

Domestic Violence

Faculty

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. (A complete biography appears at the end of this course.)

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. (A complete biography appears at the end of this course.)

Dee Spring, PhD, MFT, ATR-BC, an international lecturer, specializes in the treatment of individuals who experienced "intimate" trauma with resultant PTSD; she is a consultant and qualified expert witness in several states. She has written professional articles, book chapters, and authored two books. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Marjorie Conner Allen, BSN, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Dee Spring, PhD, MFT, ATR-BC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all healthcare professionals who may intervene to protect victims of domestic violence.

Accreditation

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CME Resource is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Designation of Credit

CME Resource designates this enduring material for a maximum of 2 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CME Resource designates this continuing education activity for 2 ANCC contact hours.

CME Resource designates this continuing education activity for 2.4 hours for Alabama nurses.

AACN Synergy CERP Category B.

Individual State Nursing Approvals

In addition to states that accept ANCC, CME Resource is approved as a provider of continuing education in nursing by: Alabama, ABNP0353 (valid through December 12, 2013); California, CEP9784; California BVNPT Provider #V10662; Florida Provider #50-2405; Iowa, #295; Kentucky, 7-0054, Kentucky Board of Nursing approval of an individual nursing continuing education provider does not constitute endorsement of program content; Texas, ANCC/Type I Provider.

Special Approval

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of CME Resource is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of CME Resource not to accept commercial support.

Course Objective

The purpose of this course is to enable healthcare professionals in all practice settings to define domestic violence and identify those who are affected by domestic violence. This course describes how a victim can be accurately diagnosed and identifies resources available for domestic violence victims.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define domestic violence.
2. Recognize the characteristics and dynamics experienced by those groups who are at risk for domestic violence, including pregnant women, children, men, and same-sex couples.
3. Describe how to screen for patients who have a history of being a victim or perpetrator of domestic violence, including aspects of a culturally sensitive assessment.
4. Outline interventions targeted to victims of domestic violence.
5. Review resources available for domestic violence victims.



Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Domestic violence continues to be a prevalent problem in the United States. Because of the number of individuals affected, it is likely that most healthcare professionals will encounter patients in their practice who are victims. Accordingly, it is essential that healthcare professionals are taught to recognize and accurately interpret behaviors associated with domestic violence. It is incumbent upon the healthcare professional to establish and implement protocols for early identification of domestic violence victims and their abusers. In order to prevent domestic violence and promote the well-being of their patients, healthcare professionals in all settings must take the initiative to properly assess all women for abuse during each visit and, for those women who are or may be victims, to offer education, counseling, and referral information.

Victims of domestic violence suffer emotional, psychological and physical abuse, all of which can result in both acute and chronic signs and symptoms of physical and mental disease, illness and injury. Frequently, the injuries sustained require abused victims to seek care from healthcare professionals immediately after their victimization. Subsequently, nurses are often the first healthcare providers that victims encounter and are in a critical position to identify domestic violence victims in a variety of clinical practice settings where victims receive care.

Accordingly, healthcare professionals must educate themselves to enhance awareness of the presence of battered women in each particular practice or clinical setting.

DEFINING DOMESTIC VIOLENCE

Domestic violence, which is sometimes also referred to as “spousal abuse,” “battering,” or “intimate partner violence,” refers to the victimization of an individual with whom the abuser has or has had an intimate or romantic relationship. Researchers in the field of domestic violence have not agreed on a uniform definition of what constitutes violence or an abusive relationship. The prevailing perception about domestic violence is that assaults are “physical, frequent, and life-threatening” [1]. The Centers for Disease Control and Prevention (CDC), in their publication “Costs of Intimate Partner Violence Against Women in the United States,” define intimate partner violence (IPV) as, “violence committed by a spouse, ex-spouse, or current or former boyfriend or girlfriend. It occurs among both heterosexual and same-sex couples and is often a repeated offense” [2]. Domestic violence can consist of any of many behaviors or combination of behaviors, falling under physical, psychological, verbal, sexual, and financial/economic abuse (*Table 1*).

BEHAVIORS AND DOMESTIC VIOLENCE			
Physical Abuse	Psychological/Verbal Abuse	Sexual Abuse	Financial/Economic Abuse
Kicking, punching, biting, slapping, strangling, choking, abandoning in unsafe places, kicking, burning with cigarettes, throwing acid, beating with fists, throwing objects, refusing to help when sick, stabbing, shooting	Intimidation, verbal abuse, humiliation, put-downs, ridiculing, control of victim's movement, stalking, threats, threatening to hurt victim's family and children, social isolation, ignoring needs or complaints	Rape, forms of sexual assault such as forced masturbation, fellatio, oral coitus, sexual humiliation, perpetrator refuses to use contraceptives, coerced abortions	Withholding of money, refuse to allow victim to open bank account, all property is in the perpetrator's name, victim is not allowed to work
Source: Compiled by Authors			Table 1

Whatever the definition, it is important for health-care professionals to understand that domestic violence, in the form of emotional and psychological abuse and physical violence, is prevalent in our society. Unfortunately, domestic violence and abuse has become a fact of life for many Americans [4]. This course will use the terms “domestic violence” and “IPV” interchangeably.

PREVALENCE

Over the past two decades, domestic violence has emerged as one of the most serious public health problems facing women in this country [5]. Nearly 5.3 million incidents of IPV occur each year among U.S. women 18 years of age and older, and 3.2 million occur among men. Although many of these incidents are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting, 2 million injuries and 1,300 deaths from IPV occur nationwide every year [2; 26]. One of the difficulties in addressing the problem is that the abuse of women cannot be predicted by any demographic feature related to age, ethnicity, race, religious denomination, education, socioeconomic status or class [7].

Women who are abused often suffer severe physical injuries and will likely seek care at a hospital or clinic. The health and economic consequences of domestic violence are significant. Statistics vary from report to report and due to the lack of recent studies on the national cost of domestic violence, the U.S. Congress funded the CDC to conduct a study to determine the cost of domestic violence on the healthcare system [2]. The CDC report, which relied on data from the National Violence Against Women Survey conducted in 1995, estimated the costs of IPV by measuring how many female victims were nonfatally injured; how many women used medical and mental health care services; and how many women lost time from paid work and household chores in 1995. The estimated total cost of IPV against women in 1995 was over 5.8 billion. It must be noted that the costs of any one victimization may continue for years, therefore

the above number most likely underestimates the actual cost of IPV [2].

The rate of domestic violence against women has declined from 1993 to 2001, dropping from 1.1 million violent crimes against women in 1993 to 588,490 in 2001. The rate of overall family violence also fell by more than one-half in this time period [9;10]. Studies reveal that several factors may be contributing to the reduction in violence, including a decline in the marriage rate and a decrease of domesticity, better access to federally-funded domestic violence shelters, improvements in women’s economic status, and demographic trends, such as the aging of the population [21; 39].

IDENTIFYING DOMESTIC VIOLENCE IN GROUPS AT RISK

Nurses are in a critical position to identify domestic violence victims in a variety of clinical practice settings where women receive care. Nurses are often the first healthcare provider a victim of domestic violence will encounter in a healthcare setting, and must therefore, be prepared to provide care and support for these victims [6]. Although women are most often the victim of domestic violence, we must keep in mind that domestic violence extends to others in the household as well. For example, domestic violence occurs when children are abused by their parents or when parents are abused by their children, when the elderly are abused, and when siblings abuse each other [19].

PREGNANT WOMEN

Because a gynecologist or obstetrician is frequently a woman’s primary care physician, these healthcare providers must be particularly sensitive to domestic violence issues [19]. A 2002 report by the U.S. General Account Office (GAO) found that there is a lack of data regarding the prevalence of violence against pregnant women. A review of the literature found levels of 3.9% to 8.3%; however, these studies lack comparability and therefore cannot be used to concretely determine prevalence. The GAO report cites a 2001 surveillance project implemented by the

CDC, the Pregnancy Risk Assessment Monitoring System (PRAMS) that monitored the prevalence of violence against women whose pregnancies resulted in live births for 15 participating states and found that between 2.4% and 6.6% of pregnant women experience violence. This study may underestimate the problem as it did not report pregnancies that ended with fetal death, abortion, or death of the mother [41].

Although prevalence data is lacking, the overarching problem of violence against women cannot be ignored, especially as both mother and unborn child are at risk. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will insure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [7; 20]. Healthcare professionals should also be aware of the possible psychological consequences of abuse during pregnancy. There is a higher risk of stress, depression and addiction to alcohol and drugs in abused women. These conditions may result in damage to the fetus from drugs and alcohol and a loss of interest on the part of the mother in her or the fetus's health [22].

CHILDREN

Children who are raised in violent homes are also in danger. These children are at high risk for abuse and for emotional damage that may affect them as they grow older. As many as 70% of children from violent homes have witnessed their fathers battering their mothers. Interestingly, studies demonstrate that children who witness domestic violence are more likely to grow into a perpetrator or victim of domestic violence than a child who was himself or herself abused, thereby creating a "cycle of violence." For example, male adolescents who witness domestic violence are many times more likely to batter their mates later in life [23]. A meta-analysis of 118 studies of the psychosocial outcomes of children exposed to domestic violence found that 63% of child witnesses exhibited more aggression, anxiety, difficulties with peers, and academic problems than the average child [42]. In

addition to witnessing violence, these children may also become direct victims of violence, as between 50% and 70% of husbands who batter their wives also batter their children [6]. Moreover, victims of abuse will often turn on their children; statistics demonstrate that 85% of domestic violence victims abuse or neglect their children.

Teenage children are also victimized. According to the U.S. Department of Justice, between 1993 and 1999, 22% of all homicides against females 16 to 19 years of age were committed by an intimate partner. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them as compared to 54% in older age groups [43]. Accordingly, healthcare professionals who see young children and adolescents in their practice must have the tools necessary to detect these "silent victims" of domestic violence and to intervene quickly to protect young children and adolescents from further abuse.

ELDERLY

Abused and neglected elders, who may be mistreated by their spouses, partners, children, and other relatives, are among the most isolated of all victims of family violence. In a national study conducted by the National Center on Elder Abuse in 1996, there was a total of 293,000 reports of elder abuse to Adult Protective Services in the United States. This was a 150% increase from the 117,000 reports in 1986 [44]. The prevalence rate of elder abuse in institutional settings is not clear. However, in one nonprobability study, 36% of nursing and aide staff disclosed to having witnessed at least one incident of physical abuse by other staff members in the preceding year. When asked whether they themselves perpetrated physical abuse against an elderly resident, 10% admitted they had [18].

Because elder abuse can occur in family homes, nursing homes, board and care facilities, and even medical facilities, healthcare professionals must remain keenly aware of the potential for abuse. When abuse occurs between elder partners, it is primarily manifested in one of two ways, either as a long-standing pattern of marital violence, or as abuse originating in old age. In the latter case, abuse

may be precipitated by issues related to advanced age, including the stress that accompanies disability and changing family relationships [6].

It is important to understand that the domestic violence dynamic involves not only a victim but a perpetrator as well. For example, an adult son or daughter who lives in the parents' home and depends on the parents for financial support may be in a position to inflict abuse. This abuse may not always manifest itself as violence, but can lead to an environment where the elder parent is controlled and isolated. The elder may be hesitant to seek help because the abuser's absence from the home may leave the elder without a caregiver [6]. Because these elderly victims are often isolated, dependent, infirm, or mentally impaired, it is easy for the abuse to remain undetected. Healthcare professionals in all settings must remain aware of the potential for abuse and keep a watchful eye on this particularly vulnerable group.

MEN

Statistics confirm that domestic violence is predominantly perpetrated by men against women; however, there is evidence to suggest that women also exhibit violent behavior against their male partners [24]. Studies demonstrate that up to 12% of murdered men are killed by female partners, although this has been shown to be largely an issue of self-defense. It is persuasively argued that the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims [25]. Approximately 1.5 million women are raped and/or physically assaulted by an intimate partner each year, compared to 834,700 men [26]. In addition, 1 out of every 4 women has been physically assaulted or raped by an intimate partner, compared to 1 out of every 14 men [26]. IPV accounted for 20% of nonfatal violence against women in 2001 and 3% against men [9]. Nevertheless, healthcare professionals must always keep in mind that males can also be victimized.

SAME SEX COUPLES

Domestic violence exists in the gay and lesbian community, and the rates are thought to mirror those of heterosexual women, approximately 25% [28]. It is interesting to note, however, that women living with female intimate partners experience less intimate partner violence than women living with men [26]. Conversely, men living with male intimate partners experience more intimate partner violence than do men who live with female intimate partners [26]. This supports other statistics indicating that intimate partner violence is perpetrated primarily by men. Because of the stigma of being gay, victims may be reticent to report abuse and afraid that their sexual orientation will be revealed. Many in this community feel that support services are not available to them due to homophobia of the service providers. Unfortunately, this results in the victim feeling isolated and unsupported. Healthcare professionals must strive to be sensitive and supportive when working with homosexual patients.

MILITARY FAMILIES

As with domestic violence in the civilian population, military victims face a host of barriers in disclosing abuse. In addition to shame and embarrassment, fear of reprisals, feelings of isolation, and lack of available services, many military victims found when they did report abuse, military personnel were not sensitive to their needs [3]. Given these barriers to disclosure, it is difficult to assess the prevalence of domestic violence among military families. According to one report, a total of 61,827 initial substantiated cases, 5,772 subsequent incidents, and 3,921 reopened cases were reported to the Army Central Registry from 1989 to 1997 [8]. More than two-thirds of the victims were female, and almost half of the referrals were from law enforcement agencies. According to the U.S. Department of Defense, since inception of the Army Central Registry, the Army itself has recorded 57,421 confirmed cases of domestic violence.

The Army Family Advocacy Program is mandated to focus on identification, reporting, prevention, and treatment for child abuse and domestic violence [11]. In terms of prevention and intervention, the Family Advocacy Program provides a range of strategies including prevention efforts such as parent support groups for new parents, education programs for married couples to learn how to deal with stress, parenting classes, communicating and coping instruction, and anger management courses [13].

Risk factors are complex and multifaceted. Brewster conducted a study of 2,991 abusers who used physical domestic violence that received treatment at the Air Force Family Advocacy Program and agreed to participate in the study. As with the general population, the physical violence sustained was more severe when the offender was male. However, previously reported domestic violence cases were higher than the base rate for the general population—one in four had been reported for spouse abuse, and one in eight offenders had been substantiated for spouse abuse [12].


It has also been speculated that exposure to the trauma of combat and the development of post-traumatic stress symptoms provokes military veterans to be violent at home [14]. Furthermore, when these veterans do obtain treatment, either voluntarily or as mandated, many do not complete their treatment regimens. A sample of 62 male perpetrators from a domestic violence rehabilitation program participated in a study. Forty-eight men were veterans, while the remaining 14 were active duty. In general, findings showed that there was a relationship between the severity of post-traumatic stress disorder (PTSD) and the severity of domestic violence. Furthermore, there was a relationship between the severity of PTSD and the witnessing of parental domestic violence during childhood. Findings also indicated that those who did not complete treatment were usually older than 35 years of age, had higher levels of post-traumatic stress, experienced higher levels of stress in their daily lives, and reported less mutuality in their relationships [14].

SCREENING FOR DOMESTIC VIOLENCE AND ABUSE

A tremendous barrier to diagnosing and treating domestic violence is a lack of knowledge and training. Healthcare workers recognize and accurately interpret behaviors associated with domestic violence and abuse. However, healthcare professionals are hesitant to inquire about abuse [29; 30]. A Gallup poll initiated by the American College of Obstetricians and Gynecologists indicates that only 6% of its membership of over 33,000 physicians routinely ask their patients about abuse [6]. Approximately 10% of primary care physicians routinely screen for intimate partner abuse during new patient visits, and 9% routinely screen during periodic checkups [22]. A study by the CDC found that less than one-half of the physicians studied had recent training on intimate partner abuse, and only 17% routinely screened patients during their first prenatal visit [31]. In addition, a 1999 survey of managed care organizations found that less than one-third of HMOs in the United States have policies, procedures, and guidelines for screening domestic violence victims [32].

It is imperative that healthcare professionals work together to establish specific guidelines that will facilitate identification of batterers and their victims. These guidelines should review appropriate interview techniques, and should also include the utilization of screening tools, such as intake questionnaires. The following is a review of certain signs and symptoms that may indicate the presence of abuse. Although battered women do not display typical signs and symptoms when they present to healthcare providers, there are certain cues that we can attribute to abuse. The obvious cues are the physical ones. Injuries range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites, or knife wounds. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of

the body. In one hospital-based study, domestic violence victims were 13 times more likely to sustain injury to breast, chest, or abdomen than accident victims. Abused women are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen in a woman, particularly in combination with evidence of old injury, physical abuse should be suspected [20].



The Institute for Clinical Systems Improvement (ICSI) recommends that staff should have heightened awareness of a possible domestic violence situation when the patient presents with: somatic complaints without diagnosis (chronic pain, fatigue, headache), post-traumatic stress symptoms, gastrointestinal pain, unexplained neurological changes, depression, and/or multiple or erratic visits with a series of vague complaints.

(http://www.icsi.org/domestic_violence/domestic_violence_2589.html.
Last accessed November 7, 2007.)

Level of Evidence: A (randomized, controlled trial), B (cohort study), C (Non-randomized trial with concurrent or historical controls, case-control study, study of sensitivity and specificity of a diagnostic test, and/or population-based description study), D (cross-sectional study, case series, case report), and R (consensus statement, consensus report, or narrative review)

In addition to physical signs and symptoms, battered women also exhibit psychological cues that resemble an agitated depression. As a result of prolonged stress, these women often manifest various psychosomatic symptoms that generally lack an organic basis. For example, they may complain of backaches, headaches, and digestive problems. Often they will complain of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical [20; 33]. In many women, this constellation of symptoms has been labeled “Battered Women’s Syndrome.” Unfortunately, physicians typically respond to these women by diagnosing the patient to be neurotic or irrational [25]. Healthcare professionals must cast aside these misperceptions of abused victims and work within their respective

practice settings to develop screening mechanisms to detect women who exhibit these symptoms.

For every victim of abuse, there is also a perpetrator. Like their victims, perpetrators of domestic violence come from all socioeconomic backgrounds, races, religions, and walks of life [27]. Accordingly, healthcare professionals must likewise be aware that seemingly supportive family members may, in fact, be abusers. Perpetrators and their victims in lower socioeconomic groups are more likely to turn up in hospital emergency rooms and local community clinics. Conversely, people of higher socioeconomic status are more able to turn to the private clinician for assistance [27].

Abuser characteristics have been studied far less frequently than victim characteristics. Some studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. A man who abuses alcohol is also likely to abuse his mate, although the abuser may not necessarily be inebriated at the time the abuse is inflicted [34]. Screening questionnaires should include questions that explore social drinking habits of both the victim and his or her mate.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the batterer’s dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [27]. In addition, battered women have frequently reported that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing. One battered woman gave the following examples of her controlling husband, “he insisted that no one (including guests and their toddler children) wear shoes in the house, that the furniture be in the same indentations in the carpet, that the vacuum marks in the carpet be parallel, and that any sand that spilled from the children’s sandbox during their play be removed from the surrounding grass” [35]. In addition, healthcare professionals should be on the lookout for men who have low self-esteem, are frequently angry and depressed and are “very dependent on their partners as the sole source of love, support, intimacy, and problem solving” [33].

Both batterers and battered partners are noted for being extremely dependent upon each other. It appears that each member of the couple believes that he or she will perish without the other, and that the survival of each can only occur if the conjugal relationship remains intact. This belief ostensibly arises from their negative self images, which cause the couple to doubt both their ability to live independently and to find other partners who will accept them. Both tend to deny or minimize the scope and severity of the violence in their relationship. This denial makes the conjugal relationship appear more viable and desirable to both [36].

The particular relationship dynamics reviewed above are not easily detected under the best of circumstances. They may be especially difficult to uncover in circumstances where the parties are suspicious and frightened, as might be expected when a victim presents to an emergency room. The key to detection, however, is to establish a proper screening tool that can be utilized in the particular setting, and to maintain a keen awareness for the cues described above. Screening should be carried out at the entry points of contact between victims and medical care (e.g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, and pediatric care) [20].

The key to an initial screening is to obtain an adequate history. Establishing that a patient's injuries are secondary to battering is the first task. Clearly there will be times when a victim is injured so severely that treatment of these injuries becomes the first priority [37]. After such treatment is rendered, however, it is important that healthcare professionals not ignore the reasons that brought the victim to the emergency room.

Of female trauma patients, 16% to 30% will report that they have been battered when asked directly about how the injury occurred. Obviously, however, some women will not admit to a history of battering. Any trauma or burn that seems incompatible with a history of the injury is suggestive of battering and indicative of the need for gentle probing regarding how things are at home. Information must also be collected to facilitate a comprehensive assessment of the victim's needs, resources, and priorities in

STRUCTURED INTERVIEW FOR TREATMENT PLANNING

1. How were you hurt?
2. Has this happened before?
3. When did it first happen?
4. How badly have you been hurt in the past?
5. Was a weapon involved?
Is there a weapon in the house?
6. What kind of weapon?
7. Who lives in the home?
8. What are the children's ages?
9. Are the children in danger?
10. Have they been hit or hurt by him?
11. How badly have they been hit or hurt by him?
12. Have you ever told anyone about this before?
If so, who?
13. What have you done in the past to protect yourself?
14. What have you done in the past to get help?
15. Have you ever called the police?
16. If yes, when, and what did they say/do?
17. Did you report this incident to the police?
If not, why not?
18. If yes, what precinct?
19. What did they say/do?
20. Have you ever obtained a protective order?
21. Have you tried to press charges this time or before?
22. Does your boyfriend/husband have a criminal record?
23. Has he beaten or hurt other people?
24. Has he threatened to kill you?
25. Has he tried to kill you?
26. If so, what did he do?
27. Are you afraid to go home?
28. Where can you go?
29. Have you ever called a crisis center for help?
30. If so, who is your contact person there?
31. If not, why not?
32. Do you know the phone number of the local crisis center?

Source: [46]

Table 2

order to develop immediate and long-range plans designed to minimize and eliminate future abusive episodes. A structured interview that can be used to obtain the necessary information for treatment planning is outlined in **Table 2** [37].

After the history is obtained and initial treatment is started, it is imperative that healthcare professionals document all findings and recommendations in the victim's medical record. The medical record can be an invaluable document in establishing the credibility of the battered woman's story when she seeks legal aid [37].

CULTURALLY SENSITIVE ASSESSMENT

During the assessment process, a practitioner must be open and sensitive to the client's/patient's worldview, cultural belief systems and how he/she views the illness [45]. This may reduce the tendency to over-pathologize or minimize health concerns of ethnic minority patients. Pachter proposed a dynamic model that involves several tiers and transactions [40]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that he/she does not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups he/she comes in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [40]. Pachter advocates the notion that there is tremendous diversity within groups. For example, one cannot automatically assume that a Cuban immigrant adheres to traditional beliefs. Often, there are many variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the client/patient and the professional [40]. The negotiation consists of a dialogue that involves a

genuine respect of beliefs. It is important to remember that these beliefs may affect symptoms or appropriate interventions in the case of domestic violence.

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. These components are meant to provide an introduction to help practitioners recognize the range of dimensions, including physical, biological, social, and cultural factors, that affect immigrants and ethnic minorities. By incorporating cultural sensitivity into the assessment of individuals with a history of being victims or perpetrators of domestic violence, it may be possible to intervene and offer treatment more effectively.

INTERVENTIONS FOR DOMESTIC VIOLENCE

SAFETY PLANNING

All practitioners who deal with domestic violence should periodically review safety planning with victims. Homicide is of high risk for victims, thus safety planning is crucial. When advocating a safety plan, it is important to:

- Encourage the victim to be aware of weapons in the house.
- Have victims make a plan of what to do if violence escalates and where to go if leaving is an option.
- If children are old enough, they should be instructed about the safety plan and assigned roles.
- When possible, women should save some money in a private bank account or hide money for escape. Women should be informed that if the abuser finds out about a separate bank account, she could be in danger.

- Encourage victims to keep a bag packed with necessities and stored in a safe place in the event leaving must be immediate.
- Advise victims to work out a code word or signal with the children so they will know when to implement an escape plan.
- Encourage victims to keep a list of important phone numbers in their packed bag. Memorizing important numbers provides more safety.
- Recommend that copies of important documents and necessary items be available.

Although safety planning may be advocated, it does not necessarily mean victims will employ safety planning guidelines.

LEGAL INTERVENTIONS

There are five states with mandatory reporting laws to address domestic violence [15]. For example, California requires healthcare providers to report injuries resulting from firearm or assaultive violence, including injuries from intimate violence. However, there is a great amount of controversy among helping professionals about mandatory reporting laws. Those in favor of mandatory reporting for adult domestic violence maintain these laws improve the safety of the victim and will assist law enforcement to effectively intervene. Simultaneously, those who oppose the mandatory reporting laws also consider mandatory reporting creates a safety issue and may violate victims' rights of autonomy [3].

Domestic violence victims can obtain protective orders through a civil proceeding [16]. Until the enactment of Pennsylvania's Protection of Abuse Act in 1976, only two states had protective order legislation [16]. Protective orders now prohibit the abuser from communicating with the victim and/or other family members in a threatening manner. The order also prohibits the abuser from going to the home or place of employment of the victim or family members. Violations of protective orders can result in fines, imprisonment or a combination of both [16].

SUPPORT GROUPS

Support groups for crime victims can be beneficial. Often, victims think they are the only ones who have experienced the abuse. Victims may express shame and guilt, assume responsibility for the incident, and question what they did wrong to provoke the abuse. Support groups offer the opportunity for victims to meet others who are going through similar experiences and have similar feelings and concerns. Because batterers often utilize psychological tactics, such as isolation to keep the victim away from interacting and talking with family, friends, and other individuals, the victim's primary source of information, companionship, and support comes from the batterer [17]. Support groups diminish victims' sense of isolation and provide education.

SHELTERS

Shelters provide a haven for domestic violence victims and their children. They provide temporary emergency housing and a range of services to help victims "get back on their feet." Services vary but may include job training, support groups, skills development groups, and counseling.

RESOURCES AND REFERRALS

After identifying victims and their abusers, healthcare professionals should immediately implement a plan of action that includes providing a referral to a local domestic violence shelter to assist the victim and the victim's family. The acute situation should be referred immediately to local law enforcement officials. Other resources in an acute situation include crisis hotlines and rape relief centers. Once a victim is introduced into the system, counseling and follow-up is generally available by individual counselors who specialize in the care of battered women and their spouses and children. These may include social workers, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make the resources accessible and safe, and to enhance support for women who are unsure of their options [38].

**American Bar Association
Commission on Domestic Violence**

Provides valuable information about a wide-range of domestic violence issues and extensive links to other resources and organizations.
<http://www.abanet.org/domviol/home.html>

Communities Against Violence Network
CAVNET is a nonprofit organization and has developed an international network of professionals addressing domestic violence, sexual assault, rape, incest, stalking, and crime victims with disabilities, bringing together a diverse community which includes law enforcement, judges, clergy, lawyers, social workers, domestic violence shelters, rape crisis centers, disability advocates, and hundreds of others.

<http://cavnet2.org>

Family Violence Prevention Fund

Works in the area of preventing family violence. Provides information on public policy, violence in different population groups, and general information on resources.

<http://endabuse.org>

**Minnesota Center Against
Violence and Abuse (MINCAVA)**

The mission of MINCAVA is to support research, education, and access to violence-related resources.

<http://www.mincava.umn.edu>

National Coalition Against Domestic Violence

Serves as a national information and referral center for the general public, practitioners, organizations, and the victims of domestic violence.

<http://www.ncadv.org>

National Center for Victims of Crime

The National Center for Victims of Crime is recognized as the nation's leading advocate for crime victims.

<http://www.ncvc.org>

National Organization for Victim Assistance

Private, non-profit organization committed to the recognition and implementation of victim rights and services.

<http://www.trynova.org>

Office on Violence Against Women

Handles the U.S. Department of Justice's legal and policy issues regarding violence against women, provides national and international leadership, and responds to requests for information regarding violence against women.

<http://www.usdoj.gov/ovw>

**RESOURCES FOR ETHNIC MINORITY
AND IMMIGRANT WOMEN**

**Asian and Pacific Islander
Institute on Domestic Violence**

Is a network of professionals from various disciplines to serve as a forum and clearinghouse to provide information on domestic violence in the Asian and Pacific Islander communities.

<http://www.apiahf.org/apidvinstitute/ResearchAndPolicy/resources.htm>

**Institute on Domestic Violence
in the African American Community**

An interdisciplinary forum by which scholars and practitioners can disseminate information about domestic violence in the African American community.

<http://www.dvinstitute.org>

**The National Latino Alliance for the
Elimination of Domestic Violence (Alianza)**

Part of a national effort to address the domestic violence needs and concerns of under-served populations. It represents a growing network of Latina and Latino advocates, practitioners, researchers, community activists, and survivors of domestic violence.

<http://www.dvalianza.org>

RESOURCES FOR WOMEN WITH DISABILITIES

Center for Research on Women with Disabilities

<http://www.bcm.edu/crowd>

RESOURCES FOR THE GAY COMMUNITY

Gay Men's Domestic Violence Project

Provides community education and direct services to gay, bisexual, and transgendered male victims and survivors of domestic violence.

<http://www.gmdvp.org>

National Gay and Lesbian Taskforce

<http://www.thetaskforce.org>

Annual Report on Lesbian, Gay, Bisexual, Transgender Domestic Violence

<http://www.ncavp.org>

CONCLUSION

To lump all behavior in chaotic relationships under the category of violence can be misleading to the public. The common image of violence for the majority of people is physical harm, attack, and observable injury. Differentiating types of behavior in intimate relationships is necessary to define consequences related to outcome studies to form an evidence base for treatment. The formulation of accurate definitions is instrumental in designing methodology to compare differences. More accurate and sensitive instruments to measure the depth of the social problem are needed to reveal differences in gender initiated violence, show the accuracy of occurrences of mutual battering, and quantify post-effects of intimate violence on men, women, and children.

The long-term focus on domestic violence is responsible for major reforms on multiple levels within various systemic functions related to criminal prosecution, legislative views and actions, and healthcare protocols. Given the pervasive nature of abuse in relationships, histories of partners including mental, psychological, and behavioral documentation is vital when determining the causes and effects of abuse. How historical and cultural belief systems are connected to domestic violence is essential in determining an accurate measurement of intimate violence.

FACULTY BIOGRAPHIES

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. In the fall of 1989, she began law school at Florida State University. After graduating from law school in 1992, Ms. Allen took a two-year job as law clerk to the Honorable William Terrell Hodges, United States District Judge for the Middle District of Florida. After completing her clerkship, Ms. Allen began her employment with the law firm of Smith, Hulsey & Busey in Jacksonville, Florida where she has worked in the litigation department defending hospitals and nurses in medical malpractice actions. Ms. Allen resides in Jacksonville and is currently in-house counsel to the Mayo Clinic Jacksonville.

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Master's degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Currently Dr. Yick Flanagan is a faculty member at Capella University, School of Human Services and Canyon College, Department of Social Work. She is the founder of *E-Research*, an e-mail newsletter that focuses on topics of health, mental health, and violence in a cross-cultural context. Dr. Yick Flanagan has recently moved her research focus to the area of racism and mental health consequences in ethnic minority communities. She and her fellow colleagues are currently administering a survey on Asian Americans, Hispanics, and African Americans' experiences with racism and discrimination.

Dee Spring, PhD, MFT, ATR-BC, an international lecturer, specializes in the treatment of individuals who experienced "intimate" trauma with resultant PTSD; she is a consultant and qualified expert witness in several states. She has written professional articles, book chapters, and authored two books. Dr. Spring has taught at many universities and conducted training for professionals in a variety of settings. Additionally, she designed, implemented and directed the first federally funded rape crisis center in the world to utilize visual art in crisis intervention and treatment for victims of sexual assault. She is Past President of the California Society for the Study of Trauma and Dissociation and a past member of the Board of Directors of the American Art Therapy Association, receiving awards from both for clinical and educational achievements, contributions, and innovations related to research and use of visual art in trauma treatment.

Works Cited

1. Fischer K, Vidmar N, Ellis R. The Culture of Battering and the Role of Mediation in Domestic Violence Cases. *Southern Methodist University Law Review*. 1993;46:2117-2174.
2. National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta, GA: Centers for Disease Control and Prevention; 2003.
3. Erez E, Bach S. Immigration, domestic violence, and the military: The case of "military brides." *Violence Against Women*. 2003;9(9):1093-1117.
4. Medley DF. Separating the Victim From the Abuser: Chapter 94-135 and the Florida Legislature's Most Recent Attempts to Control Domestic Violence. *Saint Thomas Law Review*. 1994;7:169-196.
5. Warshaw C. Domestic Violence: Challenges to Medical Practice. *Journal of Women's Health*. 1993;2:73-80.
6. Governor's Task Force on Domestic Violence, Executive Office of the Governor. *The First Report of the Governor's Task Force on Domestic Violence*. January 1994.
7. Chez RA. Battering During Pregnancy. *Complications of Pregnancy: Medical, Surgical, Gynecologic, Psychosocial and Perinatal*. Baltimore: Williams & Wilkins, 1992. 263-268.
8. McCarroll JE, Newby JH, Thayer LE, Norwood AE, et al. Reports of spouse abuse in the U.S. Army Central Registry (1989-1997). *Military Medicine*. 1999;164(2):77-84.
9. Rennison CM. Intimate partner violence, 1993-2001. Washington, DC: Bureau of Justice Statistics, Department of Justice; 2003. Publication No. NCJ197838. Available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv01.pdf>. Last accessed November 6, 2007.
10. Bureau of Justice Statistics, Department of Justice. Rate of Family Violence Dropped by More than One-Half from 1993 to 2002; Press Release, June 12, 2005. Available at <http://www.ojp.usdoj.gov/bjs/pub/press/fvspr.htm>. Last accessed November 6, 2007.
11. Newby JH, McCarroll JE, Thayer LE, Norwood AE, et al. Spouse abuse by Black and White offenders in the U.S. Army. *Journal of Family Violence*. 2000;15(2):199-208.
12. Brewster AL. Evaluation of spouse abuse treatment: Description and evaluation of the Air Force family advocacy programs for spouse physical abuse. *Military Medicine*. 2002;167(6):464-469.
13. U.S. Department of Defense. Stop the violence. 2005. Available at <http://www.defenselink.mil/speeches/1996/s19960723-becraft.html>. Last accessed August 19, 2005.
14. Gerlock AA. Domestic violence and post-traumatic stress disorder severity for participants of a domestic violence rehabilitation program. *Military Medicine*. 2004;169(6):470-474.
15. Howard D, Wang MQ. Risk profiles of adolescent girls who were victims of dating violence. *Adolescence*. 2003;38(149):1-13.
16. Carlson MJ, Harris SD, Holden GW. Protective orders and domestic violence: Risk factors for re-abuse. *Journal of Family Violence*. 1999;14(2):205-226.
17. Brandl B, Hebert M, Rozwadowski J, Spangler D. Feeling safe, feeling strong: Support groups for older abused women. *Violence Against Women*. 2004;9(12):1490-1503.
18. Tatara T, Kuzmeskus L. *Summaries of the statistical data on elder abuse in domestic settings: An exploratory study of staff statistics for FY 95 and 96*. Washington, DC: NCEA; 1997.
19. Chez RA. Woman Battering. *American Journal of Obstetrics and Gynecology*. 1988;158:1-4.
20. Council on Scientific Affairs, American Medical Association. Violence Against Women, Relevance for Medical Practitioners. *Journal of the American Medical Association*. 1992;267:3184-3189.
21. National Institute of Justice. The Decline of Intimate Partner Homicide. *National Institute of Justice Journal*. 2005;252:33-34.
22. Newberger EH, Barkan SE, Lieberman ES, McCorminick MC, Yllo K, Garry LT, et al. Abuse of pregnant women and adverse birth outcome. Current knowledge and implications for practice. *Journal of the American Medical Association*. 1992 May 6; 267 (17):2370-2372.
23. Levine D. Children in Violent Homes: Effects and Responses. *The Florida Bar Journal*. 1994 Oct;68:62-65.
24. Chavez JJ. Battered Men and California Law. *Southwestern University Law Review*. 1992;22:239-264.
25. Council on Ethical and Judicial Affairs, American Medical Association. Physicians and Domestic Violence, Ethical Considerations. *Journal of the American Medical Association*. 1992;267:3190-3193.
26. Tjaden P, Thoennes N. *Full Report of the Prevalence, Incidence, and Consequences of Intimate Partner Violence Against Women: Findings from the National Violence Against Women Survey*. Report for grant 93-IJ-CX-0012, funded by the National Institute of Justice and the Centers for Disease Control and Prevention. Washington (DC): NIJ; 2000.
27. Sonkin DJ, Martin D, Walker LE. *The Male Batterer, A Treatment Approach*. New York: Springer Publishing Company, 1985.
28. LAMBDA, Gay, Lesbian, Bisexual, Transgender Community Services. Available at <http://www.lambda.org>. Last accessed November 6, 2007.
29. Jecker NS. Privacy Beliefs and the Violent Family, Extending the Ethical Argument for Physician Intervention. *Journal of the American Medical Association*. 1993;269:776-780.
30. Sugg NK, Inui T. Primary Care Physicians' Response to Domestic Violence. *Journal of the American Medical Association*. 1992;267:3157-3160.

#9789 Domestic Violence

31. Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. *The Journal of the American Medical Association*. 1999 Aug;282(5):468-474.
32. Family Violence Prevention Fund's National Health Resource Center on Domestic Violence. *National Survey of Managed Care Organizations*. San Francisco, CA: August 1999.
33. Scherer DD. Tort Remedies for Victims of Domestic Abuse. *South Carolina Law Review*. 1992;43:543-579.
34. Sedlak AJ. Prevention of Wife Abuse. In: VB Van Hasselt, RL Morrison, AS Bellack, M Hersen (eds.) *Handbook of Family Violence*. New York: Plenum Press, 1988. 319-358.
35. Fischer K, Vidmar N, Ellis R. The Culture of Battering and the Role of Mediation in Domestic Violence Cases. *Southern Methodist University Law Review*. 1993;46:2117-2174.
36. Okun L. *Woman Abuse, Facts Replacing Myths*. Albany: State University of New York Press, 1986.
37. McLeer SV, Anwar R. The Role of the Emergency Physician in the Prevention of Domestic Violence. *Annals of Emergency Medicine*. 1987;16:1155-1161.
38. American College of Obstetrician-Gynecologists. The Battered Woman. *ACOG Technical Bulletin*. 1989 Jan;124:1-7.
39. Farmer A, Tiefenthaler J. Explaining the Recent Decline in Domestic Violence. *Contemp Econ Policy*. 2003;21(2):158-172.
40. Pachter LM. Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271(9):690-695.
41. United States General Accounting Office. Violence Against Women: Data on Pregnant Victims and Effectiveness of Prevention Strategies are Limited. May 2002; Centers for Disease Control and Prevention Pregnancy Risk Assessment Monitoring System;(PRAMS). Available at <http://www.gao.gov/new.items/d02530.pdf>. Last accessed November 6, 2007.
42. Kitzman KM, Gaylord NK, Holt AR, Kenny, ED. Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*. 2003; 71 (2): 339-352.
43. U.S. Bureau of Justice Press Release. Violence Rates Among Intimate Partners Differ Greatly According to Age. October 29, 2001. Available at <http://www.ojp.usdoj.gov/bjs/pub/press/ipva99pr.htm>. Last accessed November 6, 2007.
44. Pillemer KA, Moore DW. Highlights from a study of abuse of patients in nursing homes. *Journal of Elder Abuse and Neglect* 1990;2(1-2): 5-29.
45. Panos PT, Panos AJ. A model for a culture-sensitive assessment of patients in health care settings. *Social Work in Health Care*. 2000;31(1):49-62.
46. McLeer SV, Anwar R. A Study of Battered Women Presenting in an Emergency Department. *American Journal of Public Health*. 1989;79:65-66.

Evidence-Based Practice Recommendations Citation

Institute for Clinical Systems Improvement. *Domestic violence*. Bloomington, MN: Institute for Clinical Systems Improvement; 2006. Available at http://www.icsi.org/domestic_violence/domestic_violence_2589.html. Last accessed November 7, 2007.