Domestic Violence: The Kentucky Requirement

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
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Faculty

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. In the fall of 1989, she began law school at Florida State University. After graduating from law school in 1992, Ms. Allen took a two-year job as law clerk to the Honorable William Terrell Hodges, United States District Judge for the Middle District of Florida. After completing her clerkship, Ms. Allen began her employment with the law firm of Smith, Hulsey & Busey in Jacksonville, Florida where she has worked in the litigation department defending hospitals and nurses in medical malpractice actions. Ms. Allen resides in Jacksonville and is currently in-house counsel to the Mayo Clinic Jacksonville.

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Marjorie Conner Allen, BSN, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Senior Director of Development and Academic Affairs

Sarah Campbell

Director Disclosure

The director has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Audience
This course is designed for all Kentucky counselors and therapists who may intervene to protect victims/survivors of domestic violence.

Accreditations & Approvals
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Special Approvals
This course fulfills the Kentucky requirement for 3 hours of Domestic Violence Education.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Course Objective
The purpose of this course is to enable Kentucky counselors and therapists in all practice settings to define domestic violence and identify those who are affected by domestic violence. This course describes how a victim can be accurately diagnosed and identifies resources available for domestic violence victims/survivors.

Learning Objectives
Upon completion of this course, you should be able to:

1. Define domestic violence.
2. Recognize the characteristics and dynamics experienced by those groups who are at risk for domestic violence, including pregnant women, children, men, and same-sex couples.
3. Describe how to screen for patients who have a history of being a victim/survivor or perpetrator of domestic violence, including aspects of a culturally sensitive assessment.
4. Outline interventions targeted to victims/survivors of domestic violence.
5. Review resources available for domestic violence victims/survivors.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Domestic violence continues to be a prevalent problem in the United States. Because of the number of individuals affected, it is likely that most healthcare professionals will encounter patients in their practice who are victims/survivors. Accordingly, it is essential that healthcare professionals are taught to recognize and accurately interpret behaviors associated with domestic violence. It is incumbent upon the healthcare professional to establish and implement protocols for early identification of domestic violence victims/survivors and their abusers. In order to prevent domestic violence and promote the well-being of their patients, healthcare professionals in all settings must take the initiative to properly assess all patients for abuse during each visit and, for those who are or may be victims/survivors, to offer education, counseling, and referral information.

Victims/survivors of domestic violence suffer emotional, psychologic, and physical abuse, all of which can result in both acute and chronic signs and symptoms. Victims/survivors may present with physical and mental disease, illness, and injury. Frequently, the injuries sustained require abused victims/survivors to seek care from healthcare professionals immediately after their victimization. Subsequently, physicians and nurses are often the first healthcare providers that victims/survivors encounter and are in a critical position to identify domestic violence victims/survivors in a variety of clinical practice settings where victims/survivors receive care. Healthcare professionals must educate themselves to enhance awareness of domestic violence in each particular practice or clinical setting.

DEFINING DOMESTIC VIOLENCE

Domestic violence, termed spousal abuse, battering, or intimate partner violence (IPV), refers to the victimization of an individual with whom the abuser has or has had an intimate or romantic relationship. The Centers for Disease Control and Prevention (CDC) defines IPV as, "physical violence, sexual violence, stalking, and psychologic aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" [21].

Domestic violence can consist of any of many behaviors or combination of behaviors, falling under physical, psychologic, verbal, sexual, and financial/economic abuse (***Table 1).***

The state of Kentucky has formulated the following definitions [2]:

- "Domestic violence and abuse" refers to physical injury, serious physical injury, stalking, sexual abuse, strangulation, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, strangulation, or assault between family members or members of an unmarried couple.
- "Family member" is defined as a spouse (including a former spouse), a grandparent, a grandchild, a parent, a child, a stepchild, or any other person living in the same household as a child if the child is the alleged victim/survivor.
- "Member of an unmarried couple" is used to describe each member of an unmarried couple that allegedly has a child in common, any children of that couple, or a member of an unmarried couple who are living together or have formerly lived together.

These are legal definitions utilized by the courts to determine under which circumstances an individual should be prosecuted for domestic violence.

DOMESTIC VIOLENCE BEHAVIORS			
Physical Abuse	**Psychologic/Verbal Abuse**	**Sexual Abuse**	**Financial/Economic Abuse**
Kicking, punching, biting, slapping, strangling, choking, abandoning in unsafe places, burning with cigarettes, throwing acid, throwing objects, refusing to help when sick, stabbing, shooting	Intimidation, humiliation, put-downs, ridiculing, control of victim's/survivor's movement, stalking, threats, threatening to hurt victim's/survivor's family and children, social isolation, ignoring needs or complaints	Rape, forms of sexual assault (such as forced masturbation, fellatio, or oral coitus), sexual humiliation, perpetrator refuses to use contraceptives, coerced abortion	Withholding of money, refuse to allow victims/survivors to open bank account, all property is in the perpetrator's name, victim/survivor is not allowed to work

Source: Compiled by Authors *Table 1*

It is important for healthcare professionals to understand that domestic violence, in the form of emotional and psychologic abuse and physical violence, is prevalent in society. Unfortunately, domestic violence and abuse has become a fact of life for many Americans. This course will use the terms "domestic violence" and "IPV" interchangeably.

PREVALENCE

Since the 1970s, domestic violence has emerged as one of the most serious public health problems facing women in this country [1]. According to the CDC's 2016/2017 National Intimate Partner and Sexual Violence Survey, almost 1 in 2 women (47.3%) and more than 2 in 5 men (44.2%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime [3]. Although many of these incidents consist of pushing, grabbing, shoving, slapping, and hitting, 32.5% of female and 24.6% of male victims/survivors of intimate partner violence experienced severe physical violence. In addition, 16% victims of homicide are killed by a current or former intimate partner [1; 5].

According to the Kentucky Cabinet for Health and Family Services, individuals in Kentucky are more likely to experience IPV than the national average [6]. The most recent data indicates that nearly half (45.3%) of women and one-third (35.5%) of men in Kentucky reported having been the victim/survivor of IPV [68]. It is also estimated that one in nine women in Kentucky will be the victim/survivor of sexual assault in their lifetime [6]. In one day in 2019, 1,420 victims/survivors of abuse were sheltered by various types of programs in Kentucky, but an additional 128 requests for service were denied due to lack of resources [68]. In the United States, it is estimated that 30% of all female and 5% of male murder victims are killed by intimate partners [7]. One study of firearm homicide followed by suicide in Kentucky determined that in 80% of cases, the victim and perpetrator were family members or intimates [8]. Furthermore, 72% of all murders/suicides involved an intimate partner, with the overwhelming majority (94%) involving a female victim [68]. This demonstrates that domestic violence, and its associated consequences, is a real threat to the residents of Kentucky. As a result of these troubling statistics, the Kentucky Legislature enacted legislation that requires all mental health professionals, physicians, and nurses who have been granted licensure or certification after July 15, 1996, to complete a 3-hour continuing education course on domestic violence [9].

Victims/survivors of abuse often suffer severe physical injuries and will likely seek care at a hospital or clinic. The health and economic consequences of domestic violence are significant, although statistics vary from report to report. One of the difficulties in addressing the problem is that abuse cannot be predicted by any demographic feature related to age, ethnicity, race, religious denomination, education, or socioeconomic status or class.

In 2003, the CDC published the results of its U.S. Congress-funded study to determine the cost of domestic violence on the healthcare system [1]. The CDC report, which relied on data from the National Violence Against Women Survey conducted in 1995, estimated the costs of IPV by measuring how many female victims/survivors were nonfatally injured; how many women used medical and mental healthcare services; and how many women lost time from paid work and household chores in 1995. The estimated total cost of IPV against women in 1995 was more than $5.8 billion; when updated to 2003 dollars, the cost is more than $8.3 billion. It must be noted that the costs of any one victimization may continue for years; therefore, these numbers most likely underestimate the actual cost of IPV [1; 10]. An analysis of the 2012 National Intimate Partner and Sexual Violence Survey showed that victims/survivors of domestic violence lost 741 million days of productivity, a total of $110 billion across the lifetimes of all victims/survivors [4].

The rate of serious domestic violence against women has declined significantly from 1994 to 2018, from nearly 6.9 million females 12 years of age or older in 1994 to nearly 3.3 million in 2018 [11]. The rate of overall family violence also fell by more than one-half in this time period [11]. Studies reveal that several factors may be contributing to the reduction in violence, including a decline in the marriage rate and a decrease of domesticity, better access to federally funded domestic violence shelters, improvements in women's economic status, and demographic trends, such as the aging of the population [13; 14].

PERPETRATORS OF DOMESTIC/SEXUAL VIOLENCE

Abuser characteristics have been studied far less frequently than victim characteristics. Some studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. A man who abuses alcohol is also likely to abuse his mate, although the abuser may not necessarily be inebriated at the time the abuse is inflicted [100]. Domestic violence assessment questionnaires should include questions that explore social drinking habits of both victims and their mates.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the abuser's dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [101]. Domestic violence victims frequently report that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing and often includes maintaining complete control of finances and activities of the victim (e.g., work, school, social interactions) [101].

In addition, abusers often suffer from low self-esteem and their sense of self and identity is directly connected to their partner [101]. Borderline personality disorder, characterized by impulsivity, fluctuation of emotions, and instability in sense of identity and interpersonal relationships, has been identified as a risk factor for perpetrating domestic violence [160].

Extreme dependence is common in both abusers and those being abused. Due to low self-esteem and self-worth, emotional dependence often occurs in both partners, but even more so in the abuser. Emotional dependence in the victim stems from both physical and psychologic abuse, which results in a negative self-image and lack of self-worth. Financial dependence is also very common, as the abuser often withholds or controls financial resources to maintain power over the victim [102].

In some cases, a perpetrator and victim will seek help together (joint or couples counseling) to resolve issues in their relationship. Some domestic-violence-focused joint counseling approaches have been described [103]. However, many organizations, including the National Domestic Violence Hotline, the Department of Justice, the American Bar Association, and Futures Without Violence, recommend against joint counseling for violent couples due to the risk of additional harm to and isolation of the victim [104; 105]. A better option for abusive partners is battering intervention and prevention programs.

IDENTIFYING DOMESTIC VIOLENCE IN GROUPS AT RISK

Healthcare professionals are in a critical position to identify domestic violence victims in a variety of clinical practice settings in which women receive care. Nurses are often the first healthcare provider a victim of domestic violence will encounter in a healthcare setting, and must therefore, be prepared to provide care and support for these individuals. Although women are most often the victims/survivors of violence, domestic violence extends to others in the household as well. For example, domestic violence occurs when children are abused by their parents, when parents are abused by their children, when elderly are abused, and when siblings abuse each other.

PREGNANT WOMEN

Because a gynecologist or obstetrician is frequently a woman's primary care physician, these healthcare providers should be particularly sensitive to domestic violence issues [15]. According to the CDC, IPV affects as many as 324,000 pregnant women each year [16]. This represents approximately 8% of all pregnant women in the United States. As with all domestic violence statistics, this number is presumed to be lower than the actual incidence as a result of under-reporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes IPV more prevalent among pregnant women than some of the health conditions included in prenatal screenings, including pre-eclampsia and gestational diabetes [16]. Because 96% of pregnant women receive prenatal care, this is an optimal time to screen for domestic violence and develop trusting relationships with the women. Possible factors that may predispose pregnant women to IPV include young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [16; 17].

The overarching problem of violence against women cannot be ignored, especially as both mother and unborn child are at risk. One study found that pregnant women who had been treated at a hospital after a violent incidence had an eight-fold increased risk of fetal death [69]. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will ensure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [18; 19]. Healthcare professionals should also be aware of the possible psychologic consequences of abuse during pregnancy. There is a higher risk of stress, depression, and addiction to alcohol and drugs in abused women, and victims/survivors are less likely to obtain prenatal care and to develop postpartum depression [20; 69; 70].

MINORITY WOMEN

The United States is becoming increasingly diverse in terms of ethnic composition. By 2044, the U.S. will become a majority-minority nation [71]. In 2021, 13.6% of the U.S. population was foreign-born, most of whom reside in the West [72]. It is inevitable, therefore, that race, culture, and ethnicity will have a profound effect on American culture. Consequently, health professionals must become more aware of, and sensitive to, the cultural norms, belief systems, and needs of culturally diverse patients in order to provide relevant services and interventions. Results from the National Violence Against Women Survey indicate that all racial minorities in the United States experience more IPV than white Americans, with

the exception of Asian Americans [22]. It has been suggested that ethnic minority groups may be more vulnerable to violence as a result of environmental risk factors such as poverty, racism, oppression, and discrimination. For example, one study suggests that nearly one-third of African American women experience IPV in their lifetimes, compared with one-fourth of white American women [22]. Another study with 1,155 Mexican American women found that 10.7% of the sample reported physical abuse by a current partner. Researchers found that those born in the United States reported a rate of violence higher than those born in Mexico [23]. In a qualitative study of 10 Mexican women who experienced IPV, immigration status (specifically the fear of deportation) was the primary reason they did not leave the relationship or seek help [73].

In the Asian American community, the mistaken notion that Asian Americans have achieved success often cloaks the issue of domestic violence. In a telephone interview with 336 Asian American women in the San Francisco and Los Angeles areas, 27% experienced emotional abuse by an intimate partner, 16% reported being pressured to have sex without their consent, and 12% reported that an intimate partner had hurt or had attempted to hurt them by means of hitting, kicking, slapping, shoving, object throwing, or threatening their lives with a weapon [24]. Research indicates that perpetrators in these cases are overwhelmingly male [74]. Although this is a small study, it does indicate that domestic abuse is an issue for some Asian Americans.

Culture, race, and ethnicity also influence help-seeking patterns. Help-seeking behavior is in part influenced by an individual's definition and understanding of abuse, which is ultimately influenced by culture. For example, an ethnic minority woman who is being abused by her husband may not seek help if she does not label the event as a problem. Instead, she may believe the abuse is something to be persevered. Financial limitations, suspiciousness or wariness of health or mental health professionals, limited English proficiency, and inconvenience in locating and traveling to agencies are also hindrances specific to these populations [25].

CHILDREN

Children who are raised in violent homes are also in danger. These children are at high risk for abuse and for emotional damage that may affect them as they grow older. Slightly more than half of female victims/survivors of domestic violence live in a household with at least one child younger than 12 years of age, and between 3.3 million and 10 million children witness domestic violence annually [24; 26]. Studies demonstrate that children who witness domestic violence are more likely to grow into a perpetrator or victim of domestic violence than a child who was himself or herself abused, thereby creating a cycle of violence. For example, in one study, adolescent witnesses of abuse were also more likely to report having perpetrated abuse (42%) compared to non-witnesses (15%) [27]. Research regarding the psychosocial outcomes of children exposed to domestic violence has found that child witnesses exhibit more aggression, anxiety, difficulties with peers, and academic problems than the average child [26; 28]. An estimated 47% of children who have witnessed IPV at home are younger than 6 years of age, and these preschool-age children are more likely to show evidence of internalizing behavior problems (e.g., anxiety, depression, somatic complaints) compared to older children, who show more signs of externalizing behavior problems (e.g., bullying, aggression, misconduct) [29]. In addition to witnessing violence, these children may also become direct victims/survivors of violence, as child maltreatment occurs in 30% to 60% of families in which IPV is reported [30]. Moreover, statistics demonstrate that 85% of domestic violence victims/survivors abuse or neglect their children.

Indirect exposure to violence may also have consequences. In one study, children whose mothers were victims/survivors of IPV exhibited externalizing problems regardless of whether they directly witnessed the violence [75]. The researchers concluded that the children may sense and internalize their mothers' psychologic distress [75].

Adolescents are also victimized. Between 7% and 17.5% of all homicides against girls 12 to 17 years of age are committed by an intimate partner [31; 12]. Among young women 18 to 24 years of age, the rate is 42.9%. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them, compared to 54% in older age groups [32]. Accordingly, healthcare professionals who see young children and adolescents in their practice must have the tools necessary to detect these "silent victims" of domestic violence and to intervene quickly to protect young children and adolescents from further abuse.

Adverse childhood experiences (including domestic violence) contribute to lifelong negative emotional, physical, and behavioral consequences. These adverse childhood experiences appear to be dose-related, in that the more traumatic the childhood experiences, the more severe the outcomes will be in later life [76]. In addition, if the stressors endure over a long period of time (referred to as "toxic stress"), it can lead to negative changes to the brain [76].

Sexual Assault

In contrast to sexual victimization of adolescents and adults, who usually present in the aftermath of an assault, pre-pubertal victimization of children tends to be "discovered" when the child is found to have signs of physical or sexual abuse (e.g. genital injury or scarring) or when a sexually transmissible infectious agent is identified. Gonorrhea, syphilis, and HIV (not linked to prior blood transfusion or maternofetal transmission) acquired during the postnatal period of childhood are indicative of sexual abuse. Chlamydia infection might be indicative of sexual abuse in children 3 years of age of older. Sexual abuse should be suspected when genital herpes, Trichomonas vaginalis, or anogenital warts are diagnosed [28]. In cases in which any STD has been diagnosed in a child, further evaluation for other STDs and for the possibility of sexual assault/abuse should be made in consultation with a specialist.

Just as the identification of a sexually transmissible infection in a child raises suspicion for prior sexual assault/abuse, so too does known or suspected childhood sexual assault/abuse warrant an assessment for STDs. The decision to perform a diagnostic evaluation and to collect vaginal or other specimens should be made on an individual case basis. Among factors to consider in the decision to screen a child for STDs are [28; 78]:

- Child has experienced penetration or has evidence of recent or healed penetrative injury.
- The perpetrator of the abuse is a stranger.
- The perpetrator is known to have an STD or is at high risk for STDs.
- Child has a relative or another person in the household with an STD.
- Child has symptoms or signs of active infection (e.g., vaginal discharge or pain, genital itching or odor, genital lesions or ulcers).
- Child or parent requests STD testing.

The physical examination and collection of vaginal specimens is often frightening or uncomfortable for a child and should be conducted by an experienced clinician. The CDC and the American Society of Pediatrics provide updated guidance for healthcare providers involved in the evaluation of childhood sexual assault/abuse.

ELDERLY

Abused and neglected elders, who may be mistreated by their spouses, partners, children, and other relatives, are among the most isolated of all victims/survivors of family violence. Among the elderly, it is estimated that 1 in 10 individuals will experience at least one form of abuse (e.g., physical, psychologic, financial, sexual, neglect) [34]. Those 65 years of age and older are projected to number 83.7 million in the United States by 2050, almost double the number in 2012, exponentially increasing the number of individuals experiencing elder abuse [34].

Because elder abuse can occur in family homes, nursing homes, board and care facilities, and even medical facilities, healthcare professionals must remain keenly aware of the potential for abuse. When abuse occurs between elder partners, it is primarily manifested in one of two ways, either as a long-standing pattern of marital violence, or as abuse originating in old age. In the latter case, abuse may be precipitated by issues related to advanced age, including the stress that accompanies disability and changing family relationships.

It is important to understand that the domestic violence dynamic involves not only a victim but a perpetrator as well. For example, an adult son or daughter who lives in the parents' home and depends on the parents for financial support may be in a position to inflict abuse. This abuse may not always manifest itself as violence, but can lead to an environment in which the elder parent is controlled and isolated. The elder may be hesitant to seek help because the abuser's absence from the home may leave the elder without a caregiver. Because these elderly victims/survivors are often isolated, dependent, infirm, or mentally impaired, it is easy for the abuse to remain undetected [77]. Healthcare professionals in all settings must remain aware of the potential for abuse and keep a watchful eye on this growing and particularly vulnerable group.

MEN

Statistics confirm that domestic violence is predominantly perpetrated by men against women; however, there is evidence to suggest that women also exhibit violent behavior against their male partners [35]. Studies demonstrate that approximately 5% of murdered men are killed by intimate partners [31]. It is persuasively argued that the impact on the health of female victims/survivors of domestic violence is generally much more severe than the impact on the health of male victims/survivors [36]. However, approximately 7% of men are raped and/or physically assaulted by an intimate partner in their lifetime [3; 24]. In 2008, men experienced 101,000 nonfatal violent victimizations by an intimate partner [37]. Healthcare professionals should always keep in mind that men can also be victimized and experience mental health consequences of the abuse. Because IPV is perceived as a "woman's issue," men who are victims/survivors of IPV may perceive the experience as a threat to their manhood [78].

SAME-SEX COUPLES

Domestic violence exists in the gay, lesbian, bisexual, transgender, and other gender and sexual minorities (LGBT+) community, with the 2010 National Intimate Partner and Sexual Violence Survey indicating that 43.8% of lesbian women, 61.1% of bisexual women, 26% of gay men, and 37.3% of bisexual men reporting ever having experienced rape, physical violence, and/or stalking by an intimate partner [38]. The lifetime prevalence rate of psychologic abuse was 59% for gay men and 53% for bisexual men [38]. Men living with male intimate partners experience significantly more IPV than men who live with female intimate partners [4]. This supports other statistics indicating that IPV is perpetrated primarily by men. Three dominant barriers to help-seeking by LGBT+ victims/survivors have been identified: lack of understanding of the problem, stigma, and systemic inequities [80]. In general, much of the IPV literature and knowledge base has focused on heterosexual women's experiences with IPV. Furthermore, because of the stigma of being gay, victims/survivors may be reticent to report abuse and afraid that their sexual orientation will be revealed. Many in this community feel that support services are not available to them due to prejudices of the service providers. Unfortunately, this results in the victim/survivor feeling isolated and unsupported. Healthcare professionals should strive to be sensitive and supportive when working with homosexual patients.

MILITARY FAMILIES

As with domestic violence in the civilian population, military victims/survivors face a host of barriers in disclosing abuse. In addition to shame and embarrassment, fear of reprisals, feelings of isolation, and lack of available services, many military victims/survivors found when they did report abuse, military personnel were not sensitive to their needs [39]. Given these barriers to disclosure, it is difficult to assess the prevalence of domestic violence among military families. According to the U.S. Department of Defense, there were a total of 18,208 reported incidents of domestic abuse in 2009 [40]. However, it should be noted that a 2010 report released by the U.S. General Accounting Office (GAO) indicated that the U.S. Department of Defense's use of multiple registries and inclusion of only those reports made to the Family Advocacy Program (excluding cases handled by civilian law enforcement, identified by nonmilitary medical staff, and reported to commanders) make calculating the actual number of domestic violence cases impossible [40]. Reports from the Congressional Research Service indicate that among the active-duty population, there were 16,912 reported incidents of spouse and intimate partner abuse in 2018 [33]. Among these, 8,039 reports (6,372 victims/survivors) met the Department of Defense definitions. Physical abuse accounted for the highest number of reports (73.7%), followed by emotional abuse (22.6%), sexual abuse (3.6%), and neglect (0.06%) [33].

The Family Advocacy Program is responsible for seeing that victims/survivors remain safe and have access to support and advocacy services and that offenders receive appropriate intervention services [41]. The Program works to prevent domestic abuse by educating service members and families about the issue; identifying families experiencing domestic abuse; providing support services to victims/survivors of abuse; and providing treatment for abusers.

Risk factors among this group are complex and multifaceted. Brewster conducted a study of 2,991 abusers who used physical domestic violence that received treatment at the Air Force Family Advocacy Program and agreed to participate in the study. As with the general population, the physical violence sustained was more severe when the offender was male. However, previously reported domestic violence cases were higher than the base rate for the general population—one in four had been reported for spouse abuse, and one in eight offenders had been substantiated for spouse abuse [42].

Presence of a psychiatric disorder can also increase the risk of domestic violence in military families. In one systematic review, 27.5% of male veterans with PTSD disclosed to perpetrating physical violence in the last year, and 91% reported using psychologic violence against their partner [81]. Male members of the military with depression had a 3.95 increased likelihood of perpetrating physical violence against their partner compared to men without a mental disorder [81].

It has also been speculated that deployment, exposure to the trauma of combat, and the development of post-traumatic stress symptoms provokes military veterans to be violent at home [43; 44]. Furthermore, when these veterans do obtain treatment, either voluntarily or as mandated, many do not complete their treatment regimens.

INDIVIDUALS EXPERIENCING HOMELESSNESS

The intersection of homelessness and domestic and/or sexual violence is bidirectional and complex. Studies indicate up to 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives, and as many as 57% of all homeless women report domestic violence as the immediate cause of their homelessness [62; 63; 64]. Furthermore, victims of stranger-perpetrated violence are more likely to have been homeless on multiple occasions [146].

Homeless domestic violence victims face unique barriers to accessing help, including affordable housing, as a result of actions of their perpetrator. They may face housing discrimination, lack stable employment histories, and have poor credit as a result of their abuse histories [62]. In addition, a study published by the National Online Resource Center on Violence Against Women found that homeless women are "particularly vulnerable to multiple forms of interpersonal victimization, including sexual and physical assault at the hands of strangers, acquaintances, pimps, sex traffickers, and intimate partners on the street, in shelters, or in precarious housing situations" [63]. The sexual assault experiences of homeless women are more likely to be violent and include multiple sexual acts than women with housing [65].

Because homeless victims of violence face specific barriers to seeking and receiving services, interventions and assistance should be targeted to their specific needs. Homeless young adults who are sexually assaulted, for example, are reluctant to obtain a post-assault exam in part because they fear of getting involved in the legal system [147]. It is also important to remember that additional marginalizing factors (e.g., gender/sexual minority status, geographic isolation) compound the problems experienced by survivors.

PEOPLE WITH PHYSICAL AND/OR COGNITIVE DISABILITIES

Research indicates that disability predicts recent intimate partner violence victimization in both men and women [66]. National data indicate that women with a disability are significantly more likely to report experiencing every form of intimate partner violence, including rape, other sexual violence, physical violence, stalking, psychologic aggression, and control of reproductive or sexual health [66]. Stalking and psychologic aggression by an intimate partner are more likely in men with disabilities. Women with disabilities are 3.3 times more likely to be raped [133]. Most perpetrators are acquaintances of the victim [67].

The type of disability may also be an indicator or risk. In a national sample of victims of sexual assault who were disabled, the majority (60.5%) had a psychiatric disability and 25% had an intellectual/developmental disability; the smallest percentage (15.6%) had physical/sensory disabilities [67]. People with intellectual disabilities are sexually assaulted at a rate seven times higher than those without disabilities [68]. A survey study found that individuals with autism were more likely to have experienced physical and sexual violence when they were children, and they were not likely to have disclosed the incidence(s) [148].

Although persons with disabilities are more likely to be victimized, it can be difficult for them to seek and obtain help. Legal action was taken in only 13.6% of cases [67]. Differently able individuals may be less likely to be believed when they report abuse or may be unable to effectively communicate their experiences [69]. Police and prosecutors are often reluctant to take these cases because they are difficult to win in court [68]. In addition, there is a lack of coordinated community services and supports for disabled survivors of sexual assault [67].

PEOPLE WITH BEHAVIORAL HEALTH PROBLEMS

Behavioral health problems, including substance use disorders, eating disorders, and compulsive behaviors, commonly co-occur with intimate partner violence and sexual violence. According to the American Society of Addiction Medicine, substance abuse co-occurs in 40% to 60% of IPV incidents, with several lines of evidence suggesting that substance use/abuse plays a facilitative role in IPV by precipitating or exacerbating violence [70]. Both victims and abusers are 11 times more likely to be involved in domestic violence incidents on days of heavy substance use [71]. Opioid misuse and intimate partner violence are correlated; women who have experienced IPV and sexual violence are more likely to use opioids [149].

It is unclear if substance abuse precedes the violence, or vice versa. However, victimization is considered a positive risk factor for substance use disorders, and women in abusive relationships have often reported being coerced into using alcohol and/or drugs by their partners [70].

Women with a history of eating disorders are also at increased risk for intimate partner violence [72]. In a study of undergraduate women, recent (i.e., last three months) sexual assault was associated with more severe eating disorder symptoms [73; 74]. In another study, eating disorders were significantly correlated with lifetime intimate partner violence, PTSD, and depression among female participants [150].

ADOLESCENTS AND YOUNG ADULTS

Perpetrators of dating violence among young adults include witnessing interparental violence, experiencing child abuse, alcohol abuse, adherence to traditional gender roles, and relationship power dynamic issues [75]. Female perpetrators are more likely than men to display internalizing symptoms (e.g., depression), trait anger and hostility, and to be victims of past dating violence; young male perpetrators are more likely than women to report lower socioeconomic status and educational attainment, antisocial personality characteristics, and increased relationship length [75].

Cyberdating abuse or violence refers to abusive behaviors perpetrated using technology that occur in the dating context. In general, the control tactics are similar regardless of whether technology is involved [151]. Forms of sexual cyber abuse include sending unwanted sexual content, pressuring someone to send nude photos, and using technology to engage in sexual encounters [151]. Technologically mediated sexual violence can predict real-life violence. In fact, sexting has been identified as a unique risk factor for dating violence in young adulthood [76].

Young women are more likely than men to experience dating violence, as is the case among most subgroups. However, nonsexual violence in dating relationships is more likely to involve the reciprocal use of violence by both partners (mutual aggression) than adult abusive relationships [77]. Additional risk factors for dating violence include low self-esteem, substance use disorder, depression, isolation, pornography use, and hooking up for sex [144].

LOW-INCOME POPULATIONS

As with most sociodemographic risk factors for domestic and sexual violence, the correlation between lower socioeconomic status and violence is potentially bidirectional. Economic abuse (considered a form of intimate partner violence) may precede more severe forms of physical and sexual violence. Women who are financially dependent on their abusers are less able to leave and more likely to return to an abusive relationship, particularly if they are financially dependent on their abusers [79; 152]. Greater economic dependence is associated with more severe abuse and homicide by an intimate partner [153].

Financial instability is also a potential adverse effect of intimate partner violence. Current or past exposure to violence has been found to negatively affect ability to sustain stable employment, and women in abusive relationships frequently lose their jobs, experience high job turnover, are forced to quit, or are fired [80].

Victims of sexual violence also experience short- and long-term economic consequences, and low-income individuals are more vulnerable. Victims exceed non-victims in the average number and cost of medical care visits. Beyond medical costs, there are productivity costs and other long-term costs to victims and their families such as pain and suffering, trauma, disability, and risk of death. Sexual violence and the trauma resulting from it can have an impact on the survivor's employment in terms of time off from work, diminished performance, job loss, or being unable to work. These impacts disrupt earning power and have a long-term effect on the economic well-being of survivors [81].

PEOPLE LIVING IN RURAL COMMUNITIES

A large national study found that lifetime intimate partner violence victimization rates in rural areas (26.7% in women, 15.5% in men) are similar to the prevalence found among men and women in non-rural areas [82]. There is some evidence that intimate partner homicide rates may be higher in rural areas than in urban or suburban locales [83; 153].

Substance use disorders and unemployment are more common among IPV perpetrators in rural areas [83]. It has been suggested that IPV in rural areas may be more chronic and severe and may result in worse psychosocial and physical health outcomes. Poverty in rural areas is also associated with an increased risk for IPV victimization and perpetration for both men and women [84]. Residents of rural areas are less likely to support government involvement in IPV prevention and intervention than urban residents [83].

Although the rates are similar, the risk factors, effects, and needs of rural victims are unique. For example, research indicates that rural women live three times further from their nearest IPV resource than urban women. In addition, domestic violence programs serving rural communities offer fewer services for a greater geographic area than urban programs [85].

Not only do rural women experience geographic isolation, they tend to be socially isolated as well. Because rural communities tend to be tight-knit, there can be more stigma and ostracism when residents reach out for assistance [154].

It is important to assess victims' proximity to available resources and to help in times of crisis. Rural victims may benefit from improved access to services, including technology-based outreach (e.g., video-conferencing, telehealth programs) [86]. In rural areas, there may also be fewer sexual assault nurse examiners or the requirements for qualification and training may be absent or inconsistent [155].

IMMIGRANTS AND REFUGEES

A variety of persons migrate to the United States, including legal immigrants granted the indefinite or time-limited right to live in the United States by immigration authorities; undocumented immigrants who have not been granted such a right; and refugees who are unable or unwilling to return to their country of origin due to fears of persecution based on their race or ethnicity, religion, nationality, political opinion, or gender identity or sexual orientation. For simplicity, all three groups are referred to as immigrants [87].

Recent immigrants are at increased risk for violence victimization. In one study of Chinese immigrants in the United States, acculturation and socioeconomic status were associated with severity, frequency, length, and type of abuse [88]. Persons who are displaced due to conflict in their home countries are also vulnerable to sexual violence. Studies indicate that approximately one in five refugees or displaced women in complex humanitarian settings have experienced sexual violence, but this is likely an underestimation [89]. Refugees may also experience torture and sexual violence prior to being displaced. Among male survivors, sexual torture is substantially under-reported, and estimates indicate that 5% to 15% of male survivors were sexually abused by threats of castration or rape, being raped or forced to perform sex in view of others, or receiving electric shock or mutilation to the genitals [90; 91]. Fewer women than men are tortured in aggregate, but around 50% of female torture survivors report sexual torture, typically by rape and sometimes in front of family members [92; 93; 94]. Studies also show that sexual violence victimization is more likely while in transit to a host country [156]. Sexual and gender minority migrants may feel they need to conceal their identities for fear of sexual harassment and possible violence [156].

Immigrants tend to underuse health services, especially undocumented immigrants, who typically lack health insurance and may avoid seeking medical attention out of fear of being deported. Immigration status and the inability to understand domestic violence within given cultural norms are major barriers to help-seeking among recent immigrants [95]. They may also face language barriers, exacerbating an inability to seek help and lack of trust in health and social services. When migrants do seek help, access to interpreters may be limited [157]. The Violence Against Women Act puts some protections in place for noncitizen women, including the ability to self-petition for citizenship (instead of requiring a citizen sponsor) and immigration relief to victims of sexual/other violence or human trafficking [96]. Access to bilingual and culturally appropriate services is also a major concern.

PEOPLE OF COLOR

In the United States, intimate partner violence disproportionately affects women of color [136]. Black and multiracial non-Hispanic women have significantly higher lifetime prevalence of rape, physical violence, or stalking by an intimate partner [137]. Black, American Indian or Alaska Native, and multiracial non-Hispanic men have a significantly higher lifetime prevalence of rape, physical violence, or stalking compared with white non-Hispanic men. These findings may be a reflection of the many stressors that racial and ethnic minority communities continue to experience. For example, a number of social determinants of mental and physical health, such as low income and limited access to education, community resources, and services, likely play important roles. These factors and medical mistrust, historical racism and trauma, perceived discrimination, and immigration status may affect help-seeking and the assessment of victims [136].

When race and ethnicity are considered, it is important to remember that there is great diversity within these groups. Certain factors may be generally applicable, but there may be unique contributions by ethnic sub-group [138].

HEALTH EFFECTS AND IMPLICATIONS OF DOMESTIC VIOLENCE

As is clear, victims of domestic violence experience a wide range of physical and psychologic injuries. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of the body. In one hospital-based study, domestic violence victims were 13 times more likely to sustain injury to breast, chest, or abdomen than accident victims. Abuse victims are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen in a patient, particularly in combination with evidence of old injury, physical abuse should be suspected [11].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The U.S. Preventive Services Task Force recommends that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.

(https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed April 27, 2023.)

Level of Evidence: B (There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.)

As a result of prolonged stress, victims often manifest various psychosomatic symptoms that generally lack an organic basis. For example, they may complain of backaches, headaches/migraines, and gastrointestinal problems. Often, they will complain of chronic pain, fatigue, restlessness, insomnia, or loss of appetite. Research indicates that women with a history of intimate partner violence are at greater risk of developing fibromyalgia and chronic fatigue syndrome [129]. Sleep disturbances, including truncated sleep, nightmares, and restless sleep, are also common [130]. The likelihood of having some sort of stress-related sleep disturbance is 1.24

times greater for women affected by physical intimate partner violence and 3.44 times greater for victims of sexual abuse [130]. Great amounts of anxiety, guilt, and depression or dysphoria are also typical [11; 12]. In many women, this constellation of symptoms has been labeled "battered women's syndrome."

The long-term health implications should also be considered. In a study conducted by MORE magazine and the Verizon Foundation, 88% of women who have experienced sexual abuse and 81% of women who have experienced any form of domestic violence report having chronic health conditions (compared with 62% among women who experienced no domestic violence) [13]. In this study, the most common chronic health conditions among victims were low back pain (35%), headaches (32%), difficulty sleeping (30%), and depression/anxiety (30%). Victims of violence were also found to have increased incidences of diabetes, cervical pain, gastroesophageal reflux disease, irritable bowel syndrome, and post-traumatic stress disorder (PTSD).

HEALTH EFFECTS AND IMPLICATIONS OF SEXUAL VIOLENCE

Research indicates that victims of sexual violence experience a range of acute and long-term physical and psychologic injuries as a result of the violence [14].

NON-GENITAL BODILY INJURY

Non-genital bodily injury is seen in more than half of all rape victims presenting to emergency departments [15; 16]. In one study of 162 women examined between 2002 and 2006, signs of bodily injury were found in 61% of patients, with genital injury present in 39% [17]. Most common were bruises (56%) and abrasions (41%), followed by lacerations, penetrating injury, and bites. Evidence of injury was higher in the 137 cases examined within 72 hours of assault (66% vs. 33%) and in cases in which the assaults occurred outdoors (79% vs. 52%).

On examination, one should inspect carefully for evidence of blunt traumatic injury to the head, neck, arms, legs, and torso, looking for signs of penetrating injury, lacerations, and bite marks. Bruising may be evident on the neck (attempted strangulation), hands, arms, breasts, or thighs. Signs of bodily injury are more prevalent in women younger than 30 years of age. Other factors showing a strong positive association with bodily injury include alcohol consumption, history of prior assault, and assault by strangers [15].

GENITAL INJURY

Signs of genital traumatic injury are not always found after sexual assault, and in such cases should not be taken as evidence that sexual assault did not occur [17]. When routine inspection is combined with additional examination techniques, such as colposcopy and toluidine blue staining, the rate for identifying genital injury approaches 70% [18]. A 2021 study compared 834 women, half of whom reported nonconsensual intercourse. External genital tears were found more often in the nonconsensual group [131]. Similarly, anal penetration and tears were also more common in the nonconsensual intercourse group. As such, these may be indicators of lack of consent.

The common types and location of genital injuries, and thus the areas to be examined most closely, are:

- Bruises and abrasions to the labia, fossa navicularis, or perianal area
- Ecchymoses, tears, or lacerations of the hymen
- Abrasions and/or tears of the posterior fourchette
- Tears/lacerations in the perianal area

LONG-TERM PSYCHOSOCIAL IMPACT

The impact of sexual assault leads to immediate and long-term physical and mental health consequences. In addition to the potential risk for acquiring a sexually transmitted disease (STD), approximately 1% to 5% of rape victims become pregnant [20].

LONG-TERM PHYSICAL AND EMOTIONAL IMPACT OF SEXUAL ASSAULT	
Chronic Somatic Disorders	**Psychosocial Disorders**
Pelvic pain, dyspareunia	Anxiety, depression, phobias
Functional gastrointestinal disorder	Post-traumatic stress disorder
Fibromyalgia	Sexual dysfunction
Multisystem physical complaints	Sleep disturbance
Headaches	Anorexia
Abdominal pains	Work absenteeism
Source: [22; 23; 24; 25; 26; 27; 133]	*Table 2*

The National Violence Against Women Survey (NVAWS) found that 33% of women and 24% of men received counseling from a mental health professional as a direct result of their last assault; 28% and 10%, respectively, lost time from work [21]. Survivors of sexual assault are also at increased risk for re-victimization and experience higher rates of depression, post-traumatic stress disorder, substance abuse, and suicide.

In the aftermath of sexual assault, a variety of chronic somatic, cognitive, and emotional sequelae have been observed in sexual assault victims (***Table 2***). The individual's response and subsequent ability to cope with the trauma of the assault are influenced by a number of related factors. These include the nature and severity of the assault itself, age of the victim, relationship between the victim and assailant, prior history of abuse, and the person's own ambient life stress and coping mechanisms. For some, the impact of a sexual assault experience is severe and long-lasting, often resulting in difficulty with interpersonal relationships and tasks of daily living, sexual dysfunction, loss of work time, and increased utilization of healthcare resources [22; 23; 24]. The victim's age and developmental stage can also affect help-seeking. Adolescents tend to delay seeking formal help more often than adult victims [132]. This delay could exacerbate both physical and psychosocial consequences.

A meta-analysis of clinical studies published between 1980 and 2002 revealed a significant association between prior sexual assault and the lifetime diagnosis of fibromyalgia, chronic pelvic pain, and functional gastrointestinal disorders [25]. In a cross-sectional, randomly selected study of 219 women followed in a Veterans Administration (VA) primary care clinic, a history of prior sexual assault was found to be associated with a significant increase in somatization scores, multisystem physical complaints, anxiety, work absenteeism, and health care utilization [26]. Among another cohort of women receiving VA medical and mental health care, the prevalence of post-traumatic stress disorder was found to be seven to nine times higher in women who had experienced a prior sexual assault, compared with those having no assault history [27].

It is also vital to remember that some victims have experienced cumulative sexual violence over the course of their lifetime. This often results in continued fear and anxiety and chronic stress, which is associated with an increased risk for chronic health conditions (e.g., hypertension, disordered sleeping, chronic pain, asthma) [133].

To summarize, the priorities of acute care counseling are to provide emotional support, assure a plan for patient safety, and assess coping skills and strength of support system post-discharge. When possible, arrangements should be made for ongoing counseling through sexual assault crisis programs.

In anticipation of the long-term adverse effects of sexual assault, arrangements should be made for primary care follow-up and patients and families should be offered information and access to mental health services.

SEXUALLY TRANSMITTED INFECTION

The infections commonly reported in women after sexual assault are Chlamydia, gonorrhea, trichomoniasis, bacterial vaginitis, and pelvic inflammatory disease (PID) [28]. The possible exposure to hepatitis B virus and human immunodeficiency virus (HIV) is also an important consideration. In general, the risk of infection is relatively low; published estimates are 3% to 16% for chlamydia, 7% for trichomoniasis, and 11% for PID [29]. The risk, however, does vary directly with the degree of genital trauma, associated bleeding (sustained by the victim or assailant), and the number of assailants. The CDC has published guidelines for the assessment, counseling, and preventive treatment of infection following sexual assault, including common pelvic infections, hepatitis B, human papillomavirus (HPV), and HIV [28].

Follow-up within one to two weeks after the initial evaluation provides the opportunity to review previous test results, complete an assessment for STDs, and ensure safety and adherence to prescribed medication. CDC guidelines advise that a follow-up examination at one to two months should be considered to re-evaluate for development of anogenital warts, especially in patients who received a diagnosis of other STDs following the assault. If initial tests were negative and infection in the assailant could not be ruled out, serologic tests for syphilis can be repeated at four to six weeks and three months. To exclude acquisition of HIV, tests for acute infection should be repeated at six weeks, three months, and six months after the assault [28].

IMPLICATIONS ON PREGNANCY AND PRENATAL CARE

Possible factors that may predispose pregnant women to IPV include young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [31; 32]. Because a gynecologist or obstetrician is frequently a woman's primary care physician, these healthcare providers should be particularly sensitive to domestic violence issues [30]. According to the CDC, IPV affects as many as 324,000 pregnant women each year [31]. This represents approximately 8% of all pregnant women in the United States. As with all domestic violence statistics, this number is presumed to be lower than the actual incidence as a result of under-reporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes IPV more prevalent among pregnant women than some of the health conditions included in prenatal screenings, including pre-eclampsia and gestational diabetes [31]. Because 96% of pregnant women receive prenatal care, this is an optimal time to screen for domestic violence and develop trusting relationships with the women. Pregnant women indicate they find screening useful but also have concerns regarding confidentiality and the sharing or information [134].

The overarching problem of violence against women cannot be ignored, especially as both mother and unborn child are at risk. One study found that pregnant women who had been treated at a hospital after a violent incident had an eight-fold increased risk of fetal death [33]. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will ensure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [11; 34]. Healthcare professionals should also be aware of the possible psychologic consequences of abuse during pregnancy. There is a higher risk of stress, depression, and addiction to alcohol and drugs in abused women, and victims are less likely to obtain prenatal care and to develop postpartum depression [33; 35; 36].

Low birth weight can result from either preterm birth or growth restriction in utero, both of which can be directly linked to stress. For example, pregnant women who experience physical violence are five times more likely to give birth to preterm infants and six times more likely to have an infant with low birth weight [135]. Living in an abusive and dangerous environment marked by chronic stress can therefore be an important risk factor for maternal health, as well as affecting birth weight [37].

The risk of becoming pregnant after vaginal rape is estimated to be 5%, although the risk may be higher for adolescent victims [16; 136]. It is generally recommended that rape victims of childbearing age have a baseline urine or serum pregnancy test performed, in anticipation of offering prophylaxis against pregnancy if the result is negative.

Postexposure emergency contraceptive treatment options are available for preventing pregnancy after unwanted intercourse [38]. The simplest and best-studied product is levonorgestrel (Plan B), an oral progestin-only medication developed for this purpose. The dosage regimen is 1.5 mg (two 0.75-mg tablets) administered as a single oral dose. It is considered to be most effective when administered within 12 hours of the assault. In one carefully conducted study, the success rate (prevention of pregnancy) exceeded 95% when administered up to 120 hours after unprotected intercourse [39]. This medication is safe and well tolerated, even if given to someone who is pregnant. Systemic side effects, such as headache, nausea, fatigue, and gastrointestinal/abdominal complaints, occur in less than 10% of patients. Transient vaginal bleeding in the days following treatment is more common (25% to 30%).

SCREENING FOR DOMESTIC VIOLENCE AND ABUSE

A tremendous barrier to diagnosing and treating domestic violence is a lack of knowledge and training. Healthcare workers are generally able to recognize and accurately interpret behaviors associated with domestic violence and abuse; however, they are often hesitant to inquire about abuse [45; 46]. In a nationally representative sample, only 7% of women reported ever being asked about domestic violence or family violence by a healthcare professional [47]. One meta-analysis analyzed IPV screening rates from 1992 to 2005, finding that 3% to 41% of physicians reported routine screening; physicians caring for pregnant patients reported routine screening 11% to 39% of the time [48].

Although the American Medical Association, the American College of Obstetricians and Gynecologists, the American Nurses Association, and the U.S. Preventive Services Task Force all recommend screening women for IPV at each patient contact, this practice is not being incorporated into routine clinical practice [49]. Several barriers to incorporating domestic violence screening have been identified, including lack of physical evidence of abuse, perceptions regarding prevalence of abuse, lack of training and continuing education on the topic, lack of consensus on screening guidelines, and lack of office protocols [48; 50; 82]. To help address the lack of adherence to screening guidelines, the U.S. Department of Health and Human Services included screening and counseling for interpersonal and domestic violence in women's preventive health care that must generally must be covered by health plans with no cost sharing in the 2010 Affordable Care Act [51].

It is imperative that healthcare professionals work together to establish specific guidelines that will facilitate identification of batterers and their victims/survivors. In a 2016 study of 288 healthcare facilities in Florida, 78% understood the importance of IPV screening and had some type of IPV screening policy institute in their setting [82]. However, many of the respondents did not know which screening tool was used or the types of screening questions asked. These guidelines should review appropriate interview techniques and should also include the utilization of screening tools, such as intake questionnaires. The following is a review of certain signs and symptoms that may indicate the presence of abuse. Although victims/survivors of domestic violence do not display typical signs and symptoms when they present to healthcare providers, there are certain cues that may be attributable to abuse. The obvious cues are the physical ones. Injuries range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites, or knife wounds. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of the body. In one hospital-based study, domestic violence victims/survivors were 13 times more likely to sustain injury to breast, chest, or abdomen than accident victims/survivors. Abuse victims/survivors are also more likely to have multiple injuries than accident victims/survivors. When this pattern of injuries is seen in a patient, particularly in combination with evidence of old injury, physical abuse should be suspected [19].

In addition to physical signs and symptoms, domestic violence victims/survivors also exhibit psychologic cues that resemble an agitated depression. As a result of prolonged stress, victims/survivors often manifest various psychosomatic symptoms that generally lack an organic basis. For example, they may complain of backaches, headaches, and digestive problems. Often, they will complain of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical [19; 52]. In many women, this constellation of symptoms has been labeled "Battered Women's Syndrome." Unfortunately, healthcare professionals may respond to these women by diagnosing the patient to be neurotic or irrational [36]. Healthcare professionals should cast aside these misperceptions of abused victims/survivors and work within their respective practice settings to develop screening mechanisms to detect women who exhibit these symptoms. In addition, it is important to recognize that vulnerable populations, including LGBT+ individuals, those with HIV, individuals with disabilities, and veterans are also at risk and should be screened for IPV [83].

For every victim/survivor of abuse, there is also a perpetrator. Like their victims/survivors, perpetrators of domestic violence come from all socioeconomic backgrounds, races, religions, and walks of life [53]. Accordingly, healthcare professionals must be aware that seemingly supportive family members may, in fact, be abusers. Perpetrators and their victims/survivors in lower socioeconomic groups are more likely to present in hospital emergency rooms and local community clinics. Conversely, people of higher socioeconomic status are more able to turn to the private clinician for assistance [53].

Abuser characteristics have been studied far less frequently than victim/survivor characteristics. Some studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. A man who abuses alcohol is also likely to abuse his mate, although the abuser may not necessarily be inebriated at the time the abuse is inflicted [54]. Screening questionnaires should include questions that explore social drinking habits of both the victim/survivor and his or her mate.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the batterer's dependency and jealousy is extreme suspiciousness, also referred to as intrusiveness (i.e., overdependence on controlling behaviors) [84]. In a study of 342 lesbian women, high levels of intrusiveness were correlated with higher incidences of perpetrating physical violence [84]. This characteristic may be so extreme as to border on paranoia [53]. In addition, domestic violence victims/survivors have frequently reported that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing. One battered woman gave the following examples of her controlling husband: "He insisted that no one (including guests and their toddler children) wear shoes in the house, that the furniture be in the same indentations in the carpet, that the vacuum marks in the carpet be parallel, and that any sand that spilled from the children's sandbox during their play be removed from the surrounding grass" [55]. In addition, healthcare professionals should be on the lookout for perpetrators who have low self-esteem, are frequently angry and depressed, and are "very dependent on their partners as the sole source of love, support, intimacy, and problem solving" [52].

Both batterers and battered partners are noted for being extremely dependent upon each other. It appears that each member of the couple believes that he or she will perish without the other and that the survival of each can only occur if the conjugal relationship remains intact. This belief ostensibly arises from their negative self-images, which cause the couple to doubt both their ability to live independently and to find other partners who will accept them. Both tend to deny or minimize the scope and severity of the violence in their relationship. This denial makes the conjugal relationship appear more viable and desirable to both [56].

These particular relationship dynamics are not easily detected under the best of circumstances. They may be especially difficult to uncover in circumstances in which the parties are suspicious and frightened, as might be expected when a victim presents to an emergency room. The key to detection, however, is to establish a proper screening tool that can be utilized in the particular setting, and to maintain a keen awareness for cues. Screening should be carried out at the entry points of contact between victims/survivors and medical care (e.g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, pediatric care) [19].

An initial screening should focus on obtaining an adequate history. Establishing that a patient's injuries are secondary to battering is the first task. Clearly there will be times when a victim is injured so severely that treatment of these injuries becomes the first priority [57]. After such treatment is rendered, however, it is important that healthcare professionals not ignore the reasons that brought the victim/survivor to the emergency room.

Of female trauma patients, 16% to 30% will report that they have been battered when asked directly about how the injury occurred. Obviously, however, some victims/survivors will not admit to a history of battering. Any trauma or burn that seems incompatible with a history of the injury is suggestive of battering and indicative of the need for gentle probing regarding how things are at home. Information must also be collected to facilitate a comprehensive assessment of the victim's/survivor's needs, resources, and priorities in order to develop immediate and long-range plans designed to minimize and eliminate future abusive episodes. A structured interview can be used to obtain the necessary information for treatment planning (***Table 3***) [22].

STRUCTURED INTERVIEW FOR TREATMENT PLANNING

1. How were you hurt?
2. Has this happened before?
3. When did it first happen?
4. How badly have you been hurt in the past?
5. Was a weapon involved?
   Is there a weapon in your residence?
6. What kind of weapon?
7. Who lives in your residence?
8. What are the children's ages?
9. Are the children in danger?
10. Have they been hit or hurt by the perpetrator?
11. How badly have they been hit or hurt?
12. Have you ever told anyone about this before?
    If so, who?
13. What have you done in the past to protect yourself?
14. What have you done in the past to get help?
15. Have you ever called the police?
16. If yes, when and what did they say/do?
17. Did you report this incident to the police?
    If not, why not?
18. If yes, what precinct?
19. What did they say/do?
20. Have you ever obtained a protective order?
21. Have you tried to press charges this time or before?
22. Does the perpetrator have a criminal record?
23. Has he/she beaten or hurt other people?
24. Has he/she threatened to kill you?
25. Has he/she tried to kill you?
26. If so, what did he/she do?
27. Are you afraid to go home?
28. Where can you go?
29. Have you ever called a crisis center for help?
30. If so, who is your contact person there?
31. If not, why not?
32. Do you know the phone number of the local crisis center?

Source: [46] *Table 3*

After the history is obtained and initial treatment is started, it is imperative to document all findings and recommendations in the individual's medical record. The medical record can be invaluable in establishing the credibility of the domestic violence victim's/survivor's story when he or she seeks legal aid [57].

REPORTING

Kentucky law mandates the reporting of the abuse or neglect of children and elderly and/or vulnerable adults (i.e., those with a physical or mental disability) to the Cabinet for Health and Family Services, the state or local police, and/or the local prosecutor's office [58; 60]. However, as of June 2017, Kentucky's law mandating reporting of suspected domestic or dating violence changed to a mandatory information and referral position [85].

According to the revised statute, if a professional has reasonable cause to believe that a person has experienced domestic violence or dating violence, the professional shall provide the individual with information about the regional domestic violence program or rape crisis center and information on how to access protective orders [86]. This is limited to persons with whom the professional has a professional interaction (as opposed to any contact whatsoever). In addition, a professional may report to a law enforcement agency at the request of a victim/survivor, but a report should not be made if the individual objects [86].

If a healthcare professional knowingly and willfully fails to report a case of suspected child or elder abuse as mandated by the law, then he or she can be subject to criminal penalties [58]. In fact, a healthcare professional who reports a suspected case of abuse in good faith in accordance with these laws is protected from civil and criminal liability [59].

CULTURALLY SENSITIVE ASSESSMENT

During the assessment process, a practitioner must be open and sensitive to the client's/patient's worldview, cultural belief systems, and how he/she views the injury [61]. This may reduce the tendency to over-pathologize or minimize health concerns of ethnic minority patients. Pachter proposed a dynamic model that involves several tiers and transactions [62]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. Professionals must be willing to acknowledge that they do not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups they come in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [62]. Pachter advocates the notion that there is tremendous diversity within groups. For example, one cannot automatically assume that a Chinese immigrant adheres to traditional beliefs. Often, there are many variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the client/patient and the professional [62]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. It is important to remember that these beliefs may affect symptoms or appropriate interventions in the case of domestic violence.

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. These components are meant to provide an introduction to help practitioners recognize the range of dimensions, including physical, biologic, social, and cultural factors, that affect immigrants and ethnic minorities. By incorporating cultural sensitivity into the assessment of individuals with a history of being victims/survivors or perpetrators of domestic violence, it may be possible to intervene and offer treatment more effectively.

INTERVENTIONS FOR DOMESTIC VIOLENCE

SAFETY PLANNING

All practitioners who deal with domestic violence should periodically review safety planning with victims/survivors. Homicide is of high risk for victims/survivors; therefore, safety planning is crucial. When advocating a safety plan, it is important to:

- Encourage the victim/survivor to be aware of weapons in the residence.
- Have victims/survivors make a plan of what to do if violence escalates and where to go if leaving is an option.
- If children are old enough, they should be instructed about the safety plan and assigned roles.
- When possible, victims/survivors should save some money in a private bank account or hide money for escape. Victims/survivors should be informed that if the abuser finds out about a separate bank account, they could be in danger.
- Encourage victims/survivors to keep a bag packed with necessities and stored in a safe place in the event leaving must be immediate.
- Advise victims/survivors to work out a code word or signal with the children so they will know when to implement an escape plan.
- Encourage victims/survivors to keep a list of important phone numbers in their packed bag. Memorizing important numbers provides more safety.
- Recommend that copies of important documents and necessary items be available.

Although safety planning may be advocated, it does not necessarily mean victims/survivors will employ safety planning guidelines.

It is important to note that general safety planning does not take into account the specific needs of victims/survivors who fall into vulnerable populations or affected children [87]. Because these individuals are at higher risk of marginalization and oppression, they may feel powerless to execute a safety plan. It is important for practitioners to assess each IPV victim/survivor and his/her readiness to change, circumstances, resources, and needs in order to tailor a specific safety plan [88].

LEGAL PROTECTIONS

If a victim/survivor requires or requests legal assistance, local spousal abuse centers will be able to assist in making the appropriate referral. For the purposes of this course, it is important for healthcare professionals to know that domestic violence victims/survivors in Kentucky have legal remedies available to them. The first form of legal protection is an emergency protective order, which can be filed and heard by a judge without the batterer being informed of the filing or of the hearing. In cases of dating violence and stalking/sexual assault cases, a temporary interpersonal protective order can be filed [79]. Protective orders can be filed at the Office of Circuit Court Clerk in the county of residence (or temporary residence). Each county's contact information is available at https://courts.ky.gov/courts/clerks [79].

The batterer will not be present at the hearing, and the victim/survivor can present his or her evidence unopposed. This is referred to in the legal community as an ex parte hearing. The associated forms are relatively simple to file, and an attorney is not required. Having an attorney present, however, may result in obtaining a more thorough order. If the victim/survivor is not represented by an attorney, it is important that a battered woman's advocate, often called a legal advocate, be located to accompany the individual to court. To find an advocate trained in domestic violence issues, healthcare professionals may contact a local domestic violence center. The most ideal representation and assistance in these circumstances is usually a team approach that draws upon the expertise of an attorney and a domestic violence advocate/counselor [63].

Kentucky law provides that a judge can enter an emergency protective order or a domestic violence order that [64]:

- Restrains the batterer from any unauthorized contact or communication with the petitioner or other person specified by the court
- Restrains the batterer from committing further acts of domestic violence and abuse
- Restrains the batterer from disposing of or damaging any of the property of the parties
- Directs the batterer to vacate the residence shared by the abused party
- Grants temporary custody of minor children under certain circumstances
- Restrains the batterer from coming within a certain distance of specifically described locations or persons

The judge is not restricted to only these remedies, but can enter other orders he or she believes will be of assistance in eliminating future acts of domestic violence and abuse. The emergency protective order will be effective for a fixed period of time, as noted in the order, not to exceed 14 days. A copy of this order will be served upon the batterer, and if he or she violates any condition of the order, criminal penalties may be levied [65].

The court reviews petitions for protective orders on filing and schedules an evidentiary hearing within 14 days, at which the batterer is given notice of the hearing and is allowed to attend and present witnesses. If the court finds that a protective order is warranted, a domestic violence order will be followed to restrain the batterer from having contact with the victim/survivor [66]. In a domestic violence order, the protection is effective for up to three years, at which time it can be reissued. Batterers who violate the conditions of the protective order are subject to criminal penalties, including incarceration.

If a batterer violates the terms of the protective order, the police should be contacted immediately. When the police arrive, the victim/survivor should show the police the order or inform the officers of its existence. In Kentucky, a police officer who witnesses the batterer violating the terms of the protective order is required to arrest him or her [67]. If the batterer is no longer present when the police arrive, the victim/survivor should request that a report of the violation, and of any other crimes, be written. The victim/survivor can then follow-up on the violation by contacting the prosecutor's office and ask that an arrest warrant be issued based on the violation [63]. If the county has a Global Positioning System (GPS) monitoring service, the victim/survivor can request the court to order the batterer to wear a GPS device by filing a motion form, which will be evaluated by a judge [79].

If an arrest is made for a misdemeanor, such as violating a protection order, offenders may simply be given a citation and released. If a batterer is arrested and taken into custody, he or she may be released within a few hours. It is important, therefore, to advise victims/survivors to use this time to gather their children and personal belongings, to find a safe place to stay, to begin the process of obtaining a protection order if they do not have one, and/or to seek out a domestic violence program [63]. Victims/survivors should be fully informed about the criminal justice process, their role in it, and the possible outcomes of a criminal case so they can decide whether to turn to the criminal justice system for assistance.

If the prosecuting attorney decides to pursue a criminal complaint, there will be an arraignment. During the arraignment, the court informs the batterer of the charges and ensures that he or she has legal representation. Victims/survivors may be called to testify at an evidentiary hearing or at trial. If a victim/survivor does not want to testify, a court may issue a subpoena ordering him or her to testify; noncompliance with such a subpoena is a violation of law. Most cases are resolved before trial; if the case proceeds to trial, however, victims/survivors are again required to testify [63]. If the batterer is convicted, a judge will sentence him or her to one or any combination of the following: a fine; imprisonment; probation; victim/survivor restitution; mandatory counseling; mediation; substance-abuse treatment; or public service [63].

RESOURCES AND REFERRALS

After identifying victims/survivors and their abusers, healthcare professionals should immediately implement a plan of action that includes providing a referral to a local domestic violence shelter to assist the victim/survivor and their family. The acute situation should be referred immediately to local law enforcement officials. Other resources in an acute situation include crisis hotlines and rape relief centers.

In Kentucky, there are a number of domestic violence centers that provide 24-hour crisis lines, temporary shelter, counseling, casework services, children's services, hospital/legal advocacy, information and referral services, and support to domestic violence victims/survivors and their children. A list of these centers along with the particular counties each center serves is provided here. In addition, domestic violence victims/survivors in Kentucky have access to a number of state and national reporting hotlines. These telephone numbers are available following the list of domestic violence centers.

After a victim/survivor is introduced into the system, counseling and follow-up is generally available by individual counselors who specialize in the care of domestic violence victims/survivors, their spouses, and children. These may include social workers, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make the resources accessible and safe and to enhance support for people who are unsure of their options.

DOMESTIC VIOLENCE CRISIS CENTERS

Barren River Area Safe Space (BRASS), Inc.
P.O. Box 1941, Bowling Green, KY 42102
Phone: 270-781-9334
Crisis Only: 800-928-1183 or 270-843-1183
https://www.brassinc.org
Areas Served: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren

Bethany House Abuse Shelter, Inc.
Phone: 606-679-1553
Crisis Only: 800-755-2017
http://bethanyhouseinc.org
Areas Served: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne

Green House 17 (previously the Bluegrass Domestic Violence Program)
P.O. Box 55190, Lexington, KY 40555
Phone: 859-233-0657
Crisis Only: 800-544-2022
https://www.greenhouse17.org
Areas Served: Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford

The Center for Women and Families
P.O. Box 2048, Louisville, KY 40201
Phone: 502-581-7200
Crisis Only: 1-844-BESAFE1
https://www.thecenteronline.org
Areas Served: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble

DOVES of Gateway
P.O. Box 1012, Morehead, KY 40351
Phone: 606-784-6880
Crisis Only: 800-221-4361
https://dovesofgateway.org
Areas Served: Bath, Menifee, Montgomery, Morgan, Rowan

Hazard-Perry County Community Ministries, Inc.
151 Miss Edna Lane, Hazard, KY 41702
Phone: 606-436-2662
Areas Served: Perry

LKLP Safehouse
398 Roy Campbell Dr., Hazard, KY 41702
Phone: 606-436-8853
https://www.lklp.org
Areas Served: Leslie, Knott, Letcher, Perry

Merryman House
P.O. Box 98, Paducah, KY 42002
Phone: 270-443-6001
Crisis Only: 800-585-2686
https://merrymanhouse.org
Areas Served: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, McCracken

Owensboro Area Shelter and Information Services (OASIS)
Phone: 270-685-0260
Crisis Only: 800-882-2873
https://www.oasisshelter.org
Areas Served: Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster

Safe Harbor/FIVCO
P.O. Box 2163, Ashland, KY 41105
Phone: 606-329-9304
Crisis Only: 800-926-2150
https://www.safeharborky.org
Areas Served: Boyd, Carter, Elliott, Greenup, Lawrence

Sanctuary, Inc.
P.O. Box 1165, Hopkinsville, KY 42240
Phone: 270-885-4572
Crisis Only: 800-766-0000
https://thesanctuaryinc.com
Areas Served: Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, Trigg

TurningPoint Domestic Violence Services
P.O. Box 1297, Prestonsburg, KY 41653
Phone: 606-886-6025
Crisis Only: 800-649-6605
https://www.turningpointky.org
Areas Served: Floyd, Johnson, Magoffin, Martin, Pike

SpringHaven, Inc.
Phone: 270-769-1234
Crisis Only: 800-767-5838
http://www.springhaveninc.org
Areas Served: Breckinridge, Grayson, Hardin, LaRue, Marion, Meade, Nelson, Washington

Ion Center for Violence Prevention, Northern Kentucky
835 Madison Avenue, Covington, KY 41011
24-hour Hotline: 859-491-3335
https://ioncenter.org/
Areas Served: Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton

Ion Center for Violence Prevention, Maysville
111 East Third Street, Maysville, KY 41056
24-hour Hotline: 606-564-6708
https://ioncenter.org
Areas Served: Bracken, Fleming, Lewis, Mason, Robertson

STATEWIDE SERVICES

Adult Protection Branch
Cabinet for Health and Family Services
275 East Main Street, Frankfort, KY 40621
Phone: 502-564-5497
https://chfs.ky.gov/agencies/dcbs/dpp/apb

Attorney General's Office of Victim Advocacy
700 Capitol Avenue, Capitol Suite 118, Frankfort, KY 40601-3449
Phone: 800-372-2551
https://ag.ky.gov

Department for Behavioral Health, Developmental and Intellectual Disabilities
275 E. Main Street 4WF, Frankfort, KY 40621
Phone: 502-564-4527
http://dbhdid.ky.gov/kdbhdid

Kentucky Coalition Against Domestic Violence
111 Darby Shire Circle, Frankfort, KY 40601
Phone: 502-209-5382
https://kcadv.org

ADDITIONAL TOLL-FREE TELEPHONE NUMBERS

Kentucky Adult & Child Abuse Reporting Hotline
877-597-2331
Alcohol & Drug Abuse Information
800-432-9337
800-729-6686

Kentucky State Police Emergency Hotline
800-222-5555

Prevent Child Abuse Kentucky
800-CHILDREN (244-5373)

Domestic Violence Hotline
800-799-SAFE (7233)
TDD 800-787-3224

National Center for Missing and Exploited Children
800-THE-LOST (843-5678)

Rape, Abuse, and Incest National Network (RAINN) National Sexual Assault Hotline
800-656-HOPE (4673)

Victim Information and Notification Everyday (VINE)
800-511-1670

CONCLUSION

To lump all behavior in chaotic relationships under the category of violence can be misleading to the public. The common image of violence for the majority of people is physical harm, attack, and observable injury. Differentiating types of behavior in intimate relationships is necessary to define consequences related to outcome studies to form an evidence base for treatment. The formulation of accurate definitions is instrumental in designing methodology to compare differences. More accurate and sensitive instruments to measure the depth of the social problem are needed to reveal differences in gender-initiated violence, show the accuracy of occurrences of mutual battering, and quantify post-effects of intimate violence on men, women, and children.

The long-term focus on domestic violence is responsible for major reforms on multiple levels within various systemic functions related to criminal prosecution, legislative views and actions, and healthcare protocols. Given the pervasive nature of abuse in relationships, histories of partners including mental, psychologic, and behavioral documentation are vital when determining the causes and effects of abuse. Understanding how historical and cultural belief systems are connected to domestic violence is essential in determining an accurate measurement of intimate violence.

Domestic violence will likely continue to be a significant problem in Kentucky. If abuse is to be prevented, healthcare professionals in all settings must educate themselves and assess all patients for abuse during each visit. For identified victims/survivors and perpetrators, healthcare providers must offer prompt intervention and referral information. Through these interventions, healthcare professionals can play a tremendous role in reducing and preventing domestic violence.

APPENDIX: KENTUCKY REVISED STATUTE CHAPTER 209A

The following sections are reprinted from the Kentucky Revised Statute Chapter 209A.

209A.010 Purpose of chapter.

The purpose of this chapter is to identify victims of domestic violence and abuse and dating violence and abuse, to link those victims to services, and to provide protective or therapeutic services for those who choose to accept them.

209A.020 Definitions for chapter.

As used in this chapter, unless the context otherwise requires:

(1) "Cabinet" means the Cabinet for Health and Family Services;

(2) "Dating violence and abuse" has the same meaning as in KRS 456.010;

(3) "Domestic violence and abuse" has the same meaning as in KRS 403.720;

(4) "Law enforcement officer" means a member of a lawfully organized police unit or police force of county, city, or metropolitan government who is responsible for the detection of crime and the enforcement of the general criminal laws of the state, as well as a sheriff, sworn deputy sheriff, campus police officer, law enforcement support personnel, public airport authority security officer, other public and federal peace officer responsible for law enforcement, special local peace officer appointed pursuant to KRS 61.360, school resource officer as defined in KRS 158.441, and any other enforcement officer as defined by law;

(5) "Professional" means a physician, osteopathic physician, coroner, medical examiner, medical resident, medical intern, chiropractor, nurse, dentist, optometrist, emergency medical technician, paramedic, licensed mental health professional, therapist, cabinet employee, child-care personnel, teacher, school personnel, ordained minister or the denominational equivalent, victim advocate, or any organization or agency employing any of these professionals;

(6) "Victim" means an individual who is or has been abused by a spouse or former spouse or an intimate partner who meets the definition of a member of an unmarried couple as defined in KRS 403.720, or a member of a dating relationship as defined in KRS 456.010; and

(7) "Victim advocate" has the same meaning as in KRS 421.570.

209A.030 Penalty.

A professional knowingly or wantonly violating the provisions of this chapter shall be guilty of a Class B misdemeanor and penalized in accordance with KRS 532.090. Each violation shall constitute a separate offense.

209A.050 Immunity from civil or criminal liability for acting upon reasonable cause.

Anyone acting upon reasonable cause in complying with the provisions of this chapter shall have immunity from any civil or criminal liability that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such compliance.

209A.060 Privileged relationships not ground for excluding evidence.

Neither the psychotherapist-patient privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding the domestic violence and abuse or dating violence and abuse or the cause thereof in any judicial proceeding resulting from a report pursuant to this chapter.

209A.070 Confidentiality of the identity of domestic violence program clients or former clients.

All information that identifies a current or former client of a domestic violence program is confidential and shall not be disclosed by any person except as provided by law. The cabinet shall have access to client information relating to any domestic violence program for the limited purpose of monitoring the program.

209A.100 Report by professional of act of domestic violence and abuse or dating violence and abuse to law enforcement.

(1) Upon the request of a victim, a professional shall report an act of domestic violence and abuse or dating violence and abuse to a law enforcement officer.

(2) A professional who makes a report under this chapter shall discuss the report with the victim prior to contacting a law enforcement officer.

209A.110 Report by professional to law enforcement concerning belief that client's or patient's death is related to domestic violence and abuse or dating violence and abuse.

(1) (a) A professional shall report to a law enforcement officer his or her belief that the death of a victim with whom he or she has had a professional interaction is related to domestic violence and abuse or dating violence and abuse.

(b) Following a report to a local law enforcement officer, the local law enforcement officer shall indicate a report was made by a professional on the JC-3 or equivalent form.

(2) Nothing in this chapter shall relieve a professional of the duty pursuant to KRS 620.030 to report any known or suspected abuse, neglect, or dependency of a child.

(3) Nothing in this chapter shall relieve a professional of the duty pursuant to KRS 209.030 to report to the cabinet any known or suspected abuse, neglect, or exploitation of a person eighteen (18) years of age or older who because of mental or physical dysfunction is unable to manage his or her own resources, carry out the activity of daily living, or protect himself or herself from neglect, exploitation, or a hazardous or abusive situation without assistance from others.

209A.120 Duty of law enforcement to provide assistance as required under KRS 403.785 and 456.090—Use of JC-3 form.

(1) If a law enforcement officer receives a report of domestic violence and abuse or dating violence and abuse, the officer shall use all reasonable means to provide assistance as required under KRS 403.785 and 456.090.

(2) A law enforcement officer who responds to a report of domestic violence and abuse or dating violence and abuse shall use the JC-3 form, or its equivalent replacement, as provided by the Justice and Public Safety Cabinet to document any information or injuries related to the domestic violence and abuse or dating violence and abuse.

(3) A completed JC-3 form, or its equivalent replacement, shall be kept in the records of the law enforcement officer's agency of employment.

(4) If the JC-3 form, or its equivalent replacement, includes information that only relates to a victim as defined in KRS 209A.020, the form shall not be forwarded to the cabinet.

(5) If the JC-3 form, or its equivalent replacement, includes information on known or suspected child abuse or neglect or the abuse or neglect of an elderly or disabled adult, the form shall be forwarded to the cabinet.

(6) The Kentucky State Police or the law enforcement officer's agency of employment shall provide the preceding calendar year's JC-3 data, and all other relevant data, to the Criminal Justice Statistical Analysis Center created in KRS 15.280 by February 1 of each year.

209A.130 Educational materials to be provided suspected victim of domestic violence and abuse or dating violence and abuse—Availability of online materials.

(1) If a professional has reasonable cause to believe that a victim with whom he or she has had a professional interaction has experienced domestic violence and abuse or dating violence and abuse, the professional shall provide the victim with educational materials related to domestic violence and abuse or dating violence and abuse including information about how he or she may access regional domestic violence programs under KRS 209A.045 or rape crisis centers under KRS 211.600 and information about how to access protective orders.

(2) A nonprofit corporation designated by the cabinet pursuant to KRS 209A.045 as a primary service provider for domestic violence shelter, crisis, and advocacy services in the district in which the provider is located shall make the educational materials required under this section available on its Web site or in print form for professionals to provide to possible victims of domestic violence and abuse or dating violence and abuse.

Works Cited

1. National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta, GA: Centers for Disease Control and Prevention; 2003.
2. Kentucky Revised Statute 403.720 Definitions for KRS 403.715 to 403.785.
3. Centers for Disease Control and Prevention. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Data Brief. Available at https://www.cdc.gov/violenceprevention/pdf/nisvs/NISVSReportonIPV_2022.pdf. Last accessed April 24, 2023.
4. Peterson C, Liu Y, Kresnow MJ, et al. Short-term lost productivity per victim: intimate partner violence, sexual violence, or stalking. *Am J Prev Med*. 2018;55(1):106-110.
5. Centers for Disease Control and Prevention. Preventing Intimate Partner Violence. Available at https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Last accessed April 24, 2023.
6. Cook P, Morris Mandel F, Kelly N, for the Kentucky Statewide Strategic Planning Committee for Violence Prevention. *Statewide Strategic Plan for the Prevention for Sexual Assault, Domestic Violence and Child Abuse – 2006*. Frankfort, KY: Kentucky Cabinet for Health and Family Services; 2006.
7. Bureau of Justice Statistics. Intimate Partner Violence in the U.S. Available at https://bjs.ojp.gov/content/pub/pdf/fvs02.pdf. Last accessed April 24, 2023.
8. Walsh S, Hemenway D. Intimate Partner Violence: Homicides Followed by Suicides in Kentucky. Available at https://kvdrs.ky.gov/Documents/Intimate%20Partner%20Violence%20Homicides%20Followed%20by%20Suicides%20in%20Kentucky.pdf. Last accessed April 24, 2023.
9. Kentucky Revised Statute 194A.540 Cabinet's Manner of Addressing Child Abuse, Child Neglect, Domestic Violence, Rape, and Sexual Assault: Coordination, Consultation, Recommendations, and Training.
10. Max W, Rice DP, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. *Violence Vict*. 2004;19(3):259-272.
11. Morgan RE, Oudekerk BA. Bureau of Justice Statistics: Criminal Victimization, 2018. Available at https://bjs.ojp.gov/library/publications/criminal-victimization-2018. Last accessed April 24, 2023.
12. Adhia A, Kernic MA, Hemenway D, Vavilala MS, Rivara FP. Intimate partner homicide of adolescents. *JAMA Pediatr*. 2019;173(6):571-577.
13. National Institute of Justice. The decline of intimate partner homicide. *National Institute of Justice Journal*. 2005;252:33-34.
14. Farmer A, Tiefenthaler J. Explaining the recent decline in domestic violence. *Contemp Econ Policy*. 2003;21(2):158-172.
15. Lutgendorf MA, Thagard A, Rockswold PD, Busch JM, Magann EF. Domestic violence screening of obstetric triage patients in a military population. *J Perinatol*. 2012;32(10):763-769.
16. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women. Committee Opinion: Intimate Partner Violence (Reaffirmed 2022). Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence. Last accessed April 24, 2023.
17. Chu SY, Goodwin MM, D'Angelo DV. Physical violence against U.S. women around the time of pregnancy, 2004–2007. *Am J Prev Med*. 2010;38(3):317-322.
18. McFarlane J, Maddoux J, Cesario S, et al. Effect of abuse during pregnancy on maternal and child safety and functioning for 24 months after delivery. *Obstet Gynecol*. 2014;123(4):839-847.
19. American Medical Association Council on Scientific Affairs. Violence against women: relevance for medical practitioners. *JAMA*. 1992;267:3184-3189.
20. Chambliss LR. Intimate partner violence and its implication for pregnancy. *Clin Obstet Gynecol*. 2008;51(2):385-397.
21. Centers for Disease Control and Prevention. Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0. Available at https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf. Last accessed April 24, 2023.
22. Tjaden P, Thoennes N. Full Report of the Prevalence, Incidence, and Consequences of Intimate Partner Violence Against Women: Findings from the National Violence Against Women Survey. Available at https://www.ojp.gov/pdffiles1/nij/183781.pdf. Last accessed April 24, 2023.
23. Lown EA, Vega WA. Prevalence and predictors of physical partner abuse among Mexican American women. *Am J Public Health*. 2001;91(3):441-445.
24. American Bar Association Commission on Domestic Violence. Domestic Violence Statistics. Available at https://www.americanbar.org/groups/domestic_violence. Last accessed April 24, 2023.
25. Green JW. Help-seeking behavior: the cultural construction of care. In: Green JW (ed). *Cultural Awareness in the Human Services: A Multi-Ethnic Approach*. 3rd ed. Needham Heights, MA: Allyn and Bacon; 1998: 49-79.
26. Resource Center on Domestic Violence. Prevalence Statistics and Resources. Available at https://www.rcdvcpc.org/prevalence-statistics-home.html. Last accessed April 24, 2023.

27. Fox CL, Corr M-L, Gadd D, Butler I. Young Teenagers' Experiences of Domestic Abuse. Available at http://www.boystomenproject.com/wp-content/uploads/2013/04/Poster-Experiences-of-DA.pdf. Last accessed April 24, 2023.
28. Voisin DR, Hong JS. A meditational model linking witnessing intimate partner violence and bullying behaviors and victimization among youth. *Educ Psychol Rev*. 2012;24(4):479-498.
29. Rivas MA. The relationship between exposure to intimate partner violence, behavior problems and weight status in preschool age children in Head Start programs. *McNair Scholars Research Journal*. 2013;6(1):10.
30. Edleson JL. The Overlap between Child Maltreatment and Woman Abuse. Available at https://vawnet.org/material/overlap-between-child-maltreatment-and-woman-abuse. Last accessed April 24, 2023.
31. Cooper A, Smith EL. *Homicide Trends in the United States, 1980–2008*. Washington, DC: Bureau of Justice Statistics; 2011. Available at https://www.bjs.gov/content/pub/pdf/htus8008.pdf. Last accessed April 24, 2023.
32. U.S. Bureau of Justice. Violence Rates Among Intimate Partners Differ Greatly According to Age. Available at https://bjs.ojp.gov/press-release/intimate-partner-violence-and-age-victim-1993-99. Last accessed April 24, 2023.
33. Congressional Research Service. Military Families and Intimate Partner Violence: Background and Issues for Congress. Available at https://fas.org/sgp/crs/natsec/R46097.pdf. Last accessed April 24, 2023.
34. National Center on Elder Abuse. Statistics and Data. Available at https://ncea.acl.gov/About-Us/What-We-Do/Research/Statistics-and-Data. Last accessed April 24, 2023.
35. Wallace R. Identifying potential challenges to providing emergency advocacy services to male victims of intimate partner violence. *Partner Abuse*. 2014;5(1):58-68.
36. American Medical Association Council on Ethical and Judicial Affairs. Physicians and domestic violence: ethical considerations. *JAMA*. 1992;267:3190-3193.
37. Catalano S, Smith E, Snyder H. Female Victims of Violence. Available at https://bjs.ojp.gov/content/pub/pdf/fvv.pdf. Last accessed April 24, 2023.
38. National Center for Injury Prevention and Control. NISVS 2010 Findings on Victimization by Sexual Orientation. Available at https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf. Last accessed April 24, 2023.
39. Erez E, Bach S. Immigration, domestic violence, and the military: the case of "military brides." *Violence Against Women*. 2003;9(9):1093-1117.
40. U.S. Government Accountability Office. Military Personnel: Sustained Leadership and Oversight Needed to Improve DOD's Prevention and Treatment of Domestic Abuse. Available at https://www.gao.gov/assets/gao-10-923.pdf. Last accessed April 24, 2023.
41. Military One Source. Family Advocacy Program. Available at https://www.militaryonesource.mil/benefits/family-advocacy-program. Last accessed April 24, 2023.
42. Brewster AL. Evaluation of spouse abuse treatment: description and evaluation of the Air Force family advocacy programs for spouse physical abuse. *Mil Med*. 2002;167(6):464-469.
43. McCarroll JE, Ursano RJ, Liu X, et al. Deployment and the probability of spousal aggression by U.S. Army soldiers. *Mil Med*. 2010;175(5):352-356.
44. Gerlock AA. Domestic violence and post-traumatic stress disorder severity for participants of a domestic violence rehabilitation program. *Mil Med*. 2004;169(6):470-474.
45. Jecker NS. Privacy beliefs and the violent family: extending the ethical argument for physician intervention. *JAMA*. 1993;269:776-780.
46. Sugg NK, Inui T. Primary care physicians' response to domestic violence. *JAMA*. 1992;267:3157-3160.
47. Klap R, Tang L, Wells K, Starks SL, Rodriguez M. Screening for domestic violence among adult women in the United States. *J Gen Intern Med*. 2007;22(5):579-584.
48. Stayton CD, Duncan MM. Mutable influences on intimate partner abuse in health care settings: a synthesis of the literature. *Trauma, Violence, and Abuse*. 2005;6(4):271-285.
49. U.S Preventive Services Task Force. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening. Available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening. Last accessed April 24, 2023.
50. Jaffee KD, Epling JW, Grant W, Ghandour RM, Callendar E. Physician-identified barriers to intimate partner violence screening. *J Womens Health (Larchmt)*. 2005;14(8):713-720.
51. Boinville MA. ASPE Policy Brief: Screening for Domestic Violence in Health Care Settings. Available at https://aspe.hhs.gov/reports/screening-domestic-violence-health-care-settings-0. Last accessed April 24, 2023.
52. Scherer DD. Tort remedies for victims of domestic abuse. *S C Law Rev*. 1992;43:543-579.
53. Sonkin DJ, Martin D, Walker LE. *The Male Batterer: A Treatment Approach*. New York, NY: Springer Publishing Company; 1985.
54. Sedlak AJ. Prevention of wife abuse. In: Van Hasselt VB, Morrison RL, Bellack AS, Hersen M (eds). *Handbook of Family Violence*. New York, NY: Plenum Press; 1988: 319-358.

55. Fischer K, Vidmar N, Ellis R. The culture of battering and the role of mediation in domestic violence cases. *SMU Law Rev*. 1993;46:2117-2174.
56. Okun L. *Woman Abuse: Facts Replacing Myths*. Albany, NY: State University of New York Press; 1986.
57. Krimm J, Heinzer MM. Domestic violence screening in the emergency department of an urban hospital. *J Natl Med Assoc*. 2002;94(6):484-491.
58. Kentucky Revised Statute Chapter 209 Administrative regulations—Reports of adult abuse, neglect, or exploitation—Cabinet actions—Status and disposition reports.
59. Kentucky Revised Statute Chapter 209.050 Immunity from civil or criminal liability.
60. Kentucky Revised Statute 620.030 Duty to Report.
61. Panos PT, Panos AJ. A model for a culture-sensitive assessment of patients in health care settings. *Soc Work Health Care*. 2000;31(1):49-62.
62. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271(9):690-695.
63. Warshaw C. Legal protections for battered women. In: Lee D, Durborow N, Salber PR (eds). *Improving the Health Care Response to Intimate Partner Violence: A Resource Manual for Health Care Providers*. San Francisco, CA: Family Violence Prevention Fund; 1995.
64. Kentucky Revised Statute 403.740 Dissolution of Marriage—Child Custody—Domestic Violence Order—Restrictions—Temporary Child Support—Expiration and Reissuance.
65. Kentucky Revised Statute 403.763 Violation of Order of Protection Constitutes Contempt of Court and Criminal Offense.
66. Kentucky Revised Statute 403.725 Petition for Order of Protection—Venue—Verified Contents—Concurrent Jurisdiction—Protocols for Access and Supplemental Jurisdiction—Referral.
67. Kentucky Revised Statute 403.785 Duties of Law Enforcement Officers and Agencies.
68. National Coalition Against Domestic Violence. Domestic Violence in Kentucky. Available at https://assets.speakcdn.com/assets/2497/ncadv_kentucky_fact_sheet_2020.pdf. Last accessed April 24, 2023.
69. Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during pregnancy: maternal and neonatal outcomes. *J Womens Health*. 2015;24(1):100-106.
70. Flanagan JC, Gordon KC, Moore TM, Stuart GL. Ethnic women's stress, depression, and relationship adjustment profiles as they relate to intimate partner violence and mental health during pregnancy and postpartum. *Psychol Violence*. 2015;5(1):66-73.
71. U.S. Census Bureau. Hispanic Heritage Month 2016. Available at https://www.census.gov/newsroom/facts-for-features/2016/cb16-ff16.html. Last accessed April 24, 2023.
72. U.S. Census Bureau. Selected Social Characteristics in the United States. Available at https://data.census.gov/table?q=foreign+born&tid=ACSDP1Y2021.DP02. Last accessed April 24, 2023.
73. Reina A, Lohman B. Barriers preventing Latina immigrants from seeking advocacy services for domestic violence victims: a qualitative analysis. *J Fam Violence*. 2015;30(4):479-488.
74. Sabri B, Campbell JC, Dabby FC. Gender differences in intimate partner homicides among ethnic sub-groups of Asians. *Violence Against Women*. 2016;22(4):432-453.
75. Jouriles EN, McDonald R, Vu NL, Sargent KS. Children's exposure to intimate partner violence: should sexual coercion be considered? *J Fam Psychol*. 2016;30(4):503-508.
76. De Jong AR. Domestic violence, children, and toxic stress. *Widener Law Review*. 2016;22(2):201-213.
77. Band-Winterstein T. Aging in the shadow of violence: a phenomenological conceptual framework for understanding elderly women who experienced lifelong IPV. *J Elder Abuse Negl*. 2015;27(4-5):303-327.
78. Hines DA, Douglas EM. Relative influence of various forms of partner violence on the health of male victims: study of a help seeking sample. *Psychol Men Masc*. 2016;17(1):3-16.
79. Commonwealth of Kentucky Administrative Office of the Courts. How to Obtain a Protective Order. Available at https://kycourts.gov/Legal-Help/Documents/P123ProtectiveOrderBooklet.pdf. Last accessed April 24, 2023.
80. Calton JM, CattaneoLB, Gebhard KT. Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma Violence Abuse*. 2016;17(5):585-600.
81. Trevillion K, Williamson E, Thandi G, Borschmann R, Oram S, Howard LM. A systematic review of mental disorders and perpetration of domestic violence among military populations. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(9):1329-1346.
82. Williams JR, Halstead V, Salani D, Koermer N. Intimate partner violence screening and response: policies and procedures across health care facilities. *Womens Health Issues*. 2016;26(4):377-383.
83. Ghandour RM, Campbell JC, Lloyd J. Screening and counseling for intimate partner violence: a vision for the future. *J Womens Health*. 2015;24(1):57-61.
84. Mason TB, Lewis RJ, Gargurevich M, Kelley ML. Minority stress and intimate partner violence perpetration among lesbians: negative affect, hazardous drinking, and intrusiveness as mediators. *Psychol Sex Orientat Gend Divers*. 2016;3(2):236-246.

85. Kentucky Coalition Against Domestic Violence. Mandatory Reporting. Available at https://kcadv.org/resources/laws/mandatory-reporting. Last accessed March 6, 2020.
86. Kentucky Coalition Against Domestic Violence. Domestic Violence and Dating Violence Education & Referral Act: Proposal to the 2017 General Assembly. Available at https://kcadv.org/sites/kcadv.org/files/sites/kcadv.org/files/SB%2086%20Comparison%20Chart.pdf. Last accessed April 24, 2023.
87. Murray CE, Horton GE, Johnson CH, et al. Domestic violence service providers' perceptions of safety planning: a focus group study. *J Fam Violence*. 2015;30(3):381-392.
88. Parker EM, Gielen AC. Intimate partner violence and safety strategy use: frequency of use and perceived effectiveness. *Womens Health Issues*. 2014;24(6):584-593.
89. Gerlock AA. Domestic violence and post-traumatic stress disorder severity for participants of a domestic violence rehabilitation program. *Mil Med*. 2004;169(6):470-474.
90. Catalano S. Intimate Partner Violence, 1993–2010. Available at https://www.bjs.gov/content/pub/pdf/ipv9310.pdf. Last accessed April 25, 2023.
91. Green K, Browne K. Personality disorder traits, trauma, and risk in perpetrators of domestic violence. *International Journal of Offender Therapy & Comparative Criminology*. 2020;64(2/3):147-166.
92. Fox CL, Corr M-L, Gadd D, Butler I. Young Teenagers' Experiences of Domestic Abuse. Available at http://www.boystomenproject.com/wp-content/uploads/2013/04/Poster-Experiences-of-DA.pdf. Last accessed April 25, 2023.
93. Stith SM, McCollum EE, Rosen KH. Couples Therapy for Domestic Violence: Finding Safe Solutions. Washington, DC: American Psychological Association; 2011.
94. Centers for Domestic Peace. Dangers of Couples Counseling. Available at http://www.centerfordomesticpeace.org/sites/default/files/Dangers%20of%20Couples%20Counseling.pdf. Last accessed April 25, 2023.
95. The National Domestic Violence Hotline. Should I Go to Couples Therapy with My Abusive Partner? Available at https://www.thehotline.org/resources/should-i-go-to-couples-therapy-with-my-abusive-partner. Last accessed April 25, 2023.
96. Centers for Disease Control and Prevention. Sexually Transmitted Infections Treatment Guidelines, 2021. Available at https://www.cdc.gov/std/treatment-guidelines/herpes.htm. Last accessed April 10, 2023.
97. enny C, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect, et al. The evaluation of children in the primary care setting when sexual abuse is suspected. *Pediatrics*. 2013;132:e558-e567.
98. Safe Housing Partnerships. The Intersection of Domestic Violence and Homelessness. Available at https://safehousingpartnerships.org/sites/default/files/2017-05/SHP-Homelessness%20and%20DV%20Inforgraphic_1.pdf. Last accessed April 25, 2023.
99. National Online Resource Center on Violence Against Women. No Safe Place: Sexual Assault in the Lives of Homeless Women. Available at https://vawnet.org/sites/default/files/materials/files/2016-09/AR_SAHomelessness.pdf. Last accessed April 25, 2023.
100. Doorways for Women and Families. The Facts about Sexual Assault. Available at https://www.doorwaysva.org/our-work/education-advocacy/the-facts-about-sexual-assault. Last accessed April 25, 2023.
101. Broll R, Huey L. "Every time I try to get out, I get pushed back:" the role of violent victimization in women's experience of multiple episodes of homelessness. *Journal of Interpersonal Violence*. 2020;35(17-18):3379-3404.
102. National Sexual Violence Resource Center. Housing, Homelessness, and Sexual Violence Statistics. Available at https://www.nsvrc.org/sites/default/files/NSAC11_Handouts/NSAC11_Handout_With_Statistics.pdf Last accessed April 25, 2023.
103. Santa Maria DM. Gaps in sexual assault health care among homeless young adults. *American Journal of Preventive Medicine*. 2020;58(2):191-198.
104. Breiding MJ, Armour BS. The association between disability and intimate partner violence in the United States. *Ann Epidemiol*. 2015;25(6):455-457.
105. Browne A, Agha A, Demyan A, Beatriz E. Examining Criminal Justice Responses to and Help-Seeking Patterns of Sexual Violence Survivors With Disabilities. Available at https://www.ncjrs.gov/App/AbstractDB/AbstractDBDetails.aspx?id=272356. Last accessed April 25, 2023.
106. Shapiro J. The Sexual Assault Epidemic No One Talks About. Available at https://www.npr.org/2018/01/08/570224090/the-sexual-assault-epidemic-no-one-talks-about. Last accessed April 25, 2023.
107. Basile KC, Breiding MJ, Smith SG. Disability and risk of recent sexual violence in the United States. *American Journal of Public Health*. 2016;106(5):928-933.
108. Gibbs V, Hudson J, Hwang YIJ, Arnold S, Trollor J, Pellicano E. Experiences of physical and sexual violence as reported by autistic adults without intellectual disability: rate, gender patterns and clinical correlates. *Research in Autism Spectrum Disorders*. 2021;89:101866.
109. Rape, Abuse, and Incest National Network. Sexual Abuse of People with Disabilities. Available at https://www.rainn.org/articles/sexual-abuse-people-disabilities. Last accessed April 25, 2023.
110. Soper RG. Intimate Partner Violence and Co-Occurring Substance Abuse/Addiction. American Society of Addiction Medicine. Available at https://www.asam.org/resources/publications/magazine/read/article/2014/10/06/intimate-partner-violence-and-co-occurring-substance-abuse-addiction. Last accessed May 7, 2019.

111. DrugRehab.com. Domestic Abuse and Addiction. Available at https://www.drugrehab.com/guides/domestic-abuse. Last accessed April 25, 2023.
112. Kothari R, Easter A, Lewis R, Howard LM, Micali N. Intimate partner violence among women with eating disorders during the perinatal period. *Int J Eat Disord*. 2015;48(6):727-735.
113. Fischer S, Stojek M, Hartzell E. Effects of multiple forms of childhood abuse and adult sexual assault on current eating disorder symptoms. *Eat Behav*. 2010;11(3):190-192.
114. Bonomi A, Nichols E, Kammes R, Green T. Sexual violence and intimate partner violence in college women with a mental health and/or behavior disability. *J Womens Health (Larchmt)*. 2018;27(3):359-368.
115. Williams JR, Girdler S, Williams W, Cromeens MG. The effects of co-occurring interpersonal trauma and gender on opioid use and misuse. *Journal of Interpersonal Violence*. 2021;36(23/24):NP13185-NP13205.
116. Huston JC, Grillo AR, Iverson KM, Mitchell KS. Associations between disordered eating and intimate partner violence mediated by depression and posttraumatic stress disorder symptoms in a female veteran sample. *General Hospital Psychiatry*. 2019;58:77-82.
117. Rodríguez-deArriba M-L, Nocentini A, Menesini E, Sánchez-Jiménez V. Dimensions and measures of cyber dating violence in adolescents: a systematic review. *Aggression and Violent Behavior*. 2021;58:101613.
118. Dardis CM, Dixon KJ, Edwards KM, Turchik JA. An examination of the factors related to dating violence perpetration among young men and women and associated theoretical explanations: a review of the literature. *Trauma Violence Abuse*. 2015;16(2):136-152.
119. Morelli M, Bianchi D, Baiocco R, Pezzuti L, Chirumbolo A. Sexting, psychological distress and dating violence among adolescents and young adults. *Psicothema*. 2016;28(2):137-142.
120. O'Keefe M. Teen Dating Violence: A Review of Risk Factors and Prevention Efforts. Available at https://vawnet.org/sites/default/files/materials/files/2016-09/AR_TeenDatingViolence.pdf. Last accessed April 25, 2023.
121. Southern S, Sullivan RD. Family violence in context: an intergenerational systemic model. *Family Journal*. 2021;29(3):260-291.
122. University of Washington Extension. Financial Capability and Domestic Violence. Available at https://fyi.uwex.edu/financialseries/files/2012/02/Financial-Capability-and-Domestic-Violence.pdf. Last accessed April 25, 2023.
123. Goodman LA, Smyth KF, Borges AM, Singer R. When crises collide: how intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma Violence Abuse*. 2009;10(4):306-329.
124. AbiNader MA. Correlates of intimate partner homicide in the rural United States: findings from a national sample of rural counties, 2009–2016. *Homicide Studies: An Interdisciplinary & International Journal*. 2020;24(4):353-376.
125. American Psychological Association. Violence and Socioeconomic Status. Available at https://www.apa.org/pi/ses/resources/publications/violence. Last accessed April 25, 2023.
126. Center for Disease Control and Prevention. STOP SV: A Technical Package to Prevent Sexual Violence. Available at https://stacks.cdc.gov/view/cdc/39126. Last accessed April 25, 2023.
127. Breiding MJ, Ziembroski JS, Black MC. Prevalence of rural intimate partner violence in 16 U.S. states, 2005. *J Rural Health*. 2009;25(3):240-246.
128. Edwards KM. Intimate partner violence and the rural-urban-suburban divide: myth or reality? A critical review of the literature. *Trauma Violence Abuse*. 2015;16(3):359-373.
129. Edwards KM, Mattingly MJ, Dixon KJ, Banyard VL. Community matters: intimate partner violence among rural young adults. *Am J Community Psychol*. 2014;53(1-2):198-207.
130. Peek-Asa C, Wallis A, Harland K, Beyer K, Dickey P, Saftlas A. Rural disparity in domestic violence prevalence and access to resources. *J Womens Health (Larchmt)*. 2011;20(11):1743-1749.
131. Cervantes MV, Sherman J. Falling for the ones that were abusive: cycles of violence in low-income women's intimate relationships. *Journal of Interpersonal Violence*. 2021;36(13/14):NP7567-NP7595.
132. Gray MJ, Hassija CM, Jaconis M, et al. Provision of evidence-based therapies to rural survivors of domestic violence and sexual assault via telehealth: treatment outcomes and clinical training benefits. *Train Educ Prof Psychol*. 2015;9(3):235-241.
133. Thiede E, Miyamoto S. Rural availability of sexual assault nurse examiners (SANEs). *Journal of Rural Health*. 2021;37(1):81-91.
134. Public Health Agency of Canada. Canadian Guidelines on Sexually Transmitted Infections. Section 6: Specific Populations: Immigrants and Refugees. Available at https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections. Last accessed April 25, 2023.
135. Kim C, Sung HE. The effects of acculturation on intimate partner violence among Chinese immigrants in New York City. *J Fam Violence*. 2016;31(3):325-336.
136. Vu A, Adam A, Wirtz A, et al. The prevalence of sexual violence among female refugees in complex humanitarian emergencies: a systematic review and meta-analysis. *PLoS Curr*. 2014;6.
137. Loncar M, Henigsberg N, Hrabac P. Mental health consequences in men exposed to sexual abuse during the war in Croatia and Bosnia. *J Interpers Violence*. 2010;25(2):191-203.
138. Oosterhoff P, Zwanikken P, Ketting E. Sexual torture of men in Croatia and other conflict situations: an open secret. *Reprod Health Matters*. 2004;12(23):68-77.

139. Miles SH, Garcia-Peltoniemi RE. Torture survivors: what to ask, how to document. *J Fam Pract*. 2012;61(4):E1-E6.

140. Robertson CL, Halcon L, Savik K, et al. Somali and Oromo refugee women: trauma and associated factors. *J Adv Nurs*. 2006;56(6):577-587.

141. Hooberman JB, Rosenfeld B, Lhewa D, Rasmussen A, Keller A. Classifying the torture experiences of refugees living in the United States. *J Interpers Violence*. 2007;22(1):108-123.

142. Alessi EJ, Cheung S, Kahn S, Yu M. A scoping review of the experiences of violence and abuse among sexual and gender minority migrants across the migration trajectory. *Trauma, Violence & Abuse*. 2021;22(5):1339-1355.

143. Reina AS, Lohman BJ, Maldonado MM. "He said they'd deport me:" factors influencing domestic violence help-seeking practices among Latina immigrants. *J Interpers Violence*. 2014;29(4):593-615.

144. Lee E. Linguistic support services for immigrant domestic violence victims. *Journal of Social Service Research*. 2019;45(5):715-726.

145. Chang-Muy F, Congress EP (eds). *Social Work with Immigrants and Refugees: Legal Issues, Clinical Skills, and Advocacy*. 2nd ed. New York, NY: Springer; 2016.

146. Farahi N, McEachern M. Sexual assault of women. *American Family Physician*. 2021;103(3):168-176.

147. Dodaj A. Children witnessing domestic violence. *Journal of Children's Services*. 2020;15(3):161-174.

148. Weir H, Kaukinen C, Cameron A. Diverse long-term effects of childhood exposure to intimate partner violence: development of externalizing behaviors in males and females. *Journal of Interpersonal Violence*. 2021;36(21/22):NP12411-NP12435.

149. American Medical Association Council on Scientific Affairs. Violence against women: relevance for medical practitioners. *JAMA*. 1992;267:3184-3189.

150. Chandan JS, Thomas T, Raza K, et al. Intimate partner violence and the risk of developing fibromyalgia and chronic fatigue syndrome. *Journal of Interpersonal Violence*. 2021;36(21/22):NP12279-NP12298.

151. Matos M, Gonçalves M. Sleep and women intimate partner victimization: prevalence, effects and good practices in health care settings. *Sleep Science*. 2019;12(1):35-42.

152. Scherer DD. Tort remedies for victims of domestic abuse. *S C Law Rev*. 1992;43:543-579.

153. Verizon Foundation and MORE Magazine. Survey: Exploring the Relationship between Domestic Violence and Chronic Health Conditions. Available at http://www.ncdsv.org/Verizon-More_Exploring-the-Relationship-between-DV-and-Chronic-Health-Conditions-survey-summary_10-2013.pdf. Last accessed April 25, 2023.

154. Riviello R, Sullivan J, Bhatt K, et al. Persistent adverse mental and physical health outcomes are common among women after sexual assault. *West J Emerg Med*. 2017;18(6.1):S7.

155. Riggs N, Houry D, Long G, Markovchick V, Feldhaus, KM. Analysis of 1,076 cases of sexual assault. *Ann Emerg Med*. 2000;35(4):358-362.

156. Avengo A, Mills T, Mills L. Sexual assault victimization in the emergency department: analysis by demographic and event characteristics. *J Emerg Med*. 2009;37(3):328-334.

157. Maguire W, Goodall E, Moore T. Injury in adult female sexual assault complaints and related factors. *Eur J Obstet Gynecol Reprod Biol*. 2009;142:149-153.

158. Slaughter L, Brown C, Crowley S, Peck R. Patterns of genital injury in female sexual assault victims. *Am J Obst Gynecol*. 1997;176(3):609-616.

159. Sommers MS, Fargo JD. Discriminating between consensual intercourse and sexual assault: genital-anal injury pattern in females. *Journal of Forensic and Legal Medicine*. 2021;79:102138.

160. Holmes, M. Resnick H. Kilpatrick, D, et al. Rape-related pregnancy estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol*. 1996;175(2): 320-324.

161. Tjaden P, Thoennes N. Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey. Available at https://www.ncjrs.gov/pdffiles1/nij/210346.pdf. Last accessed April 25, 2023.

162. Schwartz J. Sexual violence against women: prevalence, consequences, societal factors, and prevention. *Am J Prev Med*. 1991;7(6):363-373.

163. Goodman LA, Koss MP, Russo NP. Violence against women: physical and mental health effects. Part 1: research findings. *Applied and Prev Psychol*. 1993;2(2):79-89.

164. Ahrens C, Aldana E. The ties that bind: understanding the impact of sexual assault disclosure on survivors' relationships with friends, family, and partners. *J Trauma Dissociation*. 2012;13(2):226-243.

165. Paras M, Murad M, Chen L, et al. Sexual abuse and lifetime diagnosis of somatic disorders: a systematic review and meta-analysis. *JAMA*. 2009;302(5):550-561.

166. Stein M, Lang A, Laffaye C, Satz L, Lenox R, Dresselhaus T. Relationship of sexual assault history to somatic symptoms and health anxiety in women. *Gen Hosp Psychiatry*. 2004;26(3):178-183.

167. Suris A, Lind L, Kushner T, Borman P, Petty F. Sexual assault in women veterans: an examination of PTSD risk, health care utilization, and cost of care. *Psychosom Med*. 2004;66(5):749-756.

168. Torazzi E, Merelli V, Barbara G, et al. Similarity and differences in sexual violence against adolescents and adult women: the need to focus on adolescent victims. *Journal of Pediatric and Adolescent Gynecology*. 2021;34(3):302-310.

169. Glaser JB, Schachter CM, Benes S, et al. Sexually transmitted infection in postpubertal female rape victims. *J Infect Dis*. 1991;164(4):726-730.

170. Lutgendorf MA, Thagard A, Rockswold PD, Busch JM, Magann EF. Domestic violence screening of obstetric triage patients in a military population. *J Perinatol*. 2012;32(10):763-769.

171. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women. Committee Opinion: Intimate Partner Violence. Available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Intimate-Partner-Violence. Last accessed April 25, 2023.

172. Chu SY, Goodwin MM, D'Angelo DV. Physical violence against U.S. women around the time of pregnancy, 2004–2007. *Am J Prev Med*. 2010;38(3):317-322.

173. Creedy DK, Baird K, Gillespie K. A cross-sectional survey of pregnant women's perceptions of routine domestic and family violence screening and responses by midwives: testing of three new tools. *Women and Birth: Journal of the Australian College of Midwives*. 2020;33(4):393-400.

174. Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during pregnancy: maternal and neonatal outcomes. *J Womens Health*. 2015;24(1):100-106.

175. McFarlane J, Maddoux J, Cesario S, et al. Effect of abuse during pregnancy on maternal and child safety and functioning for 24 months after delivery. *Obstet Gynecol*. 2014;123(4):839-847.

176. Chambliss LR. Intimate partner violence and its implication for pregnancy. *Clin Obstet Gynecol*. 2008;51(2):385-397.

177. Flanagan JC, Gordon KC, Moore TM, Stuart GL. Ethnic women's stress, depression, and relationship adjustment profiles as they relate to intimate partner violence and mental health during pregnancy and postpartum. *Psychol Violence*. 2015;5(1):66-73.

178. World Health Organization. Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Available at https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf. Last accessed April 25, 2023.

179. Stewart FH, Tressell J. Prevention of pregnancy resulting from rape: a neglected preventive public health measure. *Am J Prev Med*. 2000;19(4):228-229.

180. Hoang TN, Van TN, Gammeltoft T, Meyrowitsch D, Nguyen TTH, Rasch V. Association between intimate partner violence during pregnancy and adverse pregnancy outcomes in Vietnam: a prospective cohort study. *PloS One*. 2016;11(9):e0162844.

181. Von Hertzen H, Piaggio G, Ding H. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicenter randomized trial. *Lancet*. 2002;360:1803-1810.

Evidence-Based Practice Recommendation Citation

U.S. Preventive Services Task Force. Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: U.S. Preventive Services Task Force final recommendation statement. *JAMA*. 2018;320(16):1678-1687. Available at https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed April 27, 2023.