENCE RESOURCES

It is the responsibility of all healthcare professionals to stay informed about resources such as shelters, mental health services, and programs for victims of domestic violence in their region.

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.

Although developing a safety plan may be beyond the scope or time constraints of most healthcare professionals, it is important that they are aware of the importance of such a plan and offer to refer patients to an individual or agency that can help them create one. A safety plan is intended to help a patient stay safe at all stages of the relationship. Nurses and other healthcare professionals should keep such forms and/or information available with other resources for domestic abuse victims.

Details on the elements of a safety plan, along with forms that a victim can use to create a plan, are available online. (See "Resources" at the end of this course.)

Protective Orders

Protective orders are generally issued under the civil law system. 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 in order to prevent additional acts of domestic violence, dating violence, sexual assault, or stalking.



The “petitioner” files for protection against the “respondent” and requests that the respondent have no contact (by phone, text, email, social media, or through friends or family) with the petitioner, children, or others who need protection. The respondent may also be required to stay away from the petitioner’s home, school, work, or other designated areas.

A temporary or emergency protective order is typically issued until a court hearing, and the respondent may be arrested if the order is violated in the interim. In court, the judge will issue a protective order for a specific time period. Generally, the petitioner may request through a legal process to renew the protective order if necessary. In some states, petitioners may register for VINE PO (Victim Information Notification Everyday Protective Order) by phone or online (see “Resources” at the end of this course) and will receive an email or phone call notification that the respondent has received the paperwork and the court date.

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 conduct the assessment, the screening tools and procedures to be used, and how ensure safety and confidentiality will be ensured.
4. **Intervention procedures:** Include interviewing strategies, safety assessment, planning, and discharge instructions. Addenda 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.
 (Futures Without Violence, 2016)

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
- Assist with safety planning

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 the life of every patient, healthcare professionals can identify, protect, and assist victims in resolving their situations.

To accomplish this goal, healthcare professionals must be informed and present for their patients. They need to collaborate with advocacy groups, community agencies, and law enforcement in order to be effective change agents.



RESOURCES

Danger Assessment Instrument

<http://www.dangerassessment.org/uploads/pdf/DAEnglish2010.pdf>

Domestic Abuse Intervention Project Power and Control Wheel

<https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf>

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

<https://www.youtube.com/watch?v=brVOYtNMmKk>

National Domestic Violence Hotline

<http://www.thehotline.org>

800-799-SAFE (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)

VINE (Victim notification network)

<https://www.vinelink.com/>

866-277-7477

Violence prevention (CDC)

<https://www.cdc.gov/ViolencePrevention>

What is a safety plan? (National Domestic Violence Hotline)

<http://www.thehotline.org/help/path-to-safety>

REFERENCES

Alliance for Hope (2019). Danger assessment. Retrieved from

<https://www.familyjusticecenter.org/resources/danger-assessment/>



Austermuhle M. (2020). Strangulation is a misdemeanor in D.C. and MD. Victim advocates want that to change. NPR station WAMU 88.5. Retrieved from <https://www.npr.org/local/305/2020/01/22/798557784/strangulation-is-a-misdemeanor-in-d-c-and-md-victim-advocates-want-that-to-change>

Breiding M, Basile K, Smith S, Black M, & Mahendra R. (2015). *Intimate partner violence surveillance: uniform definitions and recommended data elements*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf>

California Clinical Forensic Medical Training Center (CCFMTCC). (2014). *Forensic photography: documentation of the physical effects of violence: participant manual*. Sacramento: Author.

Centers for Disease Control and Prevention (CDC). (2019a). What is intimate partner violence? Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

Centers for Disease Control and Prevention (CDC). (2019b). Preventing intimate partner violence fact sheet. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/ipv-factsheet508.pdf>

Centers for Disease Control and Prevention (CDC). (2019c). Violence prevention risk and protective factors. Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html>

Centers for Disease Control and Prevention (CDC). (2018). Intimate partner violence. Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>

Centers for Disease Control and Prevention (CDC). (2016a). Intimate partner violence: definitions. Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>

Centers for Disease Control and Prevention (CDC). (2016b). Teen dating violence. Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/teen_dating_violence.html

Centers for Disease Control and Prevention (CDC). (2016c). Intimate partner violence: risks and protective factors. Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html>

Centers for Disease Control and Prevention (CDC). (2015). Intimate partner violence: consequences. Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html>

Centers for Disease Control and Prevention (CDC). (2009). Adverse Childhood Experience (ACE) study. Retrieved from <http://www.cdc.gov/ace/>

Child Welfare Information Gateway (CWIG). (2015). *Understanding the effects of maltreatment on brain development*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Cravens JD, Whiting JB, & Aamar R. (2015). Why I stayed/left: an analysis of voices of intimate partner violence on social media. *Contemporary Family Therapy*, 37(4), 372–85. doi:10.1007/s10591-015-9360-8

Currens S. (2017). June 29 big changes come with HB309. *Center for Women and Families*. Retrieved from <https://www.thecenteronline.org/2017/06/26/june-29th-big-changes-come-hb309/>

Dardis C, Strauss C, & Gidycz C. (2018). The psychological toll of unwanted pursuit behaviors and intimate partner violence on undergraduate women: a dominance analysis. *Psychology of Violence*. doi:10.1037/vio0000189



Domestic Abuse Intervention Project (DAIP). (2017). Understanding the power and control wheel. Retrieved from <https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf>

Everytown for Gun Safety. (2019). Mass shootings in the United States, 2009–2018, forthcoming. Retrieved from <https://every.tw/1XVAmcc>

Futures without Violence. (2016). Domestic violence and healthcare protocols. Retrieved from https://secure3.convio.net/fvpf/site/Ecommerce/645907547?VIEW_PRODUCT=true&product_id=1795&store_id=1241

Giffords Law Center. (2018). Domestic violence and firearms. Retrieved from <https://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/domestic-violence-firearms/#federal>

Glass N, Laughon K, Campbell J, et al. (2008). Non-fatal strangulation is an important risk factor for homicide of women. *J Emerg Medicine*, 35(3), 329–35. doi:10.1016/j.jemermed.2007.02.065

Gwinn C. (2017). What we learned in 2016: update from the Training Institute on Strangulation prevention webinar. [PowerPoint slides]. Retrieved from <http://www.strangulationstraininginstitute.com>

Hall JE, Karch DL, & Crosby AE. (2016). *Elder abuse surveillance: uniform definitions and recommended core data elements for use in elder abuse surveillance, version 1.0*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/EA_Book_Revised_2016.pdf

Hrelac D. (2019). Intimate partner violence in pregnancy. *American Nurse*. Retrieved from <https://www.myamericannurse.com/intimate-partner-violence-in-pregnancy/>

Ingram B. (2017). Secrecy and silence: response to intimate partner violence in the black community. *Peace over Violence*. Retrieved from <http://www.peaceoverviolence.org/2017/02/27/secrecy-and-silence-response-to-intimate-partner-violence-in-the-black-community/>

International Association of Forensic Nurses (IAFN). (2018). IAFN non-fatal strangulation documentation toolkit. Retrieved from <https://www.familyjusticecenter.org/resources/non-fatal-strangulation-documentation-toolkit/>

Lentz L. (2011). Ten tips for documenting domestic violence. *Nursing Critical Care*, 6(4), 48. Retrieved from http://journals.lww.com/nursingcriticalcare/Fulltext/2011/07000/10_tips_for_documenting_domestic_violence.1.aspx

Logan T & Lynch K. (2018). Dangerous liaisons: examining the connection of stalking and gun threats among partner abuse victims. *Violence and Victims*, 33(3), 399–416. doi:10.1891/0886-6708.v33.i3.399

Matias A, Gonçalves M, Soeiro C, & Matos M. (2019). Intimate partner homicide: a meta-analysis of risk factors. *Aggression and Violent Behavior*, 50, 101358. doi:10.1016/j.avb.2019.101358. Retrieved from <https://www.sciencedirect.com/science/article/pii/S1359178919300874>

National Alliance to End Homelessness. (2020). Domestic violence. Retrieved from <https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/domestic-violence/>

National Center for Elder Abuse (NCEA). (2020). Types of abuse. Retrieved from <https://ncea.acl.gov/Suspect-Abuse/Abuse-Types.aspx>

National Center on Elder Abuse (NCEA). (2016). Statistics/data. Retrieved from <https://ncea.acl.gov/whatwedo/research/statistics.html#prevalence>



National Coalition Against Domestic Violence (NCADV). (2018). Domestic violence and people with disabilities: what to know, why it matters, and how to help. Retrieved from <https://ncadv.org/blog/posts/domestic-violence-and-people-with-disabilities>

National Coalition of Anti-Violence Programs (NCAVP). (2018). *Lesbian, gay, bisexual, transgender, queer, and HIV affected hate and intimate partner violence in 2017*. Retrieved from <http://avp.org/wp-content/uploads/2019/01/NCAVP-HV-IPV-2017-report.pdf>.

Peterson C, Kearns M, McIntosh W, Estefan L, Nicolaidis C, McCollister K, Gordon A, & Florence C. (2018). Lifetime economic burden of intimate partner violence among U.S. adults. *American J. Prev. Med.*, 55(4), 433–44. doi:10.1016/j.amepre.2018.04.049. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6161830/>

Powers R. (2016). Domestic violence in the U.S. military. *The Balance*, November 9. Retrieved from <https://www.thebalance.com/domestic-violence-in-the-u-s-military-4052670>

Sorenson S & Schut R. (2018). Nonfatal gun use in intimate partner violence: a systematic review of the literature. *Trauma, Violence, & Abuse*, 19(4), 431–42. doi:10.1177/1524838016668589

Spencer C. (2019). A meta-analysis of risk factors for intimate partner homicide: examining male perpetration and female victimization. doi:10.1177/1524838018781101. Retrieved from <https://krex.k-state.edu/dspace/handle/2097/38765>

Taylor B, Mumford E, & Liu W. (2016). The national survey of teen relationships and intimate violence (STRiV). *National Institute of Justice Report*. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/250292.pdf>

Technology Safety. (2020). Recent survey confirms pervasive stalking behaviors that survivors and advocates have reported for years. Retrieved from <https://www.techsafety.org/blog/2020/3/2/recent-survey-confirms-pervasive-stalking-behaviors-that-survivors-and-advocates-have-reported-for-years>

Training Institute on Strangulation Prevention (TISP). (2020). Retrieved from <https://www.familyjusticecenter.org/professionals/medical/>

Training Institute on Strangulation Prevention (TISP). (2019). Recommendations for the medical/radiographic evaluation of acute, adult non-fatal strangulation. Retrieved from <https://www.strangulationtraininginstitute.com/medical-radiographic-imaging-recommendations/>

U.S. Citizenship and Immigration Services (U.S. CIS). (2020). *Number of form I-918, petition for U nonimmigrant status by fiscal year, quarter, and case status fiscal years, 2009-2019*. Retrieved from https://www.uscis.gov/sites/default/files/USCIS/Resources/Reports%20and%20Studies/Immigration%20Forms%20Data/Victims/I918u_visastatistics_fy2019_qtr4.pdf

U.S. Department of Health and Human Services (U.S. DHHS). (2018). Stalking. Retrieved from <https://www.womenshealth.gov/relationships-and-safety/other-types/stalking>

U.S. Department of Health and Human Services (U.S. DHHS). (2016). Assets for independence resource center. Retrieved from <http://idaresources.acf.hhs.gov/apex/testgrantedetailsite?id=00170000000xbyzAAB>

U.S. Department of Homeland Security (U.S. DHS). (2016). U and T visa law enforcement resource guide. Retrieved from https://www.dhs.gov/sites/default/files/publications/U-and-T-Visa-Law-Enforcement-Resource%20Guide_1.4.16.pdf

U.S. Department of Justice. (2016). Stalking. Retrieved from <https://www.justice.gov/ovw/stalking>



U.S. Immigration and Customs Enforcement (U.S. ICE). (2019). Revision of stay of removal request reviews for U visa petitioners. Retrieved from <https://www.ice.gov/factsheets/revision-stay-removal-request-reviews-u-visa-petitioners>

Vera Institute of Justice. (2016). New initiatives will reduce language barriers to victim services. Retrieved from <https://www.vera.org/newsroom/new-initiatives-will-reduce-language-barriers-to-victim-services>

Violence Policy Center. (2019). When men murder women. Retrieved from <https://vpc.org/press/nearly-2000-women-murdered-by-men-in-one-year-new-study-finds/>

Walker LE. (2017). *The battered woman syndrome* (4th ed.). New York: Springer Publishing Company.

Yale University. (2020). Sexual harassment and response and education (SHARE). LGBTQ relationships. Retrieved from <https://sharecenter.yale.edu/sexual-misconduct-information/forms-sexual-misconduct/intimate-partner-violence/lgbtq-relationship>



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TEST

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1. Which type of domestic violence is characterized by repeated and undesired attention that results in fear and concern for the safety of the victim?
 - a. Stalking
 - c. Sexual violence
 - b. Physical violence
 - d. Psychological harm

2. It is impossible to know the actual number of incidents of domestic violence 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.

3. When 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 a unique fear of reporting abuse among gay patients may be:
 - a. Learning their HIV/AIDS status.
 - b. Revealing their sexual orientation to others.
 - c. Remaining in an abusive relationship.
 - d. Undergoing additional medical screening.

4. Domestic violence survivors often face ongoing health problems such as depression and:
 - a. Raynaud's disease.
 - b. Polycystic ovarian syndrome.
 - c. Headaches.
 - d. Hiatal hernia.

5. Which is categorized by the CDC as an **individual** risk factor for an abuser?
 - a. Unemployment
 - b. Marital instability
 - c. Gender inequality
 - d. Poor neighborhood



6. Research has shown that the risk of domestic violence homicide is **highest** when the abuser:
 - a. Has access to a gun.
 - b. Is alcohol dependent.
 - c. Previously strangled the victim.
 - d. Is unemployed.

7. Perpetrators of domestic violence are typically focused on gaining:
 - a. Love.
 - b. Power and control.
 - c. Sexual favors.
 - d. Respect.

8. 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. Patterned injuries.
 - d. Untreated skin infection.

9. 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 their history matches the victim's account.
 - c. Asking the patient what they might have done to cause the violent incident.
 - d. Photographing any injured body parts from multiple perspectives.

10. Medical documentation for a patient who reports being a victim of domestic violence should include:
 - a. The patient's own words in quotes.
 - 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.



- 11.** All of the following are **correct** statements regarding domestic violence reporting requirements in most states, **except**:
- a. Abuse of children under the age of 18 typically must be reported.
 - b. Domestic violence against disabled adults unable to protect themselves must typically be reported.
 - c. Those who make a report in good faith are immune from any civil or criminal liability.
 - d. Healthcare professionals are required to report domestic violence against competent adults.
- 12.** Which is a **true** statement about the protective order process?
- a. A petitioner requests a protective order from the criminal court.
 - b. A petitioner has no recourse to obtain a protective order until a court hearing has been completed.
 - c. A protective order cannot be renewed.
 - d. An abuser who violates a protective order may be charged with a crime and face arrest.
- 13.** 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.

