Learning objectives

- List and define the five main categories of intimate partner violence.
- Explain why health care workers may use the term “survivor,” instead of “patient” or “victim” to refer to the individual experiencing intimate partner violence.
- Identify negative health behaviors that are commonly associated with intimate partner violence.
- List risk factors for victimization and perpetration.

Domestic violence, also called intimate partner violence (IPV), is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden and Thoennes 2000). The term “intimate partner violence” describes physical, sexual or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

The term “survivor” is often applied to those who have experienced intimate partner violence. Health care workers and advocates may use it instead of “patient” or “victim” because it is a more empowering term. If you or someone you know is the victim of intimate partner violence and needs help, contact your local battered women’s shelter or the National Domestic Violence Hotline at 800-799-SAFE (7233), 800-787-3224 TYY, or www.ndvh.org. These organizations can provide you with helpful information and advice.

IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering. Repeated abuse is also known as battering.

There are five main types of intimate partner violence (Saltzman et al. 2002):

- Physical violence is the intentional use of physical force with the potential for causing death, disability, injury or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one’s body, size or strength against another person.

Sexual violence is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, regardless of whether the act is completed; 2) the attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.

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

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence.

In addition, stalking is often included among the types of IPV. Stalking generally refers to repeated behavior that causes victims to feel a high level of fear (Tjaden and Thoennes 2000).

IPV is a serious problem that is common in our society. Violence by an intimate partner is linked to both immediate and long-term health, social, and economic consequences. Factors at all levels – individual, relationship, community and societal – contribute to the perpetration of IPV. Preventing IPV requires a clear understanding of those factors, coordinated resources and empowering and initiating change in individuals, families, and society.

INTIMATE PARTNER VIOLENCE: FACT SHEET

Occurrence

Statistics about intimate partner violence (IPV) vary because of differences in how different data sources define IPV and collect data. For example, some definitions include stalking and psychological abuse, and others consider only physical and sexual violence. Data on IPV usually come from police, clinical settings, nongovernmental organizations and survey research.
Most IPV incidents are not reported to the police. About 20 percent of IPV rapes or sexual assaults, 25 percent of physical assaults and 50 percent of stalkings directed toward women are reported. Even fewer IPV incidents against men are reported (Tjaden and Thoennes 2000a). Thus, it is believed that available data greatly underestimate the true magnitude of the problem. While not an exhaustive list, here are some statistics on the occurrence of IPV. In many cases, the severity of the IPV behaviors is unknown.

- Nearly 5.3 million incidents of IPV occur each year among U.S. women ages 18 and older, and 3.2 million occur among men. Most assaults are relatively minor and consist of pushing, grabbing, shoving, slapping and hitting (Tjaden and Thoennes 2000a).
- In the United States every year, about 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner. This translates into about 47 IPV assaults per 1,000 women and 32 assaults per 1,000 men (Tjaden and Thoennes 2000a).
- IPV results in nearly 2 million injuries and 1,300 deaths nationwide every year (CDC 2003).
- Estimates indicate more than 1 million women and 371,000 men are stalked by intimate partners each year (Tjaden and Thoennes 2000a).
- IPV accounted for 20 percent of nonfatal violence against women in 2001 and 3 percent against men (Rennison 2003).
- From 1976 to 2002, about 11 percent of homicide victims were killed by an intimate partner (Fox and Zawitz 2004).
- In 2002, 76 percent of IPV homicide victims were female; 24 percent were male (Fox and Zawitz 2004).
- The number of intimate partner homicides decreased 14 percent overall for men and women in the span of about 20 years, with a 67 percent decrease for men (from 1,357 to 388) versus 25 percent for women (from 1,600 to 1,202; Fox and Zawitz 2004).
- One study found that 44 percent of women killed by their intimate partner had visited an emergency department within two years of the homicide. Of these women, 93 percent had at least one injury visit (Crandall et al. 2004).
- Previous literature suggests that women who have separated from their abusive partners often remain at risk of violence (Campbell et al. 2003; Fleury, Sullivan and Bybee 2000).
- Firearms were the major weapon type used in intimate partner homicides from 1981 to 1998 (Paulozzi et al. 2001).
- A national study found that 29 percent of women and 22 percent of men had experienced physical, sexual or psychological IPV during their lifetime (Coker et al. 2002).
- Between 4 percent and 8 percent of pregnant women are abused at least once during the pregnancy (Gazmararian et al. 2000).

**CONSEQUENCES**

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson and Leone 2005). The following list describes just some of the consequences of IPV.

**Physical**

At least 42 percent of women and 20 percent of men who were physically assaulted since age 18 sustained injuries during their most recent victimization. Most injuries were minor such as scratches, bruises and welts (Tjaden and Thoennes 2000a).

More severe physical consequences of IPV may occur depending on severity and frequency of abuse (Campbell et al. 2002; Heise and Garcia-Moreno 2002; Plichta 2004; Tjaden and Thoennes 2000a). These include:

- Bruises.
- Knife wounds.
- Pelvic pain.
- Headaches.
- Back pain.
- Broken bones.
- Gynecological disorders.
- Pregnancy difficulties like low birth weight babies and perinatal deaths.
- Sexually transmitted diseases including HIV/AIDS.
- Central nervous system disorders.
- Gastrointestinal disorders.
- Symptoms of post-traumatic stress disorder:
  - Emotional detachment.
  - Sleep disturbances.
  - Flashbacks.
  - Replaying assault in mind.
- Heart or circulatory conditions.

Children may become injured during IPV incidents between their parents. A large overlap exists between IPV and child maltreatment (Appel and Holden 1998). One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al. 2001).

**Psychological**

Physical violence is typically accompanied by emotional or psychological abuse (Tjaden and Thoennes 2000a). IPV – whether sexual, physical, or psychological – can lead to various psychological consequences for victims (Bergen 1996; Coker et al. 2002; Heise and Garcia-Moreno 2002; Roberts, Klein, and Fisher 2003):

- Depression.
- Antisocial behavior.
● Suicidal behavior in females.
● Anxiety.
● Low self-esteem.

● Inability to trust men.
● Fear of intimacy.

### Social

Victims of IPV sometimes face the following social consequences (Heise and Garcia-Moreno 2002; Plichta 2004):

- Restricted access to services.
- Strained relationships with health providers and employers.
- Isolation from social networks.

### Health behaviors

Women with a history of IPV are more likely to display behaviors that present further health risks (e.g., substance abuse, alcoholism, suicide attempts).

IPV is associated with a variety of negative health behaviors (Heise and Garcia-Moreno 2002; Plichta 2004; Roberts, Auinger, and Klein 2005; Silverman et al. 2001). Studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims:

- Engaging in high-risk sexual behavior.
  - Unprotected sex.
  - Decreased condom use.
  - Early sexual initiation.
  - Choosing unhealthy sexual partners.
- Having multiple sex partners.
- Trading sex for food, money or other items
- Using or abusing harmful substances.
  - Smoking cigarettes.
  - Drinking alcohol.
  - Driving after drinking alcohol.
  - Taking drugs
- Unhealthy diet-related behaviors.
  - Fasting.
  - Vomiting.
  - Abusing diet pills.
  - Overeating.
- Overuse of health services.
- Engaging in high-risk sexual behavior.
- Unprotected sex.
- Decreased condom use.
- Early sexual initiation.
- Choosing unhealthy sexual partners.

### Economic

- Costs of IPV against women in 1995 exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (CDC 2003).
- When updated to 2003 dollars, IPV costs exceed $8.3 billion, which includes $460 million for rape, $6.2 billion for physical assault, $461 million for stalking and $1.2 billion in the value of lost lives (Max et al. 2004).
- Victims of severe IPV lose nearly 8 million days of paid work – the equivalent of more than 32,000 full-time jobs – and almost 5.6 million days of household productivity each year (CDC 2003).
- Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children’s lives threatened) are more likely to have been unemployed in the past, have health problems and be receiving public assistance (Lloyd and Taluc 1999).

### Groups at Risk

Certain groups are at greater risk for IPV victimization or perpetration.

#### Victimization

- The National Crime Victimization Survey found that 85 percent of IPV victims were women (Rennison 2003).
- Prevalence of IPV varies among race. Among the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women and Hispanic women (Tjaden and Thoennes 2000b).
- Young women and those below the poverty line are disproportionately victims of IPV (Tjaden and Thoennes 2000b).

#### Perpetration

- Studies show that for low levels of physical violence, men and women self-report perpetrating physical IPV at about the same rate. However, a common criticism of these studies is that they are generally lacking information on the context of the violence (e.g., whether self-defense is the reason for the violence) (Archer 2000).
Risk factors for victimization and perpetration

Risk factors are associated with a greater likelihood of IPV victimization or perpetration. Risk factors are not necessarily direct causes of IPV – these may be contributing factors to IPV (Heise and Garcia-Moreno 2002). Not everyone who is identified as “at risk” becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

The public health approach aims to moderate and mediate those contributing factors that are preventable, and to identify protective factors which can reduce the risk of victimization and perpetration.

A combination of individual, relational, community and societal factors contribute to the risk of being a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various points of prevention intervention.

Risk factors for victimization

- **Individual factors.**
  - Prior history of IPV.
  - Being female.
  - Young age.
  - Heavy alcohol and drug use.
  - High-risk sexual behavior.
  - Witnessing or experiencing violence as a child.
  - Being less educated.
  - Unemployment.
  - For men, having a different ethnicity from their partner’s.
  - For women, having a greater education level than their partner’s.
  - For women, being American Indian/Alaska native or African American.
  - For women, having a verbally abusive, jealous, or possessive partner.

- **Relationship factors.**
  - Couples with income, educational or job status disparities.
  - Dominance and control of the relationship by the male.

- **Community factors.**
  - Poverty and associated factors (e.g., overcrowding).
  - Low social capital – lack of institutions, relationships and norms that shape the quality and quantity of a community’s social interactions.
  - Weak community sanctions against IPV (e.g., police unwilling to intervene).

- **Societal factors.**
  - Traditional gender norms (e.g., women should stay at home and not enter workforce, should be submissive) (Crandall et al. 2004; Heise and Garcia-Moreno 2002; Stith et al. 2004; Tjaden and Thoennes 2000a)

Risk factors for perpetration

- **Individual factors.**
  - Low self-esteem.
  - Low income.
  - Low academic achievement.
  - Involvement in aggressive or delinquent behavior as a youth.
  - Heavy alcohol and drug use.
  - Depression.
  - Anger and hostility.
  - Personality disorders.
  - Prior history of being physically abusive.
  - Having few friends and being isolated from other people.
  - Unemployment.
  - Economic stress.
  - Emotional dependence and insecurity.
  - Belief in strict gender roles (e.g., male dominance and aggression in relationships).
  - Desire for power and control in relationships.
  - Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration).

- **Relationship factors.**
  - Marital conflict – fights, tension, and other struggles.
  - Marital instability – divorces and separations.
  - Dominance and control of the relationship by the male.
  - Economic stress.
  - Unhealthy family relationships and interactions.

- **Community factors.**
  - Poverty and associated factors (e.g., overcrowding).
  - Low social capital – lack of institutions, relationships and norms that shape the quality and quantity of a community’s social interactions.
  - Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence).

- **Societal factors.**
  - Traditional gender norms, for example: women should stay at home, not enter the workforce, and/or should be submissive (Black et al. 1999; Heise and Garcia-Moreno 2002; Kantor and Jasinski 1998; Stith et al. 2004; Tjaden and Thoennes 2000a)

Sample domestic violence protocol and assessment form

The following protocol and assessment form can be adapted to fit your institution’s requirements.
Sample domestic violence protocol purpose

- Guide treatment of all injuries and illness.
- Provide and communicate a safe environment for the patient.
- Identify battered women through screening and through recognition of possible indicators.

- Offer supportive counseling, validation of her concerns and attention to safety issues after discharge.
- Document the incident(s) correctly and take photos.
- Provide referral information during the health care contact.

Philosophy

ABC Hospital believes that all people are entitled to the right to live free from violence or threat of violence from current or former partners. Ninety-five percent of domestic violence involves female victims and male abusers. Sometimes men are abused by women, and domestic violence also occurs in gay and lesbian relationships. Due to the fact that the vast majority of domestic violence occurs toward women by male partners, the convention of using “she” to refer to the victim and “he” to refer to the abuser will be used in this policy and procedure.

Policy

Because health care providers may be the first non-family members to whom an abused woman turns for help, the provider has an opportunity and responsibility to provide appropriate and sensitive interventions. ABC Hospital is committed to developing and implementing policies and procedures for identifying, treating and referring victims of domestic abuse.

Legal consideration: State codes define domestic violence as a criminal offense and allows a person to seek relief through the legal system.

Definitions

Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A victim of domestic violence is anyone who has been injured or has been emotionally or sexually abused by a person with whom she has or has had a primary relationship.

Procedure

- RN role
  - Screen for domestic violence on all female patients over 16.
  - Conduct initial assessment in private (ask patient’s visitor/s to have a seat in the lobby before screening and inform them that this is standard routine, or find a time when the patient is alone, such as in the bathroom).
  - Screen for domestic violence using simple direct questions. “Because domestic violence is so common in many people’s lives, I’ve begun to ask all my patients about it routinely. Are you in a relationship with a person who hurts or threatens you?” If you are suspicious of injuries that are present ask “Did someone cause these injuries? Who?” (Refer to end for review of screening questions).
  - If domestic violence is identified:
    - Let her know that the conversations will be confidential within the limits of reporting requirements, which are injuries such as knife wounds, gunshot wounds or burns.
    - Assess immediate safety by asking these questions. “May I ask you some questions that will allow us to determine your level of safety?” Ask these questions in a thoughtful and caring manner:
      - Are you afraid to go home?
      - Are there weapons present?
      - Have there been threats of homicide or suicide?
      - Can you stay with family or friends?
      - Do you need access to a shelter?
      - Do you want police intervention?
    - If a patient verbalizes danger:
      - Ask the patient for her verbal consent to call an AWARE advocate by saying, “I’d like to call AWARE and have an advocate come and meet with you. Would that be okay?” If she declines, then seek help from social services.
- AWARE (Aid Women Against Rape Emergencies) or social services will do the safety assessment.
- Notify the MD.
- Notify security if immediate danger is present to patient or staff. The police department may need to be notified as the situation warrants.
- If the patient is not in immediate danger but positive for domestic violence:
  - Ask the patient for verbal consent to call an AWARE advocate by saying, “I’d like to call AWARE and have an advocate come and meet with you. Would that be okay?” The AWARE advocate will have the expertise to sort through a safety assessment and the patient’s wishes and willingness to press charges. If the patient declines AWARE, it will be up to the nurse or social services to help sort through the needs of the patient. (Discharge the patient with wallet cards and referral numbers for AWARE. Be careful to not document the numbers on the going-home information, but on the wallet card).
  - Document objectively; include specifics of abuse; include quotes whenever possible; document circumstances of abuse and the abuser’s name.
  - When documenting in the record, ensure that the record is in an area where the abuser does not have access.
  - A determination needs to be made as to whether the patient will be pressing charges so the police know what their role is.
- Advise patient who denies domestic violence but whom you suspect is abused.
- You suspect abuse.
  - Confer with MD.
  - Offer a resource wallet card if patient has not admitted abuse or if RN is suspicious of injuries or complaints. Attempt to facilitate disclosure with questions such as: “Your injuries concern me. Injuries such as these are often caused by abuse. Could this be happening to you?”
  - “If you are abused, please come back to the ED or contact AWARE.”
  - Do not write any domestic violence referral on discharge instructions.
- Documentation (documentation should be done on the domestic violence assessment form, or domestic violence intervention screen in Meditech).

**RN documentation**

- Document any findings of abuse or probable abuse and warning to patient of risk of further violence. Use body map.
- Document patient’s comments regarding abuse. Use patient’s own words when possible.
- Document the name of the perpetrator of the domestic violence.
- Document social work or AWARE referral and reason for referral.
- Discharge instructions should not have domestic violence indicated.
- (Wallet card will have referral information.)

- Document “positive or negative” domestic violence and explanation.
- Offer to take photos of any injuries and bruising.
- Written consent must be obtained before proceeding with photographs.
- On discharge instruction sheet, do not indicate domestic violence, abuse, or AWARE referral. (This instruction sheet could fall into the hands of the perpetrator.
- Document photos taken.

**Photos**

- When injury lends itself to photographic documentation, physician or RN will assist with photos. Make sure an identifying characteristic or ID band appears in the photo and a ruler to indicate size of the injury.
- Instant photos are taken and placed in the medical record. Note the following on the bottom of the photo.
  - Date.
  - Location (e.g., BRH, BRH ED).
  - Patient name.
  - Medical record number.
  - “Photo taken by ...” photographer’s name.
  - Part of body photographed.
- Consent must be signed before taking photos.

The ABC Hospital Domestic Violence Task Force is committed to ongoing care of the victim of domestic violence and to the training of the hospital staff and community. This is an interdepartmental/interagency task force with members from the social work services department, an advocate from AWARE, a nurse from the emergency department, and a physician. This group will come together to hold monthly meetings and discuss the objectives set out in the 10 State Program and review the hospital’s ability to care for the victim of domestic violence.

ABC Hospital will train all new employees on use of the domestic violence protocol. Staff development will meet and collaborate with AWARE quarterly.

**RN responsibilities**

Health care professionals should use “RADAR” to guide them in recognizing and treating victims of partner violence:

**Remember**

- to ask routinely about violence.
- to ask questions. “At any time, has your partner hit, kicked or otherwise hurt or frightened you?” Interview patients in private at all times.
- to document findings. Information about suspected domestic violence in a patient’s chart can be used in court cases.
- to assess patients’ safety. Is it safe to return home? Find out if there are any weapons; are children in danger? Is the violence escalating?
- to review options. Let patient know where there is help. Tell them about shelters, support groups and legal advocates.

Remember: Nurses have an obligation to tell their clients that:

- No one deserves to be abused.
- One person cannot be the cause of another person’s violence.
- They are not alone.
- Pushing, shoving, and/or slapping are acts of crime.
- While conflict is inevitable, violence is a choice.
- The batterer is responsible and needs help.
● They are not bad.
● Substance abuse does not minimize the crime.

References

1. Domestic violence, also called intimate partner violence, or IPV, is characterized by sexual intimacy between the two individuals.
   - True
   - False

2. Stalking generally refers to repeated behavior that causes victims to feel a high level of fear.
   - True
   - False

3. Because most IPV incidents are not reported to the police, it is believed that available data greatly underestimate the true magnitude of the IPV problem.
   - True
   - False

4. Estimates indicate more than 2 million women and 500,000 men are stalked by intimate partners each year.
   - True
   - False

5. From 1976 to 2002, about 11 percent of homicide victims were killed by an intimate partner.
   - True
   - False

6. Women with a history of IPV are more likely to display behaviors that present further health risks.
   - True
   - False

7. The National Crime Victimization Survey found that 70 percent of IPV victims were women.
   - True
   - False

8. Societal factors alone are direct causes of IPV.
   - True
   - False

9. Heavy alcohol and drug use is a risk factor for both victimization and perpetration of IPV.
   - True
   - False

10. Consent must be signed before the taking of photos.
    - True
    - False