

## **Addressing the Issue of Domestic Violence**

Independent Study Module  
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### **Disclosures:**

*Requirements for successful completion:* read the entire study, complete the post-test with a score of 80% or higher, complete and submit the evaluation form, and complete registration information, including full name and credentials.

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*Off-label use:* No off-label use of medications will be discussed.

*Complementary/alternative therapies:* No complementary/alternative therapies will be discussed.

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*Purpose:* The purpose of this study is educational in nature. It is not intended to provide clinical or legal advice or to be a comprehensive compendium on domestic violence. For specific implementation information, please contact an appropriate professional, organization, legal resource, or facility policy.

### **Objectives:**

- ◆ Describe the scope of the domestic violence problem in the United States today.
- ◆ Identify roles of nurses in caring for persons impacted by domestic violence.

### Notes:

- (1) This study is specifically designed to address domestic violence, also known as intimate partner violence. It does not address the separate areas of child abuse or elder abuse.
- (2) References to law information are based on the Ohio Revised Code and legislation in effect at the time of the writing of this study. Readers are encouraged to review legal information specific to the areas in which they reside, and to check periodically for new laws that affect this topic (proposed legislation is pending in the Ohio General Assembly as of December, 2009, related to a number of domestic violence issues).

## Introduction

Domestic violence is a significant problem in the United States, affecting many adults and children. The scope of the problem is actually not known, because there is both stigma attached to being a victim and fear associated with disclosure of this information. This study will explore some of the common factors associated with domestic violence, the issues encountered by families dealing with domestic violence, the legal framework related to domestic violence in Ohio, and nursing implications for caring for families in which domestic violence is a real or suspected issue. While it is possible for a female to be a perpetrator and a male a victim, the usual scenario is that the female is the victim and the male the perpetrator. Because of this prevalence, in this study, feminine pronouns will be used to describe a victim and masculine pronouns will be used to describe a perpetrator.

## Key Points

Here are three key points for nurses and other healthcare providers to share with persons who are victims of intimate partner violence:

1. The violence is not your fault. You have not done anything to cause the violence, and you do not “deserve” to be abused.
2. You are not alone. There are people who can help you, and it is ok to ask for help.
3. Help is available. There are community shelters and resources available, and you can access the National Domestic Violence Hotline ([www.ndvh.org](http://www.ndvh.org)) or **1-800-799-7233** (SAFE)

## Definition

Domestic violence is a common term for what is now being referred to in the literature as *intimate partner violence*. Intimate partner violence is defined as physical, sexual, or psychological harm perpetrated by a current or former partner or spouse. This latter term is a more descriptive definition, which helps to define “domestic”. When intimate partner violence

occurs, one person (the perpetrator) is using specific behaviors to control another person (the victim) in the relationship.

Physical violence can involve anything from a mild slap to murder. Examples of physically violent behavior include slapping or hitting, kicking or biting, pushing or shoving, retraining, choking, burning, stabbing, and shooting, among other things. The Center for Disease Control and Prevention statistics indicate that, in 2004, there were 1544 deaths specifically attributed to domestic violence ([www.cdc.gov/ncipc/dvp/ipv\\_factsheet.pdf](http://www.cdc.gov/ncipc/dvp/ipv_factsheet.pdf)). Ohio statistics indicate that 345 deaths occurred in 2006 related to intimate partner violence and 10,484 victims received shelter ([www.ncadv.org/files/Ohio.pdf](http://www.ncadv.org/files/Ohio.pdf)). The concern with each of these statistics is that the true incidence of intimate partner violence is not known. Therefore, unless there is a clearly proven injury or death caused by intimate partner violence, cases likely go unreported. Victims are extremely reluctant to acknowledge that they have been abused. Sometimes this is because they feel embarrassed or ashamed, sometimes they feel that they are powerless to change, and at other times they feel that their risk of injury or death escalates if they share their situation with someone outside the relationship. Data suggests that this fear is well founded.

Sexual abuse includes such behavior as forcing a partner to have sex against her will, having sex with a person who is unable to understand the process or decline involvement due to intellectual incapability or issues such as drug and/or alcohol use, using unwanted devices as part of sexual activity, and being physically aggressive in demanding particular sex acts, among other things.

Psychological/emotional abuse includes such behaviors as name-calling, demeaning, belittling, blaming, ridiculing, and criticizing, among other things. People are also emotionally manipulated when forced to acquiesce to the requirements of the perpetrator, forced to watch abuse of a pet or child, or forced to limit such activities as time with friends and family. Perpetrator control of money and property are additional behaviors associated with psychological abuse.

Some sources identify stalking as a form of psychological abuse. Other sources consider stalking a fourth type of abuse, along with physical, sexual, and psychological/emotional abuse. Stalking can be physical in nature – the stalker follows the victim, looks in doors or windows of the victim's location, sits in the lobby of the victim's employer, or engages in other physical manifestations of observation. Stalking can take on psychological/emotional tones, such as harassing phone calls, unwanted mail or email, or sharing intimate or demeaning pictures of the victim on public web sites. Stalking can be a significant problem in the workplace, sometimes leading to violence at work or dismissal of the victim from employment because the employer does not feel comfortable with the threat of the stalker's presence. Loss of income interferes with a victim's ability to be self-sufficient and in control.

Major components of intimate partner violence are (1) a systematic pattern of abusive behavior, (2) episodes which recur over time, (3) episodes which become increasingly frequent and severe, and (4) behavior used for the purpose of control, intimidation, or coercion. The borderline between “violence” and “non-violence” is a fine line. For example, a husband who controls the checkbook may state that he does so because he is an accountant and knows more about finances, but the wife may perceive that he does not want her to know or make decisions about the family’s money. To understand whether this is a situation involving “violence”, one may consider whether the rationale is logical, whether the wife is always excluded from use of and decisions about money, and whether this particular “symptom” is supported by other evidence of control and psychological abuse.

Questions about whether a particular situation is representative of intimate partner violence cause concern at many levels – for healthcare providers who see questionable evidence and consider reporting to authorities or documenting findings, for investigators who have personal values which may cause conflict, and for legal authorities and potentially jurors who must make decisions about “guilt” or “innocence”. Subjective data from perpetrators and victims, denial or avoidance of the topic by healthcare providers, the fear and anxiety associated with disclosure, and the threat of consequences of disclosure lead to significant difficulty in understanding the depth and breadth of the intimate partner violence problem.

The Ohio Revised Code (3113.31 ORC) defines domestic violence as the occurrence of one or more of the following acts against a family or household member:

- Attempting to cause or recklessly causing bodily injury
- Placing another person by threat of force in fear of imminent serious physical harm or committing a violation of 2903.211 (menacing by stalking) or 2911.211 ORC (aggravated trespass)
- Committing any act with respect to a child that would result in the child being an abused child
- Committing a sexually oriented offense

## **Prevalence**

Acts of violence are prevalent in our society – both in the “real” world and in the “virtual” world. It is hard to read a newspaper without learning about an act of violence. Television, video games, movies, and sporting events often have elements of violent behavior. Children and youth routinely use video game strategies involving “killing” victims with an array of weaponry. Unfortunately, the “victims” often come back to life – giving the game-player a false sense of what it means to be “dead”. For some, the lines between the virtual world and the real world become blurred, and the perception is that it is acceptable to “kill” another person, because that person won’t “really” be dead. The truth becomes painfully evident when the

“game player” becomes the perpetrator in the “real” world and trauma or death of the victim ensues.

The National Institutes of Health (NIH, 2009), estimates that intimate partner violence affects approximately one in four women in the United States, or roughly 4.8 million women per year. Statistics from the American Medical Association (2009) are similar, indicating that 20-30% of all women are victims of intimate partner violence at some point in their lives. As noted earlier, the problem with data collection is that this is an extremely difficult area for victims to acknowledge and discuss. Women who present for health care with symptoms suggestive of intimate partner violence will usually deny that they have been abused. This denial is partly based on the fact that the woman is ashamed to confirm that she has been abused and partly based on the very real concern that this admission may result in an increase in subsequent abuse. Further, many people who are victims of intimate partner violence never present for care, so no data can be collected from them. There is consensus that the actual incidence of intimate partner violence is much higher than statistics indicate.

### **The Cycle of Violence**

There is a very predictable pattern to intimate partner violence, as opposed to random acts of violence which may occur in different circumstances. In intimate partner violence scenarios, the perpetrator may, in normal everyday life, appear to be a very calm, controlled person. This may be someone who is looked up to in the community and may have a reputable job. Behind closed doors, however, there may be a need to control the victim, to the point that physical, sexual, and/or financial manifestations of violence occur.

Typically, there are three phases in the process of intimate partner violence. First is the escalation of tension. Something happens, either externally or internally, to trigger anger and upsetness in the perpetrator. This process of tension-building may occur over a period of several hours or days, or it may be very short-term in nature. The second phase is the violent act itself, followed by the third phase in which the perpetrator becomes very apologetic, vows that the violence will not be repeated, and seeks to regain the favor of the victim. This period may last for varying lengths of time before the tension begins to build and the cycle is repeated. Repetition of this cycle is symptomatic of the perpetrator’s need to control the victim and the circumstances.

### **Risk Factors**

While anyone can be a victim or perpetrator of intimate partner violence, there are some established risk factors that increase the probability that a person will become a perpetrator or a victim. According to Akers, these include:

- Being unemployed or having a relatively low income – this creates tension, fear, and a sense of powerlessness and may escalate a prospective perpetrator’s need to control *something*. Recent economic stressors in the United States, with associated high rates of unemployment, have increased the rate of intimate partner violence.
- Age 18-30
- Being pregnant increases the risk to a potential victim
- Isolation from others or having few friends and close acquaintances may be both a risk factor and a consequence of domestic violence.
- Drug or alcohol abuse can lead to loss of control and aggressive behavior. It is also important to note that drug or alcohol abuse can also be a consequence of intimate partner violence –
- the victim may use these mechanisms to escape from a painful world of abuse.
- Strong gender role delineation can be problematic if a male believes that he is “supposed” to be in control and is expected to “manage” his home or sees his significant other as “property” to be controlled. Cultural and/or religious issues related to perceptions of male/female roles in the home/family are also important considerations here.
- Past history of abuse and/or violence is another predictor of current risk. A person who has witnessed or been a victim of domestic violence as a child is more likely to be either a victim or a perpetrator as an adult.
- Current or past abuse of a pet has recently been identified as a predictor of violence against people.

### **Why Do Victims Stay in Abusive Relationships?**

Health care providers often have difficulty understanding why a woman who is being abused continues to live with the victim or return to the relationship where the abuse is occurring. There are a number of reasons why women choose to stay in abusive relationships, including the facts that they feel powerless to alter the situation, they feel they “deserve” the abuse due to current or past issues, they don’t realize that the behavior of the perpetrator is not normal, or they fear the consequences if they do leave. This is a well founded concern – the risk of harm to a woman is greater at the time she attempts to leave than at any other time, except possibly when she is pregnant.

### **Consequences**

Intimate partner violence has significant effects on victims and others. The person who is a victim of intimate partner violence lives in a constant state of unease and fear. This stress stimulates the sympathetic nervous system, with resultant increase in pulse, respiration, and other “fight or flight” physiological responses. Over time, without relief of that stress, the body begins to suffer. Chronic stress leads to conditions such as headaches, hypertension, and irritable bowel syndrome. Additionally, the victim of domestic violence seeks ways to relieve anxiety, which may result in smoking, alcohol abuse, or drug abuse. Eating disorders of anorexia or bulimia might be present. Depression is common, and suicide may occur.

There is evidence that observation of violence in the family increases the incidence of violence in children. When children see violence being used to control another person, they learn that violence is an acceptable way to express anger and control others. Children who are present in situations where violence occurs, whether or not they themselves are victims, are more likely to be in abusive relationships as adults, either as perpetrators or as victims.

Consequences to communities must also be considered. Many women who are in abusive relationships are withdrawn and fearful. This may lead to lack of participation in their children's school activities. Stress, illness, or fear may compromise their ability to hold jobs, resulting in low or no income and possibly the need for various types of public assistance. Women may choose to leave abusive relationships, requiring a need for shelters so that the woman, and possibly her dependents, do not become part of the homeless population of the city.

### **Impact on Children**

There is evidence that children who witness or are victims of violence as children will likely end up in abusive relationships as adults – either as victims or perpetrators. Children who witness violence against their mothers are often withdrawn, fearful, reluctant to participate in school or outside activities, and may have physical symptoms ranging from vague complaints of pain to serious chronic stress-related conditions. They may act out, demonstrating aggressive behavior at home, at school, or in other settings.

When a child is in the home where police respond to a domestic violence call, the police are required to report the incident to Child Protective Services. Investigation by this group, however, may not lead to evidence to take action, especially if the violence has not been perpetrated against the child and there is not clear evidence that the child's immediate safety is at risk. Even when there is suspected evidence of abuse, the focus of intervention is to provide for safety of the child(ren). This does not automatically require that children be removed from the home.

### **Screening**

Because of the prevalence of intimate partner violence, some groups recommend screening of potential victims. The American Congress of Obstetrics and Gynecology ([www.acog.org](http://www.acog.org)) recommends screening of all women in OB-Gyn practices. For women who are not pregnant, screening is recommended at routine visits, family planning visits, and preconception discussions. For women who are pregnant, ACOG recommends screening at the first prenatal visit, at least once each trimester, and at the postpartum checkup. This is particularly important, because pregnancy is often a trigger for onset or exacerbation of intimate partner violence.

To assist care providers in initiating this screening assessment, the American Congress of Obstetricians and Gynecologists suggests the statement, “Because violence is so common in many women’s lives and because there is help available for women being abused, I now ask every patient about domestic violence.”

([http://www.acog.org/departments/dept\\_notice.cfm?recno=17&bulletin=585](http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585)). The way questions are asked is important, as few women will immediately respond positively to the questions “Are you being abused?” or “Do you feel safe at home?”. The first question may be threatening to some; the second question is so broad that it is easily misunderstood – the respondent may think about things like living in a safe neighborhood or whether the home has smoke detectors, not whether intimate partner violence is occurring.

Another factor to consider, and consistent with the ACOG recommendation, is that few persons who are victims of intimate partner violence are forthcoming in discussing this issue at their first interaction with the healthcare provider. After several visits, when a trust relationship has been established and the victim is aware that the healthcare provider has a genuine interest in her health, this disclosure is more likely to occur. The value of asking about exposure to domestic violence at several visits, rather than just once, is high.

The American Medical Association ([www.ama-assn.org](http://www.ama-assn.org)) also recommends routine screening. This organization suggests that screening begin for women at age 14 and occur in all practice settings – hospitals, clinics, offices. Guidelines for screening are posted on the association’s web site at [www.ama-assn.org/ama/upload/mm/386/guidelines.pdf](http://www.ama-assn.org/ama/upload/mm/386/guidelines.pdf)

Despite the availability of screening guidelines and recommendations, recent research ([www.nlm.nih.gov/medlineplus/domesticviolence.html](http://www.nlm.nih.gov/medlineplus/domesticviolence.html)) suggests that routine screening does not work in the absence of an effective intervention protocol. This does not mean that screening should not be done; it does mean that those who do the screening must be competent in doing the screening, knowledgeable about intervention strategies, and familiar with resources that can be made available to the patient. The Ohio Domestic Violence Network ([www.odvn.org](http://www.odvn.org)) suggests that a positive screen should be followed by a danger assessment, an assessment of the victim’s current status, working with the patient to develop a safety plan, providing clear and specific discharge instructions, and referring the woman to community resources where additional assistance can be obtained.

## **Legal Implications**

Note: Because the target audience for this study is nurses in Ohio, information in this section relates to citations in the Ohio Revised Code. For learners in other areas, it is important to be aware of local laws related to this topic.

The *Columbus Dispatch* reported on Nov. 15, 2009, that Ohio police responded to approximately 75,000 domestic violence related calls in 2008, and nearly 45% of those did not

lead to an arrest of the alleged perpetrator. Remember in reading these statistics that (1) domestic violence often occurs without a call to the police, and (2) not all domestic violence responses by police are reported.

Sometimes, women call for assistance when the abuse is occurring. The perpetrator, however, may cease the violent behavior or leave before police arrive. The victim might be reluctant to press charges against the perpetrator, for fear of retribution, so the victim might change her mind about needing the police by the time they arrive or may decide not to press charges against the perpetrator.

Domestic violence is considered a misdemeanor in Ohio. Charges may escalate to a felony, though, if there is evidence that there has been assault with a weapon or other trauma resulting from physical aggression. This clearly only applies to physical violence and does not address psychological or financial abuse or stalking.

A victim of domestic violence can go to common pleas court (or the domestic relations section of the court of common pleas if there is one in her county) to seek a civil protection order (CPO). One potential problem here is that, in Ohio, the request for a protection order must be filed in the court of the county in which the abuse occurred. If a woman has fled to another area for safety, she may be unwilling or unable to return to the county in which the request needs to be filed. The order is issued by the judge and must be personally given to the perpetrator by a law enforcement officer. This order, in theory, prevents the perpetrator from having contact with the victim. Unfortunately, the orders are often violated and have limited effectiveness in protecting victims. Another common concern is that victims often do not understand their responsibilities in obtaining and operating within the protection order.

## **Personal / Family Safety**

A nurse or other healthcare provider can assist a woman who is in an abusive relationship to develop a plan to keep her as safe as possible in that relationship. A safety plan should include but is not limited to:

- Having access to important phone numbers, including hospital, doctor's office, child's school, family members, and others who may need to be contacted
- Having access to important documents – lease or mortgage papers, birth certificates, social security cards/green cards, driver's license, immunization records, checkbook, school records, medical information, and other information that would be important to have at hand.
- Developing plans for management of anger in the home – for example, avoiding arguments in the kitchen, where the perpetrator could grab knives or other “weapons” easily
- Developing a plan for a safe destination if it becomes necessary to leave the home – a known resource to the perpetrator, such as a parent's or sibling's home, may not be a good idea, because the perpetrator could easily follow. Contact information for a local shelter could be programmed into a cell phone.

- Developing different patterns of daily activities to avoid stalking or unpleasant encounters – vary the routes taken to work or church, shop at different stores, take the children to different playgrounds
- Talk with children’s school(s) about who has the right to pick up children from school, attend school functions, etc.
- Talk with the victim about other issues in her life that need to be considered to keep her and her children and/or pets as safe as possible.

## **Leaving an Abusive Relationship**

It is difficult for many women to leave a relationship in which they are being abused. There is often fear, which is well-founded, that the perpetrator will be angered by the attempt to leave and the abuse will increase, potentially to the point of homicide. Unfortunately, this fear is substantiated by data, which indicate that a woman’s risk of death is four times higher than usual when she tries to leave (Czekalinski, et al, 2009).

Factors to consider when a victim is planning to leave an abusive relationship include, but are not limited to:

- Have access to the documents, phone numbers, and other information noted above as part of a personal safety plan
- Decide whether or not to take children and/or pets if she needs to leave in a hurry, and consider the implications of this decision. Sometimes children are not the victims of the violence and will not be harmed if they stay, at least in the short term. At other times, risk to the children may be such that it is imperative to remove them from the reach of the perpetrator.
- Decide what personal items will be taken when leaving, and, if possible, have a small bag packed with essential things so that it can be grabbed quickly if needed

## **Interfacing with the Healthcare System**

A victim may present in the emergency room with trauma related from abuse. More frequently, this person is seen in a physician’s office or clinic. The reason for the visit is generally not for treatment related to the violence – at least on the surface. The woman may request a “check-up” or may seek care for stress-related issues or may have secondary problems, such as substance abuse, drug addiction, or suspected suicide. Only after establishing a trust relationship with the healthcare provider is the patient comfortable sharing that her symptoms are a result of the intimate partner violence in which she is involved. Women may believe that they are “guilty” of causing the violence, that they deserve it because of something they have done, or that they are expected to be subservient to men and that the abuse is “normal”. While none of these situations is true, they may be very much the reality for the patient, so it is important to assess the woman’s perspective and accept where she is at the beginning of the healthcare relationship. As rapport is built, the provider can begin to reframe the patients’ perspective to build a sense of autonomy and empowerment.

Questions are best asked in an open-ended format. Asking “Did your partner hit you?” is probably going to elicit a “no” answer. A better approach would be to say, “Tell me what happened to your arm”. Listen to the response, and compare the subjective data with the objective findings of the physical assessment. An indicator of an abusive relationship is often that there is a mismatch between the “story” and the physical findings.

It may be important to consider the woman’s ability to understand and to share her facts and feelings. Vocabulary is an important consideration – words like “abuse” and “violence” may cause reactions that invoke a victim’s need to protect herself, so she is less likely to be forthcoming about her current situation. There may be times when an interpreter is needed. Selection of an interpreter who is sensitive to dealing with both the potential of intimate partner violence and the cultural framework within which the patient and her partner function is of paramount importance.

When possible, it is important to interview the victim separately from the perpetrator. One clue that violence may be part of the problem for a patient is that the alleged perpetrator is always accompanying her – even to an examination room or cubicle. The perpetrator typically does not want the victim to talk with others unless he is present. For one thing, this is a way for him to maintain control over her. For another, it is a way for him to monitor what is said and to dispel any healthcare provider’s potential concern about intimate partner violence.

The Joint Commission does require that hospitals it accredits have a protocol in place for management of suspected intimate partner violence, particularly in emergency departments. Staff are expected to be educated as to signs/symptoms, interview processes, availability of community resources, opportunities for the victim and dependents to get immediate help if needed, and how to appropriately document assessment findings.

## **Healthcare Provider Reporting and Documentation**

Ohio law requires that healthcare providers, among others, report suspected child (up to age 18) or elder (age 65 or older) abuse to appropriate authorities. There is, however, no agency in Ohio that deals with suspected abuse of people between the ages of 18 and 65, unless a crime has been committed. In that case, the appropriate law enforcement agency is notified. For example, if a patient presents to the emergency department with a gunshot wound or stab wound that the healthcare provider “has reasonable cause to believe resulted from an offense of violence” (2921.22[C] ORC), that injury must be reported to law enforcement authorities.

There are numerous situations, however, where a nurse or other healthcare provider may suspect intimate partner violence, in the absence of an obvious act of violence. Section 2921.22 (F)(1) of the Ohio Revised Code stipulates that any healthcare provider who “knows or has

reasonable cause to believe” that the patient has been the victim of domestic violence “shall note that knowledge or belief and the basis for it in the patient’s or client’s records”.

Photographic records are often more helpful than words in clearly demonstrating injuries suspected to have been caused by intimate partner violence. Photography kits are often available in emergency departments for this purpose. Most photography kits contain black or gray fabric to be used as background, a color bar to be included with the picture to show skin discolorations, a measuring device to be placed next to the injury in the photograph to show the size and scope of the injury, a means to identify the patient, and an appropriate camera.

In addition to photographs, written documentation can also include diagrams. For example, the nurse might draw two body diagrams – one of the front of the body, one of the back. Numbers can be placed on the diagrams with corresponding written documentation of what was seen in each area. Data should include size of the injury as well as color, dimensions, and any other relevant information.

### **Preparing for Discharge from the Healthcare Environment**

When a nurse or other healthcare provider interacts with a person who is suspected or known to be a victim of intimate partner violence, there is an obligation to ensure that the woman has information about resources and assistance available to her after leaving the healthcare environment. This is true whether the woman is seen in the emergency room as a result of trauma or through a regular OB-Gyn or family provider/clinic appointment. Knowledge of safe havens for women is important. It may be helpful to know, also, which domestic violence shelters will accept children and/or pets. Information about these resources can be provided to women in very quiet, unassuming ways that do not arouse the suspicion of an alleged perpetrator. For example, instead of placing information about shelters in brochure holders in the facility’s reception room, put small tear strips with the shelter’s phone number (and no other identifying information) on tear strips in the women’s restroom. That way, the woman can tear the small piece of paper with the phone number on it off of the information flyer and put the small piece of paper in her wallet or pocket. The perpetrator does not know she has it, but it does provide her with a resource she can later call upon for assistance.

Healthcare providers may feel guilty if a woman is seen in the healthcare environment and later is severely injured or killed by the perpetrator. There is often the question as to whether the provider should have seen more or done more to prevent the problem from escalating. It is important to know that the healthcare provider is responsible for conducting a thorough assessment, documenting findings, opening the door to talk about violence if the patient chooses to participate in that discussion, providing information about resources, and assuring the woman that she is not alone and that help is available. Beyond that, the healthcare provider has no ability to control subsequent behaviors or outcomes.

## **Breaking the Cycle of Violence**

Several groups have programs underway to focus on breaking the cycle of violence. Remembering that children who are victims of or witnesses to violence tend to become involved in violent relationships as adults, much of the focus for change is in education and support of children. Teaching children how to address problems and frustrations without violence, how to be assertive without being aggressive, and how to function within the parameters of family, school, and society are the focus of many youth-related programs.

For teens, there are programs that have been developed in several states related to healthy dating practices. These classes, workshops, and written materials address responsible behavior in dating, including careful use of alcohol and refraining from drug use, both of which can cloud judgment. Teens are given information about ways to verbally express their needs, show respect for others, and deal with frustration and anger in healthy ways. They are taught that it is not acceptable for one partner to be dominant over another in a dating relationship.

Counseling and support for women and children who are victims of intimate partner violence is another important way to encourage change and support healthy behaviors. Counseling often begins when women go to domestic violence shelters and continues as the woman moves to a home of her own, as long as she needs the support.

Anger management classes for perpetrators are often recommended or may be required as part of a court order. There are conflicting perspectives on the value of such an intervention. Some people believe that intimate partner violence perpetrators are criminals who cannot be rehabilitated and should go to prison. Others believe that perpetrators have personality flaws that lead to their behavior and that therapy can remediate their behaviors. It is important to remember that the focus of intimate partner violence is more about power and control than about anger. Anger is often a heat-of-the-moment response rather than a purposeful, repetitive behavior directed toward controlling another person. Any therapeutic intervention must be directed at changing the long-term behaviors associated with the violence.

## **National Domestic Violence Hotline**

The National Domestic Violence Hotline ([www.ndvh.org](http://www.ndvh.org)) has a web site with extensive information for those who are in intimate partner violence-laden relationships. An interesting feature of the web site pages is an “escape button” that the user can press if she is looking at a web page and the perpetrator enters the room or moves to look at the computer screen. In addition to the web site, there is a phone hotline people can call for immediate assistance. That number is 1-800-799-7233 (SAFE). Patients can be given information about this resource, as

well as information about local shelters and support organizations, so they can access help at a time that works best for them.

## Key Points

To re-emphasize the information provided at the beginning of the study, here are three key points for nurses and other healthcare providers to share with persons who are victims of intimate partner violence:

1. The violence is not your fault. You have not done anything to cause the violence, and you do not “deserve” to be abused.
2. You are not alone. There are people who can help you, and it is ok to ask for help.
3. Help is available. There are community shelters and resources available, and you can access the National Domestic Violence Hotline ([www.ndvh.org](http://www.ndvh.org)) or 1-800-799-7233 (SAFE)

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