Domestic/Intimate Partner Violence: The Nurses' Role
Florida State Mandated Course

NYSNA Continuing Education

This course meets the Florida State Requirements for Mandatory Continuing Education on Domestic Violence as defined in S741.28 as part of biennial relicensure.

NYSNA has been granted provider status by the Florida State Board of Nursing as a provider of continuing education in nursing (Provider number 50-1437).

This continuing nursing education activity was approved by the New York State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

It has been awarded 2 contact hours.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the Professional licensing board within that state.

How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. Be sure to print the certificate and keep it for your records.

Introduction

This course meets the Florida State requirements for mandatory continuing education on domestic violence as defined in S741.28 as part of biennial relicensure.

Pick up a newspaper or watch the television news almost anywhere in the United States, and with alarming regularity, there are stories about the attack or even murder of a woman by her husband, estranged husband, live-in boyfriend, or current or former intimate partner.

Domestic violence, now often referred to as intimate partner violence or intimate violence, is primarily a crime against women. Consider the following statistics:

- Nearly 5.3 million intimate partner victimizations occur each year among U.S. women ages 18 and older. This violence results in nearly 2 million injuries and nearly 1,300 deaths (CDC, 2003).
- In the State of Florida, there were a total of 120,697 domestic violence incidents reported in 2003. Domestic violence accounted for 40% of all comparably reported violent offenses (FDLE, 2005a).
- Domestic violence accounted for 179 (19%) of the State of Florida's 924 murders during 2003. The spouse or live-in partner was the victim in 59% of these offenses. Children accounted for 13% of the victims (FDLE, 2005a).
- The number of violent crimes against women declined during the period from 1993 to 2001; in 1993 there were 1.1 million nonfatal violent crimes; in 2001 there were 588,490. This is a decline of almost 49% (USDJ, BJS, 2003).
- The number of violent crimes against men also declined from 1993 to 2001. In 1993 there were 162,870 violent crimes by an intimate partner; by 2001 there were 103,220. This is a decline of almost 42% (USDJ, BJS, 2003).
- Between 1993 and 2000, the proportion of male murder victims killed by an intimate partner was relatively stable, while the proportion of female murder victims killed by an intimate partner rose slightly (USDJ, BJS, 2003).
- The number of men murdered by an intimate partner dropped 68% from 1976 to 2000. In 1976, there were 1,357 murders; in 2000 there were 440 (USDJ, BJS, 2003).
- The number of women murdered by an intimate partner was stable for almost 20 years, but declined after 1993. The number of women murdered by an intimate partner in 1976 was 1,600; in 2000 there were 1,247 killed by intimate partners; this is a 22% decline (USDJ, BJS, 2003).
- Nine percent of murder victims in 2003 were killed by their spouse or intimate partner. Seventy-nine percent of those victims were female (FBI, 2004).
- Nearly 25% of women have been raped and/or physically assaulted by an intimate partner at some point in their lives, and more than 40% of the women who experience partner rapes and physical assaults sustain a physical injury (Tjaden & Thoennes, 2000b).
- According to the Family Violence Prevention Fund (http://endabuse.org), the average charge for medical services provided to abused women, children and older people was $1,633 per person per year. This would amount to a national annual cost of $857.3 million for the medical services; the additional cost of lost wages, lost productivity, etc. were not included.

- The Centers for Disease Control and Prevention estimates that the annual cost of lost productivity due to domestic violence equals $727.8 million, with more than 7.9 million paid workdays lost each year—the equivalent of 32,000 full-time jobs. Additionally, nearly 5.6 million days of household productivity is lost as a result of the violence (CDC, 2003).

Intimate partner violence is an epidemic public health problem. Despite its magnitude, it is frequently not recognized in the healthcare setting. Healthcare providers may treat the injuries, but often fail to identify the victims of intimate partner violence. Therefore the violence is not identified and it is not treated in the healthcare setting. This lack of recognition contributes to the ongoing abuse and suffering of victims.

Nurses and other healthcare professionals are critical links in the treatment and safety of persons involved in intimate partner violence. Victims are often not forthcoming about the nature of their injuries; they need for healthcare providers to initiate the discussion about the violence. Since nurses provide care to persons in every stage of life in a wide range of settings, they are in a unique position to intervene. Improving recognition of cases of intimate partner violence and the utilization of appropriate interventions can help to prevent the cycle of violence and the suffering it causes.

This course provides the startling facts about intimate partner violence and information that can be used by nurses in all settings to help them assess, recognize and intervene. This course meets the State of Florida mandatory continuing education requirement for nurses.

Note: “She” and “Her” are used when referring to victims and “He” and “Him” refer to the abuser because of the significant prevalence of gender related incidences. This does not imply that domestic violence cannot be female against male, or female against female, or male against male.

Objectives

At the completion of this course the learner will be able to:

- Define domestic/intimate partner violence.
- Discuss the impact of violence on the family.
- Identify 3 warning signs of potential abuse.
- State 3 nursing interventions during routine screening for domestic/intimate partner violence.
- State 3 effective questions that may be asked when screening.
- Identify 3 resources for treatment of domestic/intimate partner violence.

Definitions

Definitions of intimate partner violence can be confusing; multiple terms exist that have the same or similar meanings. What is considered intimate partner violence? Is it the same as domestic violence? What is considered violence against women? What is intimate violence? There exists a lack of consensus about the terms utilized to describe the violence that is perpetrated on women. Researchers have used terms related to violence in different ways and have used different terms to describe the same acts.

Not surprisingly, these inconsistencies have contributed to varied conclusions about the incidence and prevalence of violence against women. The lack of consistent information about the number of women affected by violence limits the ability to respond to the problem in several ways. It limits the ability to gauge the magnitude of violence against women; the identification of those groups at highest risk who might benefit from focused intervention or increased services are not easily identified; the ability to monitor changes in the incidence and prevalence of violence against women over time is limited. ***Additionally, these inconsistencies are evidenced in this course. The reader is cautioned, when viewing statistics regarding intimate partner violence the exact definitions used by each researcher may vary significantly, contributing to numbers that are inconsistent and that vary widely.***

Intimate partner violence can include intentional harm inflicted by one person on another within or following an intimate or domestic relationship. This includes physical, emotional, verbal and sexual abuse,

neglect and exploitation. Domestic violence, spousal homicide, spouse abuse, partner abuse, intimate violence, woman battering, child abuse, dating violence, same sex violence, sexual assault, date rape, marital rape, stalking and elder abuse all fall within the broad category of domestic violence.

As indicated by the National Research Council's report on Understanding Violence Against Women, the term, "violence against women" has been used to describe a wide range of acts, including murder, rape and sexual assault, physical assault, emotional abuse, battering, stalking, prostitution, genital mutilation, sexual harassment, and pornography (National Research Council, 1996).

In an effort to standardize the terms utilized relative to violence the National Center for Injury Control and Prevention (2003), part of the Centers for Disease Control and Prevention (CDC), developed definitions for consistency in terminology and data collection. These include:

Victim - Person who is the target of violence or abuse.

Perpetrator – Person who inflicts the violence or abuse or causes the violence or abuse to be inflicted on the victim.

Intimate Partners – Includes:

- Current spouses, including common-law spouses.*
- Current non-marital partners, including dating partners, first dates, boyfriends, girlfriends (heterosexual and same-gender).
- Former marital partners including divorced spouses, former common-law spouses, separated spouses, heterosexual and same-gender.
- Former non-marital partners, including former dates, former boyfriends/girlfriends, heterosexual and same-gender.

Intimate partners may be cohabiting, but need not be. The relationship need not involve sexual activities. If the victim and the perpetrator have a child in common but no current relationship, then by definition they fit in the category of former marital partners or former non-marital partners. States differ as to what constitutes a common-law marriage (only 10 states officially recognize common-law marriage).

*Please note that the NCICP definition does not include same-gender domestic partners or spouses. Although the laws of each state differ regarding common-law marriage, they are generally restricted to heterosexual couples. The omission of same-sex domestic partners in the NCICP definitions should not be interpreted as evidence that intimate partner violence does not occur in the gay, lesbian, and transgendered community (See "Who is Affected by Domestic Violence" later in this course). Additionally, as laws are changing in a number of states, marriages among couples of the same gender are occurring and have yet to be included in the statistics.

Violence is divided into four categories:

- Physical Violence
- Sexual Violence
- Threat of Physical or Sexual Violence
- Psychological/Emotional Abuse, including verbal abuse, coercive tactics, when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence.

Physical Violence – The intentional use of physical force with the potential for causing death, disability, injury or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

Sexual Violence – Sexual violence is divided into three categories:

- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.
- An attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).
- Abusive sexual contact.

Sex Act or Sexual Act – Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.

Abusive Sexual Contact – Intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).

Threat of Physical or Sexual Violence – The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. Also the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent.

Examples include: "I'll kill you"; "I'll cut you if you don't have sex with me"; brandishing a weapon; firing a gun into the air; making threatening hand gestures; reaching toward a person's breasts or genitalia.

Psychological/Emotional Abuse – Trauma to the victim caused by acts, threats of acts, or coercive tactics, such as those on the following list. This list is not exhaustive. Other behaviors may be considered emotionally abusive if they are perceived as such by the victim. Some of the behaviors on the list may not be perceived as psychologically or emotionally abusive by all victims. The expert panel for this joint venture of The National Institute of Justice and the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention defined psychological and emotional abuse as a type of violence when there had also been prior physical or sexual violence, or the prior threat of physical or sexual violence.

Psychological/emotional abuse can include, but is not limited to:

- Humiliating the victim.
- Controlling what the victim can and cannot do.
- Withholding information from the victim.
- Getting annoyed if the victim disagrees.
- Deliberately doing something to make the victim feel diminished (e.g., less smart, less attractive).
- Deliberately doing something that makes the victim feel embarrassed.
- Using money that belongs to the victim.

- Taking advantage of the victim.
- Disregarding what the victim wants.
- Isolating the victim from friends or family.
- Prohibiting access to transportation or telephone.
- Getting the victim to engage in illegal activities.
- Using the victim's children to control victim's behavior.
- Threatening loss of custody of children.
- Smashing objects or destroying property.
- Denying the victim access to money or other basic resources.
- Disclosing information that would tarnish the victim's reputation.

We all remember the saying *Sticks and stones may break our bones, but names will never hurt us* but, how many of us were hurt by name calling? Words can be weapons. **Verbal abuse** can be just as scarring, if not more so, than physical abuse. Examples of verbal abuse include (Helpguide, 2004):

- Threatening or intimidating to gain compliance
- Yelling or screaming
- Name-calling
- Constant harassment
- Embarrassing, making fun of, or mocking the victim, either alone within the household, in public, or in front of family or friends
- Criticizing or diminishing the victim's accomplishments or goals
- Telling the victim that they are worthless on their own, without the abuser
- Saying hurtful things while under the influence of drugs or alcohol, and using the substance as an excuse to say the hurtful things

It is worth mentioning that **spiritual abuse** is also considered by some authors as a form of abuse (Merrell, 2001).

Stalking is defined by Tjaden & Thoennes (1998) as harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. These actions may or may not be accompanied by a credible threat of serious harm. Legal definitions of stalking vary by state, but most define it as the willful, malicious and repeated following and harassing of another person. States also vary in their requirements regarding threat and fear relative to stalking. For example, some states require that the stalker make a credible threat of violence against the victim; other states interpret the alleged stalker's course of conduct as an implied threat.

The violence is a result of a cycle of power and control involving the perpetrator, the victim, children, the destruction of property and pets. This cycle of violence has profound effects on the victim, the family and society. Estimates indicate more than 1 million women and 371,000 men are stalked by intimate partners each year (Tjaden &Thoennes 2000b).

Definition of Domestic Violence in the State of Florida

Florida defines the crime of domestic violence to include the following: murder, manslaughter, forcible rape, forcible sodomy, forcible fondling, aggravated assault, aggravated stalking (since 1995), simple assault, simple stalking (since 1995), threat/intimidation and arson (for the period 1992-1995) (FDLE, 2005).

Who is Affected

Intimate partner violence is a serious criminal justice and public health concern. It affects individuals of all ethnic, racial, religious, age, physical ability, socioeconomic and sexual orientation backgrounds. Despite the alarming number of intimate partner violence episodes that follow, it is generally accepted that these numbers are woefully low and are not accurately reflecting the suffering of so many.

Women are the targets of violence most often; approximately 1.5 million women are victims of intimate partner violence each year, while 834,700 men are victims of intimate partner violence per year (Tjaden & Thoennes, 2000).

In 1999 1,218 women were murdered by their intimate partners. Women age 35-49 were the most vulnerable to intimate murder. During the period from 1993 to 1999, 45% of female murder victims age 20-24 were killed by intimates. Women age 16-24 experienced the highest per capita rates of intimate violence (19.6 victimizations per 1,000 women) (US Department of Justice, Bureau of Justice Statistics, 2001).

The overall incidence of intimate partner violence has decreased (as has the incidence of violent crimes overall nationally) over the past few years, Between 1976 and 1998, the number of male victims of intimate partner homicide fell an average 4% per year and the number of female victims fell an average 1% (USDJ, BJS, 2000).

The National Violence Against Women (NVAW) Survey (2000), conducted jointly by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC), surveyed 16,000 people; 8,000 men and 8,000 women. This survey indicated that intimate partner violence is pervasive in U.S. society:

- Nearly 25 percent of surveyed women and 7.5 percent of surveyed men said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their lifetime.
- Of the 25 percent of women who have been raped and/or physically assaulted by an intimate partner at some point in their lives (noted above), more than 40 percent who sustain a physical injury.
- 1.5 percent of surveyed women and 0.9 percent of surveyed men said they were raped and/or physically assaulted by a partner in the previous 12 months.
- Approximately 1.5 million women are raped and/or physically assaulted by an intimate partner annually in the United States. Because many victims are victimized more than once, the number of intimate partner victimizations exceeds the number of intimate partner victims annually.
- Approximately 4.9 million intimate partner rapes and physical assaults are perpetrated against U.S. women annually.
- Approximately 1.5 million women are raped and/or physically assaulted by an intimate partner each year.
- Nearly two thirds of women who reported being raped, physically assaulted, or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date.
- One of six U.S. women and 1 of 33 U.S. men have experienced an attempted or completed rape as a child and/or adult.
- Of the women who reported an attempted or completed rape in their lifetimes, >21 percent were younger than age 12 when they were first raped, and 32 percent were ages 12–17.

The NVAW Survey (2000) also uncovered that stalking by intimates was more prevalent than previously thought. Stalking requires the victim to feel a high level of fear. Almost 5 percent of surveyed women and 0.6 percent of surveyed men reported being stalked by a current or former spouse, cohabiting partner, or date at some time in their lifetime; 0.5 percent of surveyed women and 0.2 percent of surveyed men reported being stalked by such a partner in the previous 12 months. According to these estimates, 503,485 women and 185,496 men are stalked by an intimate partner annually in the US.

Women are significantly more likely than men, 59% and 30% respectively, to be stalked by intimate partners, about half of whom stalk their partners while the relationship is intact. They also report that there is a strong link between stalking and other forms of violence in intimate relationships: 81% of women who were stalked by a current or former husband or cohabitating partner were also physically assaulted by that partner and 31% were also sexually assaulted by that partner (Tjaden and Thoennes, 1998).

Of every 1,000 pregnant women, 154 are assaulted by their partner during the first 4 months of pregnancy; 170 out of 1,000 are assaulted during the 5th through 9th months (OMWH Factsheet, 1997). As many as 324,000 women each year experience IPV during their pregnancy (Gazmararian, et. al., 2000). Intimate partner violence during pregnancy is a significant health problem.

Among gay men and lesbians, approximately 25% experience intimate violence in their relationships. That is approximately the same rate as in heterosexual relationships (Family Violence Prevention Fund, 1996). However, the National Coalition of Antiviolence Programs (NCAVP) which surveys 11 distinct cities and regions in the US and in Toronto, Canada, the incidence of domestic violence in the gay and lesbian community reached a record in 2003. According to NCAVP (2004) the rate of domestic violence in the gay and lesbian community increased by 13%, for a record number of 6,523 cases (NCAVP, 2004)! This increase was attributed to data from just one US city—Los Angeles. There was also a slight increase on the east coast as well. However, NCACVP data shows that in the non-coastal regions the rate remained the same or declined (for example, in Chicago in 2003 the rate of domestic violence in this population decreased by 12 percent). It is important to recognize that data collection is problematic in this population, because instead of relying on law enforcement agencies, these data are reported by select agencies from each participating city or region. Additionally, among gay men and lesbians there is less likelihood of seeking assistance from law enforcement or treatment providers as victims have to deal with potential heterosexist views in addition to dealing with the intimate violence.

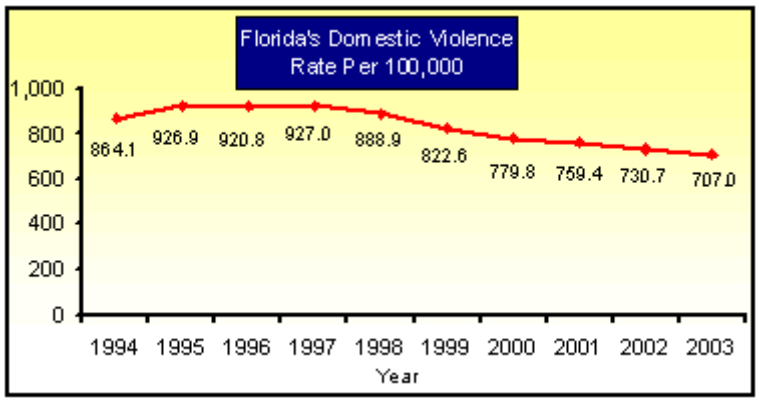
Child abuse occurs in 30-60% of family violence cases that involve families with children (Edleson, 1999). Over 50% of child abductions result from domestic violence (Grief & Hagar, 1991). Forty percent of teenage girls age 14 to 17, report knowing someone their age who has been hit or beaten by a boyfriend (Kaiser Permanente, 1995).

Sexual abuse is estimated to occur among 33% of women and girls. Sexual abuse against disabled girls and women is roughly twice as high as for non-disabled girls and women, making the conservative estimate that at least 60% of disabled females have experienced abuse (New Mobility Magazine, 1995).

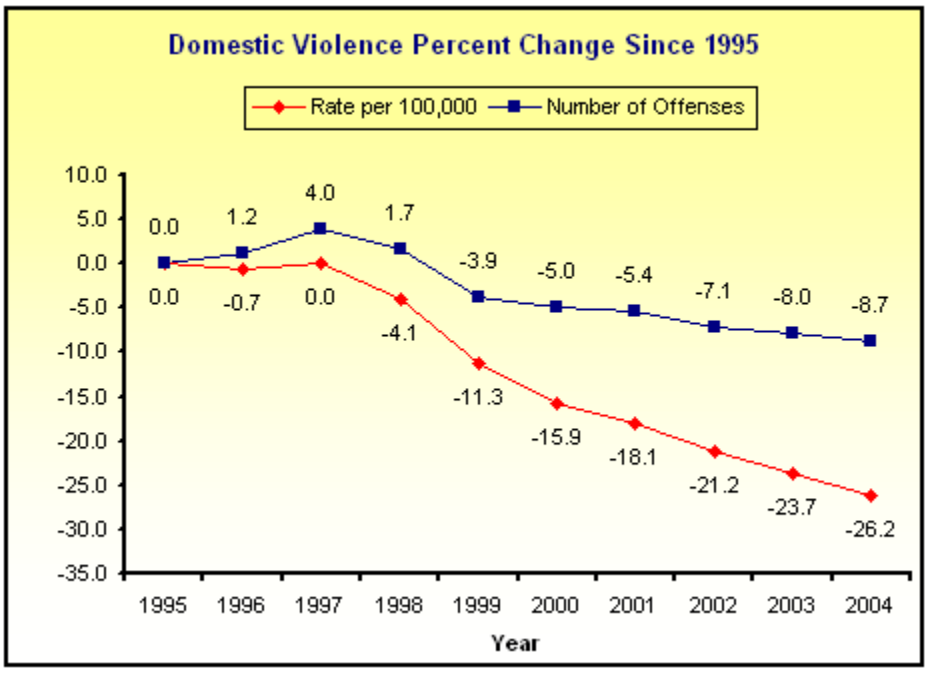
Elder abuse is estimated to be found in 32 of 1,000 persons over age 65. For this population, men are as likely to be abused as women. Of the elderly females being abused, 58% are abused by a spouse, 16% by a son and 8% by a daughter (OMWH, 1997).

In the state of Florida, domestic/intimate partner violence has declined in recent years. After years of steady increases in total domestic/intimate partner violence numbers, the total number of reported domestic violence offenses declined slightly in 1998 and again in 2001. In 2003, as compared to 1994 data, the rate of domestic/intimate partner violence decreased by 18.2 percent

Total Domestic Violence for Florida, 1992-2003 (FDLE, 2005)



Ten Year Trend, 1995-2004



This graph illustrates changes in the volume and rate (per 100,000 population) of domestic violence since 1995. From 1995 to 2004, domestic violence is up .6 percent in number and down 18.2 percent in rate.

A detailed table showing total domestic violence from 1995 - 2004 and from 1992 - 2003, can be viewed and downloaded by going to http://www.fdle.state.fl.us/FSAC/Crime_Trends/domestic_violence/.

Etiology and Contributing Factors

There is no clear, simple cause of intimate partner violence. According to the World Health Organization (WHO) (2003) theories about the etiology of intimate partner violence are many, but two are most often cited: social learning theory and feminist theory. In **social learning theory**, violent behavior is learned from one generation to the next; **feminist theory** advances that the male domination in society is reflected in intimate relationships.

Contributing factors occur on the societal level as well as on the individual level. On the societal level, the WHO (2003) identifies the following contributing factors:

- Poverty; and
- Social norms that reflect male dominance.

As previously stated, perpetrators, like their victims, are part of our culture of dominance and power. Historically, men have had privilege and power just by virtue of being male. Generally speaking, even today, it is accepted and even expected that males are socialized to be dominant, decision makers. For some men, this leads to a perspective that they have a right to dominate and control women and that women are, by their very nature, subservient to men. Ours is a culture that accepts that dominance and that some have the right to exert control over others. Men who perpetrate violence are strong subscribers to these beliefs.

On an individual level, contributing factors include (WHO, 2003):

- Witnessing interparental violence;
- Experienced abuse as a child;
- Having been raised in families with patriarchal values;
- Personal subscription to patriarchal values;
- Use of drugs or alcohol at a rate higher than the abused partner.

Certain experiences and situations seem to contribute to one becoming a perpetrator of violence. They include:

- Having been abused as a child.
- Witnessing abuse of the mother by her partner.
- Losing one's temper more often than is appropriate.
- Expressing anger in violent ways such as destroying property.
- Previous expressed violent attitudes or actions towards others.
- Abuse of alcohol and/or street drugs.
- An overly possessive attitude: constantly needing to know where the partner is, who they are with, what they are doing.
- Limiting and/or controlling the actions of the partner, especially relative to independence.
- May have very strict traditional ideas about gender roles and male privilege.
- Financially limiting the actions of the partner.

The concepts of power and control operate significantly in the perpetrator of abuse. Our culture values power and those who have been socialized in this culture tend to also value power. Hierarchical structures are evident in most of our cultural institutions: schools, churches, workplaces. As a part of living, all of us have engaged in, to some degree, at least some of the tactics batterers use to control their partners.

The Duluth Domestic Abuse Intervention Project (Pence & Paymar, 1993), referred to as "the Duluth Model", began development in the 1980s as a model for effective intervention in domestic violence. This particular model focuses on the issues of power and control in relationships as the basis for violence. The model maintains that violence and abuse in relationships is intentional and is perpetrated to maintain power and control over the victim's actions, thoughts and feelings. Individual acts of violence may occur

impulsively or under chemical influence, but this is not the cause of the behavior. Power over others as a means of controlling them is thought to motivate the actions of the abuser.

The Duluth Model also challenged the previous prevailing view of the cyclic nature of abuse, based on the belief that the perpetrator lost control after experiencing a build up of anger, frustration or painful feelings.

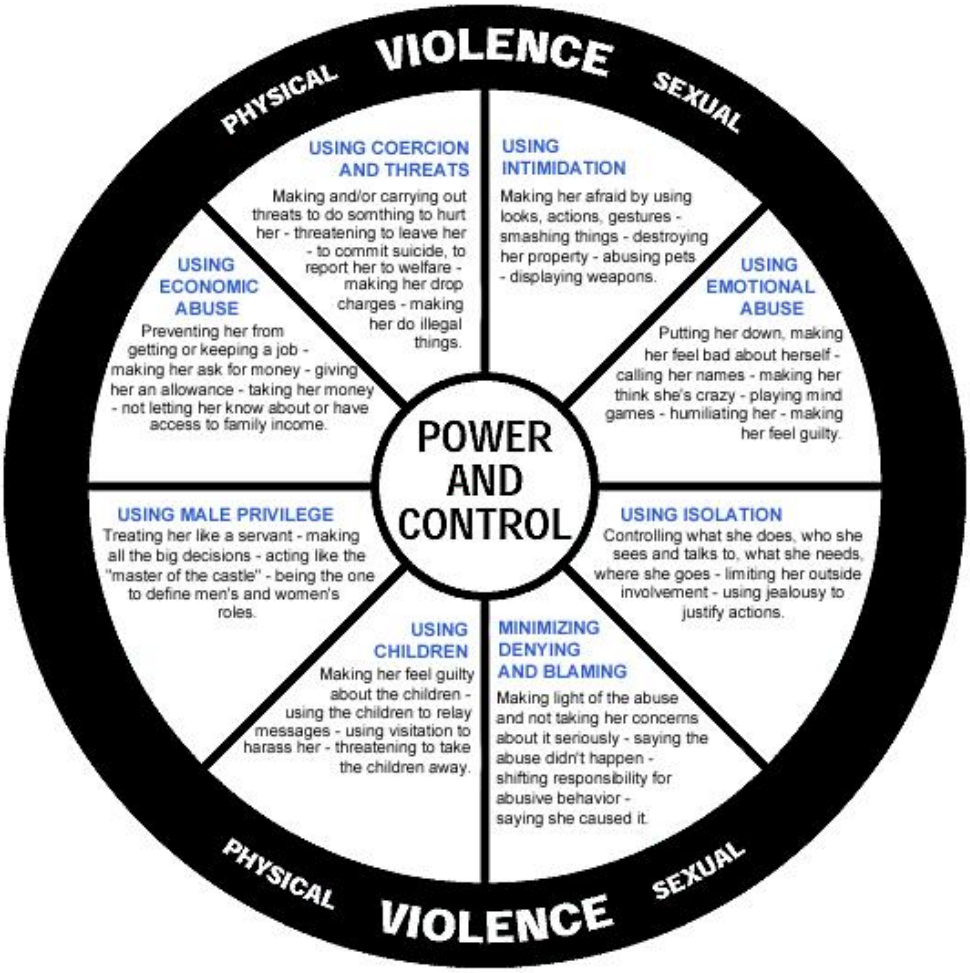
- The first phase was the tension-building phase. In this stage, the longest of the three, the abuser became increasingly angry, argumentative and controlling. The victim responded with attempts to placate the partner to avoid escalating the violence.

- The second phase, the explosion or violence phase occurred when the perpetrator's anger escalated to rage and control was lost. This was the most dangerous stage. This was when physical violence and even murder occurred.

- The third phase was the honeymoon or makeup phase. In this stage the perpetrator was thought to be remorseful and on his best behavior, in an attempt to make amends and keep the victim in the relationship.

- These phases were thought to be of varying duration and intensity.

The Duluth Model maintains that violence is not cyclical, but constant as evidenced by The Power and Control Wheel below. The perpetrator's use of violence is part of an ongoing pattern of power and control.



The intention of the perpetrator is to exert power and control over the victim-illustrated as the center of the wheel. The physical and sexual violence may occur episodically, but the other tactics occur in an ongoing manner and serve to reinforce the physical and sexual violence. These tactics take many forms, as illustrated by the spokes of the wheel:

- **Intimidation** such as inspiring fear in the partner by using looks, actions and gestures, smashing things, destroying the partner's property, abusing pets or displaying weapons.

- **Emotional** abuse can take the form of put-downs, name calling including "objectifying", discounting her, humiliating her, making her feel guilty, making her feel as though she is going crazy, playing "mind games", such as convincing the victim that she precipitates the violence.

- **Isolation** - The abuser may control what she does, who she sees and talks to, what she reads and where she goes, limiting her outside involvement, including working and using jealousy to justify actions. This isolation from family and friends further escalates the control the abuser has over the abused.

- **Minimizing, denying and blaming** are another form of control. Not taking responsibility for his behavior by minimizing can take the form of making light of the abuse and not taking the victims concerns about it seriously. For example "I only hit her once" or "I only pushed her to the floor" (even through the victim has multiple, severe injuries); "The children never saw it." "I never hit her in the face". The perpetrator may externalize responsibility for the behavior by blaming the victim, saying she caused it. For example: "She just nags me too much"; "She

goes out too much"; "She lets the children make a mess"; "She cooks slop that nobody could eat"; "When I drink too much", "When my anger gets out of control", "I have _____ (post traumatic stress disorder or hypoglycemia or attention deficit disorder or mood swings, etc.)". The perpetrator may also deny that the violence occurred at all.

- The abuser may **utilize the children** in order to create guilt, using the children to relay messages, using visitation to harass her and threaten to take the children away.

- The concept of **male privilege** may be significant to the abuser. He may treat the partner like a servant, making all the decisions, behaving as the "master of the castle", and defining men's and women's roles in a very rigid, archaic manner. Additionally, the abuser may distort religious beliefs and ideas in order to justify the abuse (Miles, 1999). The abuse can begin initially in seemingly minor ways, such as discounting the partner, or being "overprotective" and jealous. These behaviors can escalate over time to physical abuse and homicide.

- The abuser may utilize **economic** abuse, preventing her from getting or keeping a job, making her ask for money and giving her a limited allowance, taking her money, not letting her know about or have access to family income.

- **Coercion and threats** can take the form of threatening to hurt her, threatening to leave, commit suicide or make a report to welfare or child protection, forcing her to do illegal things.

About the Perpetrator

What makes a person a perpetrator of violence towards someone he allegedly loves?

As previously stated, perpetrators, like their victims, are part of our culture of dominance and power. Historically, men have had privilege and power just by virtue of being male. Generally speaking, even today, it is accepted and even expected that males are socialized to be dominant, decision makers. For some men, this leads to a perspective that they have a right to dominate and control women and that women are, by their very nature, subservient to men. Ours is a culture that accepts that dominance and that some have the right to exert control over others. Men who perpetrate violence are strong subscribers to these beliefs.

The Duluth Model also identified other common experiences of men who are perpetrators of violence:

- A history of childhood abuse;
- Exposure to male role models who have shown hostile attitudes toward women;
- Exposure to other environments that are women-hating;
- Alcoholism and other substance abuse;
- Racial and class oppression;
- Denial of love and nurturing as a child.

The Duluth Model cautions that the above list is should not be interpreted as an excuse for violent behavior, merely an explanation for why it may be occurring.

Impact of the Violence

The following information is provided by the Office of Women's Health Report, Department of Health and Human Services (DHHS), Domestic Violence Facts on their website http://www.4woman.gov/owh/violence.htm:

- Domestic violence is the leading cause of injury to women between the ages of 15-44.
- Children are involved in 60% of domestic violence cases.
- More than 3 million children witness acts of domestic violence each year.

- Up to 50% of all homeless women and children in this country are fleeing domestic violence.
- One in 10 calls made to police to alert them of domestic violence is placed by a child in the home.
- More than 53% of male abusers beat their children.
- One of every 3 abused children becomes an adult abuser or victim.
- 63% of the boys and young men between the ages of 11 and 20 who are serving time for homicide have killed their mother's abuser.
- Battered women are more likely to suffer miscarriages and to give birth to babies with low birth weights.

In addition to the death, physical injury or increased use of health services, women who are victimized by their intimate partners suffer other consequences (Graffunder, et. al, 2004; Eisenstat and Bancroft, 1999):

- Adverse mental health conditions: low self-esteem, immobilization, poor decision making, self-blame, depression, anxiety disorders, eating disorders, alcoholism, substance abuse and suicide.

- Poor physical health consequences: gynecological problems, sexually transmitted diseases, complications of pregnancy and childbirth, chronic medical conditions, chronic headaches, sleep disturbances, nausea, noncompliance/nonadherence to medical treatment, and a variety of other poorly defined somatic complaints that often lack a clearly identified medical cause.

In addition, children living in homes where intimate partner violence is prevalent have a higher incidence of emotional trauma and behavioral problems as a result of witnessing abuse. They also have higher than average rates of substance abuse, suicide, problems in school, violent and aggressive behavior, sleep disorders, enuresis and chronic somatic disorders. They may suffer constant anxiety, fear of abandonment and guilt for not being able to stop the abuse, or for loving the abuser. Boys who witness domestic violence are more likely to batter their female partners as adults than boys raised in non-violent homes (NYC Labor Union Coalition Against Domestic Violence, 1996).

According to the National Violence Against Women Prevention Research Center (NVAWPRC) (2000), children who witness violence are significantly more likely to have problems in behavioral, emotional, social, cognitive, and physical functioning than do children who have not witnessed intimate partner violence.

Behavioral	**Emotional**	**Physical**	**Cognitive**	**Social**
Aggression	Anxiety	Failure to thrive	Poor academic performance	Aggressive relationships
Tantrums	Depression	Sleeplessness	Language lag	Isolation
Acting out	Withdrawal	Regressive behaviors	Distractibility	Poor peer relationships
Immaturity	Low self-esteem	Eating disorders		Rejection by peers
Truancy	Anger	Poor motor skills		
Delinquency	Irritability	Psychosomatic symptoms		

NVAWPRC (2000) also suggests the following guidelines for addressing the needs of children in noncrisis situations and in general practice:

- Screen children for partner violence.
- Assess children who have been exposed.
- Recognize possible need for child abuse report.
- Assign independent worker to children.
- Consider crisis intervention needs.
- Be developmentally and culturally appropriate.
- Coordinate with other professionals.
- Encourage healthy parenting practices.
- Be aware of child custody issues.
- Promote parent education that teaches about the impact of exposure to partner violence.

Nursing Assessment

Nurses practice in a wide range of settings and have many opportunities for intervention. The first step is to recognize that domestic violence/intimate violence is a widespread public health issue. Its identification and acknowledgment are critical to ending abuse and protecting the health of victims.

According to The American College of Obstetricians and Gynecologists (ACOG) (2005), the physical and emotional sequelae of domestic violence takes many forms, often leading to multiple healthcare visits and possible over-utilization of services because of the failure to identify the underlying etiology. Clinical presentations associated with victimization include:

- Depression, anxiety, post-traumatic stress,
- Eating disorders, sleep disturbances,
- Alcohol, drug, and tobacco abuse,
- Somatization disorders ,
  (e.g. chronic pelvic pain, migraines, gastrointestinal disorders)
- Early initiation of sexual activity, compulsive sexual behaviors, sexual dysfunction,
- Poor or no contraceptive compliance,
- Self-neglect, malnutrition, failure to thrive,
- Aggression towards self and others,
- Suicide attempts,
- Poor adherence to medical recommendations,
- Diminished capacity for acquisition of knowledge (especially in children),
- Lying, stealing, truancy, running away (in children).

It is important to be alert to a range of presentations in victims of violence; physical evidence of abuse is not always the most prominent sign of violence.

The subject of domestic or intimate violence can be difficult for nurses to bring up. Many feel they are not prepared to intervene effectively. In addition, nurses have felt that there is a lack of privacy for screening for domestic violence in their healthcare setting as well as feeling there is not enough time to ask about domestic violence (Ellis, 1999). Regardless of the practice setting, all nurses utilize assessment skills as part of their nursing practice. It is critical to ask questions relative to domestic violence as a routine part of nursing assessment in all practice settings. Some adaptation of the following material will be needed to make it relevant to your specific practice.

Complicating the domestic violence picture further is that nurses are victims of domestic violence in their own intimate relationships. In a recent study, 38% of the nurses completing the survey said they have experienced abuse; 27.3% indicate their partners try to control them; 26.9% indicate they suffer emotional abuse; 22.7% are afraid of their partner; 14.6% have been battered; 8.1% have experienced sexual abuse (Janssen, et al, 1998). Other researchers found that 57% of nurses had personal experience with domestic violence (Ellis, 1999). It is not clear how nurses' own experiences of being, or having been abused, affects their own understanding and ability to screen and care for other women who are victims of domestic violence (Furniss, 1999).

<u>Screening Guidelines</u>

The US Department of Health and Human Services, Agency for Healthcare Quality and Research (AHQR) maintains the National Guideline Clearinghouse, a comprehensive database of evidence-based clinical practice guidelines. The US Preventative Services Task Force (USPSTF) makes recommendations for clinical practice based on their review of the clinical research. The USPSTF grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms). The USPSTF, in their *Screening for family and intimate partner violence: recommendation statement* (2004), rated the evidence as "I", that is, the USPSTF concluded that the evidence was insufficient to recommend for or against routinely providing screening for violence. Evidence that screening is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Despite the "I" rating, multiple clinical experts recommend the routine screening of women patients for intimate partner violence.

Despite the multiple factors that impact on the difficulty surrounding domestic violence screening, the literature indicates that victims of domestic violence feel that **it is up to the healthcare provider to initiate discussion about the abuse.** The following are some general guidelines for initiating discussion about domestic violence.

- It is important for the nurse to maintain a non-judgmental attitude at all times.
- It is important for the nurse to believe the patient, encourage her, but do not pressure her to talk about the violence.
- Show respect for her confidentiality; choose a quiet, private location for discussion, at a time when you are unlikely to be interrupted.
- Conduct aspects of the assessment and all of the discussion **without the partner being present.**
- Listen; support without judging.
- Provide reassurance that the violence is NOT her fault; she is not responsible for her partner's behavior; she cannot change another's behavior.
- Be clear that violence is NEVER justifiable.

Give her the time she needs to make her own decisions, support that she is capable of making her own decisions. Be careful not to tell her what to do or when to leave or not leave. She has been the victim of power and control; she does not need it further from healthcare providers. Be careful not to try to rescue her and make decisions for her.

Victims of abuse are often reluctant to disclose the abuse. The presentation of domestic violence can be so varied, that relying on observable evidence is not adequate. Nurses need to incorporate routine questions about domestic violence into their health assessments and screening. Direct questions must be incorporated into the current and past medical history or social history. Many individuals will readily talk about their violent experiences if they feel it is safe to do so. This includes being treated with dignity and respect, being taken seriously by healthcare providers and being asked questions to which they can relate. For example, an individual woman may not define herself as battered, so she may not recognize herself if asked directly if she is being battered. It is generally more productive to ask specific, direct questions such as "Has your partner ever hit you?" rather than "Are you being battered?"

<u>Sample Questions</u>

You may want to frame your questions by first offering an introduction to the subject. For example:

Domestic violence is very prevalent in our society; estimates are that as many as 4 million women are abused by partners annually. I now ask all my patients about domestic violence. Have you ever been hit by your partner?

I have found in this practice that many women and men are involved with someone who hits them, threatens them, puts them down or tries to control them. Have any of those things happened to you?

Violence is very common in our lives, I now ask everyone about domestic violence. Have you ever experienced violence, or the threat of violence, with your partner?

Many women and some men are involved in abusive relationships, but are too uncomfortable to bring it up during health exams, so I've started asking about it routinely. Are you involved in a relationship where you have experienced or fear violence?

Some direct questions to ask include:

- Is your partner jealous? Are you often accused of infidelity?
- Does your partner put you down?
- Does your partner blame you for the family's problems?
- Does your partner restrict your freedom, such as going to work or school, or seeing your friends or family?
- Has someone hit you?
- Have you been threatened or has someone close to you been threatened?
- Are you ever afraid of your partner?
- Is it safe for you at home?
- Has your partner ever forced you to have sex when you did not want to?
- Has your partner ever tried to control you by threatening to hurt you or someone close to you?

Nurses need to be vigilant to the ways that victims may offer information. Since past abuse can be predictive of future abuse, investigate further if a woman admits to having been abused as a child or if she admits to past injuries inflicted by a partner. For some women, indirect questions may be more appropriate to begin investigating the area of domestic violence. For example:

- Have you been under a lot of stress lately?
- Are you and your partner arguing and fighting more?
- Do the fights get physical?
- Have you gotten hurt?
- Are you ever afraid?
- How do you and your partner deal with conflict?
- Does your partner use alcohol? How does he/she behave when intoxicated? Does his/her behavior ever frighten you?
- Children can be quite a challenge. Does your partner lose his/her temper with the children? What happens?
- Tell me more about how you handle disagreements at home.

<u>Physical Indicators</u>

It is also important to look at this patient in context. How many previous emergency department visits have there been? What have been past injuries? Is there a recurrent trauma history? Is this patient someone who has vague, somatic complaints? Are they "difficult"? Are they a frequent complainer? Does this person present regularly with chronic headache, stomach ache, neck, pelvic or abdominal pain? Insomnia? Is there a delay in seeking medical treatment? A history of suicide attempts and substance abuse definitely needs closer examination. Some victims of abuse have high incidence of sexually transmitted diseases because they are unable to negotiate condom use or other safer sex practices with their partners.

Observation and inquiry are critical; observe the pattern of bruises or other marks on the patient's body. Do they appear only in areas where clothing would ordinarily hide them? Are they symmetrical? Are they bilateral or are there multiple injuries? Are there bruises in various stages of healing? Are there injuries that are inconsistent with the explanation provided? Are the injuries to the head, neck, torso, breasts, abdomen or genitals? Are there marks on the victim, such as on the arms, wrists, or neck? Do they appear as if they could have been made by someone attempting to restrict the victim from walking away?

<u>Behavioral Indicators</u>

Observe the victim with the perpetrator. Remember that wheel of power and control. They will likely revert to it, albeit a more socially acceptable version. The victim may look to the perpetrator prior to answering questions, looking for cues of how to respond. Does the victim seem more anxious when the partner is near? Does the partner refuse to allow the victim to be alone with healthcare providers? The partner may respond for the victim, even when the victim is fully capable of responding. The partner may object to a male provider of care, or may object to the care itself. Many of these behaviors should alert the nurse to potential violence; they do not in themselves indicate that abuse is occurring, but are signs suggesting the need for further investigation.

Nursing Interventions

The caring, the interest and the respect shown the patient, during the assessment of domestic violence, are all important and potentially productive nursing interventions. Nursing has a long tradition of caring; persons who have experienced violence in their intimate relationships can benefit from that caring.

The holistic nursing concept of “presence” or the approach of “being with” the patient is a useful concept in nursing in general, but has tremendous applicability to domestic or intimate violence situations. From the holistic nursing perspective, one of the most powerful tools for healing is the presence of the nurse in the patient's environment. As guardian of the patient's journey through illness and healing (keeper and bestower of information, medications and treatments, and mediator of the system), the nurse has the greatest impact of all the elements in the patient's environment relative to healthcare.

The healing environment of the patient increases when the nurse intentionally shifts consciousness to a centered state. We must ask ourselves: Do patients hear in my voice that I care? That I have time for them? That they are safe with me? Am I focused on the task at hand and simply touching the patient to get the job done? Or does my touch convey care, support, nurture and competence? Nurses are not simply separate selves "doing to" the patient but an integral part of the patient's environment, "being with" them on the healing journey.

One of the most significant nursing interventions is the acknowledgement of the domestic or intimate violence. Some victims of violence will acknowledge their experiences with a healthcare provider who is attentive and caring. In some cases the indirect method of questioning may be useful, for others direct questions are more productive. Some victims will willingly disclose their experiences; however, there will be individuals who will not admit to the violence. In those cases, it is important for the provider to share her or his concern with the patient. Even if the patient does not admit that violence is occurring, she may remember that the nurse was accepting and willing to be helpful and may choose to disclose the violence to the nurse at some point in the future.

Linkages to referral sources that can provide additional services to victims and their children need to be made at the earliest possible time, as they may be able to provide services relative to a wide range of needs including housing, work training, legal, mental health treatment for the victim and children, etc. It is necessary for the nurse to obtain information about the services that are available in the local area, so that the nurse can provide these to the patient. These referral sources should be posted in the work area, so that they can easily be provided to victims of domestic or intimate violence.

While it is important to provide the victim with resource phone numbers and referrals, it is imperative that the nurse do so without the perpetrator being present. Lists of resources can be pocket sized so they are more easily concealed. The victim may feel more comfortable with a concealable list of resources for immediate help. Be clear with the patient that she/he should return if any further problems arise or to contact the referrals on the resource list.

Nurses must respect a woman’s right to make her own decisions in situations of domestic violence. Whether or not to leave an abusive relationship is the woman’s choice. Nurses need to guard against feelings of failure, apathy or a judgmental attitude. It is also important to remember that the period of time after a woman leaves an abusive situation is actually the most dangerous time, with higher incidences of fatal attacks.

Intervening in domestic or intimate violence is a process. Generally the violence has occurred over time and solutions need to occur over time. Law enforcement agencies will be involved. Each state in the US varies as to how domestic or intimate violence is handled, however, more and more states are not relying on the victim pressing charges, rather the state presses charges against the perpetrator.

Safety Plan and Documentation

Safety Plan

A safety plan is a must when dealing with domestic violence. Victims need to know where they can turn for assistance. This is necessary in preparation of future violent episodes, when preparing to leave the abuser, or when the abuser leaves the home.

A safety plan for use during violent episodes can include assessment of the home. Discuss which rooms in the home have access to an exit. Discuss the need to stay away from rooms where weapons may be available. Discuss the possibility of identifying one or more neighbors to whom the victim can disclose the violence and ask that they call the police if they hear a disturbance from the victim's home. Discuss the use of a code word to use with children, family friends or neighbors if you need the police. Begin to plan for where the victim will go if she has to leave the home quickly.

It is important to recognize that when a woman leaves her abuser, she is in the greatest danger. In preparation for possible speedy departure from the violent situation, a victim should have resources available somewhere outside the home. For example, a bag that is packed with clothing for her and her children, copies of important documents such as birth certificates of the victim and her children, driver's license, Social Security cards, insurance information, medical records, welfare identification, money for cab or bus fare, important phone numbers, extra medicines, extra set of keys, etc. might be left at a family member or close friend's house. Discuss the need to open a savings account or obtain a credit card in the victim's name as a means to establish independence. Discuss a possible Order of Protection. Other safety plans include frequent phone contact from a friend who can check on the victims' welfare, monitoring the escalation of violence.

A safety plan for when the abuser leaves the home would include discussion of changing locks, changing the daily routines such as routes taken to get to work, having phone numbers to access help immediately available. Discuss a safety plan for the victim's children to take when they are not with the victim. Inform school and child care providers who has permission to pick up the children. Inform neighbors and friends that your partner no longer lives with you and that the police should be notified if he is seen near your home.

It is important to assist victims to plan ahead and develop support systems and safety plans so that they know how and where to protect themselves from the violence.

Documentation

Documentation is always critical in nursing care. However, in situations of domestic violence, the stakes are very high. It is important to document all assessment data, including signs and symptoms of any possible abuse. Utilization of a Domestic Violence Screening/Documentation Form (see Sample) can be very useful in documenting physical injuries, other assessment data and interventions. The body map can be particularly useful in describing the exact location and extent of injuries. Document the injuries, size, color and shape of bruises, especially if they form a pattern. Utilize the patient's own words regarding the injuries or abuse; document these in quotation marks. Utilize photographs whenever possible to document injuries. A consent form must be signed prior to taking any photographs.

Document all interventions; include discussion of safety plan and referrals.

Medical records are not used in legal proceedings to the extent they could be. For a variety of reasons, documentation is not as strong as it could be in providing evidence. 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.

Healthcare providers have received 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, nurses and other healthcare professionals can dramatically increase the usefulness of the information they record and thereby help their patients obtain the legal remedies they seek.

The National Institute of Justice (2001) identifies steps that clinicians can implement in order to strengthen the possibility that the medical record will be useful during legal proceedings in domestic violence or abuse cases:

- 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 her boyfriend hit her”.

Additional Treatment

The identification of domestic or intimate violence is critical for the safety and welfare of victims. However, identification is only the first step. A coordinated effort must exist among healthcare providers, emergency services personnel, law enforcement, the judicial system, social service agencies as well as long-term treatment providers.

The Duluth Model, mentioned earlier, also advocates the following guidelines for all interventions for domestic or intimate partner violence:

- The first priority of intervention should be to carry out policies and protocols which protect the victim from further harm and whenever possible, the burden of holding abusers accountable should rest with the community, not the victim.
- To make fundamental changes in a community's response to violence against women, individual practitioners must work cooperatively, guided by training, job descriptions, and standardized practices that are all oriented toward the desired changes.
- Intervention must be responsive to the totality of harm done by the violence rather than be incident or punishment focused.
- Intervention practices must be accountable to the victim, whose life is most impacted by our individual and collective actions.
- Victims must have access to safe emergency housing, information and advocacy necessary to act in the courts, and should not be denied protection because of the cost of professional assistance.
- Except in the case of self-defense, violence is a criminal offense and the police and court are used to prevent further assaults. The intensity of intervention is based on the need for protection from further harm and on creating a deterrence to the abuser.
- The primary focus of intervention is on stopping the assailant's use of violence, not on fixing or ending the relationship.
- In general, the court avoids prescribing a course of action for the victim, e.g., does not force a victim to testify by threatening jail, nor mandate treatment for the victim.
- The courts and law enforcement agencies work cooperatively with victim advocacy programs and provide the advocacy/shelter program and victim with the broadest possible access to legal information.
- When appropriate, the courts mandate educational classes for assailants and impose increasingly harsh penalties for any continued acts of harassment and violence.
- All policies and procedural guidelines benefit from review by members of the communities not represented by majority culture (e.g., communities of color, the gay/lesbian/bisexual community, people who are low income). Their review should include a close look at monitoring procedures to safeguard against the use of race, class, or lifestyle biases in implementing policies.
- Policies and procedures should act as a general deterrent to battering in the community.
- All practices and policies should be continually evaluated for effectiveness in protecting victims and to plan ongoing training for agencies.
- All interventions must account for the power imbalance between the assailant and the victim. Adherence to these principles helps to produce consistent results regardless of the beliefs or values of an individual practitioner.

For additional information about the Duluth Violence Intervention Program go to www.duluth-model.org.

Additional Legal Issues

Florida law requires that injuries from deadly weapons, knives, and firearms be reported by healthcare workers to local police. Police departments in Florida have victim advocate services and provide information about local shelters, rights, and the other services to the victim of abuse.

The legal system has slowly changed so that perpetrators of domestic violence are dealt with as is anyone charged with assault unlike previous times when victims were asked to "press charges" and after were pressured by the abuser to drop them and the case was dismissed. Police departments are also providing training and education so that domestic violence situations are recognized and dealt with rather than treated as private incidents that are minimized.

The toll free hotline in Florida provides information in English, Spanish, and Creole: **(800) 500-1119.**

Conclusion

The violence that continues to be perpetrated against women is not only a tragedy and a crime; it is a serious public health threat. The impact of violence extends beyond the victim and perpetrator, to the family and society as a whole. Children who are abused or who are witnesses to abuse of their mothers often grow up to be abusers or victims themselves. The multigenerational nature of violence must be prevented and treated within the society which helped to create it.

As trusted healthcare providers, with access to patients across the life cycle in a wide range of treatment settings, nurses are in a unique position to be able to identify and intervene to help to end the suffering.

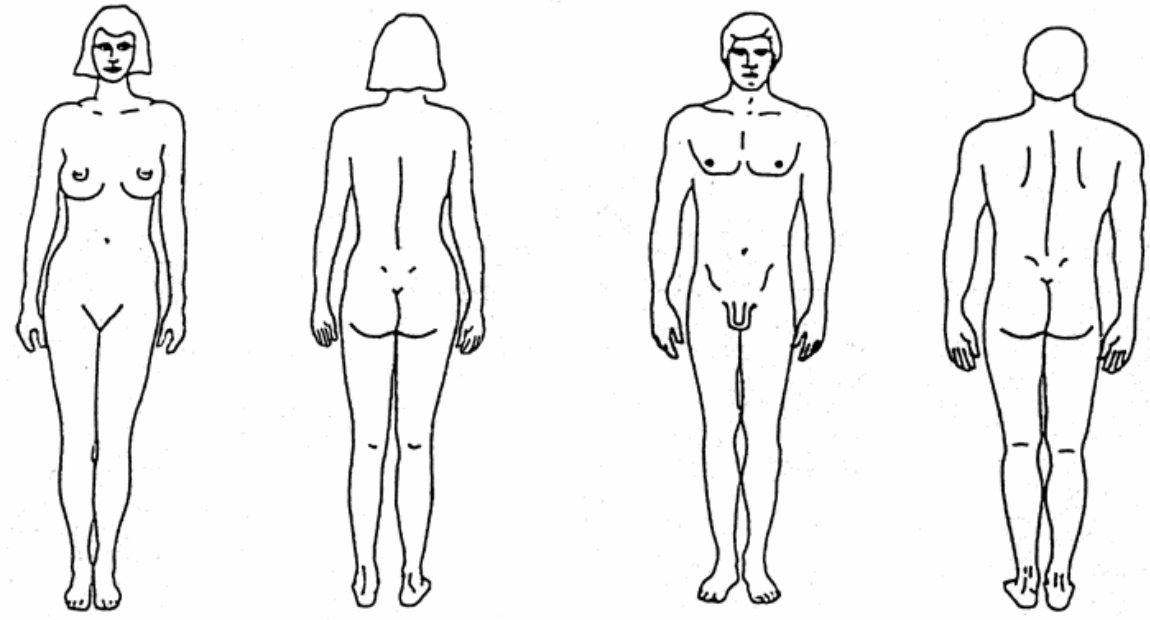
DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

Date: _____ **Patient Name: _____**

Patient ID# _____ **Provider Name: _____**

Patient Pregnant? ☐ Yes ☐ No

DV Screen
☐ DV + (Positive)
☐ DV ? (Suspected)



ASSESS PATIENT SAFETY

☐ Yes	☐ No	Is abuser here now?
☐ Yes	☐ No	Is patient afraid of their partner?
☐ Yes	☐ No	Is patient afraid to go home?
☐ Yes	☐ No	Has physical violence increased in severity?
☐ Yes	☐ No	Has partner physically abused children?
☐Yes	☐No	Have children witnessed violence in the home?
☐Yes	☐ No	Threats of homicide? By whom: _____
☐Yes	☐ No	Threats of suicide? By whom: _____
☐ Yes	☐No	Is there a gun in the home?
☐ Yes	☐ No	Alcohol or substance abuse?
☐ Yes	☐No	Was safety plan discussed?

REFERRALS

☐Hotline number given
☐Legal referral made

☐Shelter number given
☐ In-house referral made
Describe:_____
☐ Other referral made
Describe: _____

REPORTING

☐Law enforcement report made
☐Child Protective Services report made
☐Adult Protective Services report made

PHOTOGRAPHS
☐Yes ☐No Consent to be photographed?
☐Yes ☐No Photographs taken?
Attach photograph and consent form

PROGRESS NOTES **Date: _____**

(Using S.O.A.P. Format) **Time: _____**

[Describe frequency and severity of present and past abuse (use direct quotes); describe mechanism, location and extent of injury and/or other symptoms/condition.]

Resources

Nurses need to be aware of the resources available in their communities. These include local domestic violence shelters, advocacy services for domestic violence victims, local police departments' victims' advocate services, police assistance and legal assistance. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that Emergency Departments maintain lists of community referral agencies specific to domestic violence victims. Checking with the Emergency Department of a local hospital may provide a nurse with the referrals needed for local services to Domestic Violence victims. In addition, some services may be available to perpetrators of violence as well.

The National Domestic Violence Hotline is 1-800-799-SAFE (7233). This provides immediate service 24-hours a day/7 days per week in both English and Spanish.

Florida Domestic Violence Hotline: 1-800-500-1119
Florida DV Hotline TTY Number: 1-800-621-4202
(If you are deaf, hard-of-hearing, or speech-impaired, you may also use the **Florida Telecommunications Relay Service** (http://www.ftri.org/FloridaRelay/index.cfm)by dialing 711 to access your local domestic violence center.)
Disclaimer: *To protect the safety and confidentiality of victims and survivors of domestic violence, FCADV does* ***not*** *provide crisis assistance or referrals via email.*

The following is a list of the Florida Certified Domestic Violence Centers:

Florida Certified Domestic Violence Centers

(Updated January 10, 2005)

Abuse Counseling & Treatment, Inc.
Serving Lee, Hendry, and Glades Counties and the cities of Ft. Myers, Cape Coral, Clewiston, LaBelle, and Sanibel
Hotline number: (239)939-3112
PO Box 60401
Ft. Myers, FL 33906
Administration: (239)939-2553
FAX (239)939-4741
http://www.actabuse.com/

Aid to Victims of Domestic Abuse
Serving Palm Beach County and the cities of Delray Beach, Boca Raton, Boynton Beach, and West Palm Beach
Hotline numbers: (561)265-2900 or 1-800-355-8547
PO Box 667
Delray Beach, FL 33447
Administration: (561)265-3797
FAX: (561)265-2101

Another Way, Inc.
Serving Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, and Suwannee Counties and the cities of Chiefland, Cross City, Jasper, and Lake City
Hotline number: (352)493-6743
PO Box 1028
Lake City, FL 32056-1028
Administration: (386)719-2757
Administration FAX: (386)719-2758

C.A.R.E. of Charlotte County, Inc.
Serving Charlotte County and the cities of Punta Gorda and Englewood
Hotline number: (941)627-6000
PO Box 510234
Punta Gorda, FL 33951
Administration: (941)639-5499
FAX: (941)639-7079

CASA
Serving Pinellas County and the cities of St. Petersburg, Gulf Port, Largo, and Pinellas Park
Hotline number: (727)895-4912 x 1
PO Box 414
St Petersburg, FL 33731
Administration: (727)895-4912 x111
FAX: (727)821-7101
http://www.casa-stpete.org/

Citrus County Abuse Shelter, Assoc.
Serving Citrus County and the cities of Inverness, Crystal River, Floral City, Hernando, and Homosassa Springs

Peaceful Paths
Serving Alachua, Putnam, Bradford, and Union Counties and the cities of Gainesville, Alachua, and Starke
Hotline numbers: (352)377-TALK (8255) or 1-800-393-SAFE (7233)
PO Box 5099
Gainesville, FL 32627-5099
Administration: (352)377-5690
FAX: (352)378-9033
http://www.peacefulpaths.org/index.asp

Peace River Center – Domestic Violence Shelter
Serving Hardee, Highlands, and Polk Counties and the cities of Lakeland, Avon Park, Bartow, Haines City, Lake Wales, Sebring, and Winter Haven
Hotline numbers: (863)413-2700 or (863)386-1167 (Sebring)
P.O. Box 1559
Bartow, FL 33831-1559
Administration: (863)413-2708
FAX: (863)582-7280

Quigley House, Inc.
Serving Clay County and the cities of Orange Park, Green Cove Springs, Keystone Heights, and Middleburg
Hotline numbers: (904)284-0061 or TDD (904)284-0424
PO Box 142
Orange Park, FL 32067-0142
Administration: (904)284-0340
FAX: (904)284-5407
http://www.quigleyhouse.org/

Refuge House, Inc.
Serving Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties and the cities of Tallahassee, Madison, Perry, and Quincy
Hotline number: (850)681-2111 (Tallahassee) or (850)584-8808 (Taylor and Madison Counties)
PO Box 20910
Tallahassee, FL 32316-0910
Administration: (850)922-6062
FAX: (850)922-5611
http://www.refugehouse.com/

SafeHouse of Seminole
Serving Seminole and adjacent Counties and the cities of Sanford, Altamonte Springs, Lake Mary, and Longwood
Hotline number: (407)330-3933
PO Box 2921
Sanford, FL 32772
Administration: (407)302-5220
FAX: (407)302-5218
http://www.safehouseofseminole.org/

SafeSpace Domestic Violence Svcs. Inc.

Hotline number: (352)344-8111
PO Box 205
Inverness, FL 34451
Administration: (352)344-8111
FAX: (352)344-0548

Dawn Center of Hernando County
Serving Hernando County and the cities of Springhill, Brooksville, and Ridge Manor
Hotline number: (352)799-0657
P.O. Box 6179
Springhill, FL 34611
Administration (352)592-1288
FAX: (352)592-1787

Domestic Abuse Council, Inc.
Serving Volusia County and the cities of Daytona Beach, DeLand, Deltona, New Smyrna Beach, and Ormond Beach
Hotline numbers: (386)255-2102 or (386)738-4080 (Deland)
P.O. Box 142
Daytona Beach, FL 32115
Administration: (386)257-2297
FAX: (386)248-1985

Domestic Abuse Shelter
Serving Monroe County and the cities of Marathon Shores, Key Largo, Key West, and Tavernier
Hotline numbers: (305)294-0824 (low keys), (305)743-4440 (mid keys), (305)852-6222 (upper keys), (305)451-5666, or (305)872-9411
PO Box 2696
Marathon Shores, FL 33052
Administration: (305)743-5452
FAX: (305)289-1589
http://www.domesticabuseshelter.org/

Family Life Center
Serving Flagler County and the cities of Bunnell, Palm Coast, Flagler Beach, Espanola, Daytona North (Mondex), and Marineland
Hotline number: (386)437-3505
PO Box 2058
Bunnell, FL 32110
Administration: (386)437-7610
FAX: (386)437-1243
http://www.flc-safehouse.org/

FavorHouse of NW Florida, Inc.
Serving Escambia and Santa Rosa Counties and the cities of Pensacola, Gulf Breeze, Jay, and Milton
Hotline number: (850)994-3560
2001 W. Blount Street
Pensacola, FL 32501

Serving Indian River, Martin, and St. Lucie Counties and the city of Ft. Pierce
Hotline numbers: (772)464-4555 (St. Lucie), (772)569-7233 (Indian River), or (772)288-7023 (Martin)
PO Box 4075
Ft Pierce, FL 34948
Administration: (772)223-2399
FAX: (772)223-7775

Safety Shelter of St Johns County (Betty Griffin House)
Serving St. Johns County and the cities of St. Augustine, Fruit Cove, and Ponte Vedra
Hotline number: (904)824-1555
PO Box 3319
St Augustine, FL 32085
Administration: (904)808-8544
FAX: (904)808-8338
http://bettygriffinhouse.org/

Salvation Army Domestic Violence & Rape Crisis Program
Serving Bay, Gulf, Calhoun, Holmes, Jackson, and Washington Counties and the cities of Panama City, Blountstown, Chipley, Marianna, Port St. Joe, and Wewahitchka
Hotline numbers: 1-800-252-2597 or (850)763-0706
651 W. 14th Street
Unit-C
Panama City, FL 32401
Administration: (850)769-7989
FAX: (850)769-2183

Salvation Army Brevard County Domestic Violence Program
Serving Brevard County and the cities of Cocoa, Merritt Island, Rockledge, and Titusville
Hotline number: (321)631-2764
PO Box 1540
Cocoa, FL 32923-1540
Administration: (321)631-2766
FAX: (321)631-7914
http://www.salvationarmyncbrevard.org/

Salvation Army Domestic Violence Program of West Pasco
Serving Pasco County and the cities of Hudson, Bayonet Point, Holiday, New Port Richey, and Port Richey
Hotline number: (727)856-5797
PO Box 5517
Hudson, FL 34674-5517
Administration: (727)856-6498
FAX: (727)857-1907

Serene Harbor, Inc.
Serving Brevard County and the cities of Palm Bay and

Administration: (850)434-1177
FAX: (850)434-9987

Harbor House
Serving Orange County and the city of Orlando
Hotline number: (407)886-2856
PO Box 680748
Orlando, FL 32868-0748
Administration: (407)886-2244
FAX: (407)886-0006
http://www.harborhouse.us/

Haven of Lake and Sumter Counties
Serving Lake and Sumter Counties and the cities of Leesburg, Bushnell, Eustis, Tavares, and Wildwood
Hotline number: (352)753-5800
PO Box 492335
Leesburg, FL 34749-2335
Administration: (352)787-5889
FAX: (352)787-4125

Help Now of Osceola County
Serving Osceola, Orange, Polk, and Seminole Counties and the cities of Kissimmee, Holopaw, and Kenansville
Hotline number: (407)847-8562
PO Box 420370
Kissimmee, FL 34742
Administration: (407)847-3260
FAX (407)847-8121

Hope Family Services, Inc.
Serving Manatee County and the cities of Bradenton, Oneco, Palmetto, Rubonia, and Tallavast
Hotline number: (941)755-6805
PO Box 1624
Bradenton, FL 34206
Administration: (941)747-8499
FAX: (941)749-1796
http://hopefamilyservice.org/

Hubbard House
Serving Baker, Duval, and Nassau Counties and the cities of Jacksonville, Fernandina Beach, Macclenny, Neptune Beach, Hilliard, and Callahan
Hotline number: (904)354-3114
PO Box 4909
Jacksonville, FL 32201
Administration: (904)354-0076 x300
FAX: (904)354-1342
http://www.hubbardhouse.org/

Lee Conlee House
Serving Putnam County and the city of Palatka
Hotline number: (386)325-3141
PO Box 2558
Palatka, FL 32177

Melbourne
Hotline number: (321)726-8282
PO Box 100039
Palm Bay, FL 32910-0039
Administration: (321) 953-5389
FAX: (321)726-8588

Shelter for Abused Women and Children
Serving Collier County and the cities of Naples, Bonita Springs, Collier City, Everglades City, Immokalee, and Marco Island
Hotline number: (239)775-1101
PO Box 10102
Naples, FL 34101
Administration (239)775-3862
FAX: (239)775-3061
http://www.naplesshelter.org/

Shelter House, Inc.
Serving Okaloosa and Walton Counties and the cities of Ft. Walton Beach, Crestview, DeFuniak Springs, and Destin
Hotline numbers: 1-800-44-ABUSE or (850)863-4777
PO Box 220
Ft Walton Beach, FL 32549-0220
Administration: (850)243-1201
FAX (850)243-6756
http://www.shelterhousenwfl.org/

SPARCC
Serving Sarasota and DeSoto Counties and the cities of Sarasota, Arcadia, and Venice
Hotline number: (941)365-1976
2139 Main Street
Sarasota, FL 34234
Administration: (941)365-0208
FAX: (941)365-4919

Sunrise of Pasco County, Inc.
Serving Pasco County and the cities of Dade City and Land O'Lakes
Hotline number: (352)521-3120
PO Box 928
Dade City, FL 33526
Administration: (352)521-3358
FAX: (352)521-3099
http://sunrisepasco.org/

The Haven of R.C.S.
Serving Pinellas County and the cities of Clearwater, Dunedin, Largo, Palm Harbor, and Tarpon Springs
Hotline number: (727)442-4128
PO Box 10594
Clearwater, FL 33757
Outreach (727)441-2029
Administration: (727)442-2719

Administration: (386)325-4447
FAX: (386)328-7755

Martha's House
Serving Okeechobee County and the cities of Okeechobee, Buckhead Ridge, and Indiantown
Hotline number: (863)763-0202
PO Box 727
Okeechobee, FL 34973
Administration: (863)763-2893
FAX: (863)763-6712

Micah's Place
Serving Nassau County and the cities of Bryceville, Bolougne, Callahan, Fernandina Beach, Hilliard, and Yulee
Hotline number: (904)225-9979 or 1-877-ABUSE-88
P.O. Box 477
Yulee, FL 32401
Administration: (904)225-3110
FAX: (904)225-3116

Ocala Rape Crisis-Domestic Violence Center (Creative Services, Inc.)
Serving Marion County and the cities of Ocala, Belleview, Silver Springs, and Summerfield
Hotline number: (352)622-5919
PO Box 2193
Ocala, FL 34478
Administration: (352)622-5919
FAX: (352)351-9455

FAX: (727)461-5057
http://www.havenrcs.org/

The Spring of Tampa Bay
Serving Hillsborough County and the cities of Tampa, Brandon, Plant City, Ruskin, and Temple Terrace
Hotline number: (813)247-7233
PO Box 4772
Tampa, FL 33677
Administration: (813)247-5433
FAX: (813)247-2930
http://www.thespring.org/main.asp?ID=28

Vivid Visions
Serving Suwannee County and the city of Live Oak
Hotline number: (386)364-2100
PO Box 882
Live Oak, FL 32064
Administration: (386)364-5957
FAX: (386)364-1732

Women in Distress of Broward County
Serving Broward County and the cities of Ft. Lauderdale, Hallandale, Hollywood, and Pompano
Hotline number: (954)761-1133
PO Box 676
Ft Lauderdale, FL 33302
Administration: (954)760-9800
FAX: (954)687-0733
http://womenindistress.org/

YWCA Harmony House
Serving Palm Beach County and the cities of West Palm Beach, Belle Glade, Jupiter, and Tequesta
Hotline numbers: 1-800-973-9922 or (561)640-9844
2200 N Florida Mango Road
Suite 102
West Palm Beach, FL 33409
Administration: (561)640-0050
FAX: (561)640-9155
http://ywcapbc.org/

Florida Coalition Against Domestic Violence
(http://www.fcadv.org/index.html)
425 Office Plaza Dr.
Tallahassee, FL 32301
ED: Tiffany Carr
Administration: (850)425-2749
FAX: (850)425-3091
HOTLINE: 1-800-500-1119
TDD 1-800-621-4202

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Domestic/Intimate Partner Violence: The Nurse's Role

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, log in using the username and password you created, click on the "Go to Course" link and proceed to the course exam.

1. Domestic/intimate partner violence occurs

    A. Only among the poorest and least educated segments of the population.
    B. Among individuals of all ethnic, racial, religious, age, physical ability, socioeconomic and sexual orientation backgrounds.
    C. Most often with men being the victims.
    D. Most often with women being the perpetrators of violence.

2. Definitions of domestic/intimate partner violence include all the following except:

    A. Physical abuse
    B. Sexual abuse
    C. Safety planning
    D. Financial abuse

3. More than 20% of the violent crimes against women were perpetrated by a current or former intimate partner.

    A. True
    B. False

4. Pregnant women who are in abusive situations are more likely to experience increased abuse as the pregnancy progresses.

    A. True
    B. False

5. Children who live in domestic violence situations are generally unaffected by the violence unless it is directed at them.

    A. True
    B. False

6. Screening for domestic/intimate partner violence should occur

    A. Only when overt physical signs of injury are present.
    B. For all women in all healthcare settings.
    C. Whenever a woman discloses that she is the victim of domestic/intimate partner violence.
    D. Whenever domestic/intimate partner violence is suspected.

7. Physical indicators of possible domestic/intimate partner violence include all **except**:

    A. Chronic somatic complaints.
    B. Injuries that are inconsistent with the explanation provided.

C. Injuries that appear in areas where clothing would hide them.
D. Frequent fevers of unknown origin.

8. Discussion of a safety plan would include the following **except**:

A. Which rooms in the home to avoid because they may contain weapons.
B. Beginning to plan for independence, by starting a checking account or credit card in the victim's name.
C. Developing a code word to use with children so that they can summon the police.
D. Telling the victim that she needs to leave the abusive relationship.

9. Documenting in cases of suspected domestic violence should be thorough, detailed and include all of the following **except**:

A. All referrals made.
B. Assessment data, including a body map and the victim's own words in quotation marks.
C. All interventions, including discussion of safety plan.
D. Instructions to leave the abusive relationship immediately.

10. In the State of Florida, victims of domestic violence can be referred to one of the many certified domestic violence centers for services.

A. True.
B. False.