Domestic Violence

Goals and Objectives

Course Description
"Domestic Violence" is an asynchronous online continuing education program for occupational therapists and occupational therapy assistants. This course presents updated information about domestic violence, including information about types of abuse, scope of the problem, victims of abuse, perpetrators, role of health care providers, and victim resources.

Course Rationale
The purpose of this course is to present occupational therapists and occupational therapy assistants with current information about domestic violence. A greater understanding of domestic violence will enable occupational therapists and occupational therapy assistants to provide more effective and efficient care to individuals affected by abuse.

Course Goals and Objectives

Upon completion of this course, the participants will be able to:

1. define domestic violence
2. differentiate between the different types of abuse
3. name risk factors for domestic violence
4. list the causative theories behind domestic violence
5. identify the tactics utilized by abusers
6. identify the protective strategies utilized by victims of abuse
7. list the barriers victims must overcome to leave their abusers
8. name the barriers to intervention that health care professionals must overcome
9. define the role of healthcare providers in domestic violence intervention
10. identify the signs of domestic violence
11. select effective and appropriate questions used to identify victims of domestic violence
12. identify the key components of effective domestic violence documentation
13. identify the steps and documentation for reporting suspected domestic violence

Course Provider – Innovative Educational Services

Provider Contact Information – information@cheapceus.com

Course Instructor – Michael Niss, DPT

Financial/Non-financial Disclosure - Neither the Provider nor the instructor have any financial or non-financial conflict of interest related to the presentation of this CE program.

Target Audience – Occupational Therapists, Occupational Therapy Assistants

OT Scope of Practice – Foundational Knowledge

Course Educational Level – This course is applicable for introductory learners.

Course Prerequisites – None

Method of Instruction – Distance Learning – Independent; Asynchronous online text-based home study

Location - Cheapceus.com

Date – Continuously available on-demand

Course Completion Requirements / Criteria for Issuance of CE Credits – Completion of instructional materials and a score of 70% or greater on the course post-test.

Continuing Education Credits – Two (2) contact hours / .2 AOTA CEUs / NBCOT 2.5 PDUs

Course Fee - $19.95

Registration Information – No pre-registration required; available on-demand at Cheapceus.com

Special Needs Requests – Email: information@cheapceus.com or phone: 954-663-4101

Cancellation by the Learner – Learners may cancel their participation at any time and receive a full refund of all paid fees.

Cancellation by the Provider – Registrants for the cancelled activity will be contacted by an IES staff member via phone call or email within 12 hours of the cancellation decision. If the decision to cancel is made less than 14 hours prior to the event, each participant will be contacted no later than 2 hours prior to the scheduled start time of the activity. Registrants will receive a full refund if an activity is cancelled by the Provider. The refund will be processed back to the Registrant within 12 hours of the cancellation.

Complaint Resolution – Please call 954-663-4101 (24 hours/day, 7 days/week) to speak with a live customer service agent. Our goal is to work with our customers to resolve all issues to the customer's satisfaction with just one phone call whenever possible.

Refund Policy - Unrestricted 100% refund upon request. The request for a refund by the learner shall be honored in full without penalty or other consideration of any kind. The request for a refund may be made by the learner at any time without limitations before, during, or after course participation.

American Occupational Therapy Association
Approved Provider

Innovative Educational Services is an AOTA Approved Provider of professional development. PD activity approval ID# 5471. This Distance Learning – Independent PD activity is offered at .2 CEUs; Introductory; Foundational Knowledge. The assignment of AOTA CEUs does not imply endorsement of specific course content, products, or clinical procedures by AOTA.

Domestic Violence

Course Outline

Domestic Violence

Domestic violence (DV), also called intimate partner violence (IPV), is a serious health care and social issue that impacts every segment of the population. Its effects are both devastating and far-reaching and impact men, women, children, and the elderly; and can be found in every socioeconomic level, race, religion, age group, and community.

Defining Domestic Violence

Various definitions of domestic violence are utilized nationwide, reflecting both legal definitions and descriptions relevant to specific disciplines of caregivers, including victim advocates, medical professionals, and criminal justice practitioners. While it is necessary for victim service providers to determine the legal definition of domestic violence in both civil and criminal law in their respective states, it is useful to start with a generic definition of domestic violence:

Domestic violence is a pattern of coercive behavior designed to exert power and control over a person in an intimate relationship through the use of intimidating, threatening, harmful, or harassing behavior.

Domestic violence can be physical, sexual, emotional/psychological, or economic actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.

Physical Abuse

Physical abuse is usually recurrent and usually escalates both in frequency and severity. It may include the following:

- Pushing, shoving, biting, slapping, hitting, punching, or kicking the victim.
- Holding, tying down, or restraining the victim.
- Inflicting bruises, welts, lacerations, punctures, fractures, burns, scratches.
- Strangling the victim.
- Pulling the victim's hair or dragging the victim by the victim's hair or body parts.
- Assaulting the victim with a weapon.
- Inflicting injury upon pets or animals.
- Physical abuse also includes denying a partner medical care or forcing alcohol and/or drug use.

Sexual Abuse

Sexual abuse in violent relationships is often the most difficult aspect of abuse for victims to discuss. It may include any form of forced sex or sexual degradation:

- Trying to make or making the victim perform sexual acts against their will.
- Pursuing sexual activity when the victim is not fully conscious, or is not asked, or is afraid to say no.
- Physically hurting the victim during sex or assaulting her genitals, including the use of objects or weapons intravaginally, orally, or anally.
- Coercing the victim to have sex without protection against pregnancy or sexually transmittable diseases.
- Criticizing the victim and calling her sexually degrading names.

Emotional/Psychological Abuse

Emotional or psychological abuse may precede or accompany physical violence as a means of controlling through fear and degradation. It may include the following:

- Threats of harm.
- Physical and social isolation.
- Extreme jealousy and possessiveness.
- Deprivation of resources to meet basic needs.
- Intimidation, degradation, and humiliation.
- Name calling and constant criticizing, insulting, and belittling the victim.
- False accusations, blaming the victim for everything.
- Ignoring, dismissing, or ridiculing the victim's needs.
- Lying, breaking promises, and destroying the victim's trust.
- Driving fast and recklessly to frighten and intimidate the victim.
- Leaving the victim in a dangerous place.
- Refusing to help when the victim is sick or injured.
- Threats or acts of violence/injury upon pets or animals.

Economic Abuse

Making or attempting to make an individual financially dependent by maintaining total control over financial resources, withholding one's access to money, or forbidding one's attendance at school or employment. In its extreme (and usual) form, this involves putting the victim on a strict "allowance", withholding money at will and forcing the victim to beg for the money until the abuser gives them some money. It is common for the victim to receive less money as the abuse continues. This also includes (but is not limited to) preventing the victim from finishing education or obtaining employment, or intentionally squandering or misusing communal resources.

Economic or financial abuse includes:

- Controlling the finances.
- Withholding money or credit cards.
- Giving an allowance.
- Making the victim account for every penny spent.
- Stealing or taking money from the abused
- Exploiting the victim's assets for personal gain.
- Withholding basic necessities (food, clothes, medications, shelter).
- Preventing the victim from working or choosing their own career.
- Sabotaging the partner's job (making them miss work, calling constantly or repeatedly showing up on the jobsite)

Scope of the Problem

Currently, national crime victimization surveys, crime reports, and research studies indicate:

- Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.
- Females are victims of intimate partner violence at a rate about five times that of males
- Females between the ages of 16 and 24 are most vulnerable to domestic violence.
- Females account for 39 percent of hospital emergency department visits for violence related injuries, and 84 percent of persons treated for intentional injuries caused by an intimate partner.
- As many as 324,000 females each year experience intimate partner violence during their pregnancy; and pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause.
- Domestic Violence constitutes 22 percent of violent crime against females and 3 percent of violent crime against males.
- Eight percent of females and 0.3 percent of males report intimate partner rape.
- Sexual assault or forced sex occurs in approximately 40-45 percent of battering relationships.
- Approximately 33 percent of gays and lesbians are victims of domestic violence at some time in their lives.
- Twenty-eight percent of high school and college students experience dating violence and 26 percent of pregnant teenage girls report being physically abused.
- Seventy percent of intimate homicide victims are female and females are twice as likely to be killed by their husbands or boyfriends as to be murdered by strangers.
- On average, more than three women are murdered by their husbands or boyfriends in the United States every day.

- An estimated 5 percent of domestic violence cases are males who are physically assaulted, stalked, and killed by a current or former wife, girlfriend, or partner.
- Domestic Violence victims lose a total of nearly 8.0 million days of paid work – the equivalent of more than 32,000 full-time jobs – and nearly 5.6 million days of household productivity as a result of the violence.
- The costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care services.
- Intimate partner homicides make up to 40-50 percent of all murders of women in the United States.

Risk Factors

Risk factors do not automatically mean that a person will become a domestic violence victim or an offender. Also, although some risk factors are stronger than others, it is difficult to compare risk factor findings across studies because of methodological differences between studies.

Age

The female age group at highest risk for domestic violence victimization is 16 to 24. Among one segment of this high-risk age group—undergraduate college students—22 percent of female respondents in one study reported domestic violence victimization, and 14 percent of male respondents reported physically assaulting their dating partners in the year before the survey.

Socioeconomic Status

Although domestic violence occurs across income brackets, it is most frequently reported by the poor who more often rely on the police for dispute resolution. Victimization surveys indicate that lower-income women are, in fact, more frequently victims of domestic violence than wealthier women. Women with family incomes less than $7,500 are five times more likely to be victims of violence than women with family annual incomes between $50,000 and $74,000.

Although the poorest women are the most victimized by domestic violence, one study also found that women receiving government income support payments through Aid for Families with Dependent Children (AFDC) were three times more likely to have experienced physical aggression by a current or former partner during the previous year than non-AFDC supported women.

Repeat Victimization
Domestic violence, generally, has high levels of repeat calls for police service. For instance, police data showed that 42 percent of domestic violence incidents within one year were repeat offenses, and one-third of domestic violence offenders were responsible for two-thirds of all domestic violence incidents reported to the police. It is likely that some victims of domestic violence experience physical assault only once and others experience it repeatedly over a period as short as 12 months. Research suggests that the highest risk period for further assault is within the first four weeks of the last assault.

Incarceration of Offenders
Offenders convicted of domestic violence account for about 25 percent of violent offenders in local jails and 7 percent of violent offenders in state prisons. Many of those convicted of domestic violence have a prior conviction history. More than 70 percent of offenders in jail for domestic violence have prior convictions for other crimes, not necessarily domestic violence.

Termination of the Relationship
Although there is a popular conception that the risk of domestic violence increases when a couple separates, in fact, most assaults occur during a relationship rather than after it is over. However, still unknown is whether the severity (as opposed to the frequency) of violence increases once a battered woman leaves.

Domestic Violence Theories

Theories about why individuals abuse others and why some people are reluctant to end abusive relationships may seem abstract, but the theories have important implications for how health care professionals might effectively respond to the problem.

Generally, four theories explain domestic abuse: Psychological Theory, Sociological Theory, Feminist or Societal-Structural Theory, and Violent Individuals Theory

Psychological Theory
Battering is the result of childhood abuse, a personality trait (such as the need to control), a personality disturbance (such as borderline personality), psychopathology (such as anti-social personality), or a psychological disorder or problem (such as post-traumatic stress, poor impulse control, low self-esteem, or substance abuse).

Sociological Theory
Sociological theories vary but usually contain some suggestion that intimate violence is the result of learned behavior. One sociological theory suggests that violence is learned within a family, and a partner-victim stays caught up in a cycle of violence and forgiveness. If the victim does not leave, the batterer views the violence as a way to produce positive results.

Children of these family members may learn the behavior from their parents (boys may develop into batterers and girls may become battering victims). A different sociological theory suggests that lower income subcultures will show higher rates of intimate abuse, as violence may be a more acceptable form of settling disputes in such subcultures. A variant on this theory is that violence is inherent in all social systems and people with resources (financial, social contacts, prestige) use these to control family members, while those without resort to violence and threats to accomplish this goal.

Feminist or Societal-Structural Theory
According to this theory, male intimates who use violence do so to control and limit the independence of women partners. Societal traditions of male dominance support and sustain inequities in relationships.

Violent Individuals Theory
For many years it was assumed that domestic batterers were a special group, that while they assaulted their current or former intimates they were not violent in the outside world. There is cause to question how fully this describes batterers. Although the full extent of violence batterers perpetrate is unknown, there is evidence that many batterers are violent beyond domestic violence, and many have prior criminal records for violent and non-violent behavior. This suggests that domestic violence batterers are less unique and are more accurately viewed as violent criminals, not solely as domestic batterers. There may be a group of batterers who are violent only to their current or former intimates and engage in no other violent and non-violent criminal behavior, but this group may be small compared to the more common type of batterer.

Cycle of Abuse

The cycle of abuse is a social cycle theory developed in the 1970s by Lenore Walker to explain patterns of behavior in an abusive relationship.
Walker's theory rests on the idea that abusive relationships, once established, are characterized by a predictable repetitious pattern of abuse, whether emotional, psychological or physical, with psychological abuse nearly always preceding and accompanying physical abuse.

The cycle usually goes in a predictable order, and will repeat until the conflict is stopped, usually by the victim entirely abandoning the relationship. The cycle can occur hundreds of times in an abusive relationship, the total cycle taking

anywhere from a few hours, to a year or more to complete. However, the length of the cycle usually diminishes over time so that the "making-up" and "calm" stages may disappear.

Tension Building Phase
This phase occurs prior to an overtly abusive act, and is characterized by poor communication, passive aggression, rising interpersonal tension, and fear of causing outbursts in one's partner. During this stage the victims may attempt to modify his or her behavior to avoid triggering their partner's outburst.

Acting-out Phase
Violence erupts as the abuser throws objects at his or her partner, hits, slaps, kicks, chokes, abuses him or her sexually, or uses weapons. Once the attack starts, there's little the victim can do to stop it; there generally are no witnesses.

Reconciliation/Honeymoon Phase
Characterized by affection, apology, or, alternately, ignoring the incident. This phase marks an apparent end of violence, with assurances that it will never happen again, or that the abuser will do his or her best to change. During this stage the abuser feels overwhelming feelings of remorse and sadness, or at least pretends to. Some abusers walk away from the situation with little comment, but most will eventually shower their victims with love and affection. The abuser may use self-harm or threats of suicide to gain sympathy and/or prevent the victim from leaving the relationship. Abusers are frequently so convincing, and victims so eager for the relationship to improve, that victims who are often worn down and confused by longstanding abuse, stay in the relationship. Although it is easy to see the outbursts of the Acting-out Phase as abuse, even the more pleasant behaviors of the Honeymoon Phase serve to perpetuate the abuse.

Calm Phase
During this phase (which is often considered an element of the honeymoon/reconciliation phase), the relationship is relatively calm and peaceable. However, interpersonal difficulties will inevitably arise, leading again to the tension building phase.

Perpetrators of Domestic Violence

Abusers

As is the case with victims of domestic violence, abusers can be anyone and come from every age, sex, socioeconomic, racial, ethnic, occupational, educational, and religious group. They can be teenagers, college professors, farmers, counselors, electricians, police officers, doctors, clergy, judges, and popular celebrities. Perpetrators are not always angry and hostile, but can be charming, agreeable, and kind. Abusers differ in patterns of abuse and levels of

dangerousness. While there is not an agreed upon universal psychological profile, perpetrators do share a behavioral profile that is described as “an ongoing pattern of coercive control involving various forms of intimidation, and psychological and physical abuse.”

While many people think violent and abusive people are mentally ill, research shows that perpetrators do not share a set of personality characteristics or a psychiatric diagnosis that distinguishes them from people who are not abusive. There are some perpetrators who suffer from psychiatric problems, such as depression, post-traumatic stress disorder, or psychopathology. Yet, most do not have psychiatric illness, and caution is advised in attributing mental illness as a root cause of domestic violence. The Diagnostic and Statistical Manual of the American Psychological Association (DSM-V) does not have a diagnostic category for perpetrators, but mental illness should be viewed as a factor that can influence the severity and nature of the abuse.

A person engages in domestic violence because he or she wishes to gain and/or maintain power and control over an intimate other, and believes he or she is entitled to do so.

The abuser has a need to ensure that they gain/maintain control of how the partner thinks, feels, and behaves. Physical and sexual abuse is the behavior most people think of as "the problem". It is the abuse most easily recognized or identified and often the only behavior that is illegal. However, the abuser may not need to use physical forms of abuse against the victim to maintain control because the victim attempts to do all they can to avoid the physical and sexual attacks. A victim need only be threatened or harmed once to know the abuser is willing and able to use physical and/or sexual abuse against them.

Tactics of Abuse

The abuser uses many different tactics to gain and maintain control. Not all of these tactics are used in every relationship, and the tactics may be changed as the victim's response changes. The abuser will switch tactics when the victim learns to respond to one type of tactic or attack. When the struggle to challenge the abuser becomes too exhausting or too dangerous, the victim begins to modify their behavior--slowly giving up control of pieces of their life in order to avoid further abuse or to survive.

Examples of the most prevalent behavioral tactics by perpetrators include:

Abusing Power and Control

The perpetrator’s primary goal is to achieve power and control over their intimate partner. In order to do so, perpetrators often plan and utilize a pattern of coercive tactics aimed at instilling fear, shame, and helplessness in the victim. Another part of this strategy is to change randomly the list of “rules” or

expectations the victim must meet to avoid abuse. The abuser's incessant degradation, intimidation, and demands on their partner are effective in establishing fear and dependence. It is important to note that perpetrators may also engage in impulsive acts of domestic violence and that not all perpetrators act in such a planned or systemic way.

Having Different Public and Private Behavior
Usually, people outside the immediate family are not aware of, and do not witness, the perpetrator's abusive behavior. Abusers who maintain an amiable public image accomplish the important task of deceiving others into thinking they are loving, "normal", and incapable of domestic violence. This allows perpetrators to escape accountability for their violence and reinforces the victim's fears that no one will believe them.

Projecting Blame
Abusers often engage in an insidious type of manipulation that involves blaming the victim for the violent behavior. Such perpetrators may accuse the victim of "pushing buttons" or "provoking" the abuse. By diverting attention to the victim's actions, the perpetrator avoids taking responsibility for the abusive behavior. In addition to projecting blame on the victim, abusers also may project blame on circumstances, such as making the excuse that alcohol or stress caused the violence.

Claiming Loss of Control or Anger Problems
There is a common belief that domestic violence is a result of poor impulse control or anger management problems. Abusers routinely claim that they "just lost it," suggesting that the violence was an impulsive and rare event beyond control. Domestic violence is not typically a singular incident nor does it simply involve physical attacks. It is a deliberate set of tactics where physical violence is used to solidify the abuser's power in the relationship. In reality, only an estimated 5 to 10 percent of perpetrators have difficulty with controlling their aggression. Most abusers do not assault others outside the family, such as police officers, coworkers, or neighbors, but direct their abuse toward the victim or children. This distinction challenges claims that they cannot manage their anger.

Minimizing and Denying the Abuse
Perpetrators rarely view themselves or their actions as violent or abusive. As a result, they often deny, justify, and minimize their behavior. For example, an abuser might forcibly push the victim down a flight of stairs, then tell others that the victim tripped. Abusers also rationalize serious physical assaults, such as punching or choking, as "self-defense." Abusers who refuse to admit they are harming their partner present enormous challenges to persons who are trying to intervene. Some perpetrators do acknowledge to the victim that the abusive behavior is wrong, but then plead for forgiveness or make promises of refraining

from any future abuse. Even in Situations such as this, the perpetrator commonly minimizes the severity or impact of the abuse.

Victims of Abuse

As with anyone who has been traumatized, victims demonstrate a wide range of effects from domestic violence. The perpetrator's abusive behavior can cause an array of health problems and physical injuries. Victims may require medical attention for immediate injuries, hospitalization for severe assaults, or chronic care for debilitating health problems resulting from the perpetrator's physical attacks. The direct physical effects of domestic violence can range from minor scratches or bruises to fractured bones or sexually transmitted diseases resulting from forced sexual activity and other practices. The indirect physical effects of domestic violence can range from recurring headaches or stomachaches to severe health problems due to withheld medical attention or medications.

Many victims of abuse make frequent visits to their physicians for health problems and for domestic violence-related injuries. Unfortunately, research shows that many victims will not disclose the abuse unless they are directly asked or screened for domestic violence by the physician. It is imperative, therefore, that health care providers directly inquire about possible domestic violence so victims receive proper treatment for injuries or illnesses and are offered further assistance for addressing the abuse.

Psychological Impact

The impact of domestic violence on victims can result in acute and chronic mental health problems. Some victims, however, have histories of psychiatric illnesses that may be exacerbated by the abuse; others may develop psychological problems as a direct result of the abuse.
Examples of emotional and behavioral effects of domestic violence include many common coping responses to trauma, such as:

- Emotional withdrawal
- Denial or minimization
- Impulsivity or aggressiveness
- Apprehension or fear
- Helplessness
- Anger
- Anxiety or hypervigilance
- Disturbance of eating or sleeping patterns
- Substance abuse
- Depression
- Suicide

Some examples of these effects also serve as coping mechanisms for the victims. For example, some victims turn to alcohol to lessen the physical and emotional pain of abuse. Unfortunately, these coping mechanisms can serve as barriers for victims who want help or want to leave their abusive relationships.

Protective Strategies

Protective strategies that frequently are recommended by family, friends, and social services providers include contacting the police, obtaining a restraining order, or seeking refuge at a friend or relative's home or at a domestic violence shelter. It is ordinarily assumed that these suggestions are successful at keeping victims and their children safe from violence. It is crucial to remember, however, that while these strategies can be effective for some victims of domestic violence, they can be unrealistic and even dangerous options for other victims. For example, obtaining a restraining order can be useful in deterring some perpetrators, but it can cause other perpetrators to become increasingly abusive and threatening.

Since these recommendations are concrete and observable, they tend to reassure people that the victim of domestic violence is actively taking steps to address the abuse and to be safe, even if they create additional risks. Furthermore, these options only address the physical violence in a victim's life. They do not address the economic or housing challenges the victim must overcome to survive, nor do they provide the emotional and psychological safety the victims need. Therefore, victims often weigh "perpetrator-generated" risks versus "life-generated" risks as they try to make decisions and find safety.

Typically, victims do not passively tolerate the violence in their lives. They often use very creative methods to avoid and deescalate their partner's abusive behavior. Some of these are successful and others are not. Victims develop their own unique set of protective strategies based on their past experience of what is effective at keeping them emotionally and physically protected from their partner's violence. In deciding which survival mechanism to use, victims engage in a methodical problem-solving process that involves analyzing: available and realistic safety options; the level of danger created by the abuser's violence; and the prior effectiveness and consequences of previously used strategies.

After careful consideration, victims of domestic violence decide whether to use, adapt, replace, or discard certain approaches given the risks they believe it will pose to them and their children. Examples of additional protective strategies victims use to survive and protect themselves include:

- Complying, placating, or colluding with the perpetrator;
- Minimizing, denying, or refusing to talk about the abuse for fear of making it worse;
- Leaving or staying in the relationship so the violence does not escalate;

- Fighting back or defying the abuser;
- Sending the children to a neighbor or family member's home;
- Engaging in manipulative behaviors, such as lying, as a way to survive;
- Refusing or not following through with services to avoid angering the abuser;
- Using or abusing substances as an "escape" or to numb physical pain;
- Lying about the abuser's criminal activity or abuse of the children to avoid a possible attack;
- Trying to improve the relationship or finding help for the perpetrator.

Although these protective strategies act as coping and survival mechanisms for victims, they are frequently misinterpreted by laypersons and professionals who view the victim's behavior as uncooperative, ineffective, or neglectful. Because victims are very familiar with their partner's pattern of behavior, they can help the caseworker in developing a safety plan that is effective for both the victim and the children, especially when exploring options not previously considered.

In situations where certain coping strategies have adverse effects, such as using drugs to numb the pain, it is crucial that service providers make available additional support and guidance that offer positive solutions to victims of domestic violence. A thoughtful understanding of the unique approaches used by victims of domestic violence to secure their safety will help community professionals and service providers respond more effectively to their needs.

Barriers to Leaving an Abusive Relationship

The most commonly asked question about victims of domestic violence is "Why do they stay?" Family, friends, coworkers, and community professionals who try to understand the reasons why a victim of domestic violence has not left the abusive partner often feel perplexed and frustrated. Some victims of domestic violence do leave their violent partners while others may leave and return at different points throughout the abusive relationship. Leaving a violent relationship is a process, not an event, for many victims, who cannot simply "pick up and go" because they have many factors to consider. To understand the complex nature of terminating a violent relationship, it is essential to look at the barriers and risks faced by victims when they consider or attempt to leave. Individual, systemic, and societal barriers faced by victims of domestic violence include:

Fear

Perpetrators commonly make threats to find victims, inflict harm, or kill them if they end the relationship. This fear becomes a reality for many victims who are stalked by their partner after leaving. It also is common for abusers to seek or threaten to seek sole custody, make child abuse allegations, or kidnap the children. Historically, there has been a lack of protection and assistance from law enforcement, the judicial system, and social service agencies charged with

responding to domestic violence. Inadequacies in the system and the failure of past efforts by victims of domestic violence seeking help have led many to believe that they will not be protected from the abuser and are safer at home. While much remains to be done, there is a growing trend of increased legal protection and community support for these victims.

Isolation
One effective tactic abusers use to establish control over victims is to isolate them from any support system other than the primary intimate relationship. As a result, some victims are unaware of services or people that can help. Many believe they are alone in dealing with the abuse. This isolation deepens when society labels them as "masochistic" or "weak" for enduring the abuse. Victims often separate themselves from friends and family because they are ashamed of the abuse or want to protect others from the abuser's violence.

Financial Dependence
Some victims do not have access to any income and have been prevented from obtaining an education or employment. Victims who lack viable job skills or education, transportation, affordable daycare, safe housing, and health benefits face very limited options. Poverty and marginal economic support services can present enormous challenges to victims who seek safety and stability. Often, victims find themselves choosing between homelessness, living in impoverished and unsafe communities, or returning to their abusive partner.

Guilt and Shame
Many victims believe the abuse is their fault. The perpetrator, family, friends, and society sometimes deepen this belief by accusing the victim of provoking the violence and casting blame for not preventing it. Victims of violence rarely want their family and friends to know they are abused by their partner and are fearful that people will criticize them for not leaving the relationship. Victims often feel responsible for changing their partner's abusive behavior or changing themselves in order for the abuse to stop. Guilt and shame may be felt especially by those who are not commonly recognized as victims of domestic violence. This may include men, gays, lesbians, and partners of individuals in visible or respected professions, such as the clergy and law enforcement.

Emotional and Physical Impairment
Abusers often use a series of psychological strategies to break down the victim's self-esteem and emotional strength. In order to survive, some victims begin to perceive reality through the abuser's paradigm, become emotionally dependent, and believe they are unable to function without their partner. The psychological and physical effects of domestic violence also can affect a victim's daily functioning and mental stability. This can make the process of leaving and planning for safety challenging for victims who may be depressed, physically injured, or suicidal. Victims who have a physical or developmental disability are

extremely vulnerable because the disability can compound their emotional, financial, and physical dependence on their abusive partner.

Individual Belief System
The personal, familial, religious, and cultural values of victims of domestic violence are frequently interwoven in their decisions to leave or remain in abusive relationships. For example, victims who hold strong convictions regarding the sanctity of marriage may not view divorce or separation as an option. Their religious beliefs may tell them divorce is "wrong." Some victims of domestic violence believe that their children still need to be with the offender and that divorce will be emotionally damaging to them.

Hope
Like most people, victims of domestic violence are invested in their intimate relationships and frequently strive to make them healthy and loving. Some victims hope the violence will end if they become the person their partner wants them to be. Others believe and have faith in their partner's promises to change. Perpetrators are not "all bad" and have positive, as well as, negative qualities. The abuser's "good side" can give victims reason to think their partner is capable of being nurturing, kind, and nonviolent.

Community Services and Societal Values
For victims who are prepared to leave and want protection, there are a variety of institutional barriers that make escaping abuse difficult and frustrating. Communities that have inadequate resources and limited victim advocacy services and whose response to domestic abuse is fragmented, punitive, or ineffective cannot provide realistic or safe solutions for victims and their children.

Cultural Hurdles
The lack of culturally sensitive and appropriate services for victims of color and those who are non-English speaking pose additional barriers to leaving violent relationships. Minority populations include African-Americans, Hispanics, Asians, and other ethnic groups whose cultural values and customs can influence their beliefs about the role of men and women, interpersonal relationships, and intimate partner violence. For example, the Hispanic cultural value of "machismo" supports some Latino men's belief that they are superior to women and the "head of their household" in determining familial decisions. "Machismo" may cause some Hispanic men to believe that they have the right to use violent or abusive behavior to control their partners or children. In turn, Latina women and other family or community members may excuse violent or controlling behavior because they believe that husbands have ultimate authority over them and their children.

Health Care Professionals

Health care professionals have the unique opportunity and responsibility to identify victims of domestic violence and to refer and intervene on their behalf. Often health care providers are the first or only professionals to see the injuries or other medical issues of the abused, yet many victims of domestic violence move in and out of the health care system without identification or referrals. The development and implementation of policies and procedures, reinforced by staff education, may increase the rate of identification of battered adults and their children. As domestic violence recurs, identification may interrupt the cycle of violence and help prevent further incidents of abuse and violence.

Health professionals have a reputation as sources of comfort and care. Generally, patients trust their providers to make suggestions that will benefit their physical and mental wellbeing. Such a relationship can open up avenues of communication that may otherwise have remained closed. This is why it is important for health care providers to ask about the occurrence of domestic violence in the homes of their patients. In one independent study, the majority of women reported a willingness to reveal histories of abuse to health care professionals if asked directly by the professionals. Victim advocates and others encourage health care professionals to take advantage of one-on-one situations with their clients to ask about violence, especially if they suspect abuse.

Barriers to Intervention

When health care providers fail to question patients about abuse, it is usually not because they do not care about their clients' safety, but because of existing or perceived barriers. Such barriers include:

- Cultural differences
- Lack of privacy
- Language differences
- Lack of training on domestic violence
- Lack of time
- Lack of resources/referrals
- Fear or discomfort in asking questions about domestic violence
- Desire not to become involved in the issue with the patient
- Fear of litigation
- Concern about offending patients
- Lack of practical experience on how to intervene
- Misconceptions about the nature of intervention

It is hoped that, despite these barriers, health care workers will make the asking of questions a routine practice and will recognize the benefits of identifying and referring domestic violence victims.

Even when victims do not disclose information about the violence they are experiencing, it is empowering for the victims to know there are people who care and are willing to help when they are ready to disclose. In this small way, the simple act of asking can have a positive effect on the lives of these patients. At other times, the process of asking and intervening by health care professionals may save the life of their patient.

Role of the Healthcare Providers

Because medical professionals are often the first and sometimes only professionals to see a victim of domestic violence, failing to diagnose abuse increases the patient's health risk and could further harm the patient by validating their sense of entrapment.

Before dealing with victims of domestic violence, it is important for the health care provider to evaluate his or her own feelings and prejudices. Victims of domestic violence have endured much – both physically and psychologically – and any indication of disbelief about the abuse may have a devastating effect on the patient's morale and confidence in divulging the truth about the violence he/she experiences.

When faced with the knowledge that any patient is being abused, it is important that providers understand that, even though the victims may feel responsible, the acts of violence are not their fault. The violence is the action and responsibility of the abuser. Domestic violence, elder abuse and child maltreatment are crimes and no one deserves to be abused.

The provider should be patient and sympathetic when working with victims of domestic violence. Victims will often leave 7 to 12 times before leaving the abuser permanently. They stay for many reasons, including but not limited to: the lethality of the situation, the love they feel for their partners, to protect their children, and socioeconomic circumstances. The provider should continue to support the victim regardless of his or her decision to leave or stay with the abuser. The provider should also continue to document any occurrences of injury.

The provider can empower victims by helping them realize that they are strong, resourceful, and clever to have gotten as far as they have under the circumstances. It is important that these compliments be honest and reasonable. The provider may want to suggest that patients keep a journal about the violence they experience. Victims will know if they would be able to do this safely.

It is natural for providers to want to present a solution to the problem; however, by empowering patients to make their own choices, the provider will be helping patients realize their potential for taking control of their own lives. It is important for the health care provider to be realistic and honest with the patient. Suggesting

that patients confront abusers about their intention to leave may increase the lethality of the situation.

Recognizing Abuse

Although abusive relationships may differ in dynamics from one couple to another, research has shown that there are basic dynamics and certain indicators of abuse. Listed below are injuries or conditions that should raise suspicion of abuse:

- Recent trauma history
- Injury to the head, neck, torso, breasts, abdomen, or genitals
- Bilateral or multiple injuries
- Unexplained injuries, or injuries that are inconsistent with the patient's story
- Delay in seeking medical treatment
- Physical injury during pregnancy, especially on the breasts and abdomen
- Chronic pain symptoms for which no etiology is apparent
- Behavioral cues such as depression, suicide ideation, anxiety, sleep disorders, panic attacks, symptoms of post-traumatic stress disorder, and alcohol/substance abuse problems
- Overly protective, controlling partner, or a partner who refuses to leave patient
- Direct or indirect references to abuse
- Defensive wounds such as bruises/ lacerations on backs of forearms, hand, etc.
- Strangulation

Asking Questions

The health care provider's primary concern should be for the safety of the staff and the victim. Never inquire about abuse in the presence of any person who accompanies the patient. Appearances can be deceiving. Do not assume that the person who accompanies the patient has the patient's best interest at heart. Perpetrators of domestic violence are often very controlling and may not allow the victim to be alone for fear of disclosure. Providers should be prepared and have a plan for separating the perpetrator and the victim in a non-confrontational way that ensures the safety of the victim and the staff.

If a mother is accompanied by children greater than 2 years of age, then separate the mother from the children so that she can be questioned in privacy. If this is not possible, questioning may have to wait for a safer, more private situation. Never ask accompanying family or friends to act as an interpreter when there are questionable injuries. This includes interpreting for the deaf and/or for non-English speaking patients. Always use a professional interpreter.

Normalize questioning by explaining to the patient that the questions are a new personal standard or agency policy (if applicable). Most patients will not be offended if they know the questioning is policy or standard practice.

If the patient is a victim of domestic violence and is willing to discuss the problem, follow up on the issue at every visit if it is safe to do so. Respect the decision of the patient to discuss the problem or to remain silent about the issue. Victims of domestic violence will discuss the problem when they are ready. If abuse is suspected, but the patient denies being abused, the clinician may want to pose more than one question about the issue. Document the questions asked about abuse and the patient's response.

When asking questions, remember that the manner in which you ask the question is just as important as the question itself. Domestic violence is a very personal, sensitive subject and should be dealt with in a respectful, nonjudgmental way. How a question is asked is dependent on the patient. Some people may respond better to direct questions, while others may need a question framed in such a way that will not make them defensive. Questions can be softened by framing them. Below are two examples of framed questions.

"Because violence is so common in our lives today, I have begun asking all of my patients if they are in a relationship with someone who may be hurting or controlling them."

"Because violence is so common in many people's lives and witnessing violence can have negative effects on children, we've begun to ask all our families about their experience with violence."

Questions healthcare providers should avoid:

- Are you a battered woman?
- Does your husband beat you?
- You're not being hurt by your boyfriend, are you?
- Your child isn't witnessing the abuse, is she?

Intervention Basics

Health care providers should:

- Assure patients of confidentiality to the extent allowed under the state's mandatory reporting laws.
- Listen to the patient.
- Respond to the patient's feelings.
- Acknowledge that disclosure is scary for the patient.
- Tell the patient that you are glad she or he told you.
- Provide the patient with options and resources.
- Document the information in the patient's chart.

- File mandatory reports.
- Schedule a follow-up visit.

Health care providers should not:

- Joke about the violence.
- Minimize the issue or try to change the subject.
- Discuss the abuse in front of the suspected perpetrator.
- Violate confidentiality, unless it falls under the state's mandatory reporting laws.
- Give advice or dictate an appropriate response.
- Shame or blame the patient.
- Grill the patient for excessive details of the abuse.
- Lie about the legal and ethical responsibilities to report suspected abuse.

Documentation

In the past decade, a great deal has been done to improve the way the health care community responds to domestic violence. One way that effort has paid off is in medical documentation of abuse. Many health care protocols and training programs now note the importance of such documentation. But only if medical documentation is accurate and comprehensive can it serve as objective, third-party evidence useful in legal proceedings.

For a number of reasons, documentation is not as strong as it could be in providing evidence, so medical records are not used in legal proceedings to the extent they could be. In addition to being difficult to obtain, the records are often incomplete or inaccurate and the handwriting may be illegible. These flaws can make medical records more harmful than helpful.

One study of 184 visits for medical care in which an injury or other evidence of abuse was noted revealed major shortcomings in the records:

- For the 93 instances of an injury, the records contained only 1 photograph. There was no mention in any records of photographs filed elsewhere (for example, with the police).
- A body map documenting the injury was included in only 3 of the 93 instances. Drawings of the injuries appeared in 8 of the 93 instances.
- Clinician's handwriting was illegible in key portions of the records in one-third of the patients' visits in which abuse or injury was noted.
- All three criteria for considering a patient's words an excited utterance were met in only 28 of the more than 800 statements evaluated (3.4%). Most frequently missing was a description of the patient's demeanor, and often the patient was not clearly identified as the source of the information.

Thorough and accurate medical documentation must be made a priority because it can be submitted as evidence for obtaining a range of protective relief (such as a restraining order). Victims can also use medical documentation in less formal legal contexts to support their assertions of abuse. Persuasive, factual information may qualify them for special status or exemptions in obtaining public housing, welfare, health and life insurance, victim compensation, and immigration relief related to domestic violence and in resolving landlord-tenant disputes.

For formal legal proceedings, the documentation needs to be strong enough to be admissible in a court of law. Typically, the only third-party evidence available to victims of domestic violence is police reports, but these can vary in quality and completeness. Medical documentation can corroborate police data. It constitutes unbiased, factual information recorded shortly after the abuse occurs, when recall is easier.

Medical records can contain a variety of information useful in legal proceedings. Photographs taken in the course of the examination record images of injuries that might fade by the time legal proceedings begin, and they capture the moment in a way that no verbal description can convey.

Body maps can document the extent and location of injuries. The records may also hold information about the emotional impact of the abuse. However, the way the information is recorded can affect its admissibility. For instance, a statement about the injury in which the patient is clearly identified as the source of information is more likely to be accepted as evidence in legal proceedings. Even poor handwriting on written records can affect their admissibility.

Improving Documentation

Unfortunately, most health care providers have received very little information about how medical records can help domestic violence victims take legal action against their abusers. They often are not aware that admissibility is affected by subtle differences in the way they record the injuries. By making some fairly simple changes in documentation, health care professionals can dramatically increase the usefulness of the information they record and thereby help their patients obtain the legal remedies they seek.

Clinicians should do all of the following to ensure proper documentation:

- Take photographs of injuries known or suspected to have resulted from domestic violence.
- Write legibly. Computers can also help overcome the common problem of illegible handwriting.
- Set off the patient's own words in quotation marks or use such phrases as "patient states" or "patient reports" to indicate that the information recorded reflects the patient's words. To write "patient was kicked in abdomen" obscures the identity of the speaker.

- Avoid such phrases as "patient claims" or "patient alleges," which imply doubt about the patient's reliability. If the clinician's observations conflict with the patient's statements, the clinician should record the reason for the difference.
- Use medical terms and avoid legal terms such as "alleged perpetrator," "assailant," and "assault."
- Describe the person who hurt the patient by using quotation marks to set off the statement. The clinician would write, for example: The patient stated, "My boyfriend kicked and punched me."
- Avoid summarizing a patient's report of abuse in conclusive terms. If such language as "patient is a battered woman," "assault and battery," or "rape" lacks sufficient accompanying factual information, it is inadmissible.
- Do not place the term "domestic violence" or abbreviations such as "DV" in the diagnosis section of the medical record. Such terms do not convey factual information and are not medical terminology. Whether domestic violence has occurred is determined by the court.
- Describe the patient's demeanor, indicating, for example, whether she is crying or shaking or seems angry, agitated, upset, calm, or happy. Even if the patient's demeanor belies the evidence of abuse, the clinician's observations of that demeanor should be recorded.
- Record the time of day the patient is examined and, if possible, indicate how much time has elapsed since the abuse occurred. For example, the clinician might write, Patient states that early this morning his boyfriend hit him.

The patient's "excited utterances" or "spontaneous exclamations" about the incident are an exception to the prohibition of hearsay rule and can prove to be extremely valuable. These are statements made by someone during or soon after an event, while in an agitated state of mind. They have exceptional credibility because of their proximity in time to the event and because they are not likely to be premeditated.

Excited utterances are valuable because they allow the prosecution to proceed even if the victim is unwilling to testify. These statements need to be carefully documented. A patient's report may be admissible if the record demonstrates that the patient made the statement while responding to the event stimulating the utterance (the act or acts of abuse). Noting the time between the event and the time the statements were made or describing the patient's demeanor as she made the statement can help show she was responding to the stimulating event. Such a showing is necessary to establish that a statement is an excited utterance or spontaneous exclamation, and thus an exception to the hearsay rule.

Barriers to Good Documentation

There are several reasons medical recordkeeping is not generally adequate. Health care providers are concerned about confidentiality and liability.

They are concerned about recording information that might inadvertently harm the victim. Many are confused about whether, how, and why to record information about domestic violence, so in an effort to be "neutral," some use language that may subvert the patient's legal case and even support the abuser's case.

Some health care providers are afraid to testify in court. They may see the risks to the patient and themselves as possibly outweighing the benefits of documenting abuse. Even health care providers who are reluctant to testify can still submit medical evidence. Although the hearsay rule prohibits out-of-court statements, an exception permits testimony about diagnosis and treatment. In addition, some States also allow the diagnosis and treatment elements of a certified medical record to be entered into the evidentiary record without the testimony of a health care provider. Thus, in some instances, physicians and other health care providers can be spared the burden of appearing in court.

Reporting Abuse

In most states, health care professionals cannot be discharged, suspended, disciplined, or harassed for making a report of abuse. However, inversely, many states do enforce penalties against providers who fail to report suspected or confirmed cases of abuse. Such consequences can include: being charged with a misdemeanor, time in jail, and both personal and corporate fines.

When possible, a provider may want to offer a patient the option to immediately report to law enforcement. This will empower a victim to take control of their own situation and provide law enforcement with more detailed information regarding the crime.

When reporting incidents of abuse, providers should report to the municipal or county law enforcement agency where the injury occurred. If abuse occurs in more than one jurisdiction, notify the authorities closest and report the injuries that took place in that jurisdiction.

Again, it is important to document that the case was reported. If there are children in the home and they may have witnessed the abuse, then it is recommended that children family services also be notified.

Documentation of the report of abuse should include:

- Which law enforcement agency was contacted.
- What phone number was called.
- When the contact was made.
- Name of the law enforcement officer spoken with.
- Case number assigned by the law enforcement agency.

What to include in the report:

- Name and address of the injured person.
- Injured person's whereabouts, if known.
- Character and extent of the person's injuries.
- Name, address, and phone number of the person making the report.
- Information on any children who may have witnessed the incident.

After a report of abuse is made to law enforcement, the health care provider is required to inform the patient of the report, according to the HIPAA Privacy Rule (below). However, if the health care provider, in the exercise of professional judgment, believes informing the individual would place the patient in greater danger, he/she is absolved of this requirement.

HIPAA Regulations

The Health Insurance Portability and Accountability Act (HIPAA) permits covered entities to disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence. Such disclosures can be made only to government agencies authorized by law to receive such reports, such as:

- *Public health authorities*
- *Social service or protective services agencies*
- *Law enforcement authorities*

HIPAA allows providers to disclose abuse that is required to be reported to comply with state law.

The following is excerpted from the Health Insurance Portability and Accountability Act 42CFR Section 164.512(c).

Standard: Disclosures about victims of abuse, neglect or domestic violence.

(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual
or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

> *(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.*

Health care providers should never dictate a specific course of action to the patient. In abusive relationships, the victim has always been told what to do. By offering information to patients, the provider will be giving them the tools to make choices for themselves.

The patient may, understandably, become distressed when the health care provider informs the patient of a domestic violence report. The patient may beg the provider to forgo notifying the authorities. The victim may be afraid that his/her children will be removed or that he/she will be in more danger once the police are involved. Being supportive but honest and straightforward is the best response. Explain to the patient the legal requirements of health care providers. Use this opportunity to educate the patient about domestic violence.

It is important for the health care provider to be supportive of the patient after a report to authorities is made. The patient may be nervous, apprehensive or afraid. Some suggestions for supporting the victim after the report is made include:

- Contacting a crisis worker or social worker within your organization if one is available.
- Contacting a victim advocate on behalf of the victim.
- Providing the victim with resources and referral numbers.
- Offering to contact clergy of the victim's faith. Many hospitals have clergy on-site who may be able to offer comfort and resources to the victim.

Supplemental Information

The prevalence of exposure to domestic violence and the factors associated with co-occurrence of psychological and physical violence exposure: a sample from primary care patients
Selic, P., Pesjak, K., & Kersnik, J. (2011). The prevalence of exposure to domestic violence and the factors associated with co-occurrence of psychological and physical violence exposure: a sample from primary care patients. *BMC Public Health*, *11*(1), 1. CC BY 2.0

Post-traumatic Stress in Children and Adolescents Exposed to Family Violence: I. Overview and Issues
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Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence
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Complementary and Alternative Medicine for Victims of Intimate Partner Abuse: A Systematic Review of Use and Efficacy
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Domestic Violence: The Medical Forensic Response
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Bell, K. M., & Higgins, L. (2015). The impact of childhood emotional abuse and experiential avoidance on maladaptive problem solving and intimate partner violence. *Behavioral Sciences*, *5*(2), 154-175. CC BY 4.0

Resources

Asian and Pacific Islander Institute on Domestic Violence
450 Sutter St #600, San Francisco, CA 94108
Phone 415-954-9988 ext. 315, Website www.apiahf.org/apidvinstitute

The Black Church and Domestic Violence Institute
2740 Greenbriar Parkway #256, Atlanta, GA 30331
Phone 770-909-0715, Website www.bcdvi.org

Children's Defense Fund
25 "E" Street NW, Washington, DC 20001
Phone 202-628-8787, Website www.childrensdefense.org

Family Violence Prevention Fund
383 Rhode Island Street #304, San Francisco, CA 94103
Phone 415-252-8900, TTY 1-800-595-4889, Website www.endabuse.org

INCITE! Women of Color Against Violence
Website www.incite-national.org

Institute on Domestic Violence in the African American Community
University of Minnesota School of Social Work, College of Human Ecology
290 Peters Hall, 1404 Gortner Avenue, St. Paul, MN 55108
Phone 1-877-643-8222, Website www.dvinstitute.org

Jewish Women International
2000 "M" Street NW #720, Washington, DC 20036
Phone 1-800-343-2823, Website www.jewishwomen.org

LAMBDA GLBT Community Services
216 S. Ochoa Street, El Paso, TX 79901
Phone 206-350-4283, Website www.lambda.org

National Center for Elder Abuse
1201 - 15th Street NW #350, Washington, DC 20005
Phone 202-898-2586, Website www.elderabusecenter.org

National Center on Domestic and Sexual Violence
4612 Shoal Creek Boulevard, Austin, TX 78756
Phone 512-407-9020, Website www.ncdsv.org

National Clearinghouse on Abuse in Later Life
Wisconsin Coalition Against Domestic Violence
307 S. Paterson Street #1, Madison, WI 53703
Phone 608-255-0539, Website www.ncall.us

National Clearinghouse on Child Abuse and Neglect Information
330 "C" Street SW, Washington, DC 20447
Phone 1-800-394-3366, Website nccanch.acf.hhs.gov

National Coalition of Anti-Violence Programs
240 W. 35th Street #200, New York, NY 10001
Phone 212-714-1184, Website www.ncavp.org

National Domestic Violence Hotline
P.O. Box 161810, Austin, TX 78716
Phone 1-800-799-7233, TTY 1-800-787-3224, Website www.ndvh.org

National Gay and Lesbian Task Force
1325 Massachusetts Avenue NW #600, Washington, DC 20005
Phone 202-393-5177, Website www.ngltf.org

National Health Resource Center on Domestic Violence
Family Violence Prevention Fund
383 Rhode Island Street #304, San Francisco, CA 94103
Phone 1-888-792-2873, Website www.endabuse.org

National Latino Alliance for the Elimination of Domestic Violence (ALIANZA)
700 Fourth St SW, Albuquerque, NM 87102
Phone 505-224-9080, Website www.dvalianza.org

National Network to End Domestic Violence
660 Pennsylvania Avenue SE #303, Washington, DC 20003
Phone 202-543-5566, Website www.nnedv.org

Rape, Abuse & Incest National Network (RAINN)
2000 L Street NW, Suite 406, Washington, DC 20036
Phone 1-800-656-4673 ext. 3, Website www.rainn.org

Sacred Circle
National Resource Center to End Violence Against Native Women
722 Saint Joseph Street, Rapid City, SD 57701
Phone 1-877-733-7623

STOPDV, Inc.
PO Box 1410, Poway, CA 92074
Phone 858-679-2913, Website www.stopdv.com

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Domestic Violence

Post-Test

1. Which one of the following statements is FALSE? (p. 3-5)
    A. Intimate partner violence is a sub-category of domestic violence that includes any form of forced sex or sexual degradation.
    B. Domestic violence is a pattern of coercive behavior designed to exert power and control.
    C. Domestic violence includes economic actions or threats.
    D. Social isolation is an example of emotional abuse.

2. Which one of the following statements is TRUE? (p. 5-6)
    A. Females are victims of intimate partner violence at a rate about three times that of males.
    B. Females between the ages of 16 and 24 are most vulnerable to domestic violence.
    C. Domestic violence constitutes 8% of violent crime against females.
    D. Approximately 14% of homosexuals are victims of domestic violence at some time in their lives.

3. Abusers engage in domestic violence because they _____. (p. 9-10)
    A. suffer from unresolved self-loathing tendencies
    B. want to have power and control over another
    C. are cognitively and psychologically unstable
    D. have altered perceptions of societal norms

4. Protective strategies _____. (p. 13-14)
    A. allow victims of abuse to passively tolerate the violence in their lives
    B. are successful only when they include police intervention
    C. act as coping and survival mechanisms for victims of abuse
    D. are behaviors that are usually uncooperative, ineffective, or neglectful for the victim

5. Which of the following is NOT a common barrier that keeps victims in abusive relationships? (p. 14-16)
    A. Weakness and masochistic self-identity
    B. Poverty
    C. Religious beliefs
    D. Limited community advocacy services

6. Which of the following is a patient injury or condition that should raise a clinician's suspicion of abuse? (p. 19)

A. Delay in seeking medical treatment
B. Physical injury during pregnancy
C. Bruising on bilateral forearms
D. All of the above

7. _____ is an effective technique used to soften questions that patients may otherwise be hesitant or reluctant to answer. (p. 19-20)

A. Distancing
B. Approximating
C. Molding
D. Framing

8. Health care providers should NOT include which of the following in the medical record? (p. 22-23)

A. Photographs of injuries
B. The phrase "The patient claims…"
C. A description of the patient's demeanor
D. Excited utterances made by the patient

9. Health care providers should report suspected abuse to _____. (p. 24-25)

A. the municipal or county law enforcement agency where the injury occurred
B. the county district attorney's office where the patient is being treated
C. the state domestic abuse hotline
D. HIPAA

10. Per HIPAA regulations, health care providers must inform the patient after a report of abuse is made to law enforcement. The only exception to this is if ____. (p. 25-26)

A. law enforcement officials confirm that they have already received a report from another health care provider concerning the same situation.
B. the provider cannot substantiate the patient's claims of abuse
C. the provider believes informing the patient would place the patient in greater danger
D. the provider has been told by the patient that they do not want the abuse reported to law enforcement

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