**DOMESTIC VIOLENCE AND PARTNER ABUSE: THE NURSING CHALLENGE**

 

 

***Compiled by Tamara Espejo, RN, MS***

Shortly after completing these modules, Tami Espejo unexpectedly passed away. I knew her as a nurse and friend for many years. Tami had a wealth of experience in nursing and especially in mental health. Her work lives on in these modules. I miss her. Terry Rudd

8.0 Contact Hours

***California Board of Registered Nursing CEP#15122***

Key Medical Resources, Inc.

P.O. Box 2033, Rancho Cucamonga, CA 91730

**909 980-0126** **FAX: 909 980-0643**

Disclaimer: This packet is intended to provide information and is not a substitute for any facility policies or procedures or in-class training. Legal information provided here is for information only and is not intended to provide legal advice. Each state or facility may have different training requirements or regulations. Participants who practice the techniques do so voluntarily. Information has been compiled from various internet sources as indicated at the end of the packet.

**Title: DOMESTIC VIOLENCE AND PARTNER ABUSE: THE NURSING CHALLENGE**

**8.0 C0NTACT HOURS CEP #15122 70% is Passing Score**

**Please note that C.N.A.s cannot receive continuing education hours for this home study.**

1. Please print or type all information.
2. Arrange payment of $3 per contact hour to Key Medical Resources, Inc.

Call for credit card payment.

1. No charge for contract personnel or Key Medical Passport holders.
2. Please complete answers and return SIGNED answer sheet with evaluation form via

**FAX: 909 980-0643 or Email: KMR@keymedinfo.com. Put "Self Study" on subject line.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print your email clearly. Certificate will be emailed to you.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

License # & Type: (i.e. RN 555555) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_

Please place your answers on this form.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_
12. \_\_\_\_
13. \_\_\_\_
14. \_\_\_\_
15. \_\_\_\_
16. \_\_\_\_
17. \_\_\_\_
18. \_\_\_\_
19. \_\_\_\_
20. \_\_\_\_

My Signature indicates that I have completed this module on my own.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

**EVALUATION FORM**

Poor Excellent

1. The content of this program was: 1 2 3 4 5 6 7 8 9 10

2. The program was easy to understand: 1 2 3 4 5 6 7 8 9 10

3. The objectives were clear: 1 2 3 4 5 6 7 8 9 10

4. This program applies to my work: 1 2 3 4 5 6 7 8 9 10

5. I learned something from this course: 1 2 3 4 5 6 7 8 9 10

6. Would you recommend this program to others? Yes No

7. The cost of this program was: High OK Low

**Other Comments:**

# Title: DOMESTIC VIOLENCE AND PARTNER ABUSE: THE NURSING CHALLENGE

**Self Study Module 8.0 C0NTACT HOURS**

*Choose the Single Best Answer for the Following Questions and Place Answers on Form:*

# DOMESTIC VIOLENCE AND PARTNER ABUSE: THE NURSING CHALLENGE

**1.** What are the 3 major types of domestic violence?

A. Sexual abuse, intimate partner abuse, child abuse

B. Intimate partner abuse, child abuse, elder abuse

C. Intimate partner abuse, elder abuse, sexual abuse

D. Child abuse, elder abuse, sexual abuse

2. Historically women and children have been considered vulnerable to abuse because they:

A. Are viewed as property

B. Lack monetary income

C. Have been denied political power

D. Have feelings of low self-esteem

3. The Violence Against Women ACT (VAWA) includes legislation for:

A. Mandatory training and examination by health professionals

B. Monetary relief for victims of domestic violence

C. Creation of a national domestic violence hotline

D. Intervention programs for children and the elderly

4. Intimate partner abuse is about:

A. Power and control

B. Sexual patterns and relationships

C. Social and economic issues

D. Abusive and coercive behaviors

5. The primary role of the health care professional committed to decreasing domestic violence is:

A. Data collection, political activism and knowledge of the law

B. Training ER personnel, linkage to the community and providing safe houses

C. Communicator, risk manager and counselor

D. Advocacy, screening and intervention

6. Effective intervention from the health care professional in domestic abuse begins with which of the following?

A. Providing educational programs in churches and schools about domestic violence

B. Understanding the dynamics of domestic abuse

C. Recognizing that suspected abusers aren't cooperative

D. Placing domestic violence information in waiting areas

7. What percentage of domestic violence victims are women?

A. 55%

B. 65%

C. 85%

D. 95%

8. In which phase of the cycle of violence may the victim fight back?

A. Relationship phase

B. Tension-building phase

C. Event phase

D. Calm phase

9. Which phase of the abuse cycle keeps the victim in the relationship?

A. Tension-building phase

B. Event phase

C. Calm phase

D. Relationship phase

10. Children who live in a home where domestic violence occurs typically have

A. Perfect school attendance

B. Few behavioral problems

C. Good self-esteem

D. Aggressive behavior

11. What percentage of victims killed by their abusers are killed while trying to leave?

A. 50%

B. 65%

C. 70%

D. 85%

12. Which statement regarding domestic violence is true?

A. The abuser believes that he is entitled to control the victim

B. Domestic violence includes only emotional abuse

C. The abuser believes violence is unacceptable even if he thinks it is "needed"

D. Domestic violence does not tend to escalate during a victim's pregnancy

13. If a language barrier exists between you and the patient, whom should you ask to serve as an interpreter?

A. Her partner

B. One of her family members

C. One of the hospital's interpreters

D. Anyone who accompanied her to the hospital

14. When performing a domestic violence interview, you should

A. Sit down with the patient

B. Ask close-ended questions

C. Encourage the victim's partner to be present

D. Ask why the victim won't leave the abuser

15. If a patient denies being a victim of domestic violence and you suspect that she is, what should you do?

A. Ask her why she won't leave

B. Convince her to prosecute her partner

C. Offer her information on domestic violence in case she knows someone who is being abused

D. Make a plan to rescue her

16. Your encounter with an abused women is successful if you have assessed the situation, provided counsel and

A. Persuaded the victim to leave her abuser

B. Informed her of her safety options

C. Convince her to prosecute her abuser

D. Made her go to a shelter

17. Which of the following statements about domestic violence is true?

A. It affects every socioeconomic level

B. It is caused by drug and alcohol abuse

C. It predominantly occurs in lower socioeconomic levels

D. It rarely occurs during pregnancy

18. A COPES Counselor is conducting an interview with a victim of domestic violence in the emergency room. Which of the following is the counselor's *first step*?

A. Contact the appropriate legal services

B. Ensure privacy for the victim away from the abuser

C. Establish a rapport with the victim and the abuser

D. Request the presence of a security guard

19. A woman is admitted to the emergency room with a fractured arm. The woman explains to the COPES Counselor that she was injured when she provoked her husband, who was drunk and therefore she got hurt when he pushed her. Which of the following best describes the counselor's understanding of the wife's explanation?

A. The wife's explanation is appropriate acceptance of her responsibility

B. The wife's explanation is an atypical reaction of an abused woman

C. The wife's explanation is evidence that the woman may be an abuser as well as a victim

D. The wife's explanation is a typical response of a victim accepting blame for the abuser

20. A Needs Assessment Counselor is doing an assessment and suspects that a patient has been abused. Which of the following questions would be most appropriate?

A. "Are you being threatened or hurt by your partner?"

B. "Are you frightened of your partner?"

C. "Is someone bothering you?"

D. "What happens when you and your partner argue?"

**Title: DOMESTIC VIOLENCE AND PARTNER ABUSE: THE NURSING CHALLENGE**

**Self Study Module 8.0 C0NTACT HOURS**

**Please note that C.N.A.s in California cannot receive continuing education hours for home study.**

Objectives

***At the completion of this program, the learners will:***

1. Describe the cycle of domestic violence and why some victims stay in abusive relationships
2. List three physical signs and symptoms of abuse
3. Identify the most effective techniques for conducting a domestic violence interview
4. State three safety plan instructions for the victim
5. Identify interventions and resources to provide to victims of domestic violence
6. Explain three appropriate clinical interventions for the victim of abuse
7. Complete exam components at a 70% competency

### Introduction

Domestic violence is recognized globally as a critical, public health problem and a human rights violation that robs victims of "full and equal participation in all spheres of life" ([United Nations, 1995,](http://nursingworld.org/ojin/topic17/tpc17_1.htm#UN#UN)). Women and children worldwide are especially vulnerable to aggression, violence, and abuse by family members, caretakers, and intimates. Domestic violence has been defined as: "Physical, sexual, or emotional/psychological violence directed toward men, women, children, or elders occurring in current or past familial or intimate relations whether the individuals are cohabiting or not and including violence directed toward dating partners." ([AACN, 2001](http://nursingworld.org/ojin/topic17/tpc17_1.htm#AACN#AACN))

Domestic violence is associated with varied and significant health-related consequences. In addition to immediate physical injuries stemming from an assault and acute psychological distress related to victimization, domestic violence is associated with long-term psychological, physical, social, and economic effects. Nurses and other health care providers play a key role in domestic violence identification and intervention and have been visible advocates for the prevention of domestic violence throughout the world. Many health care professionals have had personal experiences with domestic violence and are forced to confront their own concerns related to violence as they attempt to help others.

**History**

According to English common law, women were viewed as chattel - first as property of their fathers, and then of their husbands. When a woman married, her legal existence was consolidated into that of her husband's; she was considered to be under his protection and influence and could not inherit property. Physical violence was used frequently by husbands against wives. According to the "rule of thumb" law, a man could beat his wife with a rod no bigger than his thumb.

In 1864, the Supreme Court of North Carolina ruled (State v. Black) that a husband could not be convicted of battering his wife unless he inflicted a permanent injury, used excessive violence, or exhibited vindictiveness. In 1868, the Supreme Court of South Carolina (State v. Rhodes) refused to hold a husband criminally responsible for having beaten his wife with a small stick.

In the late 1800s, legal reform related to domestic violence began in the United States. In the 1870s, Alabama and Massachusetts introduced the first legislation making it illegal to beat one’s wife. Several other states followed with similar legislation. However, few arrests were made, however, and district attorneys were unlikely to prosecute. In 1882, the State of Maryland passed legislation that outlawed wife beating and made it a crime punishable by 40 lashes or a year in jail.

Grassroots feminists brought the problem of violence against women to public attention in the U.S. in the l960s and 1970s and began to establish a number of community-based programs for battered women. In 1964, Haven House, the first shelter for battered women and their children, was opened in Pasadena, California. Organizations such as the National Organization of Women and the National Coalition Against Domestic Violence pushed for social services and legislative reform to better protect battered women.

In 1979, Lenore Walker published The Battered Woman, an influential book that defined the battered women’s syndrome (BWS). The major components of BWS are the post-traumatic stress symptoms and learned helplessness that develops when the woman’s attempt to end the abuse proves futile. Walker’s work was significant as the symptoms experienced by battered women were identified as responses to on-going abuse, challenging the traditional assumption that a woman’s psychological vulnerability causes or contributes to, rather than results from, her battering.

In 1982, the U.S. Commission on Civil Rights published a report entitled Under the Rule of Thumb: Battered Women and the Administration of Justice evaluating the treatment of victims of domestic violence by the criminal justice system and social service agencies. The report concluded that police officers, prosecutors, and judges provided little relief for victims of domestic violence because they considered domestic violence a private matter rather than a crime.

Congress passed the Violence Against Women Act (VAWA) in 1994 as a part of the Violent Crime Control and Law Enforcement Act. The VAWA is a group of individually conceived legislative pieces that were joined together to create a package of federal laws and grant programs specifically addressing domestic violence, sexual assault, and stalking. The VAWA was the first federal law to criminalize domestic violence. The legislation authorized grants to states, Native American tribunals, and local governments to improve criminal justice responses to domestic violence. THE VAWA included new federal statutes for interstate domestic violence, introduced a civil rights cause of action, funded a wide assortment of programs, initiated new federally-funded research on domestic violence, and created a national domestic violence hotline. The Violence Against Women Office of the Office of Justice Programs was created in 1995 to implement the VAWA.

The Violence Against Women Act of 2000, (which was amended to the Victims of Trafficking and Violence Prevention Act of 2000), reauthorized critical grant programs, established new programs, and strengthened federal laws related to domestic violence, sexual assault, and stalking. VAWA 2000 provides coverage for dating violence, supervised visitation centers, civil legal assistance, judicial education, and increased protection for battered immigrant women.

Since the 1970s, nursing has been involved in efforts to combat the problem of intimate partner abuse. Several nursing organizations have issued position statements acknowledging violence recognition, prevention, and intervention as health care priorities ([the American Association of Colleges of Nursing, 2001](http://nursingworld.org/ojin/topic17/tpc17_1.htm#AACN#AACN); [the American Nurses’ Association, 1991](http://nursingworld.org/ojin/topic17/tpc17_1.htm#ANA#ANA); [the National Black Nurses’ Association, Inc., 1994](http://nursingworld.org/ojin/topic17/tpc17_1.htm#NBNA#NBNA); [the American College of Nurse-Midwives, 1997](http://nursingworld.org/ojin/topic17/tpc17_1.htm#ACNM#ACNM); the [Emergency Nurses Association, 1998](http://nursingworld.org/ojin/topic17/tpc17_1.htm#ENA#ENA)). During the 1990s, there was a proliferation of programs in hospitals and community-based health centers that provided specialized domestic violence prevention and intervention programs for battered women and their children.

**Scope**

Based on findings and U. S. Census data, it is estimated that approximately 1.3 million women are physically assaulted annually by an intimate or ex-partner. It is also estimated, that over 200,000 women are raped each year in the United States by an intimate partner.

Many health care professionals have experienced domestic violence in their personal lives. Ellis (1999) surveyed 40 registered nurses employed in a large emergency department and found that 57.5% reported a personal experience with domestic violence. While 35% reported having been hit, kicked, or punched, only 25% of this group identified these experiences as abuse. In a survey of 275 nurses in perinatal practice, 31% reported abuse of themselves or their family members.

Significant controversy exists about the prevalence and the nature of female violence against male partners. Some experts maintain that women are as violent as are men to their partners, whereas others maintain that female to male violence differs significantly in both frequency and severity, and is often used in self-defense. Women are thus more than 2.9 times as likely as men to report abuse by a partner of the opposite sex. Male and female violence in relationships is asymmetrical as women experience male-perpetrated violence more frequently, and the abuse is more repetitious and physically injurious. The actual percentage of domestic violence victims that are women is 85%.

**Health Consequences**

The physical consequences of battering range from minor injuries to permanent disability, disfigurement, and death. The National Violence Against Women Survey found that 30.2 % of the women injured during their most recent physical assault and 35.6 % of the women injured during their most recent rape received some type of medical treatment. Women who are assaulted or raped by a current or former partner are at the

greatest risk for injury. Nurse researchers have documented that 22 % to 35 % of women who seek treatment at hospital emergency departments do so for injuries related to domestic violence. The grimmest consequence of domestic violence is death; the majority of women who are killed in the United States are killed by a current or former intimate partner.

### Spouse/Partner Abuse

Walker ([1999](http://nursingworld.org/ojin/topic17/tpc17_1.htm#Walker2#Walker2)) argued that "the single most powerful risk marker for becoming a victim of violence is to be a woman." While strangers or acquaintances commit the majority of the assaults against men, women are much more likely to be raped, assaulted, or murdered by romantic/intimate partners.

**What is Partner Violence?**

The word "partner" applies to same and opposite sex couples, in married, engaged, or cohabiting relationships, and to more casual relationships such as acquaintances or dating partners. Because of the wide range of perpetrators who can be involved, and the multiple forms of violence they commit, the term "partner violence" is more precise than alternatives such as domestic violence, wife beating, or wife battering. Partner violence may occur as isolated occurrences, but most typically multiple forms of abuse are occurring that create a pattern of control by one partner and generate fear and submission by the other partner. The acts that comprise partner violence are physical, sexual, psychological, stalking, and economic abuse.

**Physical assault includes but is not limited to:**

* pushing
* slapping
* punching
* kicking
* choking
* beating
* assault with a weapon
* tying down or restraining
* leaving the woman in a dangerous place
* refusing to allow access to medical care when the woman is sick or injured

**Sexual assault includes acts such as:**

* degrading sexual comments
* using coercion to compel a person to perform sexual acts when they have stated they don’t want to
* intentionally hurting someone during sex(including use of objects intravaginally, orally or anally)
* pursuing sex when a person is not fully conscious or is afraid to say no
* coercing someone to have sex without protection against pregnancy or sexually transmitted diseases.

Rape, the most serious form of sexual assault, is characterized by three key elements: lack of consent, penetration (no matter how slight and independent of whether ejaculation occurred), and compelling participation by force, threat of bodily harm, or with a person incapable of giving consent due to intoxication or mental incapacitation. Rape is variously referred to as stranger rape, date rape, acquaintance rape, and marital rape, but under the law, rape is rape, no matter what the relationship of the victim and perpetrator.

**Psychological abuse refers to acts such as:**

* humiliation
* intimidation and threats of harm
* intense criticizing
* insulting, belittling, ridiculing, and name calling
* verbal threats of harm or torture directed at the victim or family, children, friends, companion animals, stock animals, or property
* physical and social isolation that separates a person from their social support networks
* extreme jealously and possessiveness
* accusations of infidelity
* repeated threats of abandonment, divorce
* having an affair if the person does not comply with abuser’s wishes,
* monitoring movements, and driving fast and recklessly to frighten the victim

Stalking refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at their 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, and they may or may not be precursors to an assault or murder.

Economic abuse is restricting access to resources such as bank accounts, telephone communication, and transportation, or refusing the right to work or attend school that have the effect of keeping a victim without resources and under the control of the abuser.

Intimate partner abuse includes abuse by current or former spouses, romantic or co- habitating partners. Partner abuse does not typically involve a single violent assault; it is a cyclic, progressive process in which violence is used to control one’s partner. Most violence against women by male partners is best described as battering - that is, "a pattern of behaviors through which one person continually reinforces a power imbalance over another in an intimate/romantic relationship context" ([Mahoney et al., 2001](http://nursingworld.org/ojin/topic17/tpc17_1.htm#Mahoney#Mahoney)). Intimate partner abuse includes a variety of abusive and coercive behaviors that may be of a physical, psychological, sexual, or economic nature. For example, it is estimated that 40 to 45% of battered women also experience forced sex by male partners.

Unlike street violence, domestic partner violence occurs in the context of "shared" lives. In addition to affective ties, the victim and the perpetrator share, or have once shared a residence, financial obligations, resources, children, and/or friends. The abuse often occurs in the context of an on-going or recently severed relationship; perpetrators may therefore have on-going access to the victim. Because intimate partner violence is considered a "family concern," it is often taken less seriously than stranger or street violence. Victims often experience social and economic barriers to ending the relationship.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Understanding the Victim's World**  Effective clinical intervention starts with understanding the dynamics of domestic abuse, which is based on behaviors that seek to establish power and control over another person through fear and intimidation. It often includes the threat or use of physical force and occurs in a cycle of three repeating phases **(See below).**   |  | | --- | | **Understanding the Cycle of Violence** | | In the *tension-building* phase, the abuser may be moody, then become harshly critical and yell. He may become angered by minor aggravations or something viewed as an 'imperfection,' such as laundry left unfolded or children who cry despite efforts to quiet them. Typically, the victim tries hard to keep the abuser calm.  In the *event* phase, the abuser acts out his aggressions on the victim, either physically or verbally. During this phase, the victim may fight back or call for help.  In the *calm* phase, the abuser often will apologize profusely and promise never to attack her again. This is the phase that keeps the victim in denial and in the relationship. | | **When to Suspect Abuse** | | | Below are a few conditions and behaviors that people who are in an abusive relationship commonly display. But even if these characteristics are absent, trust any feelings you have that a patient might be suffering abuse. Suspect abuse if the patient:   * has unexplained bruises, lacerations, burns, fractures (mostly in the uppers extremities), soft tissue or multiple injuries in various stages of healing (particularly in areas that would normally be covered by clothing) * head injures such as concussions, bald patches and retinal hemorrhage * neck injuries, especially strangulation marks * facial injuries such as black eyes, missing teeth and broken nose * human bites * injuries to genitalia * history of spontaneous abortion * bruises or abdominal injuries in a pregnant woman * has delayed seeking treatment for an injury * appears embarrassed, evasive, agitated, severely anxious, or depressed * has a partner who is reluctant to leave, uncooperative, or domineering, or who insists on answering all questions for the patient. Also keep in mind that some abusers are excessively solicitous of the victim. * says her partner has a psychiatric history or problems with alcohol or drug abuse * has complaints that you can't substantiate with physical evidence * expresses a fear of returning home or concern about the safety of her children * talks about harming herself or suicidality * insomnia or nightmares * PTSD | |   Domestic violence stems from the abuser's belief that he's entitled to control the other person. He also believes that violence is acceptable if it's "needed" to produce the outcome he desires. Perpetrators of domestic violence also threaten their children, use of "male privilege" (acting like the king and treating her like a servant), intimidation, isolation, and other behaviors to exert control. Once begun, abuse tends to progress and escalate, especially during pregnancy. (Pregnant women are at greater risk for abuse than nonpregnant women because the abuser becomes jealous of the baby.) It might begin with yelling, name-calling, punching a wall, or kicking a pet. The behavior then progresses to include tripping, pushing, slapping, pinching, punching, kicking, biting, restraining, and choking. But remember this: Victims of domestic violence are "beaten down" long before they're "beaten up."Standards American Medical Association’s Practice Guidelines for Physicians ([1992](http://nursingworld.org/ojin/topic17/tpc17_2.htm#AMA92#AMA92)) recommends screening for partner violence at all portals of entry to the health care system. Screening for partner violence is important because when unidentified and unsubstantiated, the consequences of violence are usually ongoing, escalating, and involve a wide range of general medical injuries, psychological illness, and social problems. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requires the development of partner violence protocols and this, along with proposals made by the American Medical Association (AMA), have led to a greatly improved (although still not to the degree that is necessary) level of response to partner violence. Clearly, the first step in treating partner violence is to properly identify cases in which it is an issue.  **Stressors That Contribute To Partner Abuse**   * Substance abuse by one or both partners (#1 risk factor) * Unemployment * Personal feelings of inadequacy * Financial difficulties * Spouse who is an underachiever * Spouse with inadequate verbal skills * Social isolation or lack of social support * Crises, such as occupational, other accidental injury, bankruptcy, or bereavement * Pregnancy * Chronic health problems or frequent illnesses * Lack of a family religion or struggles about religion * Partners having different values and lifestyles * Unquestioned acceptance of male dominance in the relationship   Screening for partner abuse in the presence of other family members is not only futile, it can even put the patient at risk of injury if the partner is informed and intervenes to silence the victim. Gaining a better picture of what the situation is at home is important in offering resources such as specialized community services or support groups.  Like many ongoing health issues that providers address, partner violence cannot be resolved in a single appointment. However, if there is imminent danger, clinicians may offer to telephone the police or shelter to arrange for protection and transportation. Some states, such as California and many tribal nations, mandate that authorities must be notified if health care provider suspects partner violence has occurred.  **Asking the Right Questions**  When a patient is assessed who may be a victim of abuse, all these considerations affect how she responds to questions. The health care professional is seeing only one incident and a fraction of her relationship with the abuser.  The best way to identify domestic violence is to ask all patients routine screening questions. Besides helping the health care professional become more comfortable broaching the subject, this approach also allows victims to be reached whose injuries aren't obvious.  Before asking a patient screening questions about domestic violence, make sure she has total privacy. If she doesn't feel safe and supported, she'll be afraid to disclose the truth. Ask any family members or friends accompanying your patient to remain in the waiting area. If children are along, ask another staff member to stay with them. Don't make exceptions to the privacy rule, no matter how the partner appears. Some abusers are doting and compassionate in front of others. Also keep in mind that same-sex friends or partners can be abusive.  If the suspected abuser isn't cooperative, you may have to get creative. For example, ask another staff person to speak with the partner alone regarding a health condition or the bill while you interview the woman. Many abusers back down if you use an authoritative tone. But if he becomes belligerent, step back or call security. If you have to call for help, alert the patient and offer to help her make a plan so she'll be safe.  If a language barrier exists between you and the patient, try to provide an interpreter who's the same sex as the victim, familiar with her cultural background, and respectful of the need for confidentiality. Never ask a person accompanying the suspected victim to serve as an interpreter. He or she may be the abuser or want to protect the abuser.  Handle the situation with particular care when the patient is disabled and accompanied by a personal care attendant (PCA) or other support person. Legally, a disabled patient may have her PCA with her in the treatment area. But if you suspect that the PCA may be her abuser, ask the patient privately if she wants her PCA in the treatment area.  Begin the interview by sitting down next to the patient. When you sit down, patients perceive that you're taking more time with them. Ask open-ended questions in an empathetic, nonjudgmental manner and be a good listener. The patient will gauge your level of sincerity by your nonverbal behavior, including facial expressions.  To ease into a conversation, you could say, "Abuse in the home is so common that we now ask all patients: Are you in a relationship where you're being threatened or hurt?" You might also ask, "Do you feel safe at home?" Asking a woman if she is "abused at home", could elicit a response of, "no"; whereas asking the same woman whether her significant other has hit her could elicit a response of, "yes". The best questions to use avoid words like "domestic violence", "abused", "battered", or anything else that sounds demeaning or judgmental or is in reality a technical term that those lacking professional training may fail to understand fully. An example of a single, comprehensive question is the following: "At any time, has a partner hit, kicked or otherwise hurt, frightened, threatened or demeaned you?" This question covers a lot of situations.  It is unwise to put any blame or judgment on the victims. Rather simply ask specific questions that allow you to accurately document what has happened and make it clear that you are someone they can look to for guidance if they invest their trust in you and disclose their experiences.  It's not your job to rescue the woman or to convince her to prosecute her partner. Instead, give her options and let her decide what's best. Remember, she's an expert at her own survival. Praise her repeatedly for the strength and courage she's needed to survive the abuse she's experienced. Help her recognize her own personal resources, which will help her permanently escape the abusive situation.  **Following Up Positive Identifications**  It is important to listen nonjudgementally and validate the disclosure by telling the patient how sorry you are about what is happening and that no one has the right to treat another person that way. These steps in and of themselves are healing and empowering, but they are not enough. Judith Alpert and her colleagues ([1998](http://nursingworld.org/ojin/topic17/tpc17_2.htm#Alpert#Alpert)) developed a guide to recognize and treat victims of partner violence. This resource uses the acronym "RADAR" to summarize the clinical tasks required. The acronym "RADAR" stands for Remember, Ask, Document, Assess, and Review. If followed, the RADAR action steps greatly increase the quality of care. Both remembering to routinely ask patients about partner violence and asking them directly with specific questions increases the success of screening for abuse. The next three steps of the RADAR system structure clinical response and include documenting the injuries, assessing the victim’s safety, and reviewing possible options with the woman.  **Barriers to Disclosing Partner Violence**  The barriers preventing women from disclosing are very real to the victims and must be addressed for any screening method to give accurate results.   * *Fear* is the first of the barriers most victims must overcome when making the choice to disclose partner violence. This fear is multidimensional in that, not only is the victim usually fearful of the abuser retaliating against her for telling family secrets, but she is also often afraid of involving the clinician or the police in her personal situation. She may fear if she discloses, she will lose whatever control she has over the situation, and/or be blamed or stigmatized by the authorities or the clinician inquiring about the abuse. Many women have learned from unfortunate encounters with police responding to domestic violence calls that assertions of partner violence still too often meet a high level of skepticism. In legal proceedings, skepticism may continue even in the presence of physical evidence supporting the claim. Thus, many women try to avoid involving others, believing that they cannot or will not help them. * *Cultural Differences* is a second barrier many women face when deciding whether to disclose partner violence. They may feel the clinician would not understand their specific culture or may have a culturally shaped worldview that accepts the partner’s behavior as normative. Culture shapes what people define as acceptable and unacceptable in intimate relationships, what they feel causes violence that goes beyond minimal levels, what the appropriate response to violence is, and who is in the best position to help resolve the situation. What is not considered acceptable in one culture may be normal in another culture. For example, a study of female homicide in Alexandria, Egypt, found that 47% of all women killed were murdered by a relative after they had been raped. Such "honor killings" are essentially tolerated where cultural practices dictate that murdering the woman is the only way to reclaim the family name after a rape has occurred. However, in many other societies, the idea of killing a family member because she was raped is unspeakable. Although the cultural issues are not always so extreme, there are different expectations within different households, and many victims of partner violence maintain a culturally based world-view that minimizes the abuser’s behavior. * *Dependence on the abuser* is a third barrier that a woman may face when deciding whether to disclose partner violence. Dependence can be economic, social, psychological, or any combination of these types of reliance. Where will she live if she discloses violence to the physician or authorities? Perhaps her abuser prevented her from getting a job and therefore she has no money of her own to meet her basic needs and those of her children. Who will support her decision to leave if her abuser has forced her to cutoff or avoid her family and former friends? These are just a few examples of fears that may go through the victim’s mind as she contemplates placing her trust in a medical provider. * *Feelings of failure* are common for victims of partner violence who often feel responsible for the abuse. This belief can arise from the abuser blaming the victim, the authorities asking questions that imply blame (i.e. "What did you do to provoke the attack?" or "Why don’t you leave your abuser?"), or even from internalized scripts that cast women as responsible for harmony in the home. If a victim is experiencing feelings of failure related to abuse, she may not feel comfortable confiding in anyone else, preferring to work harder to try and change what is happening. * *Promise of change or hope* is the final barrier. Perhaps the abuser acts remorseful and seems greatly apologetic for the abuse, making excuses and explaining why it will never happen again, bringing gifts or offering to work extra hard to make up for what he has done. Although abusers may be sincere at the time, few are able to cease their violence without outside help (for a list of Web sites with state-certified programs for batterers go to [http://www.ncadv.org/](http://www.ncadv.org)).The majority of perpetrators, however, use remorse as one more tool to manipulate their victims into putting up with more abuse, staying with them, and not reporting the crime to the authorities.   **If She Denies Being a Victim**  If a patient you strongly suspect is being abused denies it or refuses to talk, don't think you've failed to help. Like a prisoner of war, she may be brainwashed into believing that she can't escape abuse and may not be ready to accept help.  You can still share your concerns with her and encourage her to trust you. Statements like these may help:   * "I wanted you to know that I see many women with injuries like yours, and they seldom happen accidentally. Usually they come from someone intentionally hurting them." * "I work with many women who are fearful of their partners, and when someone with injuries like yours delays getting medical treatment, they're usually living in fear."   **Why She Stays**  One of the most frustrating aspects about working with a victim of domestic violence is listening to the reasons she may give for staying in the relationship. But leaving can be as dangerous as staying: Seventy percent of victims killed by their abusers are killed while trying to leave. A victim knows only too well that the abuser's threats are real and that he's capable of carrying them out.  Even if she decides to leave, she may need months or even years to develop a safety plan to protect herself and her children. The average victim leaves seven times before leaving for good.  Another obstacle to leaving is the severe depression that frequently accompanies abuse. Depressed people don't have the energy to take action. The withdrawal and loss of self-esteem associated with depression further isolate the victim.  Religious, cultural, and societal pressures also come into play. She may wish to maintain the façade of a happy marriage because she was raised to believe that a good relationship with her partner is her responsibility. She knows that outsiders may consciously or unconsciously judge her, wondering why anyone would stay in such a relationship. Or, if the abuser is well behaved in public, she may be too ashamed to tell anyone the truth, increasing her sense of isolation.  Children living where abuse occurs also suffer, even if they're not physically abused themselves. Long-term effects may include drug use, truancy, behavioral and school problems, unwanted pregnancies, aggressiveness, illness, depression, and suicide. Even though she's aware of these effects, a mother may believe that she and the children are safer staying in the relationship than leaving because the abuser has threatened to hurt the children or kill her if she leaves.  Remain supportive and nonjudgmental. Start by expressing your concerns for her safety and the safety of her children. Review the safety plan with her and encourage her to talk with a victim advocate when she's ready.  You may be the only person who's ever offered to help and support her. Though she may not be able to act right away, your support may help her take action later.  **Make Appropriate Referrals**  Reviewing the many options your patient has is critical in supporting her through this difficult situation. It is helpful if you have a working knowledge of the different types of community resources including shelters, support groups, and legal advocacy. If you are giving an abused woman literature or telephone numbers, make sure that she will be safe in taking them. Some partners could react with increased violence to the threat they feel over their partner speaking to outsiders. If it is safe for the woman to take these materials, they can prove very useful as she is given the choice of using this information, but does not need to feel pressured into contacting support groups that she is not yet ready to embrace**.** |

**Assess Perpetrator Lethality**

Assessing your patient’s safety is a vital role in responding to disclosures of partner violence. Ask the woman if there are weapons in the house, if the violence is increasing over time, or if the children are in danger. Another factor that should be taken into consideration is the level to which the woman feels like she is entrapped. Being isolated from support other than the abuser can interfere with medical access and complicate discovery of future injuries or abuse to the woman.

**Make a Safety Plan with the Victim and With Children**

A safety plan is something that goes beyond just making sure that a woman and her children are safe in her current home environment-- it is a preparation that they can follow if placed in a dangerous situation by the abuser. Safety plans include a myriad of things, such as having a place to stay or housing available should they need to leave the home suddenly; having access to a separate bank account; always keeping a bag packed with copies of important documents or immigration papers, as well as a change of clothes; having access to legal services; having an understanding with the school regarding who specifically is allowed to pick up the children; and any other number of things that must be addressed in individual cases to insure that a woman and her children can leave on a moments notice.

***Sample Safety Plan***

### Have the patient memorize the hotline number or have it readily available

### Have the patient determine a safe place to go and plan how to get there

### If the patient continues to live with her abusive partner, have her be prepared to leave quickly

### Have the patient know where medical care can be obtained if she is injured or experiences pain after being attacked

### Encourage the patient to develop a plan of action to notify police under certain dangerous circumstances

### Instruct the patient how to obtain a restraining order or a protection-from-abuse order, which she needs to carry with her always. Tell her to have extra copies available and to leave a copy with a friend

### If the partner has been evicted from the house, have the patient change existing locks and have additional locks installed where security is needed

**How to Measure Success**

Some clinicians fall into the trap of gauging the success of their intervention by whether the victim leaves the abuser or whether she chooses to prosecute. This leaves them weary, frustrated, and feeling ineffective. Instead, success should be measured by how well the victim's situation was assessed, if counseling was provided, she was informed her about safety options, and her right to self-determination was respected without judgment.

### This encounter may be the only lifeline available to the patient at this low point in her life. Even if results are not seen that day, she will have been given the encouragement she needs to start a journey toward a safe, hopeful future that's free from abuse.

### DSM-IV Category

### V61.1 Physical abuse of adult (code 995.81 if focus of attention is on victim

### Clinical Priorities, Patient Outcome Criteria (Goals) and Interventions

### #1 The patient will make contingency plans to assure her safety in the event of future assaults and will consider her legal options to end the abusive situation As the treatment is initiated and progresses, the patient should be able to: \* Make decisions and plans that promote safety

### 1. Have the patient discuss her situation and feelings about it. 2. Have the patient identify cues to potential battering situations. 3. Talk about ways to promote safety and have the patient develop a personal plan for safety. 4. Explain to the patient the she can't change the batterer; she can only change her responses to the batterer and the abusive situation. RATIONALE: When the patient relinquishes the unrealistic hope of controlling her abusing partner, she can focus her attention on the task of helping herself 5. Assess the patient for suicide risk and the potential for accidents. RATIONALE: Battered women may view suicide as a way out of an abusive situation. They are prone to accidents because of their high level of anxiety, which influences their ability to care for themselves and their children.

### #2 The patient will make a realistic assessment of her situation and become familiar with her legal rights

### 1. Tell the patient about the prevalence of domestic violence. RATIONALE: Telling the woman that violence in the home is not uncommon enables her to realize that her situation is not unique and that she isn't alone in her experiences 2. Discuss the safety of remaining at home and emphasize the need for a workable safety plan in response to the recurrence of abuse. RATIONALE: Many women choose to remain with the abuser because of fear of failure, fear of physical harm or other retaliation, lack of resources and self-esteem, and pressure from significant others. For some women, leaving is more dangerous than staying because many women are killed by their abusers after they have left the abusive situation 3. If the patient has children, ask whether the children are also being abused. RATIONALE: Action must be taken to report child abuse. Discussion about the effects of violence on children can mobilize the woman to do something about the situation. 4. Discuss legal options such as temporary restraining order (TRO) that can be used to protect the woman from the abuse RATIONALE: Women need to know that they can obtain a TRO for 7 to 10 days and then have a hearing for a permanent restraining order

### #3 The patient will gain an increase in control over her life by making positive statements about her abilities and making decisions that promote safety As the treatment is initiated and progresses, the patient should be able to: \* Discuss her situation and start to redefine herself as a person with strengths \* Engage in problem-solving behaviors and use decision-making skills to change her situation

### 1. Accept the patient's statements about her pain and feelings of powerlessness 2. Encourage the patient to talk about situations in which feelings of powerlessness begin. 3. Encourage the patient to recall how she has coped in the past with painful or problematic situations. RATIONALE: This enables the patient to acknowledge her past strengths and abilities to cope, identifying areas that she can control 4. Encourage the patient to take personal credit for progress, such as expressing positive feelings (hope, purpose or control) and making her own decisions. RATIONALE: Acknowledging progress provides a positive sense of self and reinforces the patient's dignity 5. Discuss the basis of safety for all decisions 6. Teach and review problem-solving skills, such as ways to handle frustrations, or strategies to express anger safely and prevent the anger from being internalized. 7. Work with the patient on the problems she identifies as a way to practice and reinforce newly learned decision-making skills. RATIONALE: This exercise enables the patient to implement safety and survival skills rather than remaining in the role of the victim

### Therapies

### The treatment modalities recommended for abused women are individual, group and family therapy. The priority of care in all interactions is the patient's safety; therefore, a well-delineated plan needs to be in place. Usually, therapy is started after crisis intervention has occurred. The abusers must also participate in their own individual or group treatment to work on their own personal issues and stressors. Abusive people must develop ways to identify and appropriately handle their impulsive and explosive feelings, as well as, learn how to accept responsibility for changing their violent behavior.

**Document Findings in Medical Records**

Document your findings in the medical records when taking information from someone whom you suspect has been a victim of partner violence. Documentation can serve multiple purposes including:

1) Alerting other health care providers of ongoing domestic violence in a patient’s life

2) Serving as objective documentation that injuries not consistent with accidental origin have been observed

3) Assisting those who monitor quality of care to determine the rates of screening that is occurring

### To help her in potential legal actions, take care to document the name of the person responsible for the abuse and how he did it. For example, "Patient said that her boyfriend, John, hit her in the face with a closed fist, then picked up a bottle and struck her across the top of her head." Use direct quotes whenever possible. Also document your conversation with the patient, your patient teaching, and what resources you gave her, including any referrals to social services.

### The clinician may consider taking photographs of the injury on a Polaroid or digital camera to place in the victim’s file, providing visual evidence to support the written documentation. This is one of the most important steps medical providers can take to increase the safety of victims. Patients may not be ready to take legal steps initially or even for a substantial length of time. But when and if that point is reached, the documentation will be there to lend credibility.

### Medications

### Psychotropic medications are not ordinarily used for patients who have suffered from abuse. In some instances, a drug may be prescribed for short-term management of a particular symptom. For instance, a patient who is experiencing severe anxiety may be given an antianxiety drug, or a patient with severe depression may be prescribed an antidepressant drug to augment individual or group psychotherapy.

### In the past, many abused patients were prescribed antianxiety drugs and pain medications. Patients medicated with these drugs were less likely to appreciate their options and make decisions to help themselves and their children. Depressed patients who are medicated with appropriate antidepressants, however, are more likely to be able to make decisions and discover options. The unnecessary use of medications can be hazardous to an abused patient and should be discouraged because of the increased likelihood of sedation, which can cause poor judgment or accidents from the CNS depressant effects.

### Conclusion

### Women are being killed, beaten, raped, and abused in a wide range of other ways without having a strong base of support in the medical care system to which they can turn to seek help. Women have more frequent contact with their health care providers than with any other formal system including law enforcement, prosecution, or social services. The mental health profession has the potential for having enormous impact on the health and

### safety of women by taking up the challenge of routinely performing violence assessment. Nurses enjoy high patient trust, and their training in empathy and clinical rapport make them ideal receivers for the disclosure of partner violence.

### While universal health care screening for domestic violence is recommended by most health care organizations, it is most successfully implemented in facilities that have a formal institution-wide commitment to the practice and comprehensive protocols that outline intervention, as well as, assessment strategies.

### It is important to recognize that there are many barriers to a woman reporting partner violence and, with those in mind, use your RADAR. Finally, nurses must care for themselves. Nurses and other health care professionals who have experienced domestic violence must be supported in their efforts to find understanding, safety, peace, and healing in their own lives.

**AFTER A WHILE**

**By Veronica Shoffstall**

**After a while, you learn the subtle difference**

**between holding a hand and sharing a life**

**and you learn that love doesn't mean possession**

**and company doesn't mean security**

**and loneliness is universal.**

**And you learn that kisses aren't contracts**

**and presents aren't promises**

**and you begin to accept your defeats**

**with your head up and your eyes open**

**with the grace of a woman—not the grief of a child.**

**And you learn to build your hope on today**

**as the future has a way of falling apart in mid-flight**

**because tomorrow's ground can be too uncertain for plans**

**yet with each step taken in a new direction creates a path**

**toward the promise of a brighter dawn.**

**And you learn that even sunshine burns if you get too much**

**so you plant your own garden and nourish you own soul**

**instead of waiting for someone to bring you flowers.**

**And you learn that love, true love,**

**always has joys and sorrows**

**seems ever present, yet is never quite the same**

**becoming more than love and less than love**

**so difficult to define.**

**And you learn through it all**

**you really can endure**

**that you really are strong**

**that you do have value**

**and you learn and grow**

**with every goodbye**

**you learn.**

### Domestic Violence

### Clinical Priorities, Patient Outcome Criteria (Goals) and Interventions

### #1 The patient will make contingency plans to assure her safety in the event of future assaults and will consider her legal options to end the abusive situation

### As the treatment is initiated and progresses, the patient should be able to: \* Make decisions and plans that promote safety

### 1. Have the patient discuss her situation and feelings about it. 2. Have the patient identify cues to potential battering situations. 3. Talk about ways to promote safety and have the patient develop a personal plan for safety. 4. Explain to the patient the she can't change the batterer; she can only change her responses to the batterer and the abusive situation. RATIONALE: When the patient relinquishes the unrealistic hope of controlling her abusing partner, she can focus her attention on the task of helping herself 5. Assess the patient for suicide risk and the potential for accidents. RATIONALE: Battered women may view suicide as a way out of an abusive situation. They are prone to accidents because of their high level of anxiety, which influences their ability to care for themselves and their children.

### Domestic Violence

### #2 The patient will make a realistic assessment of her situation and become familiar with her legal rights

### 1. Tell the patient about the prevalence of domestic violence. RATIONALE: Telling the woman that violence in the home is not uncommon enables her to realize that her situation is not unique and that she isn't alone in her experiences

### 2. Discuss the safety of remaining at home and emphasize the need for a workable safety plan in response to the recurrence of abuse.

### RATIONALE: Many women choose to remain with the abuser because of fear, of failure, fear of physical harm or other retaliation, lack of resources and self-esteem and pressure from significant others. For some women leaving is more dangerous than staying because many women are killed by their abusers after they have left the abusive situation

### 3. If the patient has children, ask whether the children are also being abused. RATIONALE: Action must be taken to report child abuse. Discussion about the effects of violence on children can mobilize the woman to do something about the situation.

### 4. Discuss legal options such as temporary restraining order (TRO) that can be used to protect the woman from the abuse RATIONALE: Women need to know that they can obtain a TROfor 7 to 10 days and then have a hearing for a permanent restraining order

### Domestic Violence

### #3 The patient will gain an increase in control over her life by making positive statements about her abilities and making decisions that promote safety As the treatment is initiated and progresses, the patient should be able to: \* Discuss her situation and start to redefine herself as a person with strengths \* Engage in problem-solving behaviors and use decision-making skills to change her situation

### 1. Accept the patient's statements about her pain and feelings of powerlessness 2. Encourage the patient to talk about situations in which feelings of powerlessness begin. 3. Encourage the patient to recall how she has coped in the past with painful or problematic situations. RATIONALE: This enables the patient to acknowledge her past strengths and abilities to cope, identifying areas that she can control

### 4. Encourage the patient to take personal credit for progress, such as expressing positive feelings (hope, purpose or control) and making her own decisions. RATIONALE: Acknowledging progress provides a positive sense of self and reinforces the patient's dignity 5. Discuss the basis of safety for all decisions 6. Teach and review problem-solving skills, such as ways to handle frustrations, or strategies to express anger safely and prevent the anger from being internalized. 7. Work with the patient on the problems she identifies as a way to practice and reinforce newly learned decision-making skills. RATIONALE: This exercise enables the patient to implement safety and survival skills rather than remaining in the role of the victim

**Domestic Violence/Partner Abuse—Pt. Education Handout (4 pgs.)**

**U. S. Census data estimates that approximately 1.3 million women are physically assaulted yearly by an intimate or ex-partner. It is also estimated, that over 200,000 women are raped each year in the United States by an intimate partner.**

Some experts believe that women are as violent as are men to their partners, while others maintain that female to male violence differs significantly in both frequency and severity, and is often used in self-defense. *Women are more than 2.9 times as likely as men to report abuse by a partner of the opposite sex*. Male and female violence in relationships is uneven as women experience male-perpetrated violence more frequently, and the abuse is more repeated and with more physically injuries. *The actual percentage of domestic violence victims that are women is 85%.*

**Injuries**

The physical consequences of battering range from minor injuries to permanent disability, disfigurement, and death. Women who are assaulted or raped by a current or former partner are at the greatest risk for injury. The worst result of domestic violence is death; the majority of women who are killed in the United States are killed by a current or former intimate partner.

**What is Partner Violence?**

The word "partner" applies to same and opposite sex couples, in married, engaged, or cohabiting (living) relationships, and to more casual relationships such as acquaintances or dating partners. Because of the wide range of abusers who can be involved, and the multiple forms of violence they commit, the term "partner violence" is more accurate than alternatives such as domestic violence, wife beating, or wife battering. Partner violence may happen as isolated occurrences (just once or twice), but most typically multiple forms of abuse occur that create a pattern of control by one partner and generate fear and surrender by the other partner. The acts that comprise partner violence are physical, sexual, psychological, stalking, and economic abuse.

**Physical assault includes but is not limited to:**

* **pushing**
* **slapping**
* **punching**
* **kicking**
* **choking**
* **beating**
* **assault with a weapon**
* **tying down or restraining**
* **leaving the woman in a dangerous place**
* **refusing to allow access to medical care when the woman is sick or injured**

**Sexual assault includes acts such as:**

* **degrading sexual comments**
* **using force to make a person perform sexual acts when they have said they don’t want to**
* **purposely hurting someone during sex (including use of objects intravaginally, orally or** **anally)**
* **pursuing sex when a person is not fully conscious or is afraid to say no**
* **forcing someone to have sex without protection against pregnancy or sexually transmitted diseases.**

**Psychological abuse refers to acts such as:**

* **humiliation**
* **intimidation and threats of harm**
* **strong criticizing**
* **insulting, belittling, ridiculing, and name calling**
* **verbal threats of harm or torture directed at the victim or family, children, friends, companion animals, stock animals, or property**
* **physical and social isolation that separates a person from their social support networks**
* **extreme jealously and possessiveness**
* **accusations of infidelity**
* **repeated threats of abandonment, divorce**
* **having an affair if the person does not comply with abuser’s wishes,**
* **monitoring movements, and driving fast and recklessly to frighten the victim**

*Stalking* refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at their 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 threat of serious harm, and they may or may not be before an assault or murder.

Economic abuse is restricting access to resources such as bank accounts, telephone communication, and transportation, or refusing the right to work or attend school that have the effect of keeping a victim without resources and under the control of the abuser

**Understanding the Victim's World**

Understanding the dynamics of domestic abuse, which is based on behaviors that seek to establish power and control over another person through fear and intimidation is Important. It often includes the threat or use of physical force and occurs in a cycle of three repeating phases (See below).

|  |
| --- |
| **Understanding the Cycle of Violence** |
| **In the *tension-building* phase, the abuser may be moody, then become harshly critical and yell. He may become angered by minor aggravations or something viewed as an 'imperfection,' such as laundry left unfolded or children who cry despite efforts to quiet them. Typically, the victim tries hard to keep the abuser calm.**  **In the *event* phase, the abuser acts out his aggressions on the victim, either physically or verbally. During this phase, the victim may fight back or call for help.**  **In the *calm* phase, the abuser often will apologize profusely and promise never to attack her again. This is the phase that keeps the victim in denial and in the relationship.** |

Domestic violence comes from the abuser's belief that he's entitled to control the other person. He also believes that violence is acceptable if it's "needed" to produce the outcome he desires. Abusers also threaten their children.

Once begun, abuse tends to grow and worsen, especially during pregnancy. (Pregnant women are at greater risk for abuse than non-pregnant women because the abuser becomes jealous of the baby.) It might begin with yelling, name-calling, punching a wall, or kicking a pet. The behavior then progresses to include tripping, pushing, slapping, pinching, punching, kicking, biting, restraining, and choking.

**Stressors That Contribute To Partner Abuse**

* **Substance abuse by one or both partners (#1 risk factor)**
* **Unemployment**
* **Personal feelings of inadequacy**
* **Financial difficulties**
* **Spouse who is an underachiever**
* **Spouse with inadequate verbal skills**
* **Social isolation or lack of social support**
* **Crises, such as occupational, other accidental injury, bankruptcy, or bereavement**
* **Pregnancy**
* **Chronic health problems or frequent illnesses**
* **Lack of a family religion or struggles about religion**
* **Partners having different values and lifestyles**
* **Unquestioned acceptance of male dominance in the relationship**

**Make a Safety Plan**

A safety plan is something that goes beyond just making sure that a woman and her children are safe in their current home environment-- it is a preparation that they can follow if placed in a dangerous situation by the abuser. Safety plans include a number of things, such as having a place to stay or housing available should they need to leave the home suddenly; having access to a separate bank account; always keeping a bag packed with copies of important documents or immigration papers, as well as a change of clothes; having access to legal services; having an understanding with the school regarding who specifically is allowed to pick up the children; and any other number of things that must be addressed in individual cases to make sure that a woman and her children can leave on a moment’s notice.

***Sample Safety Plan***

### Memorize the hotline number or have it readily available

### Decide on a safe place to go and plan how to get there

### If the woman continues to live with her abusive partner, have her be prepared to leave quickly

### The woman should know where to get medical care if she is injured or has pain after being attacked

### The woman should develop a plan of action to notify police under certain dangerous circumstances

### If the woman gets a restraining order or a protection-from-abuse order, she needs to carry it with her always. Have extra copies available and to leave a copy with a friend

### If the abuser has been evicted from the house, have the woman change door locks and have additional locks installed where security is needed

**References**

American Association of Colleges of Nursing (AACN). (2001). *Position statement: Violence as a public health problem*

American College of Nurse-Midwives (ACNM). (1997). *Position statement: Violence against women*

American Nurses Association (ANA). (1991). *Position statement: Physical violence against women*.

Barnett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (1997). *Family violence across the lifespan.* Thousand Oaks, CA: Sage.

Bohn, D. K. (1998). Clinical interventions with Native American battered women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children.* (pp.241-258). Thousand Oaks, CA: Sage.

Campbell, D. W & Gary, F. A. (1998). Providing effective interventions for African American battered women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp.229-258). Thousand Oaks, CA: Sage.

Campbell, J. C. (1998). Making the health care system an empowerment zone for battered women: Health consequences, policy recommendations, introduction, and overview. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp.241-258). Thousand Oaks, CA: Sage.

Campbell, J. C. & Campbell, D. W. (1996). Cultural competence in the care of abused women. *Journal of Nurse-Midwifery, 41* (6), 457-462.

Campbell, J. C., Moracco, K. E., & Saltzman, L. E. (2000). Future directions for violence against women and reproductive health: Science, prevention, and action. *Maternal and Child Health Journal, 4* (2), 149-154.

Campbell, J. C., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women’s experience in the emergency department. *Journal of Emergency Nursing, 20* (4), 280-288.

Das Dasgupta, S. (1998). Women’s realities: Defining violence against women by immigration, race, and class. In R. K. Bergen (Ed.), *Issues in intimate violence* (pp. 209-218). Thousand Oaks, CA: Sage.

Ellis, J. M. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly, 22* (1), 27-41.

Emergency Nurses Association (ENA). (1998). *Position statement: Domestic violence*.

Fishwick, N. (1998). Issues in providing care for rural battered women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp. 280-290). Thousand Oaks, CA: Sage.

Ganley, A. L. (1998). Understanding domestic violence. In C. Warshaw & A. L Ganley (Eds.), *Improving the health care response to domestic violence: A resource manual for health care providers* (pp. 15 -45). San Francisco: Family Violence Prevention Fund.

Koss, M. & Hoffman, K. (2000). Survivors of violence by male partners: Gender and cultural considerations. In R. M. Eisler & M. Hersen (Eds.), *Handbook of gender, culture, and health* (pp. 471-490). Mahwah, NJ: Lawrence Erlbaum Associates.

Mahoney, P., Willliams, L. M., and West, C. M. (2001). Violence against women by intimate relationship partners. In C. M. Renzetti, J. L. Edleson, & R. K. Bergen (Eds), *Sourcebook on violence against women* (pp. 143-178). Thousand Oaks, CA: Sage.

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced domestic violence. *JOGNN, 27,* 175- 182.

National Black Nurses’ Association (NBNA). (1994). *NBNA position statement: Violence against women*

Renzetti, C. (1998). Violence and abuse in lesbian relationships: Theoretical and empirical issues. In R. K. Bergen (Ed.), *Issues in intimate violence* (pp.117-128). Thousand Oaks, CA: Sage.

Rodriguez, R. (1998). Clinical interventions with battered migrant farm worker women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp.271-279). Thousand Oaks, CA: Sage.

Schornstein, S. L. (1997). *Domestic violence and health care: What every professional need to know.* Thousand Oaks, CA: Sage.

Sheridan, D.J., (1998). Health-care based programs for domestic violence survivors. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp. 23 -32). Thousand Oaks, CA: Sage.

Thomas, J. (1995). Violence: Conflicts and challenges, a nursing perspective. *Violence: A plague in our land.* (Pp. 49-58). Washington, D. C.: American Academy of Nursing (AAN)

Tjaden, P. & Thoennes, N. (2000a). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*

Tjaden, P. & Thoennes, N. (2000b). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. *Violence Against Women, 6* (2), 142-161.

Torres, S. (1998). Intervening with battered Hispanic pregnant women. In J. C. Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp.259-270). Thousand Oaks, CA: Sage.

United Nations (UN). (1995). *Fourth World Conference on Women, Beijing, 4 -15 September*

U. S. Department of Justice (USDOJ). (2000). *Victims of Trafficking and Violence Prevention Act of 2000*

U. S. Department of Justice (USDOJ). (2001). *About the violence against women office.*

Walker, L. E. (1979). *The battered woman.* New York: Harper & Row.

Walker, L. E. A. (1999). Psychology and domestic violence around the world. *American Psychologist, 54* (1), 21-29.

Warshaw, C. (1998). Identification, assessment, and intervention with victims of domestic violence... In C. Warshaw & A. L Ganley (Eds.), *Improving the health care response to domestic violence: A resource manual for health care providers* (pp. 49 -86). San Francisco: Family Violence Prevention Fund.

Copyright Status

Some of the information at this packet is in the public domain. Unless stated otherwise, documents and files on NIH web servers can be freely downloaded and reproduced. Most documents are sponsored by the NIH; however, you may encounter documents that were sponsored along with private companies and other organizations. Accordingly, other parties may retain all rights to publish or reproduce these documents or to allow others to do so. Some documents available from this server may be protected under the United States and foreign copyright laws. Permission to reproduce may be required.

This is the end of the module: Please complete the evaluation and answer sheet and FAX: 909 980-0643 or email to [KMR@keymedinfo.com](mailto:Educate100@aol.com)

Key Medical Resources, Inc.