



Intimate Partner Violence

Three (3.0) Contact Hours
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Acknowledgments

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Purposes & Objectives

The purpose of this course is to provide information about the definition and effects of intimate partner violence (IPV), how to screen for IPV in the healthcare setting, and how to provide appropriate nursing interventions. The course includes information about responding to and documenting abuse, making appropriate referrals within the healthcare setting and in the community, and developing an appropriate safety plan.

After successful completion of this course, you will be able to:

1. Define intimate partner violence.
2. Identify common mental and physical health effects of IPV.
3. Identify the rationale for routine assessment of women for IPV in the healthcare setting.
4. Describe key components of a physical and mental health assessment for abused women.
5. Identify appropriate community and healthcare referrals for abused women.

Introduction

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans, regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background (American Congress of Obstetricians & Gynecologists [ACOG], (2012)). The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse (Centers for Disease Prevention & Control [CDC], 2013). It occurs on a continuum, ranging from one episode to chronic, severe battering. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

The goal is to stop IPV before it begins. There is a lot to learn about how to prevent IPV. We do know that strategies that promote healthy behaviors in relationships are important. Programs that teach young people skills for dating can prevent violence. These programs can stop violence in dating relationships before it occurs.

What is IPV?

Intimate partner violence (IPV) is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion (Family Violence Prevention Fund, 2010 in ACOG, 2012).

These types of behavior are perpetrated by someone who is, or was, involved in an intimate or dating relationship with an adult or adolescent, and is aimed at establishing control of one partner over the other (Family Violence Prevention Fund, 2010 in ACOG, 2012).

IPV can occur among heterosexual or same-sex couples and can be experienced by both men and women in every community regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death.

Legal Definitions of Intimate Partner Violence

It is important to recognize that the legal definitions of "intimate partner violence" may be different from that given in this course. Many states do not consider couples who are dating, but have never lived together and do not have children together, to be intimate partners. Some states do not recognize same-sex partners, regardless of their relationship status, to be intimate partners.

Furthermore, each state's legal code has different definitions of the kinds of behaviors it recognizes as abusive, and may only consider the most extreme forms of violence and sexual assault to be criminal.

Your facility, local police, and domestic violence shelters and hotlines can give you specifics for your state.

Different terms are often used to indicate intimate partner abuse. They include:

- Domestic violence
- Spousal or woman abuse

- Battering
- Dating violence
- Couple violence

Legal Definitions of Intimate Partner Violence

In this course the term “intimate partner violence” is used because it is the most inclusive.

“**Partners**” can be married men and women, formerly married men and women, boyfriends and girlfriends who are dating or living together, or used to date or live together, or same-sex couples who are currently dating or living together, or who dated or lived together in the past. Any couple, who has had a child together, regardless of their current or former status as a couple, is also considered “intimate partners.”

“**Domestic**” implies that the pair shares a home, which may not always be the case.

“**Spousal**” implies that the pair is married.

“**Battering**” implies only serious physical violence.

Some intimate partners may not be a “couple” and “woman abuse” does not include the men who are in abusive relationships with other men or women.

Although IPV terminology usually refers to physical violence (and threats thereof); it also encompasses emotional abuse and coercive and controlling behavior.

Test Yourself

Intimate Partner Violence includes:

Couple violence

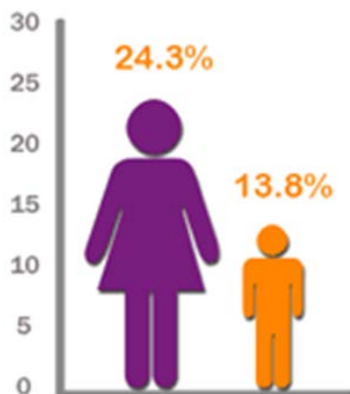
Battering

Dating violence

All of the above- **Correct!**

Statistics

Among victims of intimate partner violence, about 1 in 4 women (24.3%) and 1 in 7 men (13.8%) have experienced severe physical violence by an intimate partner (e.g., hit with a fist or something hard, beaten, slammed against something) at some point in their lifetime (CDC, 2013).



(CDC, 2013).

What Do The Numbers Mean?

According to Domestic Violence Statistics, a woman is assaulted or beaten every 9 seconds in the

U.S. Domestic violence is the leading cause of injury to women; more than car accidents, muggings, and rapes combined.

More than three women are murdered daily by their husbands or boyfriends in the U.S. The costs of intimate partner violence in the US alone exceed \$5.8 billion per year: \$4.1 billion are for direct medical and health care services, while productivity losses account for nearly \$1.8 billion.

Men who as children witnessed their parents' domestic violence are twice as likely to abuse their own wives than sons of non-violent parents.

(Domestic Violence Statistics, 2013)

These findings emphasize that sexual violence, stalking, and intimate partner violence are significant and widespread public health problems in the United States.

Based on a survey conducted in 2010, the CDC found that on average, 24 people per minute are victims of rape, physical violence, or stalking by an intimate partner in the United States (CDC, 2013). Over the course of a year, that equals more than 12 million women and men. Those numbers only tell part of the story; more than 1 million women are raped in a year and over 6 million women and men are victims of stalking in a year (CDC, 2013).

Populations Affected by IPV

Adolescents

Adolescents are at increased risk for IPV due to their inability to maintain a balance of power in an intimate relationship. According to Silverman et al (2004), approximately one in ten female high school students in the United States report experiencing physical violence from their dating partners (ACOG, 2012). Of those who reported ever having sexual intercourse, one out of five girls experienced dating violence (ACOG, 2012).

It is important for adolescents to learn to be assertive in dating relationships and be able to recognize behavior that attempts to maintain power and control in a relationship. Examples of controlling behavior are attempts to monitor cell phone usage, digital dating abuse (stalking social networking sites and / or posting nude pictures against a person's will), controlling choice of clothing, friends or attendance at social interactions.

Immigrant women

Immigrant women are at increased risk of intimate partner violence for several reasons. Immigrant women may be hesitant to report abuse due to fears of deportation. They also may have language barriers, cultural issues and lack of self-esteem that predispose them to being a victim of violence.

Women with Disabilities

Women with physical and developmental issues are less able to care for themselves and are more likely to become victims of intimate partner violence (ACOG, 2012). When an adult is dependent on someone to meet their basic needs, the potential for an imbalance in power in the relationship exists. Abusers can wield power over their victims by withholding medication and / or food, obstructing the use of assistive equipment and withholding assistance in meeting basic needs such as bathing and eating.

In addition, many shelters do not accept women with disabilities, as they do not have the resources to meet their needs (ACOG, 2012).

Older Women

According to the National Center on Elder Abuse (2013), between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection. However, there is no typical victim of elder abuse. Elder abuse occurs in all racial,

social, educational, economic and cultural setting (ACOG, 2012). Intimate partner violence is only one type of abuse older women may suffer from. Other forms of abuse can be non-sexual physical abuse, neglect, abandonment or financial exploitation.

Types of IPV

Physical violence such as hitting, punching, kicking, slapping, shoving, using a weapon, freezing, burning, throwing things or threatening to do any of these things. Physical abuse can also include biting, strangling and beating.

Sexual violence such as using physical force to make a person engage in a sexual act against their will (whether the act is completed or not), an attempted or completed sex act with an individual who is unable to communicate unwillingness (for example due to intimidation, pressure, drugs, alcohol, illness or disability) and abusive sexual contact. Sexual violence also includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape (ACOG, 2012).

Emotional or psychological violence that involves trauma to the victim that is caused by coercive tactics or acts that deliberately cause the victim to feel diminished or embarrassed, withholding information, isolating the victim from family and friends, denying access to money or other basic resources. If there has been prior threats of sexual or physical violence or acts of physical or sexual violence this is also considered as emotional/psychological violence. Psychological abuse erodes a woman's sense of self-worth and can include harassment; verbal abuse such as name calling, degradation, and blaming; threats; stalking; and isolation. Often, the abuser progressively isolates the woman from family and friends and may deprive her of food, money, transportation, and access to health care.

Threats of sexual or physical violence such as gestures, words or use of weapons to communicate intent to cause injury, disability, physical harm or death.

Stalking and Cyberstalking

Two additional types of intimate partner violence are stalking and cyberstalking.

According to the National Center for Victims of Crime (NCVC), stalking is a course of conduct that is directed at a particular individual that can cause a reasonable person to become fearful (NCVC, 2010).

Stalking is a criminal offense in many states. However, enforcement laws vary by state, charging violators with felony, misdemeanor, or contempt of court, and resulting in imprisonment for one to seven days.

Protective orders against stalking are now issued also in 50 states (OVC, 2013).

Cyberstalking

As the use of computers for communication has increased, so have cases of "cyberstalking." Many stalking laws are broad enough to encompass stalking via e-mail or other electronic communication, defining the prohibited conduct in terms of "communication," "harassment," or "threats" without specifying the means of such behavior. Others have specifically defined stalking via e-mail within their stalking or harassment statute.

For example, California recently amended its stalking law to expressly include stalking via the Internet. Under California law, a person commits stalking if he or she "willfully, maliciously, and repeatedly follows or harasses another person and makes a credible threat with the intent to place that person in reasonable fear for his or her safety, or the safety of his or her immediate family." The term "credible threat" includes "that performed through the use of an electronic communication device, or a threat

implied by a pattern of conduct or a combination of verbal, written, or electronically communicated statements." "Electronic communication device" includes "telephones, cellular phones, computers, video recorders, fax machines, or pagers."

(Office for Victims of Crime [OVC], 2013).

Differences in IPV between Men and Women

It is interesting to note that most female abusers use physical abuse as the main weapon of intimate partner abuse, compared to male abusers who employ rape and stalking as well as physical abuse to manipulate and control their victims.

The table on the right illustrates the different types of abuse that male and female victims are most commonly exposed to. From the statistics, it is evident that female victims suffer from all kinds of abuse, compared to male victims, who primarily suffer from physical violence only.

The National Intimate Partner and Sexual Violence Survey (NISVS), 2010.

Types of IPV Reported Differ Between Men and Women		
FORMS OF INTIMATE PARTNER VIOLENCE	WOMEN	MEN
Physical Violence Only	57%	92%
Rape Only	4%	--
Stalking Only	3%	--
Rape & Physical Violence	9%	--
Physical Violence & Stalking	14%	6%
Rape, Physical Violence & Stalking	13%	--

IPV: Intimate Partner Violence
NISVS, 2010 <http://www.cdc.gov/violenceprevention/nisvs>

Facts from Psychological Research: Profile of a Victim

Psychological research studies have identified several risk factors for intimate partner abuse.

According to research findings, the risk of experiencing intimate partner violence increases if a victim is:

- Poor
- Less educated
- An adolescent or a young adult
- Female
- Living in a high-poverty neighborhood
- Dependent on drugs or alcohol

American Psychological Association (2013)

Facts from Psychological Research: Profile of an Abuser

The following risk factors increase the chances of a partner becoming abusive:

- Low income
- Low academic achievement

- Young age
 - Aggressive behavior as a youth
 - Heavy alcohol and drug use
 - Depression
 - Anger and hostility
 - Prior history of being physically abusive
 - Few friends and isolation from other people
 - Unemployment
 - Emotional dependence and insecurity
 - Belief in strict gender roles (e.g., male dominance)
 - Desire for power and control in relationships
 - Being a victim of child physical or psychological abuse
- American Psychological Association (2013).

Risk Factors for IPV

Community Factors

- Overcrowding
- Poverty
- Limited community resources against IPV

Societal Factors

- A traditional gender role; women are submissive and stay at home

Relationship Factors

- Male dominance and control of the relationship
- Couples with job status, income or educational disparities

Individual Factors

- Female
- Young age
- Prior history of IPV
- Heavy alcohol or drug use
- Unemployment
- Less educated
- Experiencing or witnessing violence as a child
- High-risk sexual behaviors
- For women, a jealous, verbally abusive or possessive partner
- For women, being African American or Alaska Native/American Indian
- For women, having a higher education level than their partner
- For men, having a different type of ethnicity than their partner

Risk factors for victimization and perpetration do not necessarily cause IPV; however, they can contribute to it. When assessing for IPV it is important to have an awareness of some of these factors that alone or in combination may result in violence. They include societal, community, relationship and individual factors.

Dynamics of Intimate Partner Violence

The dynamics of IPV are specific to each particular situation and relationship. However, there are

some generalities that have been established through research and clinical observations by advocates and healthcare professionals.

Battering relationships represent the most severe type of violent intimate relationship. The violence associated with battering tends to increase in severity and frequency over time.

Several nursing researchers have used qualitative data to examine the process of enduring abuse and breaking free common to many battered women. Early in the abusive relationship, battered women often do not recognize the controlling behaviors as problematic and attribute any violence to other causes such as substance abuse or stress from work or unemployment. The victim generally does not label the behavior as abusive and would not label themselves as abused or battered. The victim may also think that the behavior will change if the situation were different (e.g. less stressful). The victim may be trying to make changes to themselves that will influence the batterer's behavior (a calm environment, keeping the children quiet, etc.).

Test Yourself

What type of dysfunctional relationship represents the most severe type of intimate partner violence?

Answer: **Battering**

Abusive Relationships

Over time, the majority of battered victims will leave an abusive relationship or manage to make the violence stop. These individuals frequently use active problem solving and deliberate resistance strategies to attempt to manage the abusive behavior and the other issues in their lives that often include the health and safety of themselves and their children.

If victims react and use violence against their abusive partners, it is generally in self-defense. In spite of the most creative attempts by abused victims to remain safe, batterers can be extremely dangerous and often become even more dangerous after the victim leaves (Campbell et al., 2003). In these relationships, children are also seriously at risk for direct child abuse as well as the deleterious effects from witnessing violence.

Although many violent relationships can be extremely dangerous and increasingly abusive, not all incidents of IPV are life threatening. However, these relationships can compromise an individual's health; but victims may not be ready to leave their partners or to use a criminal justice approach to address the violence.

Nurses and other healthcare professionals will benefit from learning how to identify and intervene (when appropriate) in all types of abusive relationships.

Test Yourself

Most battered victims retaliate by hitting back.

True

False- **Correct! Most victims use active problem solving and deliberate resistance strategies to attempt to manage the abusive behavior.**

Effects of IPV

Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death (ACOG, 2012). Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (ACOG, 2012).

The U.S. Department of Health and Human Services has recommended that IPV assessment and counseling should be a core part of women's preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.

According to the National Intimate Partner and Sexual Violence Survey (2010), 81% of women and 35% of men who experienced IPV reported at least one health-related or other impact.

- Of women with lifetime IPV experience, 42% reported injuries and 63% reported PTSD symptoms.
- Of men with lifetime IPV experience, 14% reported injuries and 16% reported PTSD symptoms.

Physical Health Effects: Injuries

The most obvious health effect of IPV is physical injury resulting from violence. Twenty percent of women treated in emergency departments for violence-related injuries reported being injured by a spouse, ex-spouse, or boyfriend (CDC, 2013). However, most women do not seek medical care when injured.

IPV injuries are typically located on the face, neck, or head. You may find bruises, fractures, and lacerations from falls and collisions. Sometimes there will be no visible injury; however, the patient will present with concussive symptoms.

According to Bowman (2012), up to 35% of women's visits to an emergency department are related to injury from ongoing abuse. Typically, injuries resulting from domestic violence include fractures, eye and ear injuries, lacerations, and brain injuries. Furthermore, brain injuries occur in up to 36% of domestic abuse related injuries (Varvaro et al., 2003 in Bowman, 2012).

Test Yourself

You are taking care of a victim of IPV. You anticipate that most of her injuries will be located on her:

Arms

Legs

Head / Face- **Correct!**

Chest

Physical Health Effects: Illness

A wide variety of health problems are associated with IPV. Research has shown that women who experience abuse use health services for a variety of non trauma-related reasons at greater frequency than do women who have not experienced abuse.

Abused women appear to have more frequent upper respiratory infections, gastrointestinal disorders, chronic pain (headaches, backache), neurological symptoms, and hypertension than do non-abused women (ACOG, 2012). It is not clear if the etiology of these problems is related to IPV injury, often untreated or incorrectly diagnosed, or related to stress.

Physical complaints are also commonly found in women who are experiencing major depressive disorder, anxiety disorders, and posttraumatic stress syndrome, all of which occur more often in abused than non-abused women.

Physical Health Effects: Illness

Numerous studies in a variety of settings indicate that abused women have higher rates of sexually transmitted infections (STI), including HIV/AIDS (CDC, 2013). Women who reported sexual abuse or

rape by an intimate partner may be even more likely to have experienced STIs than women who experience physical violence alone.

In addition, evidence suggests that IPV increases the risk of a woman committing suicide and may also increase the risk of contracting HIV, and thus of AIDS-related death (World Health Organization, 2013).

Risks for STIs in this population may include:

- Direct risk from forced sex
- High number of sex partners
- Fear of telling the male partner to seek treatment
- Delays in the female partner seeking treatment
- Increased use of alcohol and other drugs
- Lack of condom use

Mental Health Effects

Abused women appear to have increased rates of mental health disorders such as depression, post-traumatic stress disorder (PTSD), and substance-abuse when compared to women without such a history (ACOG, 2012).

Multiple Long-Term Health Consequences

The National Intimate Partner and Sexual Violence Survey (2010) also found that women with lifetime victimization experience were significantly more likely to report having:

- Asthma
- Irritable bowel syndrome
- Diabetes

Both women and men with lifetime victimization experience were significantly more likely to report:

- Frequent headaches
- Chronic pain
- Difficulty sleeping
- Activity limitations
- Self-assessed poor physical and mental health

Consequences of Intimate Partner Violence

Some women subjected to IPV present with acute injuries to the head, face, breasts, abdomen, genitalia, or reproductive system, whereas others have non-acute presentations of abuse such as reports of chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections (ACOG, 2012). These non-acute symptoms often represent clinical manifestations of internalized stress that can lead to post traumatic stress disorder (PTSD). PTSD is often associated with depression, anxiety disorders, substance abuse, and suicide. Research confirms the long-term physical and psychological consequences of ongoing or past violence (Commonwealth Fund, 1998 in ACOG, 2012).

Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner (El Kady et al., 2005 in ACOG, 2012). High rates of birth control sabotage and pregnancy pressure and coercion in abusive relationships are correlated with

unintended pregnancies (Family Violence Prevention Fund, 2011 in ACOG, 2012).

The societal and economic effects of IPV are profound. Approximately one quarter of a million hospital visits occur as a result of IPV annually (CDC, 2013).

Additional medical costs are associated with ongoing treatment of alcoholism, attempted suicide, mental health symptoms, pregnancy, and pediatric-related problems associated with concomitant child abuse and witnessing abuse. Intangible costs include women's decreased quality of life, undiagnosed depression, and lowered self-esteem. Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children. Efforts to control health care costs should focus on early detection and prevention of IPV.

Why don't women leave violent partners?

Evidence suggests that most abused women are not passive victims; they often adopt strategies to maximize their safety and that of their children (WHO, 2013). Heise and colleagues (1999) argue that what might be interpreted as a woman's inaction may in fact be the result of a calculated assessment about how to protect herself and her children (WHO, 2013). They go on to cite evidence of various reasons why women may stay in violent relationships, including:

- Fear of retaliation
- Lack of alternative means of economic support
- Concern for their children
- Lack of support from family and friends
- Stigma or fear of losing custody of children associated with divorce
- Love and the hope that the partner will change

Despite these barriers, many abused women eventually do leave their partners, often after multiple attempts and years of violence. In the WHO multi-country study, 19–51% of women who had ever been physically abused by their partner had left home for at least one night, and 8–21% had left two to five times (WHO, 2013).

Factors associated with a woman leaving an abusive partner permanently appear to include an escalation in violence severity; a realization that her partner will not change; and the recognition that the violence is affecting her children (WHO, 2013).

Role of Health Care Providers

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through assessments, offering ongoing support, and reviewing available prevention and referral options.

Health care providers are often the first professionals to offer care to women who are abused. The U.S. Department of Health and Human Services (USDHHS) has endorsed the Institute of Medicine's recommendation that IPV assessments and counseling be a core part of women's health visits (ACOG, 2012).

Nurses are in the unique position to provide assistance for women who experience IPV because of the nature of the patient–nurse relationship and the many opportunities for intervention that occur during the course of annual examinations, family planning, pregnancy, and follow-up visits for ongoing care. Assessing all patients at various times is also important because some women do not disclose abuse the first time they are asked. Health care providers should assess all women for IPV at periodic intervals, such as annual examinations and new patient visits.

Signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner should prompt an assessment for IPV.

Assessing for IPV

Many professional organizations have called for routine, universal assessments for intimate partner violence in most healthcare settings, including the American College of Obstetricians and Gynecologists (ACOG), the American Nurses' Association (ANA), the Emergency Nurses' Association (ENA), and the American College of Nurse Midwives (ACNM).

The CDC (2013) has issued guidelines based on expert opinion that recommends assessing women at the following health visits:

Primary Care:

First visit for new chief complaint, new patient encounter, new intimate relationship and periodic exams.

Emergency Department & Urgent Care:

All visits.

OB/GYN:

Each prenatal & postpartum visit; new intimate relationship; all gynecological, family planning, STI clinic, and abortion clinic visits. According to ACOG (2012), screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup.

Mental Health:

Every initial assessment; each new intimate relationship & annually if ongoing or periodic treatment.

Inpatient:

As part of admission & discharge.

Type of Screenings

Screenings or assessments can be face-to-face or self-administered by the patient in the form of a screening worksheet. Studies have shown that patient self-administered or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening (Chen et al., 2007 in ACOG, 2012).

Face-to-face screening for IPV should be done privately, and be conducted in a manner that does not convey judgment and one with which they are comfortable.

Protocols for Screening

Written protocols will facilitate the routine assessment process, and should include the following concepts:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- Health care providers should avoid questions that use stigmatizing terms such as "abuse," "rape," "battered," or "violence" and use culturally relevant language instead.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake

forms so that all patients are screened whether or not abuse is suspected.

- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

(ACOG, 2012)

IPV Screening Tools

The National Center for Injury Prevention and Control (2007) suggests that healthcare providers use a recognized IPV screening tool in cases of suspected abuse (Basile et al., 2007).

To view a table that provides an overview of several screening tools that can be used to assess for abuse : [Click Here!](#)

RADAR

RADAR is an acronym for a screening tool developed by the Massachusetts Medical Society that consists of a set of action steps to take with potential victims of IPV. The “RADAR” acronym stands for:

R

Remember to ask routinely about IPV as a matter of routine patient care.

A

Ask direct questions about violence, such as: “At any time, has a partner hit, kicked or otherwise hurt or frightened you?” Interview your patient in private at all times.

D

Document your findings related to suspected intimate partner violence in the patient’s chart.

A

Assess patient safety. Is it safe to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

R

Review options with your patient. Know about the types of referral resources in your community (shelters, support groups, legal advocates).

Within each “letter” of the acronym “RADAR” there are more specific questions and guidelines.

These can be found in **Appendix II**.

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Using Screening Tools

Ideally, women would have the opportunity to complete both a written screening and a face-to-face screen by a healthcare provider. Regardless of how the screening is conducted, the woman should be ensured privacy while answering the questions.

Some women may not disclose abuse but have signs that suggest it to the nurse. A woman may present with injuries that are not consistent with the described explanation of how they occurred. Multiple injuries in various stages of healing, especially when they appear on the head, trunk, or genitals, can also indicate abuse. In that case, the nurse can gently confront the inconsistency, making statements such as “in my experience, this kind of injury doesn’t usually happen from what you’ve described.”

Other women present with more subtle signs and symptoms, which may include:

- A pattern of somatic complaints of unknown origin (chronic pelvic and other pain complaints, neurological complaints or gastrointestinal symptoms)
- A pattern of difficulty in keeping appointments

- Increased anxiety in the partner's presence or the presence of a partner who refuses to allow the woman private time with the provider

A provider can document that IPV was not disclosed and note objective findings about the injuries or any inconsistencies in relationship to the mechanism of injury.

In addition, victims should be provided with written information on abuse "to share with a friend." The nurse should inform the woman that resources are always available to assist her. If possible, a follow up visit should be scheduled.

Test Yourself

A pattern of somatic complaints of unknown origin can indicate IPV.

True- **Correct!**

False

Effectiveness of Screening

The effectiveness of screening for IPV is controversial due to a lack of significant research findings (ACOG, 2012). Clinicians agree that providing information about IPV is crucial. In particular OB/GYN visits can provide a window of opportunity to offer help to those women that need it.

Although providers are often concerned that women will be offended by screening for IPV, research has shown that both abused and non-abused women support routine screening in healthcare settings (Sachs et al., 2002).

A variety of studies have also found that abused women supported screening and believed that the screening would make it easier for women to obtain help if they need it (Sachs et al., 2002).

Intervention & Counseling Strategies

Interventions will vary based on the severity of the abuse, the patient's decisions about what assistance is required. It is important to let the patient know that you will help regardless of whether she or he decides to stay in or leave the abusive relationship.

For all patients who disclose current abuse, providers should:

Provide validation:

- Listen non-judgmentally
- "I am concerned for your safety (and the safety of your children)"
- "You are not alone and help is available"
- "You don't deserve the abuse and it is not your fault"
- "Stopping the abuse is the responsibility of your partner not you"

Provide information:

- "Domestic violence is common and happens in all kinds of relationships"
- "Violence tends to continue and often becomes more frequent and severe"
- "Abuse can impact your health in many ways"
- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones"

Respond to safety issues:

- Offer the patient a brochure about safety planning and review the plan together
- Review ideas about keeping information private and safe from the abuser
- Offer the patient immediate and private access to an advocate in person or via phone
- Offer to have a provider or advocate discuss safety then or at a later appointment

- If the patient wants immediate police assistance, offer to place the call
- Reinforce the patient's autonomy in making decisions regarding her/his safety
- If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained

Make referrals to local resources:

- Describe any advocacy and support systems within the health care setting
- Refer patient to advocacy and support services within the community
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or lesbian, gay, transgender or bisexual clients)
- Offer a choice of available referrals including on-site advocates, social workers, local DV resources or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224

Some states have requirements to report current victimization to law enforcement, or social services. Become familiar with your state laws (**See Appendix I**).

Confidentiality

Inappropriate disclosure of health information may violate patient/provider confidentiality and threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV.

If you practice in a state with a mandated reporting law, inform patients about any limits of confidentiality prior to conducting assessment.

Providing Educational Material

Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure (ACOG, 2012).

Patients should be offered information that includes community resources (mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and appropriate referrals. Clinicians should not try to force patients to accept assistance or secretly place information in her purse or carrying case because the perpetrator may find the material and increase aggression.

Futures Without Violence and the ***American College of Obstetricians and Gynecologists*** have developed patient education cards about IPV and reproductive coercion for adults and teens that are available in English and Spanish. For more information visit [Futures Without Violence Online Store](#).

If the healthcare professional determines that a patient is involved in a violent relationship, he or she should acknowledge the trauma and assess the immediate safety of the patient and her children while assisting the patient in the development of a safety plan.

Interacting with a Victim of Abuse

As a healthcare professional, your response to a victim that states he or she is the victim of abuse will

depend on the circumstances and the healthcare setting. At a minimum, you should do the following:

- **Address any urgent medical needs:** Take a comprehensive history and complete a thorough physical examination, remembering that your documentation records can be used in court for criminal and civil proceedings.
- **Engage in safety planning:** Perform a safety assessment and work together with the victim to develop a personalized safety plan
- **Provide information about available resources and support organizations**
- **Report the abuse**

What to say:

- I believe you.
- How can I help?
- Are you safe to go home?
- How did this injury occur?
- Has this happened before?

What not to say:

- Does your spouse/partner abuse you?
- Are you a victim of domestic violence?
- Is your spouse/partner a “batterer”?
- Why don’t you leave?

Assessment of Immediate Danger

The healthcare professional should first determine whether there is any immediate threat to the safety of the victim. This can be achieved by asking questions such as:

- “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?”

The Family Violence Prevention Fund, (2004).

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment (The Family Violence Prevention Fund, 2004).

Obtaining a Comprehensive History

It is very important to obtain a history of the abuse. Discuss the history of abuse from a current or most recent partner, but also ask about abuse with prior partners.

The history should include the frequency of abuse, the types of abuse (physical, sexual, emotional, financial), use of weapons, if any, and the name of the perpetrator(s). Using a calendar indicating holidays can help the victim recall when incidents occurred. Mark incidents on the calendar on a 1 to 5 scale of severity (See Danger Assessment that follows later in the course). This allows the woman to create a visual representation of the severity of the abuse and facilitates identification of any patterns of abuse.

Allow the victim to tell their story while listening empathetically. It is useful to ask specific questions regarding forced sexual activities, use of threats, use of weapons, coercive behaviors, name-calling, and other behaviors that women may not label as "abuse."

Identifying the Abuse: The Power & Control Wheel

Some nurses find it helpful to use a power and control wheel (**See Appendix IV**). This wheel was developed from the experience of battered women in Duluth who had been abused by their male partners. The nurse can explain the wheel and ask the individual to indicate what kinds of behaviors (such as extreme jealousy or isolation from friends and family) were experienced in addition to physical and sexual violence. This exercise helps the victim to describe the full picture of the abuse.

Battering is one form of intimate partner violence. It is characterized by the pattern of actions that an individual uses to intentionally control or dominate his intimate partner. That is why the words "power and control" are in the center of the wheel. A batterer systematically uses threats, intimidation, and coercion to instill fear in his partner. These behaviors are the spokes of the wheel. Physical and sexual violence holds it all together; this violence is the rim of the wheel.

Battered women can point to each of the tactics on the wheel and clearly explain how these behaviors were used against them. They are able to see that they are not alone in their experience and more fully understand how their batterer could exert such control over them.

The wheel can also be used in counseling and education groups for men who batter to help group participants identify the tactics they use. By seeing that their behavior is not atypical for men who batter, there is an impetus (for those who are motivated to change) to explore the beliefs that contribute to their behavior. The wheel is also used in a variety of settings to describe battering. The wheel makes the pattern, intent and impact of violence visible. (Domestic Abuse Intervention Programs, 2013).

The Physical Examination

The physical examination of a battered woman can be very useful. If the woman says that she has been battered within the past 72 hours, and especially if she was sexually assaulted, she should be referred to a trained forensic nurse examiner (FNE) or a sexual assault nurse examiner (SANE) if such a program is available. In some states, an abbreviated exam can be conducted up to 96 hours after the attack (Pyrek, 2006).

SANE nurses are trained to perform very detailed examinations that include photographing injuries and recovering physical evidence such as DNA, hair, fibers, and other debris that might be necessary for legal proceedings. SANEs are trained to minimize the re-traumatization that is sometimes associated with collecting forensic evidence after an assault (Littel, 2001).

Test Yourself

SANEs only examine female abuse victims; physicians examine male victims.

True

False- **Correct! Men may also be the victim of a sexual assault and will require a thorough examination by a SANE.**

Examining & Documenting the Abuse

If the services of an FNE are not available, the nurse should note any areas of injury on a body map as well as providing a concise description of the size, color, texture, state of healing, and location. It is important to systematically inspect for injuries since the victim may have marks that they do not know about or have forgotten about.

Injuries from abuse are usually patterned injuries. Strangulation, burns, punching, slapping, kicking, biting, and beating with objects often create identifiable patterns of tears, bruising, abrasion, redness, and swelling. These patterns should be noted and documented.

Although charts relating colors of bruising to time of injury exist, more recent research has shown that they are not reliable (Family Violence Prevention Fund, 2004). The severity of the injury and healing time of injuries varies widely from person to person. Injuries in various stages of healing, however, are a strong indicator of continuing abuse.

Unintentional injuries such as bumping against a table or tripping and falling usually cause wounds and bruising over bony prominences (such as knees and shins), on the outer aspects of limbs (such as shoulder and hips), and occur in an asymmetrical pattern. Injuries from abuse can also occur in these areas. A victim may, for example, curl up in a fetal position while being kicked, resulting in injuries along the shins. Injuries to the neck, abdomen, trunk, and back, on the inner aspects of limbs (such as inner thighs or inner aspect of the arms), or that have a symmetrical pattern may indicate intentional injury.

Use of Photographs for Evidence

Photographs can be extremely useful in documenting physical injury. The victim's permission to photograph should be obtained and kept with the photographs. For each injury, one photograph should be taken from a distance, so that the relative location of the injury is evident, and one close up. Each image should include a ruler that does not obscure the site of the injury. Each photograph should be labeled with the patient's name and record number or date of birth, the location of the injury, and the date. Some institutions have medical photographers who are used for patient documentation in these circumstances.

Additional Findings

Because of their frequent appearance in conjunction with or as sequelae of IPV, there is a cluster of healthcare problems that should be particularly inquired about and examined for in all battered women. These include gynecological problems such as sexually transmitted diseases, urinary tract infections, gastrointestinal problems (especially chronic irritable bowel syndrome), chronic pain (back pain, pelvic pain and headaches), neurological problems, and mental health problems such as depression, suicidal ideation, PTSD and substance abuse.

If the patient has sustained a head injury from the attack a neurological exam is in order, and possibly imaging tests. These health conditions can occur even after the abuse has ended.

After a positive screen for abuse, at least one follow up visit is recommended and victims should be referred to a specialist for further care.

Safety Planning

It is very important for the healthcare professional to perform a safety assessment and develop a personalized safety strategy, after abuse has been identified. In order to provide appropriate safety planning it is necessary to have an accurate reading of the degree of danger present in the situation for her/him and for any children if present.

Begin by performing a safety assessment in which you assess the victim's immediate safety by asking "Are you safe to go home right now?" If the victim's answers no, assist them in developing a plan. The plan should include how she/he will exit the healthcare setting, who will assist in leaving safely (for example, security officers or police officers), and where she/he will go (to a friend's house, shelter, etc.)

If the woman is safe to leave at that time, she can be assisted in identifying her current level of safety and developing an appropriate safety plan. This can be done in several different ways, depending on the setting. At a minimum you should let the woman know that she has options to help her stay safer while in an abusive relationship, encourage her to think about her safety and that of her children, and provide her with the appropriate hotline numbers and other local resources so that the woman can discuss safety planning. You can ask if the woman has a safe place to make the calls, and, if not, provide her with a phone in the healthcare facility from where she can make private phone calls.

One of the hallmarks of effective safety planning in healthcare systems is that safety planning is conducted with the victim, not for the victim.

Safety Planning

Sharing Available Resources

Healthcare professionals can provide invaluable support to victims of IPV by providing information about resources that are available to the victim. Police and security phone numbers, shelter hotline, social work, etc. should be available and maintained to be used as needed. If needed, the victim can be moved to another room within the setting and assisted with calling an abuse hotline while practitioners see other clients.

Try to ensure that your client has access to a phone where the abuser cannot hear or track the calls she/he makes. This privacy can be enormously empowering for a victim in a battering relationship.

Also note that while some areas do not have local hotlines, there are state and national hotline numbers available in all areas. Use the National Domestic Violence Hotline to access these numbers (1-800-799-SAFE).

Safety Plan

Try To Do The Following:

- Hide money
- Hide an extra set of house and car keys
- Establish a code word with family and friends
- Ask a neighbor to call the police if violence begins
- Remove any weapons
- Have available:
 - Social security numbers (his, yours, children)
 - Rent and utility receipts
 - Birth certificates (yours and children)
 - Bank account numbers
 - Insurance policies and number
 - Marriage license
 - Valuable jewelry
 - Important phone numbers
- Hide a bag with extra clothing

Support Agencies

To assist clinicians in responding to IPV, a local domestic violence agency is often the best resource. It is important to note that when abuse is identified, it is very useful to offer a private phone for the patient to use to call a domestic violence agency (ACOG, 2012). Controlling partners often monitor cell phone call logs and Internet usage. Offering a private phone to call the National Domestic Violence hotline is a simple but important part of supporting a victim of violence.

The National Domestic Violence hotline is a multilingual resource that can connect a patient to local domestic violence programs, help with safety planning, and provide support. A protocol with all the information needed to perform an IPV assessment should be kept on site.

Referrals

Healthcare professionals are in the ideal situation to make referrals to victims of intimate partner violence. Referrals may include social service, criminal justice, mental health, and specialty medical services as needed.

Types of referrals may include:

- Contacting a shelter or a hotline.
- Promoting support groups related to domestic violence.
- Encouraging the enrollment of partners into a program for abusers.
- Medical, social work, and substance abuse specialists referrals. Specialists with experience in treating IPV are preferred.

It is important for victims of abuse to understand that options are available, and that there are people who will help them.

At a minimum, all victims should be referred to at least one support resource such as a local hotline. The National Domestic Violence Hotline is: 1-800-799-SAFE or 1-800-787-3224 (TTY)

Empowering Victims in the Healthcare Setting

Assure victims of abuse that the healthcare setting is a safe and empowering place for individuals that are experiencing IPV. Posters and pamphlets about IPV are appropriate for use in the healthcare setting and send the message that the healthcare providers are interested in hearing about abuse and prepared to respond. Consider putting pamphlets and shelter cards in places where women can access them privately, such as examination rooms and the bathroom.

Encourage your facility to offer training on IPV to all staff that interact with clients. Staff who answer the phones and make appointments, housekeeping staff, and aides all may hear or see things that alert the provider to the possibility of abuse.

Respect the victim's strengths and join with them in identifying their needs and obtaining needed assistance as they move toward living a fulfilling, violence-free life.

National Intimate Partner & Sexual Violence Surveillance System (NISVSS)

The Centers for Disease Control and Prevention's National Center for Injury Prevention and Control (NCIPC), in collaboration with the National Institutes of Justice (NIJ), and the Department of Defense (DoD) has developed a telephone survey, the National Intimate Partner and Sexual Violence Surveillance System (NISVSS).

Since 2010, the NISVSS has been collecting ongoing population-based surveillance data, generating accurate and reliable incidence and prevalence estimates for intimate partner violence, sexual violence, dating violence and stalking victimization IPV, SV, dating violence, and stalking victimization.

[Click here to learn more this survey](#)

Reporting

Reporting of the abuse of children is mandatory; however, reporting IPV, particularly mandatory reporting, is controversial.

Although the intent of mandatory reporting is to identify and protect individuals before the next act of violence, the individual's safety, in fact, may be jeopardized (ACOG, 2012). Most states do not mandate reporting of IPV or only mandate reporting in certain circumstances.

To ensure compliance with state laws and federal regulations, it is important to contact the local law enforcement or domestic violence agency to become familiar with the laws in a specific jurisdiction. A summary of state laws can be found at: www.futureswithoutviolence.org.

All fifty states and the District of Columbia have laws in effect authorizing the provision of adult protective services in cases of elder abuse or the abuse of individuals with disabilities, although the laws vary significantly between states (ACOG, 2012). Clinicians are generally mandated to report abuse in these instances. A current listing of state laws on elder abuse can be found at: www.ncea.aoa.gov.

Documentation

Documentation of the clinical interaction provides important evidence for any future legal proceedings. Accurate reflection of the patient's condition, including any pertinent photographs or body maps, should be included with direct and specific quotations. The health care provider should review with the patient in advance what form of future communication is best because medical bills and follow-up phone calls may prompt retaliation from the abuser. Despite encountering violence, a patient may deny her circumstances based on fear of retaliation from her partner, fear of involvement with law enforcement and the justice system, embarrassment, or shame. Even if women do not reveal violence to their physicians, hearing validating messages and knowing that options and resources may be available could help prompt them to seek help on their own in the future.

Tips for documenting IPV are:

- Record exact words of victim in quotes, noting the time, identifying the speaker and describing the speaker's demeanor.
- Take several photos, noting the time.
- Mark injuries on a body map, noting the time.
- Make sure your handwriting is legible.

(ACOG, 2012)

Prevention Efforts

Prevention efforts must be aimed at reducing the occurrence of intimate partner violence through the promotion of healthy, respectful, nonviolent relationships. These prevention efforts should address change at the individual, relationship, community, and societal levels (CDC, 2013).

Preventing physical violence, rape, and stalking will save lives, reduce health impacts, and save money (The National Intimate Partner and Sexual Violence Survey , 2010).

Health Care: Progress & Opportunities

Since 1993, Futures Without Violence has been part of the DHHS National Health Resource Center on Domestic Violence, and has developed national consensus guidelines with health care providers and leaders to guide education, training, and system changes.

In addition, the Affordable Care Act of 2010 built on this work to create policy and practice change. By making insurance affordable and easier to obtain, the Affordable Care Act allows abused women, children and teens to have access to services to treat their abuse. Additionally, it enables women who are staying in abusive relationships for the economic support, to flee and seek safety away from that partner (Futures Without Violence, 2012).

Victims of violence and abuse were specifically included in several new protections and programs, and the new law opens the door to integrating violence and abuse prevention into public health programs.

Health Care: Progress & Opportunities

Some proposed changes and opportunities include:

Supporting Routine Screening and Counseling of Domestic or Interpersonal Violence

Since August 1, 2012, all new and non-grandfathered health plans must cover screening and counseling of domestic violence, and plans cannot require cost sharing or deductibles for these services.

Screening and assessing for domestic violence is considered a primary prevention service, similar to obesity screening, smoking cessation, and alcohol misuse, which is already covered by providers.

Prohibiting Pre-Existing Condition Exclusion Based on Domestic Violence History

Beginning January 1, 2014, the Affordable Care Act will prohibit insurance companies, health care providers, and health programs that receive federal financial assistance from denying coverage to women based on many factors, including being a survivor of domestic or sexual violence.

Supporting Home Visitation Programs to Prevent Domestic Violence

This program aims to decrease IPV in two ways:

1. States are required to do a needs assessment during the planning phase to identify at-risk communities including communities with high concentrations of domestic violence.
2. States are allowed up to 25 percent of the funding to be used for new program models, which could directly address the needs of mothers and children who are experiencing or at risk of experiencing domestic violence, the link between domestic violence and child abuse and neglect, and the impact of domestic violence on the health and well-being of children and families.

(Futures Without Violence, 2012).

Conclusion

Based on the prevalence and health burden of IPV among women, assessment and education can improve the lives of victims who experience IPV.

As a caring healthcare professional, you can have an impact on IPV. Whether it is by helping one person through the trauma of the situation, or setting in place standards and guidelines in your facility, each healthcare practitioner has the means to make a difference.

Appendix I: State Laws

To view a chart of state laws from The Family Violence Prevention Fund (2004), [click here](#).

Retrieved from <http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>

Appendix II: RADAR

R= Routinely Screen Female patients

Although many women who are victims of domestic violence will not volunteer any information, they will discuss it if asked simple, direct questions in a non-judgmental way and in a confidential setting.

Interview the patient alone.

A= Ask Direct Questions

"Because violence is so common in many women's lives, I've begun to ask about it routinely."

"Are you in a relationship in which you have been physically hurt or threatened?" If no, "Have you ever been?"

"Have you ever been hit, kicked or punched by your partner?"

"Do you feel safe at home?"

"I notice you have a number of bruises; did someone do this to you?"

If the patient answers "yes":

Encourage her to talk about it:

"Would you like to talk about what has happened to you?" or "How do you feel about it?" "What would you like to do about this?"

Listen non-judgmentally. This serves both to begin the healing process for the woman and to give you an idea of what kind of referrals she may need.

Validate her experience: "You are not alone" or "No one has to live with violence." "You do not deserve to be treated this way." "You are not to blame." "What happened to you is a crime." "Help is available to you."

If the patient answers "no", or will not discuss the topic:

Be aware of any clinical signs that may indicate abuse; injury to the head, neck, torso, breasts, abdomen or genitals; bilateral or multiple injuries; delay between onset of injury and seeking treatment; explanation by the patient which is inconsistent with the type of injury; any injury during pregnancy, especially to abdomen or breasts; prior history of trauma; chronic pain symptoms for which no etiology is apparent; psychological distress such as depression, suicidal ideation, anxiety and/or sleep disorders; a partner who seems overly protective or who will not leave the woman's side.

If any of these clinical signs are present, ask more specific questions. Make sure she is alone. "It looks as though someone may have hurt you. Can you tell me how it happened?" "Sometimes when people feel the way you do, it may be because they are being hurt at home. Is this happening to you?"

If the patient denies abuse, but you strongly suspect it, document your opinion, and let her know there are resources available to her should she choose to pursue such options in the future. Make a follow-up appointment to see her.

D= Document your findings

Record a description of the abuse as she has described it to you. Use statements such as "the patient states she was..." If she gives the specific name of the assailant, use it in your record. "She says her boyfriend John Smith struck her..." Record all pertinent physical findings. Use a body map to supplement the written record. Offer to photograph injuries. When serious injury or sexual abuse is detected, preserve all physical evidence. Document an opinion if the injuries were inconsistent with the patient's explanation.

A= Assess Patient Safety

Before she leaves the medical setting, find out if she is afraid to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Have there been threats to her children? Is there a gun present?

R= Review Options and Referrals

If the patient is in imminent danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity of a private phone to make a call. If she does not need immediate assistance, offer information about hotlines and resources in the community. Remember that it may be dangerous for the woman to have these in her possession. Do not insist that she can take them. Make a follow-up appointment to see her.

RADAR action steps developed by the Massachusetts Medical Society. Copyright 1992 Massachusetts Medical Society. Reprinted with permission (2013).

Appendix III: Resources

General Resources

Hotlines:

National Domestic Violence Hotline

1-800-799-SAFE (7233) or 1-800-787-3224 (TTY)

www.ndvh.org

The National Domestic Violence Hotline creates access by providing 24-hour support through advocacy, safety planning, resources and hope to everyone affected by domestic violence. The Hotline is a nonprofit organization that provides crisis intervention, information and referral to victims of domestic violence.

Rape Abuse & Incest National Network (RAINN) Hotline

1-800-656-HOPE (4673)

Web Sites:

Futures Without Violence (previously known as Family Violence Prevention Fund)

www.futureswithoutviolence.org

National Coalition Against Domestic Violence

www.ncadv.org

National Network to End Domestic Violence

www.nnedv.org

The National Network to End Domestic Violence is a membership and advocacy organization of state domestic violence coalitions, allied organizations and supportive individuals.

National Resource Center on Domestic Violence

www.nrcdv.org

Office on Violence Against Women (U.S. Department of Justice)

www.usdoj.gov/ovw

U.S. Department of Justice Office on Violence Against Women

www.ovw.usdoj.gov

National Office with information and links about domestic violence. Also contains information on current legislative issues related to violence against women.

Nursing Network on Violence Against Women, International

www.nnvawi.org

An excellent resource for nursing professionals that includes up to date information, assessment tools, patient education and research in the arena of violence against women.

Resources by State

Womenshealth.gov, a division of the U.S. Department of Health & Human Services (USDHHS) offers a list of resources for women who have experienced abuse. The resources are organized by state, and The District of Columbia, Puerto Rico, and the U.S. Virgin Islands are also included.

Click [here](#) to access these resources.

Appendix IV: The Power & Control Wheel

To see photo, [click here](#).

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