Domestic and Sexual Violence

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Faculty

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 Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

John M. Leonard, MD, Professor of Medicine Emeritus, Vanderbilt University School of Medicine, completed his post-graduate clinical training at the Yale and Vanderbilt University Medical Centers before joining the Vanderbilt faculty in 1974. He is a clinician-educator and for many years served as director of residency training and student educational programs for the Vanderbilt University Department of Medicine. Over a career span of 40 years, Dr. Leonard conducted an active practice of general internal medicine and an inpatient consulting practice of infectious diseases.

Faculty Disclosure

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

Contributing faculty, John M. Leonard, MD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This introductory course is designed for psychologists in all practice settings.

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Course Objective

The purpose of this course is to provide psychologists with the skills and confidence necessary to identify victims of sexual or domestic violence and to intervene appropriately and effectively.

Learning Objectives

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

1. Identify common types of domestic and sexual violence.
2. Outline signs of abuse or victimization.
3. Describe the health effects and implications of domestic violence and/or sexual assault, including effects on pregnancy, developing fetuses, and child witnesses.
4. Evaluate the unique risk factors for and consequences of domestic and sexual violence in special populations.
5. Discuss traits of perpetrators of domestic and/or sexual violence.
6. Analyze screening and assessment methods to identify victims of abuse.
7. Describe appropriate responses to domestic and sexual violence, including best practices for follow-up care.

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 today. 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 should take the initiative to properly assess all patients for abuse during each visit and, for those who are or may be victims, to offer education, counseling, and referral information.

Victims of domestic violence suffer emotional, psychologic, 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, physicians and 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, each healthcare professional should educate himself or herself to enhance awareness of the presence of abuse victims in his or her particular practice or clinical setting.

Specifically, healthcare professionals should be aware of the signs and symptoms associated with domestic violence. In addition, when family violence cases are identified, there should be a plan of action that includes providing information on, and referral to, local community resources related to legal aid, sheltering, victim counseling, batterer counseling, advocacy groups, and child protection.

AN OVERVIEW OF THE ISSUE

DEFINING DOMESTIC VIOLENCE

Domestic violence, termed spousal abuse, battering, or intimate partner violence (IPV), refers to the victimization of an individual with whom the abuser has or has had an intimate or romantic relationship. The Centers for Disease Control and Prevention (CDC) defines IPV as, "physical violence, sexual violence, stalking, and psychologic aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" [1]. The World Health Organization defines intimate partner violence as "behaviour by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours" [19].

Domestic violence can consist of any of many behaviors or combination of behaviors, falling under physical, psychologic, verbal, sexual, and financial/economic abuse (***Table 1***).

It is important for healthcare professionals to understand that domestic violence, in the form of emotional and psychologic abuse and physical violence, is prevalent in society. Unfortunately, domestic violence and abuse has become a fact of life for many Americans. This course will use the terms "domestic violence" and "IPV" interchangeably.

DEFINING SEXUAL VIOLENCE

According to the Massachusetts Coalition Against Sexual Assault and Domestic Violence, sexual violence is defined as "a multi-layered oppression that occurs at the societal and individual level and is connected to and influenced by other forms of oppression, in particular, sexism, racism, and heterosexism…On an individual level, sexual violence is a wide range of sexual acts and behaviors that are unwanted, coerced, committed without consent, or forced either by physical means or through threats" [2]. The Association of American Universities (AAU) defines it as "nonconsensual penetration or sexual touching by force or incapacitation" [57].

DOMESTIC VIOLENCE BEHAVIORS			
Physical Abuse	**Psychologic/Verbal Abuse**	**Sexual Abuse**	**Financial/Economic Abuse**
Kicking, punching, biting, slapping, strangling, choking, abandoning in unsafe places, burning with cigarettes, throwing acid, throwing objects, refusing to help when sick, stabbing, shooting	Intimidation, humiliation, put-downs, ridiculing, control of victim's movement/relationship/ behaviors, 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, or oral coitus), sexual humiliation, unwanted touching, perpetrator refuses to use contraceptives, coerced abortion	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 Author			*Table 1*

Whether out of impulse, compulsion, anger, or the assertion of power, sexual assault is a criminal act of violence imposed on the vulnerable and the innocent, causing immediate physical and emotional suffering and often having long-lasting adverse psychologic effects. Rape is the legal term for a sexual assault during which there is penetration of a body orifice (vagina, anus, or mouth) involving force, the threat of force, or incapacity and nonconsent of the victim.

It is important to consider that there is a wide range of sexual violence that can manifest in many different ways and settings/situations. For example, it can entail forced marriage and child marriage, forced lack of precautions to prevention sexually transmitted infections, and/or reproductive coercion (e.g., forced abortion, forced pregnancy) is considered a form of sexual violence [2; 126]. It is estimated that 35.6% of the global population have experienced sexual violence. It is important to note that men can be victims of sexual violence, although it is more challenging to obtain prevalence rates for this population [126].

CONTRACEPTIVE COERCION

Control of reproductive or sexual health is also a recognized trend in IPV. This type of abuse includes trying to impregnate or become pregnant against a partner's wishes, refusal to use birth control (e.g., condoms, oral contraceptives), manipulating a contraceptive so it becomes ineffective, preventing or forcing abortion, or stopping a partner from using birth control [3; 127]. It does not necessarily involve physical force, and it ultimately undermines the autonomy of the individual in regard to their reproductive health [127].

Research indicates that this form of violence is relatively common. A 2018 systematic review found that 5% to 16% of women had experienced reproductive coercion [127]. In another study of young women (16 to 29 years of age) presenting to family planning clinics in California found that 53% of respondents reported physical or sexual partner violence, 19% reported experiencing pregnancy coercion, and 15% reported birth control sabotage [4]. Of those who reported being victims of partner violence, 35% reported reproductive control. Research indicates that reproductive coercion is often one of multiple forms of interpersonal violence experienced by a victim [128]. Furthermore, studies suggest that reproductive control and unintended pregnancy may disproportionately affect women of color [5].

According to the American College of Obstetricians and Gynecologists (ACOG), interventions that focused on awareness of reproductive and sexual coercion and provided harm-reduction strategies reduced pregnancy coercion by 71% among women who experienced IPV [6]. The ACOG recommends the following screening questions:

- Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?

- Has your partner ever tried to get you pregnant when you did not want to be pregnant?
- Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?
- Does your partner support your decision about when or if you want to become pregnant?

Interventions targeted to protect victims of contraceptive coercion include helping conceal contraceptives, placement of an intrauterine device or other implanted birth control, and appropriate referrals [6].

SIGNS OF ABUSE/VICTIMIZATION

DOMESTIC VIOLENCE

It is imperative that healthcare professionals work together to establish specific guidelines that will facilitate identification of batterers and their victims. In a 2016 study of 288 healthcare facilities in Florida, 78% understood the importance of IPV screening and had some type of IPV screening policy institute in their setting [7]. However, many of the respondents did not know which screening tool was used or the types of screening questions asked. 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 victims of domestic violence do not display typical signs and symptoms when they present to healthcare providers, there are certain cues that may be attributable 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. In addition to physical signs and symptoms, domestic violence victims also exhibit psychologic cues that resemble an agitated depression. If the perpetrator is present with the victim during an assessment, they may attempt to control the situation; this may manifest as an unwillingness to leave the victim alone or answering questions for the victim.

Unfortunately, healthcare professionals may respond to these women by diagnosing the patient to be neurotic or irrational [8]. Healthcare professionals should 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. In addition, it is important to recognize that vulnerable populations, including lesbian, gay, bisexual, transgender, and other gender/sexual minority (LGBT+) individuals, those with human immunodeficiency virus (HIV), individuals with disabilities, and veterans are also at risk and should be screened for IPV [9].

SEXUAL VIOLENCE

Although most cases of sexual violence are accompanied by physical force and/or active resistance, visible injuries are rare. Possible signs of sexual violence victimization include [10]:

- Unwanted touching
- Rape (i.e., actual or attempted unwanted vaginal, oral, or anal penetration by an object or body part)
- Being forced or manipulated into doing unwanted, painful, or degrading acts during intercourse
- Being taken advantage of while one is drunk or otherwise not likely to give consent
- Being denied contraception or protection against sexually transmitted infections
- Taking any kind of sexual pictures or film without consent
- Being forced to perform sexual acts on film or in person for money
- Threatening break up when sex is refused

HEALTH EFFECTS AND IMPLICATIONS OF DOMESTIC VIOLENCE

As is clear, victims of domestic violence experience a wide range of physical and psychologic injuries. 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. Abuse victims are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen in a patient, particularly in combination with evidence of old injury, physical abuse should be suspected [11].

As a result of prolonged stress, victims often manifest various psychosomatic symptoms that generally lack an organic basis. For example, they may complain of backaches, headaches/migraines, and gastrointestinal problems. Often, they will complain of chronic pain, fatigue, restlessness, insomnia, or loss of appetite. Research indicates that women with a history of intimate partner violence are at greater risk of developing fibromyalgia and chronic fatigue syndrome [129]. Sleep disturbances, including truncated sleep, nightmares, and restless sleep, are also common [130]. The likelihood of having some sort of stress-related sleep disturbance is 1.24 times greater for women affected by physical intimate partner violence and 3.44 times greater for victims of sexual abuse [130]. Great amounts of anxiety, guilt, and depression or dysphoria are also typical [11; 12]. In many women, this constellation of symptoms has been labeled "battered women's syndrome."

The long-term health implications should also be considered. In a study conducted by MORE magazine and the Verizon Foundation, 88% of women who have experienced sexual abuse and 81% of women who have experienced any form of domestic violence report having chronic health conditions (compared with 62% among women who experienced no domestic violence) [13]. In this study, the most common chronic health conditions among victims were low back pain (35%), headaches (32%), difficulty sleeping (30%), and depression/anxiety (30%). Victims of violence were also found to have increased incidences of diabetes, cervical pain, gastroesophageal reflux disease, irritable bowel syndrome, and post-traumatic stress disorder (PTSD).

HEALTH EFFECTS AND IMPLICATIONS OF SEXUAL VIOLENCE

Research indicates that victims of sexual violence experience a range of acute and long-term physical and psychologic injuries as a result of the violence [14].

NON-GENITAL BODILY INJURY

Non-genital bodily injury is seen in more than half of all rape victims presenting to emergency departments [15; 16]. In one study of 162 women examined between 2002 and 2006, signs of bodily injury were found in 61% of patients, with genital injury present in 39% [17]. Most common were bruises (56%) and abrasions (41%), followed by lacerations, penetrating injury, and bites. Evidence of injury was higher in the 137 cases examined within 72 hours of assault (66% vs. 33%) and in cases in which the assaults occurred outdoors (79% vs. 52%).

On examination, one should inspect carefully for evidence of blunt traumatic injury to the head, neck, arms, legs, and torso, looking for signs of penetrating injury, lacerations, and bite marks. Bruising may be evident on the neck (attempted strangulation), hands, arms, breasts, or thighs.

LONG-TERM PHYSICAL AND EMOTIONAL IMPACT OF SEXUAL ASSAULT	
Chronic Somatic Disorders	**Psychosocial Disorders**
Pelvic pain, dyspareunia	Anxiety, depression, phobias
Functional gastrointestinal disorder	Post-traumatic stress disorder
Fibromyalgia	Sexual dysfunction
Multisystem physical complaints	Sleep disturbance
Headaches	Anorexia
Abdominal pains	Work absenteeism
Source: [22; 23; 24; 25; 26; 27; 133]	*Table 2*

Signs of bodily injury are more prevalent in women younger than 30 years of age. Other factors showing a strong positive association with bodily injury include alcohol consumption, history of prior assault, and assault by strangers [15].

GENITAL INJURY

Signs of genital traumatic injury are not always found after sexual assault, and in such cases should not be taken as evidence that sexual assault did not occur [17]. When routine inspection is combined with additional examination techniques, such as colposcopy and toluidine blue staining, the rate for identifying genital injury approaches 70% [18]. A 2021 study compared 834 women, half of whom reported nonconsensual intercourse. External genital tears were found more often in the nonconsensual group [131]. Similarly, anal penetration and tears were also more common in the nonconsensual intercourse group. As such, these may be indicators of lack of consent.

The common types and location of genital injuries, and thus the areas to be examined most closely, are:

- Bruises and abrasions to the labia, fossa navicularis, or perianal area
- Ecchymoses, tears, or lacerations of the hymen
- Abrasions and/or tears of the posterior fourchette
- Tears/lacerations in the perianal area

LONG-TERM PSYCHOSOCIAL IMPACT

The impact of sexual assault leads to immediate and long-term physical and mental health consequences. In addition to the potential risk for acquiring a sexually transmitted disease (STD), approximately 1% to 5% of rape victims become pregnant [20]. The National Violence Against Women Survey (NVAWS) found that 33% of women and 24% of men received counseling from a mental health professional as a direct result of their last assault; 28% and 10%, respectively, lost time from work [21]. Survivors of sexual assault are also at increased risk for re-victimization and experience higher rates of depression, post-traumatic stress disorder, substance abuse, and suicide.

In the aftermath of sexual assault, a variety of chronic somatic, cognitive, and emotional sequelae have been observed in sexual assault victims (***Table 2***). The individual's response and subsequent ability to cope with the trauma of the assault are influenced by a number of related factors. These include the nature and severity of the assault itself, age of the victim, relationship between the victim and assailant, prior history of abuse, and the person's own ambient life stress and coping mechanisms. For some, the impact of a sexual assault experience is severe and long-lasting, often resulting in difficulty with interpersonal relationships and tasks of daily living, sexual dysfunction, loss of work time, and increased utilization of healthcare resources [22; 23; 24]. The victim's age and developmental stage can also affect help-seeking.

Adolescents tend to delay seeking formal help more often than adult victims [132]. This delay could exacerbate both physical and psychosocial consequences.

A meta-analysis of clinical studies published between 1980 and 2002 revealed a significant association between prior sexual assault and the lifetime diagnosis of fibromyalgia, chronic pelvic pain, and functional gastrointestinal disorders [25]. In a cross-sectional, randomly selected study of 219 women followed in a Veterans Administration (VA) primary care clinic, a history of prior sexual assault was found to be associated with a significant increase in somatization scores, multisystem physical complaints, anxiety, work absenteeism, and health care utilization [26]. Among another cohort of women receiving VA medical and mental health care, the prevalence of post-traumatic stress disorder was found to be seven to nine times higher in women who had experienced a prior sexual assault, compared with those having no assault history [27].

It is also vital to remember that some victims have experienced cumulative sexual violence over the course of their lifetime. This often results in continued fear and anxiety and chronic stress, which is associated with an increased risk for chronic health conditions (e.g., hypertension, disordered sleeping, chronic pain, asthma) [133].

To summarize, the priorities of acute care counseling are to provide emotional support, assure a plan for patient safety, and assess coping skills and strength of support system post-discharge. When possible, arrangements should be made for ongoing counseling through sexual assault crisis programs. In anticipation of the long-term adverse effects of sexual assault, arrangements should be made for primary care follow-up and patients and families should be offered information and access to mental health services.

SEXUALLY TRANSMITTED INFECTION

The infections commonly reported in women after sexual assault are *Chlamydia*, gonorrhea, trichomoniasis, bacterial vaginitis, and pelvic inflammatory disease (PID) [28]. The possible exposure to hepatitis B virus and human immunodeficiency virus (HIV) is also an important consideration. In general, the risk of infection is relatively low; published estimates are 3% to 16% for chlamydia, 7% for trichomoniasis, and 11% for PID [29]. The risk, however, does vary directly with the degree of genital trauma, associated bleeding (sustained by the victim or assailant), and the number of assailants. The CDC has published guidelines for the assessment, counseling, and preventive treatment of infection following sexual assault, including common pelvic infections, hepatitis B, human papillomavirus (HPV), and HIV [28].

Follow-up within one to two weeks after the initial evaluation provides the opportunity to review previous test results, complete an assessment for STDs, and ensure safety and adherence to prescribed medication. CDC guidelines advise that a follow-up examination at one to two months should be considered to re-evaluate for development of anogenital warts, especially in patients who received a diagnosis of other STDs following the assault. If initial tests were negative and infection in the assailant could not be ruled out, serologic tests for syphilis can be repeated at four to six weeks and three months. To exclude acquisition of HIV, tests for acute infection should be repeated at six weeks, three months, and six months after the assault [28].

IMPLICATIONS ON PREGNANCY AND PRENATAL CARE

Possible factors that may predispose pregnant women to IPV include young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [31; 32]. Because a gynecologist or obstetrician is frequently a woman's primary care physician, these healthcare providers should be particularly sensitive to domestic violence issues [30]. According to the CDC, IPV affects as many as 324,000 pregnant women each year [31]. This represents approximately 8% of all pregnant women in the United States. As with all domestic violence statistics, this number is presumed to be lower than the actual incidence as a result of under-reporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes IPV more prevalent among pregnant women than some of the health conditions included in prenatal screenings, including pre-eclampsia and gestational diabetes [31]. Because 96% of pregnant women receive prenatal care, this is an optimal time to screen for domestic violence and develop trusting relationships with the women. Pregnant women indicate they find screening useful but also have concerns regarding confidentiality and the sharing or information [134].

The overarching problem of violence against women cannot be ignored, especially as both mother and unborn child are at risk. One study found that pregnant women who had been treated at a hospital after a violent incident had an eightfold increased risk of fetal death [33]. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will ensure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [11; 34]. Healthcare professionals should also be aware of the possible psychologic consequences of abuse during pregnancy. There is a higher risk of stress, depression, and addiction to alcohol and drugs in abused women, and victims are less likely to obtain prenatal care and to develop postpartum depression [33; 35; 36].

Low birth weight can result from either preterm birth or growth restriction in utero, both of which can be directly linked to stress. For example, pregnant women who experience physical violence are five times more likely to give birth to preterm infants and six times more likely to have an infant with low birth weight [135]. Living in an abusive and dangerous environment marked by chronic stress can therefore be an important risk factor for maternal health, as well as affecting birth weight [37].

The risk of becoming pregnant after vaginal rape is estimated to be 5%, although the risk may be higher for adolescent victims [16; 136]. It is generally recommended that rape victims of childbearing age have a baseline urine or serum pregnancy test performed, in anticipation of offering prophylaxis against pregnancy if the result is negative.

Postexposure emergency contraceptive treatment options are available for preventing pregnancy after unwanted intercourse [38]. The simplest and best-studied product is levonorgestrel (Plan B), an oral progestin-only medication developed for this purpose. The dosage regimen is 1.5 mg (two 0.75-mg tablets) administered as a single oral dose. It is considered to be most effective when administered within 12 hours of the assault. In one carefully conducted study, the success rate (prevention of pregnancy) exceeded 95% when administered up to 120 hours after unprotected intercourse [39]. This medication is safe and well tolerated, even if given to someone who is pregnant. Systemic side effects, such as headache, nausea, fatigue, and gastrointestinal/abdominal complaints, occur in less than 10% of patients. Transient vaginal bleeding in the days following treatment is more common (25% to 30%).

HEALTH EFFECTS AND IMPLICATIONS OF CHILDREN EXPOSED TO DOMESTIC VIOLENCE

Children may be victims of domestic violence either directly (if victims of the perpetrator) or indirectly (if witnessing the violence or suffering the fallout). Witnessing may also include overhearing threats or witnessing the consequences of domestic violence [137]. However, there is evidence that child abuse and intimate partner violence often occur within the same household and that exposure to violence in childhood may increase the risk of experiencing or perpetrating different forms of violence later in life [40].

Children exposed to family violence are at high risk for abuse and for emotional damage that may affect them as they grow older. The Department of Justice estimates that of the 76 million children in the United States, 46 million will be exposed to some type of violence during their childhood [12]. Results of the National Survey of Children's Exposure to Violence indicated that 11% of children were exposed to IPV at home within the last year, and as many as 26% of children were exposed to at least one form of family violence during their lifetimes [41]. Of those children exposed to IPV, 90% were direct eyewitnesses of the violence; the remaining children were exposed by either hearing the violence or seeing or being told about injuries [41].

A number of studies indicate that child witnesses are at increased risk for post-traumatic stress disorder, impaired development, aggressive behavior, anxiety, difficulties with peers, substance abuse, and academic problems than the average child [43; 44; 45; 137]. Men who are exposed to intimate partner violence are more likely to perpetrate violence in their lifetimes [138]. Children exposed to violence may also be more prone to dating violence (as a perpetrator or a victim), and the ability to effectively cope with partnerships and parenting later in life may be affected, continuing the cycle of violence into the next generation [46; 47]. Overall, children who witness domestic violence appear to display neurological and functional changes, placing them at increased risk of developing hypertension, diabetes, and cardiovascular conditions later in life [137].

In addition to witnessing violence, various studies have shown that these children may also become direct victims of violence, and children who both witness and experience violence are at the greatest risk for adverse psychosocial outcomes [48]. Research indicates that between 30% and 60% of husbands who batter their wives also batter their children [49]. Moreover, victims of abuse will often turn on their children; statistics demonstrate that 85% of domestic violence victims abuse or neglect their children. According to the U.S. Department of Justice, between 1980 and 2008, 17.5% of all homicides against female adolescents 12 to 17 years of age were committed by an intimate partner [8]. Among young women (18 to 24 years of age), the rate is 42.9%. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them, compared with 54% in older age groups [50]. Accordingly, healthcare professionals who see young children and adolescents in their practice (e.g., pediatricians, family physicians, school nurses, pediatric nurse practitioners, community health nurses) should 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. Without such critical intervention, the cycle of violence will never end.

DOMESTIC VIOLENCE AND SEXUAL VIOLENCE IN SPECIAL POPULATIONS

ELDERLY

Abused and neglected elders, who may be mistreated by their spouses, partners, children, or other relatives, are among the most isolated of all victims of family violence. In a national study conducted by the National Institute of Justice in 2010, 4.6% of participants (community dwelling adults 60 years of age or older) were victims of emotional abuse in the past year, 1.6% physical abuse, 0.6% sexual abuse, 5.1% potential neglect, and 5.2% current financial abuse by a family member [51]. The estimated annual incidence of all elder abuse types is 2% to 10%, but it is believed to be severely under-measured. According to one study, only 1 in 14 cases of elder abuse are reported to the authorities [52]. In the National Intimate Partner and Sexual Violence survey, 23% of persons 70 years of age and older disclosed having experienced abuse by an intimate partner [139]. In addition, 57% experienced abuse by a person other than an intimate partner [139].

The prevalence rate of elder abuse in institutional settings is not clear. In a 2019 systematic study of elder residents in institutional settings, the most commonly reported abuse experienced in the previous 12 months was psychological (33.4%), followed by physical abuse (14.1%) and financial abuse (13.8%) [140]. In a 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 [53]. In a random sample survey, 24.3% of respondents reported at least one incident of elder physical abuse perpetrated by a nursing home staff member [54].

It is important to understand that the needs of older patients will increase, as will the numbers of elder victims of domestic violence. Because elder abuse can occur in family homes, nursing homes, board and care facilities, and even medical facilities, healthcare professionals should 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 [55].

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 in which 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 [55]. 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 should remain aware of the potential for abuse and keep a watchful eye on this particularly vulnerable group. Rapport is key in order to gain the trust of the victim. All elder abuse screening tools require trust and rapport to be effective [141].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.

(https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed May 9, 2022.)

Level of Evidence: I (Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.)

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER VICTIMS

Domestic violence exists in LGBT+ communities, and the rates are thought to mirror those of heterosexual women—approximately 25% [56]. However, women living with female intimate partners experience less IPV than women living with men. Conversely, men living with male intimate partners experience more IPV than do men who live with female intimate partners. In addition, 77% of IPV homicide victims reported in 2015 were transgender women or cisgender men [142]. This supports other statistics indicating that IPV is perpetrated primarily by men. A form of abuse specific to the gay community is for an abuser to threaten or to proceed with "outing" a partner to others [56].

Transgender individuals appear to be at particular risk for violence. According to a large national report, transgender victims of IPV were 1.9 times more likely to experience physical violence and 3.9 times more likely to experience discrimination than other members of the LGBT+ community [142]. In a study using 2011–2013 National College Health Assessment data involving more than 88,000 college students, transgender and bisexual students reported the highest levels of intimate partner violence [143]. These increased rates may be due to experiences with marginalization; the use of power and abuse are expressions of control and agency [143].

Because of the stigma of being LGBT+, victims may be reticent to report abuse and afraid that their sexual orientation or biologic sex will be revealed. In one study, the three major barriers to seeking help were a limited understanding of the problem of LGBT+ IPV, stigma, and systemic inequities [58]. Many in this community feel that support services (e.g., shelters, support groups, crisis hotlines) are not available to them due to homophobia of the service providers. Providers' responses can be dismissive to LGBT+ domestic violence victims [144]. The stigma experienced can exacerbate the domestic violence, with victims further isolating themselves and tolerating the abuse [145]. Healthcare professionals should strive to be sensitive and supportive when working with homosexual patients.

Twenty-six percent of transgender and gender non-conforming individuals have been physically assaulted and 10% have been sexually assaulted [59]. In a study of transgender women, 78.1% experienced gender-related psychologic abuse and 50% experienced gender-related physical abuse [60]. The Transgender Day of Remembrance is held in November of each year to memorialize those who were killed due to anti-transgender hatred or prejudice. In total, more than 375 murders worldwide were documented in 2021 alone, the most of any year on record; the actual count is likely much higher [61]. The National Center for Transgender Equality recommends that ending violence against transgender people should be a public health priority, because of the direct and indirect negative effect violence has on both victims and on the healthcare system that treats them.

INDIVIDUALS EXPERIENCING HOMELESSNESS

The intersection of homelessness and domestic and/or sexual violence is bidirectional and complex. Studies indicate up to 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives, and as many as 57% of all homeless women report domestic violence as the immediate cause of their homelessness [62; 63; 64]. Furthermore, victims of stranger-perpetrated violence are more likely to have been homeless on multiple occasions [146].

Homeless domestic violence victims face unique barriers to accessing help, including affordable housing, as a result of actions of their perpetrator. They may face housing discrimination, lack stable employment histories, and have poor credit as a result of their abuse histories [62]. In addition, a study published by the National Online Resource Center on Violence Against Women found that homeless women are "particularly vulnerable to multiple forms of interpersonal victimization, including sexual and physical assault at the hands of strangers, acquaintances, pimps, sex traffickers,

and intimate partners on the street, in shelters, or in precarious housing situations" [63]. The sexual assault experiences of homeless women are more likely to be violent and include multiple sexual acts than women with housing [65].

Because homeless victims of violence face specific barriers to seeking and receiving services, interventions and assistance should be targeted to their specific needs. Homeless young adults who are sexually assaulted, for example, are reluctant to obtain a post-assault exam in part because they fear of getting involved in the legal system [147]. It is also important to remember that additional marginalizing factors (e.g., gender/sexual minority status, geographic isolation) compound the problems experienced by survivors.

PEOPLE WITH PHYSICAL AND/OR COGNITIVE DISABILITIES

Research indicates that disability predicts recent intimate partner violence victimization in both men and women [66]. National data indicate that women with a disability are significantly more likely to report experiencing every form of intimate partner violence, including rape, other sexual violence, physical violence, stalking, psychologic aggression, and control of reproductive or sexual health [66]. Stalking and psychologic aggression by an intimate partner are more likely in men with disabilities. Women with disabilities are 3.3 times more likely to be raped [133]. Most perpetrators are acquaintances of the victim [67].

The type of disability may also be an indicator or risk. In a national sample of victims of sexual assault who were disabled, the majority (60.5%) had a psychiatric disability and 25% had an intellectual/developmental disability; the smallest percentage (15.6%) had physical/sensory disabilities [67]. People with intellectual disabilities are sexually assaulted at a rate seven times higher than those without disabilities [68]. A survey study found that individuals with autism were more likely to have experienced physical and sexual violence when they were children, and they were not likely to have disclosed the incidence(s) [148].

Although persons with disabilities are more likely to be victimized, it can be difficult for them to seek and obtain help. Legal action was taken in only 13.6% of cases [67]. Differently able individuals may be less likely to be believed when they report abuse or may be unable to effectively communicate their experiences [69]. Police and prosecutors are often reluctant to take these cases because they are difficult to win in court [68]. In addition, there is a lack of coordinated community services and supports for disabled survivors of sexual assault [67].

PEOPLE WITH BEHAVIORAL HEALTH PROBLEMS

Behavioral health problems, including substance use disorders, eating disorders, and compulsive behaviors, commonly co-occur with intimate partner violence and sexual violence. According to the American Society of Addiction Medicine, substance abuse co-occurs in 40% to 60% of IPV incidents, with several lines of evidence suggesting that substance use/abuse plays a facilitative role in IPV by precipitating or exacerbating violence [70]. Both victims and abusers are 11 times more likely to be involved in domestic violence incidents on days of heavy substance use [71]. Opioid misuse and intimate partner violence are correlated; women who have experienced IPV and sexual violence are more likely to use opioids [149].

It is unclear if substance abuse precedes the violence, or vice versa. However, victimization is considered a positive risk factor for substance use disorders, and women in abusive relationships have often reported being coerced into using alcohol and/or drugs by their partners [70].

Women with a history of eating disorders are also at increased risk for intimate partner violence [72]. In a study of undergraduate women, recent (i.e., last three months) sexual assault was associated with more severe eating disorder symptoms [73; 74]. In another study, eating disorders were significantly correlated with lifetime intimate partner violence, PTSD, and depression among female participants [150].

CHILDREN AND ADOLESCENTS

Dating Violence

Perpetrators of dating violence among young adults include witnessing interparental violence, experiencing child abuse, alcohol abuse, adherence to traditional gender roles, and relationship power dynamic issues [75]. Female perpetrators are more likely than men to display internalizing symptoms (e.g., depression), trait anger and hostility, and to be victims of past dating violence; young male perpetrators are more likely than women to report lower socioeconomic status and educational attainment, antisocial personality characteristics, and increased relationship length [75].

Cyberdating abuse or violence refers to abusive behaviors perpetrated using technology that occur in the dating context. In general, the control tactics are similar regardless of whether technology is involved [151]. Forms of sexual cyber abuse include sending unwanted sexual content, pressuring someone to send nude photos, and using technology to engage in sexual encounters [151]. Technologically mediated sexual violence can predict real-life violence. In fact, sexting has been identified as a unique risk factor for dating violence in young adulthood [76].

Young women are more likely than men to experience dating violence, as is the case among most subgroups. However, nonsexual violence in dating relationships is more likely to involve the reciprocal use of violence by both partners (mutual aggression) than adult abusive relationships [77]. Additional risk factors for dating violence include low self-esteem, substance use disorder, depression, isolation, pornography use, and hooking up for sex [144].

Sexual Assault

In contrast to sexual victimization of adolescents and adults, who usually present in the aftermath of an assault, pre-pubertal victimization of children tends to be "discovered" when the child is found to have signs of physical or sexual abuse (e.g. genital injury or scarring) or when a sexually transmissible infectious agent is identified. Gonorrhea, syphilis, and HIV (not linked to prior blood transfusion or maternofetal transmission) acquired during the postnatal period of childhood are indicative of sexual abuse. *Chlamydia* infection might be indicative of sexual abuse in children 3 years of age of older. Sexual abuse should be suspected when genital herpes, *Trichomonas vaginalis*, or anogenital warts are diagnosed [28]. In cases in which any STD has been diagnosed in a child, further evaluation for other STDs and for the possibility of sexual assault/abuse should be made in consultation with a specialist.

Just as the identification of a sexually transmissible infection in a child raises suspicion for prior sexual assault/abuse, so too does known or suspected childhood sexual assault/abuse warrant an assessment for STDs. The decision to perform a diagnostic evaluation and to collect vaginal or other specimens should be made on an individual case basis. Among factors to consider in the decision to screen a child for STDs are [28; 78]:

- Child has experienced penetration or has evidence of recent or healed penetrative injury.
- The perpetrator of the abuse is a stranger.
- The perpetrator is known to have an STD or is at high risk for STDs.
- Child has a relative or another person in the household with an STD.
- Child has symptoms or signs of active infection (e.g., vaginal discharge or pain, genital itching or odor, genital lesions or ulcers).
- Child or parent requests STD testing.

The physical examination and collection of vaginal specimens is often frightening or uncomfortable for a child and should be conducted by an experienced clinician. The CDC and the American Society of Pediatrics provide updated guidance for healthcare providers involved in the evaluation of childhood sexual assault/abuse.

LOW-INCOME POPULATIONS

As with most sociodemographic risk factors for domestic and sexual violence, the correlation between lower socioeconomic status and violence is potentially bidirectional. Economic abuse (considered a form of intimate partner violence) may precede more severe forms of physical and sexual violence. Women who are financially dependent on their abusers are less able to leave and more likely to return to an abusive relationship, particularly if they are financially dependent on their abusers [79; 152]. Greater economic dependence is associated with more severe abuse and homicide by an intimate partner [153].

Financial instability is also a potential adverse effect of intimate partner violence. Current or past exposure to violence has been found to negatively affect ability to sustain stable employment, and women in abusive relationships frequently lose their jobs, experience high job turnover, are forced to quit, or are fired [80].

Victims of sexual violence also experience short- and long-term economic consequences, and low-income individuals are more vulnerable. Victims exceed non-victims in the average number and cost of medical care visits. Beyond medical costs, there are productivity costs and other long-term costs to victims and their families such as pain and suffering, trauma, disability, and risk of death. Sexual violence and the trauma resulting from it can have an impact on the survivor's employment in terms of time off from work, diminished performance, job loss, or being unable to work. These impacts disrupt earning power and have a long-term effect on the economic well-being of survivors [81].

PEOPLE LIVING IN RURAL COMMUNITIES

A large national study found that lifetime intimate partner violence victimization rates in rural areas (26.7% in women, 15.5% in men) are similar to the prevalence found among men and women in non-rural areas [82]. There is some evidence that intimate partner homicide rates may be higher in rural areas than in urban or suburban locales [83; 153].

Substance use disorders and unemployment are more common among IPV perpetrators in rural areas [83]. It has been suggested that IPV in rural areas may be more chronic and severe and may result in worse psychosocial and physical health outcomes. Poverty in rural areas is also associated with an increased risk for IPV victimization and perpetration for both men and women [84]. Residents of rural areas are less likely to support government involvement in IPV prevention and intervention than urban residents [83].

Although the rates are similar, the risk factors, effects, and needs of rural victims are unique. For example, research indicates that rural women live three times further from their nearest IPV resource than urban women. In addition, domestic violence programs serving rural communities offer fewer services for a greater geographic area than urban programs [85].

Not only do rural women experience geographic isolation, they tend to be socially isolated as well. Because rural communities tend to be tight-knit, there can be more stigma and ostracism when residents reach out for assistance [154].

It is important to assess victims' proximity to available resources and to help in times of crisis. Rural victims may benefit from improved access to services, including technology-based outreach (e.g., videoconferencing, telehealth programs) [86]. In rural areas, there may also be fewer sexual assault nurse examiners or the requirements for qualification and training may be absent or inconsistent [155].

IMMIGRANTS AND REFUGEES

A variety of persons migrate to the United States, including legal immigrants granted the indefinite or time-limited right to live in the United States by immigration authorities; undocumented immigrants who have not been granted such a right; and refugees who are unable or unwilling to return to their country of origin due to fears of persecution based on their race or ethnicity, religion, nationality, political opinion, or gender identity or sexual orientation. For simplicity, all three groups are referred to as immigrants [87].

Recent immigrants are at increased risk for violence victimization. In one study of Chinese immigrants in the United States, acculturation and socioeconomic status were associated with severity, frequency, length, and type of abuse [88]. Persons who are displaced due to conflict in their home countries are also vulnerable to sexual violence. Studies indicate that approximately one in five refugees or displaced women in complex humanitarian settings have experienced sexual violence, but this is likely an underestimation [89]. Refugees may also experience torture and sexual violence prior to being displaced. Among male survivors, sexual torture is substantially under-reported, and estimates indicate that 5% to 15% of male survivors were sexually abused by threats of castration or rape, being raped or forced to perform sex in view of others, or receiving electric shock or mutilation to the genitals [90; 91]. Fewer women than men are tortured in aggregate, but around 50% of female torture survivors report sexual torture, typically by rape and sometimes in front of family members [92; 93; 94]. Studies also show that sexual violence victimization is more likely while in transit to a host country [156]. Sexual and gender minority migrants may feel they need to conceal their identities for fear of sexual harassment and possible violence [156].

Immigrants tend to underuse health services, especially undocumented immigrants, who typically lack health insurance and may avoid seeking medical attention out of fear of being deported. Immigration status and the inability to understand domestic violence within given cultural norms are major barriers to help-seeking among recent immigrants [95]. They may also face language barriers, exacerbating an inability to seek help and lack of trust in health and social services. When migrants do seek help, access to interpreters may be limited [157]. The Violence Against Women Act puts some protections in place for noncitizen women, including the ability to self-petition for citizenship (instead of requiring a citizen sponsor) and immigration relief to victims of sexual/other violence or human trafficking [96]. Access to bilingual and culturally appropriate services is also a major concern.

PEOPLE OF COLOR

In the United States, intimate partner violence disproportionately affects women of color [97]. Black and multiracial non-Hispanic women have significantly higher lifetime prevalence of rape, physical violence, or stalking by an intimate partner [98]. Black, American Indian or Alaska Native, and multiracial non-Hispanic men have a significantly higher lifetime prevalence of rape, physical violence, or stalking compared with White non-Hispanic men. These findings may be a reflection of the many stressors that racial and ethnic minority communities continue to experience. For example, a number of social determinants of mental and physical health, such as low income and limited access to education, community resources, and services, likely play important roles. These factors and medical mistrust, historical racism and trauma, perceived discrimination, and immigration status may affect help seeking and the assessment of victims [97; 158]. Level of acculturation should also be taken into account. Some studies have found there is a relationship between acculturation and interpersonal intimate violence. It is possible that as racial and ethnic minority women are exposed to Western norms, they are less likely to adhere to traditional gender roles. As they challenge these cultural norms, they are at increased risk of abuse [159].

When race and ethnicity are considered, it is important to remember that there is great diversity within these groups. Certain factors may be generally applicable, but there may be unique contributions by ethnic sub-group [99].

PERPETRATORS OF DOMESTIC/ SEXUAL VIOLENCE

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 [100]. Domestic violence assessment questionnaires should include questions that explore social drinking habits of both victims and their mates.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the abuser's dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [101]. Domestic violence victims frequently report that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing and often includes maintaining complete control of finances and activities of the victim (e.g., work, school, social interactions) [101].

In addition, abusers often suffer from low self-esteem and their sense of self and identity is directly connected to their partner [101]. Borderline personality disorder, characterized by impulsivity, fluctuation of emotions, and instability in sense of identity and interpersonal relationships, has been identified as a risk factor for perpetrating domestic violence [160].

Extreme dependence is common in both abusers and those being abused. Due to low self-esteem and self-worth, emotional dependence often occurs in both partners, but even more so in the abuser. Emotional dependence in the victim stems from both physical and psychologic abuse, which results in a negative self-image and lack of self-worth. Financial dependence is also very common, as the abuser often withholds or controls financial resources to maintain power over the victim [102].

In some cases, a perpetrator and victim will seek help together (joint or couples counseling) to resolve issues in their relationship. Some domestic-violence-focused joint counseling approaches have been described [103]. However, many organizations, including the National Domestic Violence Hotline, the Department of Justice, the American Bar Association, and Futures Without Violence, recommend against joint counseling for violent couples due to the risk of additional harm to and isolation of the victim [104; 105]. A better option for abusive partners is battering intervention and prevention programs.

ASSESSMENT AND SCREENING METHODS

SCREENING

There is no universal guideline for identifying and responding to domestic violence, but it is universally accepted that a plan for screening, assessing, and referring patients of suspected abuse should be in place at every healthcare facility. Guidelines should review appropriate interview techniques for a given setting and should also include the utilization of assessment tools. Furthermore, protocols within each facility or healthcare setting should include referral, documentation, and follow-up. This section relies heavily on the guidelines outlined in the Family Violence Prevention Fund's National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings; however, protocols should be customized based on individual practice settings and resources available [49]. The CDC has provided a compilation of assessment tools for healthcare workers to assist in recognizing and accurately interpreting behaviors associated with domestic violence and abuse, which may be accessed at https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf [106].

In a study with 170 nurses, 56% stated that they have almost never screened their patients for domestic violence [161]. Several barriers to screening for domestic violence have been noted, including a lack of knowledge and training, time constraints, lack of privacy for asking appropriate questions, disruption to normal routines, lack of organizational policies, lack of supervision, personal discomfort, and the sensitive nature of the subject [49; 130; 161]. Although awareness and assessment for IPV has increased among healthcare providers, many are still hesitant to inquire about abuse [107]. At a minimum, those exhibiting signs of domestic violence should be screened. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen and musculoskeletal injuries. These are often distinguishable from accidental injuries, which are more likely to involve the extremities of the body. Abuse victims are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen, particularly in combination with evidence of old injury, physical abuse should be suspected [100].

As a result of prolonged stress, various psychosomatic symptoms that generally lack an organic basis often manifest. For example, complaints of backaches, headaches, and digestive problems are common. Often, there are reports of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical. Women who experience IPV are also more likely to report asthma, irritable bowel syndrome, and diabetes [3]. Healthcare professionals should look beyond the typical symptoms of a domestic violence victim and work within their respective practice settings to develop appropriate assessment mechanisms to detect victims who exhibit less obvious symptoms.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process. Trauma-informed practices include [108]:

- Reflecting an understanding of trauma and its many effects on health and behavior
- Addressing both physical and psychologic safety concerns
- Using a culturally informed, strengths-based approach
- Helping to illuminate the nature and effects of abuse on victims' everyday experience
- Providing opportunities for patients to regain control over their lives

Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include [109]:

- Trauma-related symptoms
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders)
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences)
- Substance abuse
- Social support and coping styles
- Availability of resources
- Risks for self-harm, suicide, and violence
- Health screenings

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Intimate Partner Violence Screening Tool, focus on acknowledging a specific type of traumatic event [109]. These tools may be used to screen and assess for the presence of adverse or traumatic life experiences. However, it is not necessary to use a formal tool to screen for trauma and exploration of trauma should be done by trained, experienced, and skilled staff. This process requires a safe, comfortable, and respectful environment and a trusting, caring relationship.

ASSESSMENT OF IMMEDIATE SAFETY FOR DOMESTIC VIOLENCE VICTIMS
Are you in immediate danger?
Is your partner at the health facility now?
Do you want to (or have to) go home with your partner?
Do you have somewhere safe to go?
Have there been threats or direct abuse of the children (if s/he has children)?
Are you afraid your life may be in danger?
Has the violence gotten worse or is it getting scarier? Is it happening more often?
Has your partner used weapons, alcohol or drugs?
Has your partner ever held you or your children against your will?
Does your partner ever watch you closely, follow you or stalk you?
Has your partner ever threatened to kill you, him/herself or your children?
Source: [49] *Table 3*

Terms such as "violence," "abuse," and "battering" should be avoided, as patients may not identify with these terminologies and they can be stigmatizing [162]. As mentioned previously, it is not necessary for an individual to disclose painful experiences to be helped. By using universal precautions and treating all people as if they have been exposed to trauma and by using trauma-informed approaches, healing and recovery can be promoted [110].

Universal Trauma-Informed Education

A trauma-informed approach to screening and care of victims of violence creates a space that is supportive, safe, and conducive to healing. Trauma-informed care principles emphasize that trauma affects many dimensions of an individual's and their family's lives. Practitioners should be mindful that triggers in the environment can result in retraumatization, and their responses can also inadvertently retraumatize the victim [163]. Therefore, universal trauma-informed education focuses less on formalized screening tools and checklists and more on creating spaces in which traumatic experiences are freely discussed. The space should be safe and there should be no distractions so the practitioner can actively listen and engage with the victim [163]. In this approach, the practitioner conveys universal information about intimate partner violence, in some cases tailored to the specific setting or patient population [111]. These settings "facilitate disclosure for victims of IPV and meet disclosure with empathy, competence, and appropriate referrals" [111]. This approach can be used in any healthcare or human services setting.

ASSESSMENT

Healthcare providers have reported that even if routine screening and inquiry results in a positive identification of IPV, the next steps of assessing and referring are often difficult, and many feel that they are not adequately prepared [107]. According to the Family Violence Prevention Fund, the goals of the assessment are to create a supportive environment, gather information about health problems associated with the abuse, and assess the immediate and long-term health and safety needs for the patient to develop an intervention [49].

Assessment of domestic violence victims should occur immediately after disclosure of abuse and at any follow-up appointments. Assessing immediate safety is priority. Having a list of questions readily available and well-practiced can help alleviate the uncertainty of how to begin the assessment (***Table 3***). If the patient is in immediate danger, referral to an advocate, support system, hotline, or shelter is indicated [49].

If the patient is not in immediate danger, the assessment may continue with a focus on the impact of IPV on the patient's mental and physical health and the pattern of history and current abuse [49]. These responses will help formulate an appropriate intervention.

Culturally Sensitive Assessment

Many trauma-related symptoms and disorders are culture specific, and a patient's cultural background should be considered in screening and assessment [109]. During the assessment process, a practitioner should be open and sensitive to the patient's worldview, cultural belief systems and how he/she views the illness [112]. Assessment tools should be culturally appropriate for the patient, whenever possible. This may reduce the tendency to overpathologize or minimize health concerns of ethnic minority patients.

Pachter proposed a dynamic model that involves several tiers and transactions [113]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional should 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 [113]. 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 patient and the professional [113]. 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. 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.

Sexual Assault Victims

Given the societal context of sexual assault reporting, the practitioner should accept the person's account of his or her traumatic experience without investigating the authenticity of the claims. Victims/survivors may anticipate disbelief and denial from the clinician due to past negative responses to their disclosures from friends, family, or the criminal justice system.

Practitioner gender should also be considered when working with sexual assault survivors. Avoid assuming that a female or male patient will prefer a practitioner of either the same or the opposite gender. Instead, discuss this issue with the patient and, if possible, let him or her choose the provider gender [114].

The proper clinical assessment of a person who has been sexually assaulted requires a systematic, patient, and thorough approach. It is of necessity time-consuming and should be conducted with sensitivity and respect for the patient's emotional state. Preferably, providers who have been specifically trained for this task should perform the initial clinical examination. More than 500 hospitals and other health facilities in the United States have now addressed this need by adopting the sexual assault nurse examiner (SANE) program. A SANE is a trained nurse specialist who works within an interdisciplinary team to carry out a general and forensic clinical examination of the sexual assault patient and to develop a strategy for support and after-care [115].

The evaluation and treatment of sexual assault victims should incorporate the following components [115; 116]:

- General assessment and treatment of physical injuries, with special attention to the genitalia
- Forensic evaluation, where indicated and with informed consent
- Pregnancy risk assessment and prevention
- Evaluation, treatment, and prevention of STDs
- Psychologic assessment, crisis intervention, and follow-up referral for counseling

As discussed, when appropriate, a trauma-informed approach should be used for victims of sexual violence—during both physical and psychologic assessments.

Ending Assessments and Safety Planning

In some contexts of repeated trauma exposure, victims presenting for treatment may remain vulnerable to ongoing threat and further trauma. With victims of domestic violence and victims of sexual assault perpetrated in their current job setting or by an intimate partner, treatment may be affected by returning to unsafe environments. In the presence of ongoing risk, interventions should initially focus on ensuring safety, stabilization, and symptom management, instead of initiating the trauma-focused components of treatment. Ensure, to the extent possible, the safety, security, and survival needs of the patient by helping secure food, hydration, clothing, hygiene, and shelter. This will include promoting patient stabilization and the importance of sleep and replacing medications that are destroyed or lost. Patients also benefit from education on the process they are experiencing. There are apps developed to help with safety planning, including myPlan (https://www.myplanapp.org) and docuSAFE (https://www.techsafety.org/docusafe) [164].

Patients should be counseled regarding limiting ongoing harm by reducing the use of alcohol, tobacco, caffeine, and illicit psychoactive substances, if needed. Family, friends, and community resources should be identified. From the initial point of contact onward, it is vital to establish a working treatment alliance with the patient and maintain a supportive, non-blaming, nonjudgmental stance [114; 117].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The World Health Organization asserts that women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support.

(https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf. Last accessed May 9, 2022.)

Level of Evidence: Strong/Indirect Evidence

It is important to note that general safety planning does not take into account the specific needs of victims who fall into vulnerable populations or affected children [118]. Because these individuals are at higher risk of marginalization and oppression, they may feel powerless to execute a safety plan. It is important for practitioners to assess each victim and his/her readiness to change, circumstances, resources, and needs in order to tailor a specific safety plan [119]. Victims often feel they would have to sacrifice too much in order to be safe or that choosing safety would result in new problems [165].

BEST PRACTICES IN FOLLOW-UP CARE FOR VICTIMS OF VIOLENCE

Many victims of domestic and sexual violence do not seek help for fear of retaliation, lack of knowledge regarding access services, or fear of being blamed or punished [166]. When they do seek help, practitioners should be careful not to inadvertently retraumatize. After ensuring a safe environment, it is imperative that healthcare professionals document all findings and recommendations regarding domestic violence in the victim's medical record, including a patient's denial of abuse, if applicable. If domestic violence is disclosed, documentation should include relevant history, results of the physical examination, findings of laboratory and other diagnostic procedures, and results of the assessment, intervention, and referral. The medical record can be an invaluable document in establishing the credibility of the victim's story when seeking legal aid [49].

Healthcare professionals should offer a follow-up appointment if disclosure of past or current abuse is present. Reassurance that assistance is available to the patient at any time is critical in helping to break the cycle of abuse [49].

In addition to providing acute care and scheduling follow-up appointments, providers should connect victims of violence with available resources. 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.

After a victim is introduced into the system, counseling and follow-up is generally available by individual counselors who specialize in the care of domestic/sexual violence victims. 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 victims who are unsure of their options.

BUILDING EFFECTIVE COMMUNITY PARTNERSHIPS AND COLLABORATIONS WITH COMMUNITY-BASED AGENCIES

Domestic and sexual violence impact many domains of a victim's life, and collaboration between health, mental health, social service, forensic, law enforcement, and community-based agencies is vital to providing the best possible care and support. Community agencies provide services such as 24-hour hotlines, shelter, support groups, counseling, and legal advocacy. These agencies and the specialized services they provide for victims of sexual and domestic violence are essential [120].

Interprofessional collaboration provides the opportunity to make effective system changes because agencies partner together by aligning complementary and supplementary services and skills to coordinate multi-systems level services to victims [167]. Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients/patients and their families to improve health, mental health, and social and/or family outcomes [168]. This approach can be particularly helpful for certain vulnerable subpopulations.

In a qualitative study, all of the stakeholders felt that interprofessional collaboration was beneficial in cases of domestic/sexual violence, resulting in more coordinated and integrated services [169].

When interprofessional collaboration is working well, practitioners are able to focus more fully on their tasks while remaining confident that other services are being provided.

Despite these positive outcomes, there are challenges. In order to share responsibilities, all parties must respect and trust their colleagues' roles and expertise. To this end, it is important to be very clear about each professional's skills, competencies, and expectations. Communication is vital in helping to define boundaries and parameters [169].

APPROPRIATE RESPONSES AND DOCUMENTATION

Healthcare and mental health professionals involved in the care of patients who have been victims of abuse should fully document suspected abuse, assessment results, any evidence of abuse, and interventions/safety planning in the patient's record or clinical notes. Bruises are less visible on persons with darker skin, and documentation may not necessarily accurately represent the severity of the abuse [170]. All aspects of patient assessment, documentation, safety planning, communication, intervention, and follow-up should take into account the immediate and long-term safety of the victim and any dependents [123].

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

- Encourage the victim to be aware of weapons in the residence.
- 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, victims should save some money in a private bank account or hide money for escape. Victims should be informed that if the abuser finds out about a separate bank account, they 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.
- Victims should check security settings on devices and change passwords.

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

Ideally, the victim of a sexual or physical assault should be offered a formal forensic evaluation; this requires written documentation of informed consent. Injuries should be documented in photographs, diagrams, or sketches. A growing number of hospitals now employ dedicated forensic nurses, including SANEs, as part of a multispecialty sexual assault team [115].

SANEs have completed specialized training in the medical forensic care of the patient who has experienced physical violence, abuse, or sexual assault. An important component of the care offered by the SANE is the medical forensic examination. This consists of a medical forensic history, a detailed physical and emotional assessment, written and photographic documentation of injuries, and collection and management of forensic samples. The SANE is trained to ensure that evidence is collected and documented according to established

protocol and local jurisdiction procedures and that the "chain of custody" is properly maintained in the event of later legal proceedings. Evidence collection kits designed for this purpose are available commercially or, in some states, may be obtained through designated distribution centers. Medically trained rape crisis advocates typically accompany SANEs to provide support, information, and follow-up guidance to victims [123].

Often, however, these trained specialists are not the first professionals to interact with the patient. Consequently, all healthcare professionals, particularly those in an emergency care setting, should have an understanding of the principles that govern proper collection and preservation of evidence during the examination of an assault victim. At stake is the successful prosecution of the assault perpetrator, which often is compromised by insufficient or improperly collected evidence or by not following evidence through the chain of custody.

LEGAL INTERVENTIONS

Domestic violence victims can obtain protective orders through a civil proceeding [42]. Until the enactment of Pennsylvania's Protection of Abuse Act in 1976, only two states had protective order legislation [42]. Protective orders 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 [42].

Protective orders do not require the involvement of the police and involve actions intended to protect the victim, including ensuring continuation of health insurance and removal of firearms [171]. In an analysis of 607 protective orders issued in Arizona, the most frequent request was that the petitioner's home be protected [171]. Victims can file for a temporary or permanent protective order. A temporary protective order does not require the abuser to be present. These orders last about 30 days or until a court date is scheduled. A permanent protective order requires both the victim and abuser to be present in court. Permanent protective orders last for about 12 months [121].

Laws for dating violence are different. All 50 states and the District of Columbia have state laws related to dating violence. However, the term "dating violence" is not used. Instead, the following terms are used: "sexual assault," "domestic violence," and "stalking" [122]. Only 39 states and the District of Columbia offer the option of protective orders for dating violence victims. The National Center for Victims of Crime is a resource to obtain additional information about state laws.

For more information about legal interventions, state coalitions for domestic violence can be contacted. The American Bar Association has compiled a list of domestic violence state coalitions. Although, the American Bar Association Commission on Domestic and Sexual Violence suggests victims do Internet searches for local domestic violence resources, they caution them to use a local library or go to a friend's home where they can access a computer without the abuser being able to track Internet and email activities [123].

CASE MANAGEMENT

Because abused women often suffer physical injuries, they will likely seek care from a healthcare professional who can make referrals to counseling services. Some women seek counseling on their own. After identifying victims and their abusers, mental health professionals should immediately implement a plan of action that includes providing referrals for available community services and safe havens to assist the victim and the victim's family.

Most abused women are in ongoing danger when seeking help. If they decide to leave, the risk factors increase significantly [124]. Accordingly, if the victim consents, acute situations should be referred immediately to local law enforcement officials. Other resources include crisis hotlines

and rape relief centers. After victims are in the system, counseling and follow-up is generally available through victims of crime programs. A list of approved services is provided and includes social workers, marriage and family therapists, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make resources accessible and safe and to enhance support for crime victims who are unsure of their options [125].

Assisting crime victims is essential. Coordinating and accessing an array of social service benefits, which include mental health counseling, healthcare, legal and advocacy services, and other public benefits, is crucial. Consequently, it is vital for professionals to establish relationships with community organizations and be acquainted with appropriate contact persons. When working with diverse cultural and ethnic groups, it is also important to develop relationships with culturally sensitive and bilingual professionals who can provide appropriate interventions.

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. Victims at shelters often represent different stages of victimization. In addition, an average of five to seven attempts are necessary before a victim is able to successfully leave an abusive environment/partner. Therefore, the needs of each domestic violence victim are unique [172].

To access shelter information by geographic region, there is a valuable website sponsored by the Office for Victims of Crime. The Directory of Crime Victim Services is available at https://ovc.ojp.gov/directory-crime-victim-services. This is a search engine that allows resources and services to be located by state.

RESOURCES

Futures without Violence
https://www.futureswithoutviolence.org

MilitaryOneSource
https://www.militaryonesource.mil/leaders-service-providers/child-abuse-and-domestic-abuse

National Coalition Against Domestic Violence
https://ncadv.org

National Domestic Violence Hotline
1-800-799-7233
1-855-812-1011 (VP)
1-800-787-3224 (TTY)
https://www.thehotline.org

Office on Violence Against Women
https://www.justice.gov/ovw

National Network to End Domestic Violence (NNEDV)
https://nnedv.org

National Sexual Violence Resource Center
https://www.nsvrc.org

Rape, Abuse, and Incest National Network (RAINN)
1-800-656-4673
https://www.rainn.org

National Center for Victims of Crime
https://victimsofcrime.org

The Network/La Red
https://tnlr.org

Matahari Women Workers' Center
https://www.mataharijustice.org

Victim Rights Law Center
https://www.victimrights.org

WomensLaw
https://www.womenslaw.org

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