**PREPARED BY MICHELLE BROOMFIELD RN**

**PURPOSE**

The purpose of this course is to educate and reinforce the knowledge of nurses; ARNP, RN, LPN , CNA, THREAPISTS and other professionals who are working within the health care environment, as well as other students/ individuals regarding Domestic violence; the number of patients within the healthcare setting who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services. The course is available online as well as within the classroom setting.

**Objectives**

At the conclusion of this course, the student will be able to:

1. Define Domestic Violence / Abuse
2. Identify population at risk for Domestic Violence
3. Discuss signs of Domestic Violence
4. Discuss the characteristics of the Abuser
5. Describe interventions to prevent Domestic Violence
6. Discuss screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence
7. Describe how to provide patients with information on resources in the local community, such as domestic violence centers and other advocacy groups

# INTRODUCTION

According to the United States Department of Justice, domestic violence is defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person.

# DOMESTIC VIOLENCE IN KENTUCKY

According to the National Coalition Against Domestic Violence;

Kentucky programs sheltered 3,295 victims of abuse and their children between July 1, 2013 and June 30, 2014; 40% of these were children.

Kentucky programs provided 119,718 bed-nights between July 1, 2013 and June 30, 2014; 45% of these were for children.

In a single day in Kentucky in 2014, 10% of persons seeking services were turned away due to lack of resources.

1 in 9 women in Kentucky has been a victim of forcible rape.

## DOMESTIC VIOLENCE PROGRAMS IN KENTUCKY

1st Congressional District

Sanctuary Inc. Hopkinsville (270) 885-4572

Merryman House Paducah (270) 443-6282

2nd Congressional District

Barren River Area Safe Space Bowling Green (270) 781-9334

SpringHaven Elizabethtown (270) 765-4057

OASIS Owensboro (270) 685-0260

**Domestic violence is:**

- A pattern of behavior used to establish power and control over another person through fear and intimidation, often including the threat or use of violence.
- Other terms for domestic violence include intimate partner violence (IPV), battering, relationship abuse, spousal abuse, or family violence.

**Individuals who are most likely to suffer from Domestic Abuse or become a victim of Domestic Violence**

Domestic violence and abuse can happen to ANYONE, regardless of;

- gender,
- race,
- ethnicity,
- sexual orientation,
- income, or other factors.
- Women and men can be victims of domestic violence.

**Men are also victims of Domestic Violence**

- Men are victims of nearly 3 million physical assaults in the United States of America.

**How Often Does Domestic Violence Occur?**

- 1 in 4 women will experience domestic violence during her lifetime.

**Why Does Domestic Abuse occur?**

- No victim is to blame for any occurrence of domestic abuse or violence.
- While there is no direct cause or explanation why domestic violence happens, it is caused by the abuser or perpetrator.

**When and Where Does Domestic Violence Occur?**

- Domestic violence is most likely to take place between 6 pm and 6 am.
- More than 60% of domestic violence incidents happen at home.

**What Happens to Victims of Domestic Violence?**

- Domestic violence is the third leading cause of homelessness among families, according to the United States Department of Housing and Urban Development.
- At least 1/3 of the families using New York City's family shelter system are homeless because of domestic violence.

**Domestic Violence in America: General Statistics and Facts**

- Women ages 18 to 34 are at greatest risk of becoming victims of domestic violence.
- More than 4 million women experience physical assault and rape by their partners.
- 1 in 3 female homicide victims are murdered by their current or former partner every year.

**Effects of Domestic Violence on Children:**

- More than 3 million children witness domestic violence in their homes every year.
- Children who live in homes where there is domestic violence also suffer abuse or neglect at high rates (30% to 60%).
- Children exposed to domestic violence at home are more likely to have health problems, including becoming sick more often, having frequent headaches or stomachaches, and being more tired and lethargic.
- Children are more likely to intervene when they witness severe violence against a parent; this can place a child at great risk for injury and/ or death.

**Effects of Domestic Violence on Mental Health:**

- Domestic violence victims face high rates of depression, sleep disturbances, anxiety, flashbacks, and other emotional distress.
- Domestic violence contributes to poor health for many survivors including chronic conditions such as heart disease or gastrointestinal disorders.
- Most women brought to emergency rooms due to domestic violence were socially isolated and had few social and financial resources.

**Economic Cost of Domestic Violence:**

- Domestic violence costs more than $37 billion a year in law enforcement involvement, legal work, medical and mental health treatment, and lost productivity at companies.

**HIGH COST**

Intimate Partner Violence is associated with:

- High cost of violence for society
- High cost for individuals who experience abuse
- High health care costs.

**What Happens when Domestic Violence victims do not receive help?**

- Without help, girls who witness domestic violence are more vulnerable to abuse as teens and adults.
- Without help, boys who witness domestic violence are far more likely to become abusers of their partners and/or children as adults, thus continuing the cycle of violence in the next generation.

## The cycle of violence theory

The theory that domestic violence occurs in a cycle was developed by Lenore Walker in 1979 as a result of a study that was conducted within the United States.

The cycle usually goes in the following order (see below), and will repeat until the conflict is stopped, usually by the survivor entirely abandoning the relationship or by some form of intervention.

The cycle can occur hundreds of times in the abusive relationship, the total cycle taking anywhere from a few hours to a year or more to complete.

### 1. Tension building

Stress build up from the pressures of daily life, such as conflict over the children, marital issues, misunderstandings, or other family conflicts. Stress/ tension also build up as a result of illness, legal/ financial problems, unemployment, or catastrophic events, such as war, floods or rape. During this stage, the abuser feels threatened, annoyed, ignored or wronged. The feeling lasts on average several minutes to hours, it may last as much

as several months. To prevent violence, the victim may try to reduce the tension by becoming nurturing and compliant.

**2. Acute violence**

This stage is characterized by outbursts of violent, abusive incidents which may be preceded by verbal abuse and psychological abuse. During this stage the abuser attempts to dominate his/her partner, with the use of domestic violence. In intimate partner violence (IPV), children are negatively affected by having witnessed the violence and the partner's relationship degrades as well. The release of energy reduces the tension, and the abuser may feel or express that the victim -had it coming to them.

**3. Reconciliation/honeymoon**

The perpetrator / abuser may begin to feel guilt feelings, remorse or fear that the partner will leave or call the police. The victim feels fear, pain, humiliation, confusion, disrespect and may mistakenly feel responsible. This stage is characterized by apology, affection or alternatively, ignoring the incident, this phase marks an apparent end of violence, with assurances that it will never happen again, or that the abuser will do his or her best to change. During this stage the abuser may feel or claim to feel overwhelming remorse and sadness. Some abusers walk away from the situation with little comment, but most will eventually shower the survivor with love and affection. The abuser may use self-harm or threats of suicide to gain sympathy and/or prevent the survivor from leaving the relationship. Abusers are frequently very convincing, and survivors so eager for the relationship to improve, that survivors (who are often worn down and confused by longstanding abuse) stay in the relationship.

**4. Calm**

During this phase (which is often considered an element of the honeymoon/ reconciliation phase), the relationship is relatively calm and peaceable. During this period the abuser may agree to participate in counseling, may ask for forgiveness, and create a normal atmosphere. In intimate partner relationships, the perpetrator may buy presents or the couple may engage in passionate sex. Over time, the batterer's apologies and requests for forgiveness become less sincere and are generally stated to prevent separation or intervention. However, interpersonal difficulties will inevitably arise, leading again to the tension building phase.

The effect of the continual cycle may include distress, loss of love, contempt, and/or physical disability. Intimate partners may separate, divorce or someone may be killed.

**#1 FACT: MOST DOMESTIC VIOLENCE INCIDENTS ARE *NEVER* REPORTED.**

Help change the facts. Make a difference for victims of domestic violence.

The National Domestic Violence Hotline provides statistics from various sources such as the CDC, Bureau of Justice Statistics (BJS) as follows:

- On average, 24 individuals per minute are victims of physical violence, rape or stalking by an intimate partner within the United States: more than 12 million women and men over the course of a year. (CDC 2012)
- Nearly 3 in 10 women (29%) and 1 in 10 men (10%) in the United States have experienced physical violence, rape and/or stalking by a partner and report a related impact on their functioning (CDC 2012)
- Nearly, 15% of women (14.8%) and 4% of men have been injured as a result of Intimate Partner Violence that included physical violence, rape and/or stalking by an intimate partner in their lifetime (CDC 2012)
- 1 in 4 women (24.3%) and 1 in 7 men (13.8%) aged 18 and older in the United States have been victims of severe physical violence by an intimate partner in their lifetime.(CDC 2014).
- Intimate Partner Violence alone affects more than 12 million people each year (CDC 2010).
- More than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States have experienced physical violence, rape and/or stalking by an intimate partner in their lifetime. (CDC 2010).
- Nearly half of all women and men in the United States have experienced psychological aggression by an intimate partner in their lifetime (48.4% and 48.8%, respectively). (CDC 2010)
- Female ages 18 to 24 and 25 to 34 generally experienced the highest rates of intimate partner violence. (BJS.gov 2012)
- From 1994 to 2010, about 4 in 5 victims of intimate partner violence were female.(BJS.gov 2012)

- Most female victims of intimate partner violence were previously victimized by the same offender, including 77% of females ages 18 to 24, 76% of females ages 25 to 34, and 81% of females ages 35 to 49.(BJS.gov 2012)

**INTIMATE PARTNER VIOLENCE (IPV)**

Intimate partner violence (IPV) is a very serious and preventable public health problem that is affecting millions of individuals within the United States of American. The term intimate partner violence describes sexual violence, physical violence, stalking, psychological aggression; coercive acts by a former or current intimate partner.

An intimate partner is an individual with whom one has a close personal relationship that can be characterized by factors such as regular contact, identifying as a couple, emotional connection, ongoing physical contact and/ or sexual behavior, knowledge about and/ or familiar about each other's lives. The relationship may not involve all of these factors. Some examples of intimate partners include but not limited to former or current spouse, boyfriend or girlfriend, sexual or dating partners. Intimate partner violence (IPV) does not require sexual intimacy.

Intimate partner violence (IPV) may vary in severity and frequency. It often occurs on a continuum, therefore it can range from one episode that might have lasting impact or one episode that might not have lasting impact, to chronic and/ or severe episodes over a number of years.

**There are four main types of Intimate partner violence (IPV)**

**1. Physical violence** is the intentional use of physical force with the potential for causing harm, death, injury or disability. Physical violence may include, but is not limited to:

- hitting,
- punching,
- slapping,
- scratching
- pushing
- shoving

- throwing
- Grabbing
- Biting
- Choking
- Shaking
- Pulling hair
- Burning
- use of restraints
- use of a weapon
- Use of strength body or size against another person
- Coercing people to commit any of these acts that are listed above.

**2. Sexual violence** is divided into five categories. Any of these acts constitute sexual violence, whether the act was completed or attempted. Also all of these actions occur without the consent of the victim. This includes cases in which the victims are not able to give consent due to being incapacitated, or experiencing lack of alertness/ awareness, lack of consciousness e.g. too intoxicated (through their involuntary or voluntary use of drugs or alcohol).

- **Rape or penetration of victim;** This includes completed or attempted, forced or alcohol/drug-facilitated unwanted vaginal, oral, or anal insertion. Forced penetration occurs through the perpetrator's use of physical force against the victim or threatens to physically harm the individual/ victim.
- **Victim was made to penetrate someone else;** This includes completed or attempted, forced or alcohol/drug facilitated incidents when the victim was made to sexually penetrate a perpetrator or someone else without the victim's consent.
- **Non-physically pressured unwanted penetration;** This includes incidents in which the victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated.
- **Unwanted sexual contact;** This includes intentional touching of the victim or making the victim touch the perpetrator, either directly or through the clothing, on the genitalia, anus, groin, breast, inner thigh, or buttocks without the victim's consent.
- **Non-contact unwanted sexual experiences;** This includes unwanted sexual events that are not of a physical nature that occur without the victim's consent.

Examples include unwanted exposure to sexual situations such as pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; and /or unwanted filming, taking or disseminating photographs of a sexual nature of another person.

**3.Stalking;** a pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else such as a family member or friend. Some examples include:

- Repeated, unwanted emails, phone calls or texts
- leaving cards, flowers, letters or other items when the victim does not want them
- watching or following the victim from a distance
- Spying, approaching or showing up in places when the victim does not want to see them
- sneaking into the individual's home or car
- damaging the victim's personal property
- threatening or harming the victim's pet
- making threats to physically harm the victim.

**4. Psychological Aggression;** the use of verbal and non-verbal communication with the intent to harm another individual mentally or emotionally, and/or to exert control over another person. Psychological aggression can include expressive aggression such as:

- name-calling,
- humiliating
- coercive control such as limiting access to money, transportation, friends and family
- excessive monitoring of whereabouts
- threats of sexual or physical violence
- control of sexual or reproductive health such as refusal to use birth control or coerced pregnancy termination
- exploitation of victim's vulnerability such as immigration status, disability; exploitation of perpetrator's vulnerability

- presenting false information to the victim with the intent of making them doubt their own memory or perception for example mind games.

**Prevention**

The Centers for Disease Control and Prevention (CDC) presence information on Intimate partner violence prevention strategies as follows; intimate partner violence (IPV) is a serious problem that has harmful and long lasting effects on individuals, families, and the community. The goal for Intimate partner violence prevention is to stop it from happening in the first place but the solutions are just as complex as the problem.

Prevention efforts should ultimately reduce the occurrence of Intimate partner violence IPV by:

- Promoting healthy, respectful, non-violent relationships.
- Healthy relationships can be promoted by addressing change at all levels of the social ecology that influence Intimate partner violence: individual, relationship, community, and society.
- Additionally, effective prevention efforts will reduce known risk factors for Intimate partner violence and promote healthy relationships.

**Intimate Partner Violence: Risk and Protective Factors**

Individuals with certain risk factors are more likely to become victims or perpetrators of intimate partner violence (IPV). Those risk factors contribute to IPV but might not be direct causes. Not everyone who is identified as at risk becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same, while others are associated with one another. For example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

A combination of individual, relational, community and societal factors contribute to the risk of becoming an IPV victim or perpetrator. Understanding these multilevel factors can help identify various opportunities for prevention.

**Risk Factors for Intimate Partner Violence**

**Individual Risk Factors**

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (such as male dominance and aggression in relationships)
- Desire for power and control in relationships
- Perpetrating psychological aggression
- Being a victim of psychological or physical abuse (consistently one of the strongest predictors of perpetration)
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child

**Relationship Factors**

- Marital fights, conflict, tension, and other struggles
- Marital instability such as divorces or separations

- Dominance and control of the relationship by one partner over the other
- Economic stress
- Unhealthy family relationships and interactions

**Community Factors**

- Poverty and associated factors such as overcrowding
- Low social capital; lack of institutions, relationships, and norms that shape a community's social interactions
- Weak community sanctions against intimate partner violence such as unwillingness of neighbors to intervene in situations where they witness violence.

**Societal Factors**

- Traditional gender norms for example women should stay at home, do not enter workforce, and become submissive; men support the family and make the decisions)

**CDC DATA SOURCES**

**The Behavioral Risk Factor Surveillance System (BRFSS)**

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. The health departments of the 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands conduct the survey.

**National Violent Death Reporting System**

CDC has funded 18 states and established the National Violent Death Reporting System (NVDRS) to gather, share, and link state-level data on violent deaths. NVDRS provides CDC and states with a more complete understanding of violent deaths. This

enables policy makers and community leaders to make informed decisions about violence prevention programs, including those that address intimate partner violence.

**National Intimate Partner and Sexual Violence Survey**

The Centers for Disease Control and Prevention's National Center for Injury Prevention and Control (NCIPC), in collaboration with the National Institutes of Justice (NIJ), and the Department of Defense (DoD) has developed a telephone survey, the National Intimate Partner and Sexual Violence Survey (NISVS). Since 2010, NISVS collects ongoing population-based surveillance data, generating accurate and reliable incidence and prevalence estimates for intimate partner violence, sexual violence, dating violence and stalking victimization IPV, SV, dating violence, and stalking victimization.

**The National Survey of Family Growth**

The National Survey of Family Growth gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. The survey results are used by the U.S. Department of Health and Human Services and others to plan health services and health education programs, and to do statistical studies of families, fertility, and health.

**Pregnancy Risk Assessment Monitoring System**

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of CDC and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Data on physical abuse during and after pregnancy are collected.

**Youth Risk Behavior Surveillance System**

CDC's Youth Risk Behavior Surveillance System monitors health risk behaviors that contribute to the leading causes of death and disability, including intimate partner violence (in the form of teen dating abuse), among young people in the United States.

## OTHER FEDERAL DATA SOURCES

### Federal Bureau of Investigation (FBI)

Since the 1930s, the Federal Bureau of Investigation (FBI) has been collecting data on crime in the United States. Each year, the FBI publishes a summary of Crime in the United States, Hate Crime Statistics, special studies, reports, and monographs.

### National Crime Victimization Survey (NCVS)

National Crime Victimization Survey (NCVS) is the primary source of information on criminal victimization in the United States. Each year, data are obtained from a nationally representative sample of 77,200 households comprising nearly 134,000 persons on the frequency, characteristics, and consequences of criminal victimization in the United States. The survey enables the Bureau of Justice Statistics to estimate the likelihood of victimization by rape, sexual assault, robbery, assault, theft, household burglary, and motor vehicle theft. This information is provided for the population as a whole as well as for segments of the population such as women, the elderly, members of various racial groups, city dwellers, or other groups. The NCVS provides the largest national forum for victims to describe the impact of crime and characteristics of violent offenders.

## CONSEQUENCES OF INTIMATE PARTNER /DOMESTIC VIOLENCE

Some of the consequences of intimate partner violence/ domestic violence include:

- Deaths and
- Injuries.

Physical violence by the intimate partner / domestic violence is also associated with multiple adverse health outcomes. There are several health conditions that is associated with intimate partner / domestic violence that may be a direct result of the physical violence such as bruises, broken bones, knife wounds, traumatic brain injury, pelvic or back pain and headaches. Other conditions are the result of the impact of

intimate partner / domestic violence on the cardiovascular, endocrine, gastrointestinal, and the immune systems through stress or other factors /mechanisms.

Health conditions that may be associated with intimate partner / domestic violence include but not limited to:

- Chronic pain syndrome
- Headaches and Migraines
- Disorders of the Central nervous system
- Disorders of the Gastrointestinal system
- Irritable bowel syndrome
- Asthma
- Bladder and kidney infections
- Joint disease
- Circulatory conditions
- Cardiovascular disease
- Fibromyalgia

Children might become injured during intimate partner violence incidents between the parents. There is a large overlap between intimate partner violence and child maltreatment.

**REPRODUCTIVE EFFECTS**

- Gynecological disorders
- Sexual dysfunction
- Pelvic inflammatory disease
- Sexually transmitted infections,(STD) including HIV/AIDS
- Pregnancy difficulties such as low birth weight babies, perinatal deaths
- Delay of prenatal care
- Preterm delivery
- Unintended pregnancy

**Psychological**

Physical violence is typically accompanied by emotional or psychological abuse. IPV; whether sexual, physical, or psychological, can lead to various psychological consequences for victims.

- Anxiety
- Depression
- Symptoms of post-traumatic stress disorder (PTSD)
- Antisocial behavior
- Suicidal behavior in females
- Low self-esteem
- Inability to trust others, especially in intimate relationships
- Fear of intimacy
- Emotional detachment
- Sleep disturbances
- Flashbacks
- Replaying assault in the mind

**Social**

Victims of IPV sometimes face the following social consequences

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

**Health Behaviors**

Women with a history of intimate partner violence (IPV) are more likely to display behaviors that present further health risks such as substance abuse, alcoholism, suicide attempts; than women without a history of IPV.

Intimate partner violence (IPV) is associated with a variety of negative health behaviors. Studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

- Engaging in high-risk sexual behavior
  - Unprotected sex
  - Decreased condom use
  - Early sexual initiation
  - Choosing unhealthy sexual partners
  - Multiple sex partners
  - Trading sex for food, money, or other items
- Using harmful substances
  - Smoking cigarettes
  - Drinking alcohol
  - Drinking alcohol and driving
  - Illicit drug use
- Unhealthy diet-related behaviors
  - Fasting
  - Vomiting
  - Abusing diet pills
  - Overeating
- Overuse of health services

According to the Centers for Disease Control and Prevention CDC, Intimate partner violence, sexual violence, and stalking are important and widespread public health problems in the United States. On average, 20 people per minute are victims of physical violence by an intimate partner in the United States. Over the course of a year, that equals more than 10 million women and men. Those reports only tell apart of the story; nearly 2 million women are raped in a year and over 7 million women and men are victims of stalking in a year (CDC 2015).

Sexual violence, stalking, and intimate partner violence are public health problems known to have a negative impact on millions of persons in the United States each year, not only by way of immediate harm but also through negative longterm health impacts.

**SIGNS OF DOMESTIC VIOLENCE**

Domestic violence is so common, that there is a possibility that you may know an individual who is experiencing domestic violence or has been affected. You may recognize some of the signs such as:

- They may have unexplained bruises or injuries
- The individual may have become anxious or withdrawn
- He / she may stop seeing or visiting you as often
- They may not seem to have any money or ability to access money
- He /she may frequently callout /miss work
- He /she may frequently miss social events
- The individual may appear afraid of his/ her partner or the abuser
- The individual may appear anxious about what the partner/relative might say or do
- They might receive regular telephone calls from the partner frequently checking up on them
- He /she may talk about their partner's possessiveness and /or unpredictable behavior
- They may talk about their partner's jealousy
- You may observe that the individual is regularly criticized or insulted by their partner/relative in your presence.

**Observed signs of domestic violence**

If you observed signs of domestic violence, encourage the individual or your relative or friend to talk to you. Express concern, and if they have not confided in you, start with non-specific comments or questions to show that you care.

Ask questions or express concern /statements such as:

"You seem worried about something. Can I help in any way?"

"Is everything okay at home?"

"You seem worried about something. Can I help at all?"

“What can I do to help?”

“How can I help?”

**Some reasons why people stay in an abusive relationship**

It is often very difficult to understand why someone would stay in an abusive relationship. To assist this individual you will need to try to understand and support the individual. Do not try to judge them. Do not become irritated, you want to be able to help them, and not turn them away by your reaction.

Some of the reasons people stay in an abusive relationship are:

- They are frightened of what the abuser might do to them. (Murders relating to domestic violence often happen after the individual has left the abusive relationship).
- They still love their partner

- They might be worried about the consequences for the children
- They might be worried that their children will be taken away
- Often they cannot afford to live on their own, no financial / access to money
- They have lost their self-confidence; therefore they think that they cannot manage on their own.
- They are embarrassed about what has been happening to them
- They are ashamed of what has been happening to them
- They stay in the abusive relationship because of cultural reasons
- They do not think that anyone will believe them
- They do not think that anyone can help them out of the situation

Help the individual by being there to be supportive and be non-judgmental, help him/ her work out the best solution for himself / herself.

**Healthcare professional Assessment**

You noticed that the patient exhibits signs of domestic violence or he/ she might confide in you therefore you need to assess the immediate safety needs. According to the National Association of Social Workers assess the immediate safety needs of the victim, ask questions such as:

Are you in any immediate danger?

Do you need or want or security, or the police to be updated immediately?

Where is your partner now?

Where will he or she be when you are finish with your medical care?

**Assess the pattern and/ history of the abuse**

As the individual confide in you assess the partner's physical, sexual, psychological tactics, as well as the economic coercion of the patient.

Ask questions such as:

How long has the domestic violence been going on?

Has your partner harmed or forced you sexually?

Has your partner harmed your family and /or friends?

Does your partner control your activities?

Does your partner control your money?

Does your partner control your children?

**Assess the connection between domestic violence and the patient's health issues**

Assess the impact of domestic violence /abuse on the individual's (victim) physical, psychological, and spiritual well being. Ask questions such as:

What is the degree of the partner's control over the individual (victim)?

How is your partner's abusive behavior affecting your physical health?
For example chronic neck or back pain, migraine and other frequent headaches, stammering, arthritis, problems with vision /seeing, sexually transmitted infections, stomach ulcers, chronic pelvic pain, spastic colon, frequent diarrhrea, constipation and eating disorders etc.

How is the abusive behavior affecting your mental health?
For example:

- Stress,
- Depression,
- suicidal ideation,
- psychiatric disorder,
- Substance abuse problems.

**Assess the victim's current access to advocacy and support groups.**

- What resources (if any), in addition to the health care provider, are available now?
- What resources have you used or tried in the past? What happened?
- Did you find those resources helpful or appropriate?
- Are there culturally appropriate community resources available to the patient?

**Assess patient's safety: Is there future risk of death or significant injury or harm due to the domestic violence?**

Ask about the abuser's tactics: severity of the violence, or escalation in frequency, suicide or homicide threats, use of alcohol or drugs, as well as about the health consequences of past abuse.

Ask questions such as, has your partner ever:

- Threatened to use or used weapons against you?
- Choked or attempted to strangle you?
- Taken you hostage to get what he or she wants?
- Taken your children hostage to get what he or she wants?
- Threatened to hurt your children?
- Hurt your children?
- Stalked you?

Other questions such as:

- Are you afraid for your life?
- Has the abuse been getting worse?
- Does your partner use alcohol or drugs?
- Have you ever thought about killing yourself?
- Have you attempted to do so in the past?
- Have you ever felt so bad that you did not want to go on living?

**INTERVENTION**

Goals for effectively responding to domestic violence victims include:

- Increasing the individuals' safety and support victims in protecting themselves and their children by providing support, validating their experiences and providing information about resources and options that are available.
- Informing the patients/ victims about any limits in confidentiality such as; child abuse or domestic violence reporting requirements.
- The goal is not to get the victims /patients to leave their abusers, or to fix the problem for the patients, but to provide support and information.

You can assist by listening to the patient and provide validating messages such as:

- There is no excuse for domestic violence. You deserve better.
- I am concerned this is harmful to you.
- I am concerned this can be harmful to your children
- This is complicated. Sometimes it takes time to figure this out.
- You are not alone in trying to figure this out. There may be some options. I will support your choices.
- I care and I am glad you told me. I want to work together to keep you as safe and healthy as possible.

Provide information about domestic violence to the patient:

- Domestic violence is very common and it occurs in all kinds of relationships.
- Most domestic violence continues and often becomes more severe and more frequent.
- Domestic violence within the home can hurt the children.
- Domestic violence has an impact on the patient's health status.
- Stopping domestic violence is the responsibility of the perpetrator, not the victim.

Listen and respond to safety issues:

- Show the patients/ victims a brochure regarding safety planning and review it with them.

- Review ideas regarding how to keep information private and safe from the abuser
- Offer the patients immediate access to an advocate 24 hour local, state or national domestic violence hotline number.
- Offer to have a provider or advocate discuss safety then, however if not possible at that time schedule for a later appointment.
- When patients say they feel that they are in danger, take it very seriously.
- If the patient is at high risk and is planning to leave the relationship, explain that leaving without telling the partner is the **SAFEST** alternative.
- Make sure that the patients/ victims have a safe place to go and encourage them to talk to an advocate.
- Reinforce the patients' autonomy regarding making decisions about their treatment.

**MAKE REFERRALS TO LOCAL RESOURCES:**

- Explain any advocacy and support systems within the health care setting.
- Refer patient advocacy and support services within the community including legal options and advocacy services, etc.
- Whenever possible, refer the patients to organizations that:
  - reflect their cultural background or
  - address their special needs such as organizations with multiple language capacity,
  - Specialize in working with disabled, teen, deaf, hard of hearing etc.

**If no local resources are available, refer patient to an advocate from the multi-lingual National Domestic Violence Hotline 24 hours a day by dialing 800-799-SAFE, TTY 800-787-3224.**

**CONTACT:**

| **HOTLINE** | **Telephone #** | **TTY** |
|---|---|---|
| National Domestic Violence Hotline | 1-800-799-SAFE (7233) | 1-800-787-3224 (TTY) |
| National Sexual Assault Hotline | 1-800-656-HOPE (4673) | |
| National Teen Dating Abuse Helpline | 1-866-331-9474 | 1-866-331-8453 (TTY) |

## Follow-up steps for health care practitioners

- Schedule a follow-up appointment. Ensure that the patient/ victim will have a connection to a primary care provider.
- Domestic violence, just like other health issues frequently requires multiple interventions over time. Ask the patient what happened after the last visit.
- Review the medical records and ask about past episodes of domestic violence in order to communicate a concern for the patient and a willingness to address this health issue openly.
- Ask the patient if she / he has a phone number or an address that is safe to contact them.

## Effects of domestic violence on children

Depending on their age some possible effects are:

- Physical injuries.
- Sexual abuse.
- Behavioral difficulties.
- Learning difficulties.
- Slow speech and language development.
- Bedwetting.
- Nightmares.
- Not doing so well at school as they should.
- Not making friends.
- Anxiety.
- Depression.
- Self-harm.
- Drug and alcohol abuse.
- Loss of a parent.
- Change in their relationship with their mother.
- Insecurity; they do not feel safe in their own home.

## SCREENING PROCEDURES

The American Congress of Obstetricians and Gynecologists (ACOG) recommend that physicians screen ALL patients for intimate partner violence.

For women who are not pregnant, screening should occur:

- At routine ob-gyn visits
- Family planning visits
- Preconception visits.

For women who are pregnant, screening should occur at various times over the course of the pregnancy because some women do not disclose abuse the first time they are asked and abuse may begin later in the pregnancy.

Screening should occur:

- At the first prenatal visit
- At least once per trimester, and
- At the postpartum checkup.

Domestic violence screening can be conducted by making the following statement and asking these three simple questions.

Because domestic violence is so common in several women's lives and because there is help available for women being abused, I now ask every patient about domestic violence:

1. Within the past year or since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?
2. Are you in a relationship with a person who threatens or physically hurts you?
3. Has anyone forced you to have sexual activities that made you feel uncomfortable? (ACOG 2015).

## **Screening/Counseling**:

Screening may consist of a few short, open-ended questions asked by a clinician to the victim/ patient. Screening can also be facilitated by using forms and /or other assessment tools. Counseling usually include provision of basic information, including information regarding how the patient’s health concerns may relate to violence and referrals for additional assistance whenever the patients disclose abuse.

Universal Screening: A clinician screening every female patient through age 64 for domestic violence, as opposed to only screening certain patients because of risk factors or warning signs.

**Health care settings provide the opportunity for identification & intervention**

Health care settings provide an opportunity for screening, identification and intervention because of:

- Confidentiality,
- Trusting relationship and
- Victim is away from the abuser.

The clinicians /health care providers often see the patient individually. This provides the patient with an opportunity and the patient has the ability to talk to someone without the abuser being present.

Clinicians can also discuss abuse in the health care context, helping the patient understand the implications of abuse for their health, safety and well being.

The patient may also feel more comfortable disclosing abuse to a physician or health care provider with whom they have a trusting relationship. The victim may also share openly because of physician-patient confidentiality expectations.

There are some cases where confidentiality will be limited. Some states have mandatory reporting laws, and the health care providers are obligated to disclose Intimate partner violence to authorities. Explaining confidentiality to the patient during screening requires a clear understanding of those laws.

**Major medical associations/ organizations recommend routine screening**

Various medical associations agree that asking women about their experiences with Intimate partner violence is very important for reducing its incidence and the severity.

**U.S. Preventive Services Task Force**

The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine, was created in 1984. The Task Force members come from the fields of preventive medicine and primary care, including:

- internal medicine,
- family medicine,
- pediatrics,
- behavioral health,
- obstetrics and gynecology, and
- Nursing.

Their recommendations are based on a rigorous review of existing peer-reviewed evidence and are intended to help primary care clinicians and patients decide together whether a preventive service is right for a patient's needs.

The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as:

- Screenings,
- counseling services, and
- Preventive medications.

U.S. Preventive Services Task Force (USPSTF) in 2013 released a recommendation stating that clinicians should:

- Screen women of childbearing age for intimate partner violence such as domestic violence, and
- Provide and refer women who screen positive to intervention services.

Since 1998, the Agency for Healthcare Research and Quality (AHRQ) has been authorized by the U.S. Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support to the Task Force.

Every year, the Task Force makes a report to Congress that identifies critical evidence gaps in research related to clinical preventive services and recommends priority areas that deserve further examination (USPSTF 2014).

**Patient Population Under Consideration**

These recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is defined across studies as ranging from 14 to 46 years, with most research focusing on women age 18 years or older. The term intimate partner violence describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

A vulnerable adult is a person age 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability or dysfunction or brain damage. Definitions vary by state, and sometimes include the receipt of personal care services from others.

Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect. Child abuse and neglect is addressed in a separate recommendation; not included in this course.

**Assessment of Risk**

Although all women are at potential risk for abuse, some factors that elevate risk include:

- Young age,
- Substance abuse,
- Marital difficulties, and
- Economic hardship.

**Screening Tests**

There are several screening instruments that can be used to screen women for Intimate Partner Violence.

Those with the highest levels of sensitivity and specificity for identifying Intimate Partner Violence are:

- Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions);
- Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT);
- Slapped, Threatened, and Throw (STaT);

- Humiliation, Afraid, Rape, Kick (HARK);
- Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and
- Woman Abuse Screen Tool (WAST).

  - The Hurt, Insult, Threaten, Scream (HITS) instrument includes 4 questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- administered or clinician-administered.

  - Humiliation, Afraid, Rape, Kick (HARK) is a self-administered 4-item instrument.

  - Slapped, Threatened, and Throw (STaT) is a 3-item self-report instrument that was tested in an emergency department setting.

**Interventions**

Evidence from randomized trials support a variety of interventions for women of childbearing age, which includes:

- Counseling,
- Home visits,
- Information cards,
- Referrals to community services, and
- Mentoring support.

Depending on the type of intervention, these services may be provided by:

- Clinicians,
- Nurses,
- Social workers,
- Non-clinician mentors,
- Community workers.

Counseling generally includes information on safety behaviors, safety plan, supportive care, guided referrals / community resources. In addition to counseling, home visits may include emotional support, education on problem-solving strategies, and parenting support.

**Useful Resources**

The U.S. Preventive Services Task Force (USPSTF) has several recommendations that may be relevant, including screening for depression and alcohol misuse. Other useful resources include Web sites that contain materials useful to primary care providers. Providers often need guidance on:

- how to address concerns about Intimate Partner Violence (IPV) with sensitivity and clarity and
- How to screen for Intimate Partner Violence (IPV) and provide follow-up care.

Intimate partner violence introduces vital safety issues that compel the provider to be fully informed on factors such as sensitivity. Providers, Clinicians, Health care and community workers also need easy access to available tools, specific guidelines, and other related materials to help them develop a clinical environment dedicated to the safety of the patients.

Guidance is also available on how providers can work with local community-based domestic violence programs to receive training, information, and other resources to ensure effective management of patients who are victims of Intimate partner violence.

**Reporting Requirements/ The Law**

Healthcare providers / clinicians and all those who are involved in the patient's care need to be aware of their state and local reporting requirements. The laws vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom.

Although reporting suspected elder and child abuse is mandated in all 50 states and the District of Columbia, this is not the case with Intimate partner violence (IPV). Providers also need to be familiar with requirements in the privacy regulations of the Federal Health Insurance Portability and Accountability Act, which require that patients be advised on health information use and disclosure practices. Again, state laws around privacy issues or concerns vary (check your State laws).

The Centers for Disease Control and Prevention (CDC) has resources available for those needing additional information.

**Other Federal Resources**

- ACF's Family Violence Prevention and Services Program
  The Family Violence Prevention and Services Program administers the Family Violence Prevention and Services Act (FVPSA), the primary federal funding stream

dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their children.

- National Women's Health Information Center
  The National Women's Health Information Center, operated by the Office on Women's Health, is the most current and reliable resource on women's health.
- U.S. Department of Justice Office of Victims of Crime
  The Office for Victims of Crime (OVC) provides substantial funding to state victim assistance and compensation programs the lifeline services that help victims to heal.
- U.S. Department of Justice Office on Violence Against Women
  The Office on Violence Against Women works with victim advocates and law enforcement to develop grant programs that support a wide range of services, including advocacy, emergency shelter, law enforcement protection, and legal aid, for victims of domestic violence, sexual assault, and stalking.

**Additional Online Resources**

- **American Institute on Domestic Violence**
  The institute offers on-site workshops and conference presentations that address the corporate cost of domestic violence in the workplace.
- **Asian and Pacific Islander Institute on Domestic Violence**
  This is a national network that works to raise awareness in Asian and Pacific Islander communities about domestic violence; expand leadership and expertise within Asian and Pacific Islander communities about prevention, intervention, advocacy, and research; and promote culturally relevant programs, research, and advocacy by identifying promising practices.
- **Casa de Esperanza**
  This organization helps to develop effective responses to domestic violence and facilitates support systems in the lives of Latinas where they live.
- **Corporate Alliance to End Partner Violence (CAEPV)**
  CAEPV is a national, nonprofit alliance of corporations and businesses throughout the United States and Canada, working to prevent partner violence.

- **FaithTrust Institute**
  Formerly known as The Center for the Prevention of Domestic and Sexual Violence, FaithTrust Institute is an interreligious, educational resource that addresses sexual and domestic violence issues.
- **Minnesota Center Against Violence and Abuse (MINCAVA)**
  MINCAVA is an electronic clearinghouse with educational resources about all types of violence, including higher education syllabi, published research, funding sources, upcoming training events, individuals or organizations that serve as resources, and searchable databases with more than 700 training manuals, videos, and other education resources.
- **National Center for Victims of Crime (NCVC)**
  NCVC is a nonprofit organization that serves victims of all types of crime, including intimate partner violence.
- **National Center on Domestic and Sexual Violence (NCDSV)**
  Develops and provides innovative training and consultation, influences policy, and promotes collaboration and diversity in working to end domestic and sexual violence.
- **National Coalition Against Domestic Violence (NCADV)**
  NCADV is a membership organization of domestic violence coalitions and service programs.
- **National Domestic Violence Hotline**
  The National Domestic Violence Hotline connects individuals to help in their area by using a nationwide database that includes detailed information about domestic violence shelters, other emergency shelters, legal advocacy and assistance programs, and social service programs.
- **National Health Resource Center on Domestic Violence**
  For more than a decade, the Center has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence.
- **National Latino Alliance for the Elimination of Domestic Violence (the Alianza)**
  The Alianza is a group of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence.

- **National Network to End Violence Against Immigrant Women**
  The Network coordinates national advocacy efforts aimed at removing the barriers battered immigrant women and children face when they attempt to leave abusive relationships.
- **National Network to End Domestic Violence (NNEDV)**
  NNEDV is a membership and advocacy organization of state domestic violence coalitions and provides legislative and policy advocacy and provides training, technical assistance, and funds to domestic violence advocates through the NNEDV Fund.
- **National Resource Center on Domestic Violence (NRCDV)**
  The Center is a comprehensive source of information for those wanting to educate themselves and help others on the many issues related to domestic violence. A wide range of free, comprehensive, and individualized technical assistance information, training, specialized resource materials, and key initiatives designed to enhance current domestic violence intervention and prevention strategies can be accessed from the website.
- **National Sexual Violence Resource Center (NSVRC)**
  NSVRC identifies and disseminates information, resources, and research on all aspects of sexual violence prevention and intervention. The NSVRC website features links to related resources and information about conferences, funding, job announcements, and special events. Additional activities include coordinating national sexual assault awareness activities, identifying emerging policy issues and research needs, issuing a biannual newsletter, and recommending speakers and trainers.
- **National Violence Against Women Prevention Research Center**
  The Center provides information to scientists, practitioners, advocates, grassroots organizations, and any other professional or lay person interested in current topics related to violence against women and its prevention.
- Prevention Connection: The Violence Against Women Prevention Partnership
  Prevention Connection, a project of the California Coalition Against Sexual Assault, features an online public Listserv and bi-monthly web-based forums that provide prevention experts with a vehicle for analyzing and discussing ongoing efforts to prevent domestic and sexual violence.

- **Prevent IPV**
  The IPV Prevention Council represents a unified national effort committed to enhancing the capacity of state/territory domestic violence coalitions and community-based domestic violence programs to advance a comprehensive national prevention agenda and broaden support for its full implementation at the national, state, territory and local levels. The website features a searchable collection of resources generated in the field including training tools, campaigns, promising programs, evidence, policies, and other materials that can be adapted in communities to advance the prevention of intimate partner violence.
- **Rape, Abuse & Incest National Network (RAINN)**
  Hotline: 800-656-HOPE
  RAINN is the nation's largest anti-sexual assault organization. RAINN's national hotline works as a call-routing system.
- **The Stalking Resource Center**
  The Center advocates for stronger rights, protections and services for crime victims; provides education, training and evaluation; and serves as a trusted source of current information through collaboration with state, local, and federal partners.
- **Violence Against Women Electronic Network (VAWnet)**
  VAWnet provides a collection of full-text, searchable resources on domestic violence, sexual violence, and related issues as well as links to an "In the News" section, calendars listing trainings, conferences, grants, and access to the Domestic Violence Awareness Month and Sexual Assault Awareness Month subsites.
- **Workplaces Respond to Domestic and Sexual Violence: A National Resource Center**
  This project offers information on the Internet for the benefit of those interested in providing effective workplace responses to victims of domestic violence, sexual violence, dating violence and stalking.
- **World Health Organization/TEACH-VIP**
  A comprehensive injury prevention and control curriculum which has been developed through the efforts of WHO and a network of global injury prevention experts.
- **World Health Organization/World Report on Violence and Health**
  This report, produced by the World Health Organization, is written mainly for

researchers and practitioners. Its goals are to raise global awareness about the problems of violence and show that violence is preventable. (The report includes a chapter specifically on intimate partner violence; Chapter 4)

## SURVEY REPORT

The following survey report includes details from the Prevalence and Characteristics of Sexual violence, Staking, and Intimate Partner Violence Victimization (CDC 2014):

NISVS is a national random digit–dial telephone survey of the non-institutionalized English- and Spanish-speaking U.S. population aged ≥18 years. NISVS gathers data on experiences of sexual violence, stalking, and intimate partner violence among adult women and men in the United States by using a dual-frame sampling strategy that includes both landline and cellular telephones. The survey was conducted in 50 states and the District of Columbia; in 2011, the second year of NISVS data collection, 12,727 interviews were completed, and 1,428 interviews were partially completed.

### Results In the United States

- An estimated 19.3% of women and 1.7% of men have been raped during their lifetimes;
- An estimated 1.6% of women reported that they were raped in the 12 months preceding the survey.

The case count for men reporting rape in the preceding 12 months was too small to produce a statistically reliable prevalence estimate;

- An estimated 43.9% of women and 23.4% of men experienced other forms of sexual violence during their lifetimes, including being made to penetrate, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences.

- The percentages of women and men who experienced these other forms of sexual violence victimization in the 12 months preceding the survey were an estimated 5.5% and 5.1%, respectively.

- An estimated 15.2% of women and 5.7% of men have been a victim of stalking during their lifetimes. An estimated 4.2% of women and 2.1% of men were stalked in the 12 months preceding the survey.

With respect to sexual violence and stalking, female victims reported predominantly male perpetrators, whereas for male victims, the sex of the perpetrator varied by the specific form of violence examined.

Male rape victims predominantly had male perpetrators, but other forms of sexual violence experienced by men were either perpetrated predominantly by women (i.e., being made to penetrate and sexual coercion) or split more evenly among male and female perpetrators (i.e., unwanted sexual contact and noncontact unwanted sexual experiences). In addition, male stalking victims also reported a more even mix of males and females who had perpetrated stalking against them.

The lifetime and 12-month prevalence of rape by an intimate partner for women were;

- an estimated 8.8% and 0.8%, respectively;
- an estimated 0.5% of men experienced rape by an intimate partner during their lifetimes, although the case count for men reporting rape by an intimate partner in the preceding 12 months was too small to produce a statistically reliable prevalence estimate.
- An estimated 15.8% of women and 9.5% of men experienced other forms of sexual violence by an intimate partner during their lifetimes, whereas an estimated 2.1% of both men and women experienced these forms of sexual violence by a partner in the 12 months before taking the survey.
- Severe physical violence by an intimate partner (including acts such as being hit with something hard, being kicked or beaten, or being burned on purpose) was experienced by;
    - an estimated 22.3% of women and 14.0% of men during their lifetimes and by
    - an estimated 2.3% of women and 2.1% of men in the 12 months before taking the survey.
    - Finally, the lifetime and 12-month prevalence of stalking by an intimate partner for women was an estimated 9.2% and 2.4%, respectively, while

the lifetime and 12-month prevalence for men was an estimated 2.5% and 0.8%, respectively.

Many victims of sexual violence, stalking, and intimate partner violence were first victimized at a young age.

Among female victims of completed rape;

- an estimated 78.7% were first raped before age 25 years (40.4% before age 18 years).

Among male victims who were made to penetrate a perpetrator;

- an estimated 71.0% were victimized before age 25 years (21.3% before age 18 years).
- In addition, an estimated 53.8% of female stalking victims and 47.7% of male stalking victims were first stalked before age 25 years (16.3% of female victims and 20.5% of male victims before age 18 years).
- Finally, among victims of contact sexual violence, physical violence, or stalking by an intimate partner, an estimated 71.1% of women and 58.2% of men first experienced these or other forms of intimate partner violence before age 25 years (23.2% of female victims and 14.1% of male victims before age 18 years).

**Interpretation:**

A substantial proportion of United States female and male adults have experienced some form of sexual violence, stalking, or intimate partner violence at least once during their lifetimes, and the sex of perpetrators varied by the specific form of violence examined. also a substantial number of United States adults experienced sexual violence, stalking, or intimate partner violence during the 12 months preceding the 2011 survey. Consistent with previous studies, the overall pattern of results suggest that women, in particular, are heavily impacted over their lifetime.

The results also indicate that many men experience sexual violence, stalking, and physical violence by an intimate partner. Because of the broad range of short term and

long term consequences known to be associated with these forms of violence, the public health burden of stalking, sexual violence and intimate partner violence is substantial. The results suggest that these forms of violence frequently are experienced at an early age because a majority of victims experienced their first victimization before age 25 years, with a substantial proportion experiencing victimization in adolescence or childhood.

**Public Health Action**

Because a substantial proportion of sexual violence, intimate partner violence and stalking are experienced at a young age, primary prevention of these forms of violence needs to begin early. Prevention efforts need to take into consideration that female sexual violence and stalking victimization is perpetrated predominately by men and that a substantial proportion of male sexual violence and stalking victimization including unwanted sexual contact, rape, noncontact unwanted sexual experiences, and stalking also is perpetrated by men.

The Centers for Disease Control and Prevention (CDC) seeks to prevent these forms of violence with strategies that address known risk factors for perpetration and by changing social norms and behaviors by using bystander and other prevention strategies.

Primary prevention of intimate partner violence is focused on:

- Promoting healthy relationship behaviors and other protective factors, with the goal to help adolescents develop positive behaviors before their first relationships. The early promotion of healthy relationships while behaviors are still relatively modifiable should make it more likely that young individuals can avoid violence in their relationships.

**Prevalence of Sexual Violence Victimization**

According to the Centers for Disease Control and Prevention (Surveillance Summaries continues), in the United States, an estimated 19.3% of women (or >23 million women) have been raped during their lifetimes;

- Completed forced penetration was experienced by an estimated 11.5% of women.

- Nationally, an estimated 1.6% of women (or approximately 1.9 million women) were raped in the 12 months before taking the survey.
- An estimated 1.7% of men (or almost 2.0 million men) were raped during their lifetimes;
- 0.7% of men experienced completed forced penetration. (The case count for men reporting rape in the preceding 12 months was too small to produce a statistically reliable prevalence estimate).
- An estimated 43.9% of women experienced sexual violence other than rape during their lifetimes, and an
- estimated 5.5% of women were victims of sexual violence other than rape in the 12 months preceding the survey.
- For men, an estimated 23.4% experienced sexual violence other than rape during their lifetimes, and
- 5.1% experienced sexual violence other than rape in the 12 months before completing the survey.
- An estimated 0.6% of women (>700,000 women) were made to penetrate a perpetrator during their lifetimes. The case count for women reporting being made to penetrate a perpetrator in the preceding 12 months was too small to produce a statistically reliable prevalence estimate.
- For men, the lifetime prevalence of being made to penetrate a perpetrator was an estimated 6.7% (>7.6 million men), while an estimated 1.7% of men were made to penetrate a perpetrator in the 12 months preceding the survey.
- An estimated 12.5% of women experienced sexual coercion during their lifetimes. Sexual coercion was experienced by an estimated 2.0% of women in the 12 months before taking the survey.
- An estimated 5.8% of men experienced sexual coercion during their lifetimes while an estimated 1.3% of men experienced sexual coercion in the 12 months before taking the survey.
- Approximately one in four women (27.3%) is estimated to have experienced some form of unwanted sexual contact during their lifetimes. In the 12 months

preceding the survey, an estimated 2.2% of women experienced unwanted sexual contact.

- An estimated 10.8% of men experienced unwanted sexual contact during their lifetimes, with an estimated 1.6% of men having experienced unwanted sexual contact in the 12 months before taking the survey.
- Approximately one in three women (32.1%) is estimated to have experienced some type of noncontact unwanted sexual experience during their lifetimes, and an estimated 3.4% of women experienced this in the 12 months before taking the survey.
- An estimated 13.3% of men experienced noncontact unwanted sexual experiences during their lifetimes, and an estimated 2.5% of men experienced this type of victimization in the previous 12 months.

**Prevalence of Sexual Violence Victimization by Race/Ethnicity**

According to the CDC(Surveillance Summaries) in the United States,

- an estimated 32.3% of multiracial women,
- 27.5% of American Indian/Alaska Native women,
- 21.2% of non-Hispanic black women,
- 20.5% of non-Hispanic white women, and
- 13.6% of Hispanic women were raped during their lifetimes.

The case counts of other racial/ethnic categories of women were too small to report statistically reliable estimates. Lifetime estimates of rape for men by race/ethnicity were also not statistically reliable for reporting because of a small case count, with one exception: an estimated 1.6% of non-Hispanic white men were raped during their lifetimes.

- An estimated 64.1% of multiracial women,
- 55.0% of American Indian/Alaska Native women,
- 46.9% of non-Hispanic white women, and
- 38.2% of non-Hispanic black women experienced sexual violence other than rape during their lifetimes.

- In addition, an estimated 35.6% of Hispanic women and 31.9% of Asian or Pacific Islander women experienced sexual violence other than rape during their lifetimes.
- Among men, an estimated 39.5% of multiracial men experienced sexual violence other than rape during their lifetimes.
- In addition, 26.6% of Hispanic men,
- 24.5% of American Indian/Alaska Native men,
- 24.4% of non-Hispanic black men, and
- 22.2% of non-Hispanic white men experienced sexual violence other than rape during their lifetimes, and
- an estimated 15.8% of Asian or Pacific Islander men experienced this type of sexual violence during their lifetimes.

**Characteristics of Sexual Violence Perpetrators**

For female rape victims,

- an estimated 99.0% had only male perpetrators.
- In addition, an estimated 94.7% of female victims of sexual violence other than rape had only male perpetrators.

For male victims, the sex of the perpetrator varied by the type of sexual violence experienced. The majority of male rape victims (an estimated 79.3%) had only male perpetrators.

For three of the other forms of sexual violence, a majority of male victims had only female perpetrators: being made to penetrate (an estimated 82.6%), sexual coercion (an estimated 80.0%), and unwanted sexual contact (an estimated 54.7%). For noncontact unwanted sexual experiences, nearly half of male victims (an estimated 46.0%) had only male perpetrators and an estimated 43.6% had only female perpetrators.

**The majority of victims of all types of sexual violence knew their perpetrators.**

- Almost half of female victims of rape (an estimated 46.7%) had at least one perpetrator who was an acquaintance, and an estimated 45.4% of female rape victims had at least one perpetrator who was an intimate partner.
- More than half (an estimated 58.4%) of women who experienced alcohol/drug facilitated penetration were victimized by an acquaintance.
- An estimated 44.9% of male victims of rape were raped by an acquaintance, and an estimated 29.0% of male victims of rape were raped by an intimate partner. (The estimates for male victims raped by other types of perpetrators are not reported because the case counts were too small to calculate a reliable estimate (CDC 2014).

For sexual violence other than rape of both women and men, the type of perpetrator varied by the form of sexual violence experienced.

The majority of female victims of sexual coercion (an estimated 74.1%):

- Had an intimate partner as a perpetrator, and
- nearly half of female victims of unwanted sexual contact (an estimated 47.2%) had an acquaintance as a perpetrator.
- About half of the female victims of noncontact unwanted sexual experiences had a stranger as a perpetrator (an estimated 49.3%).

Among men who were made to penetrate a perpetrator;

- an estimated 54.5% were made to penetrate an intimate partner and an estimated 43.0% were made to penetrate an acquaintance.
- The majority of male victims of sexual coercion (an estimated 69.5%) had an intimate partner as a perpetrator.
- Among male victims of unwanted sexual contact, about half (an estimated 51.8%) had an acquaintance as a perpetrator.
- Finally, among male victims of noncontact unwanted sexual violence, an estimated 39.2% had an acquaintance as a perpetrator, followed by an intimate partner (an estimated 30.9%), or a stranger (an estimated 30.9%).

## Stalking Victimization

### Prevalence of Stalking Victimization

In the United States:

- An estimated 15.2% of women (18.3 million women) have experienced stalking during their lifetimes that made them feel very fearful or made them believe that they or someone close to them would be harmed or killed.
- In addition, an estimated 4.2% of women (approximately 5.1 million women) were stalked in the 12 months before taking the survey.
- Nationally, an estimated 5.7% of men (or nearly 6.5 million) have experienced stalking victimization during their lifetimes, while an estimated 2.1% of men (or 2.4 million) were stalked in the 12 months before taking the survey (CDC 2014)

### Prevalence of Stalking Victimization by Race/Ethnicity

- An estimated 24.5% of American Indian/Alaska Native women experienced stalking during their lifetimes, and
- an estimated 22.4% of multiracial women were stalked during their lifetimes.
- An estimated 15.9% of non-Hispanic white women experienced stalking during their lifetimes, and
- the prevalence of stalking for Hispanic and non-Hispanic black women was an estimated 14.2% and 13.9%, respectively.
- The estimate for Asian or Pacific Islander women was not reported because the case count was too small to produce a reliable estimate.
- An estimated 9.3% of multiracial men experienced stalking during their lifetimes,
- as did an estimated 9.1% of non-Hispanic black men, 8.2% of Hispanic men, and 4.7% of non-Hispanic white men.
- The estimates for the other racial/ethnic groups of men are not reported because case counts were too small to produce a reliable estimate.

**Frequency of Stalking Acts among Stalking Victims**

A variety of tactics were used to stalk victims during their lifetimes.

- An estimated 61.7% of female stalking victims were approached, such as at their home or work; over half (an estimated 55.3%) received unwanted messages, such as text and voice messages;
- an estimated 54.5% received unwanted telephone calls, including hang-ups .
- In addition, nearly half (an estimated 49.7%) of female stalking victims were watched, followed, or spied on with a listening device, camera, or global positioning system (GPS) device.
- An estimated 58.2% of male stalking victims received unwanted telephone calls,
- an estimated 56.7% received unwanted messages.
- An estimated 47.7% of male stalking victims were approached by their perpetrator, and
- an estimated 32.2% were watched, followed, or spied on with a listening or other device.

**Characteristics of Stalking Perpetrators**

Among persons who were victims of stalking during their lifetimes, the sex of the perpetrator varied somewhat by the sex of the victim.

Among female stalking victims;

- an estimated 88.3% were stalked by only male perpetrators;
- an estimated 7.1% had only female perpetrators.

Among male stalking victims;

- almost half (an estimated 48.0%) were stalked by only male perpetrators
- while a similar proportion (an estimated 44.6%) were stalked by only female perpetrators.

Both female and male victims often identified their stalkers as persons whom they knew or with whom they had an intimate relationship.

Among female stalking victims;

- an estimated 60.8% were stalked by a current or former intimate partner,
- nearly one-quarter (an estimated 24.9%) were stalked by an acquaintance,
- an estimated 16.2% were stalked by a stranger, and
- an estimated 6.2% were stalked by a family member.

Among male stalking victims;

- an estimated 43.5% were stalked by an intimate partner,
- an estimated 31.9% by an acquaintance,
- an estimated 20.0% by a stranger, and
- an estimated 9.9% by a family member.

**Intimate Partner Violence Victimization**

**Prevalence of Intimate Partner Violence Victimization**

The lifetime and 12-month prevalence of rape by an intimate partner for women was:

- An estimated 8.8% and 0.8%, respectively.
- Nationally, an estimated 15.8% of women experienced other forms of sexual violence by an intimate partner during their lifetimes,
- an estimated 2.1% of women experienced other forms of sexual violence by a partner in the 12 months before taking the survey.
- The lifetime prevalence of physical violence by an intimate partner was an estimated 31.5% among women and in the 12 months before taking the survey,
- an estimated 4.0% of women experienced some form of physical violence by an intimate partner.
- An estimated 22.3% of women experienced at least one act of severe physical violence by an intimate partner during their lifetimes.
- With respect to individual severe physical violence behaviors, being slammed against something was experienced by an estimated 15.4% of women, and
- being hit with a fist or something hard was experienced by 13.2% of women.
- In the 12 months before taking the survey, an estimated 2.3% of women experienced at least one form of severe physical violence by an intimate partner.

- The lifetime and 12-month prevalence of stalking by an intimate partner for women was an estimated 9.2% and 2.4%, respectively.
- Finally, an estimated 47.1% of women experienced at least one act of psychological aggression by an intimate partner during their lifetimes;
- an estimated 14.2% of women experienced some form of psychological aggression in the 12 months preceding the survey.

Nationally, an estimated ;

- 0.5% of men experienced rape by an intimate partner during their lifetimes. However, the case count for men reporting rape by an intimate partner in the preceding 12 months was too small to produce a statistically reliable prevalence estimate.

- An estimated 9.5% of men experienced other forms of sexual violence by an intimate partner during their lifetimes,

- an estimated 2.1% of men experienced other forms of sexual violence by an intimate partner in the 12 months before taking the survey.

- The lifetime prevalence of physical violence by an intimate partner was an estimated 27.5% for men, and in the 12 months before taking the survey,

- an estimated 4.8% of men experienced some form of physical violence by an intimate partner.

- An estimated 14.0% of men experienced at least one act of severe physical violence by an intimate partner during their lifetimes.

- With respect to individual severe physical violence behaviors, being hit with a fist or something hard was experienced by an estimated 10.1% of men, and

- 4.6% of men have been kicked by an intimate partner.

- In the 12 months before taking the survey, an estimated 2.1% of men experienced at least one form of severe physical violence by an intimate partner.

- The lifetime and 12-month prevalence of stalking by an intimate partner for men was an estimated 2.5% and 0.8%, respectively.

- Finally, an estimated 46.5% of men experienced at least one act of psychological aggression by an intimate partner during their lifetimes;

- an estimated 18.0% of men experienced some form of psychological aggression in the 12 months preceding the survey.

**Prevalence of Intimate Partner Violence Victimization by Race/Ethnicity**

Nationally;

- an estimated 11.4% of multiracial women,
- 9.6% of non-Hispanic white women,
- 8.8% of non-Hispanic black women, and
- 6.2% of Hispanic women were raped by an intimate partner during their lifetimes.

The case counts for men reporting rape by an intimate partner during their lifetimes were too small to produce statistically reliable prevalence estimates by race/ethnicity.

- An estimated 26.8% of multiracial women,
- 17.4% of non-Hispanic black women,
- 17.1% of non-Hispanic white women, and
- 9.9% of Hispanic women experienced sexual violence other than rape by an intimate partner during their lifetimes.

The case counts of other female racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates.

In addition;

- an estimated 18.2% of multiracial men,
- 14.8% of non-Hispanic black men,
- 13.5% of Hispanic men, and
- 7.6% of non-Hispanic white men experienced sexual violence other than rape by an intimate partner at some point during their lifetimes.

The case counts of other male racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates.

- An estimated 51.7% of American Indian/Alaska Native women,
- 51.3% of multiracial women,
- 41.2% of non-Hispanic black women,
- 30.5% of non-Hispanic white women,

- 29.7% of Hispanic women, and
- 15.3% of Asian or Pacific Islander women experienced physical violence by an intimate partner during their lifetimes.
- An estimated 43.0% of American Indian/Alaska Native men,
- 39.3% of multiracial men,
- 36.3% of non-Hispanic black men,
- 27.1% of Hispanic men,
- 26.6% of non-Hispanic white men, and
- 11.5% of Asian or Pacific Islander men experienced physical violence by an intimate partner during their lifetime.
- An estimated 13.3% of multiracial women,
- 9.9% of non-Hispanic white women,
- 9.5% of non-Hispanic black women, and
- 6.8% of Hispanic women were stalked by an intimate partner during their lifetimes.

The case counts of other female racial/ethnic groups (Asian or Pacific Islander and American Indian/Alaska Native) were too small to report statistically reliable estimates.

In addition, an estimated 1.7% of non-Hispanic white men were stalked by an intimate partner during their lifetimes. The case counts of all other male racial/ethnic groups were too small to report statistically reliable estimates.

**Prevalence of Intimate Partner Violence–Related Impact:**

- An estimated 27.3% of women have experienced contact sexual violence (rape, sexual coercion, or unwanted sexual contact), physical violence, or stalking by an intimate partner during their lifetimes and have experienced at least one measured negative impact related to these or other forms of violence (noncontact unwanted sexual experiences, psychological aggression, or control of reproductive or sexual health) experienced in that relationship.
- More specifically, an estimated 23.7% of women were fearful,
- 20.7% were concerned for their safety,
- 20.0% experienced one or more PTSD symptoms,
- 13.4% were physically injured,
- 6.9% needed medical care,

- 3.6% needed housing services,
- 3.3% needed victim advocate services,
- 8.8% needed legal services,
- 2.8% contacted a crisis hotline,
- 9.1% missed at least 1 day of work or school,
- 1.3% contracted a sexually transmitted infection, and
- 1.7% became pregnant as a result of the violence experienced by an intimate partner.

Nationally:

- an estimated 11.5% of men have experienced contact sexual violence,
- physical violence, or stalking by an intimate partner during their lifetimes and have experienced at least one measured negative impact related to these or other forms of violence experienced in that relationship.
- More specifically, an estimated 6.9% of men were fearful,
- 5.2% were concerned for their safety,
- 5.2% experienced one or more PTSD symptoms,
- 3.5% were physically injured,
- 1.6% needed medical care,
- 1.0% needed housing services,
- 4.0% needed legal services, and
- 4.8% missed at least 1 day of work or school.

The case counts for men needing victim advocacy services, having contacted a crisis hotline, or contracting a sexually transmitted infection as a result of these types of violence were too small to produce statistically reliable estimates.

**Age of First Victimization**

**Completed Rape**

Among female victims of completed rape (completed forced penetration and completed alcohol- or drug-facilitated penetration), this form of sexual violence was first experienced by:

- an estimated 78.7% before age 25 years,
- by an estimated 40.4% before age 18 years (28.3% at ages 11–17 years and 12.1% at age ≤10 years), and by
- an estimated 38.3% at age 18–24 years.

In addition, among female victims of completed rape;

- an estimated 15.2% first experienced this at age 25–34 years,
- an estimated 4.6% at age 35–44 years, and
- an estimated 1.5% at age ≥45 years.

The case counts for men reporting lifetime completed rape were too small to produce statistically reliable estimates for all age categories.

**Being Made to Penetrate a Perpetrator**

Among males who were made to penetrate a perpetrator, this was experienced first by;

- An estimated 71.0% before age 25 years,
- with an estimated 21.3% having first experienced this before age 18 years (18.6% at age 11–17 years) and
- an estimated 49.7% at age 18–24 years.

In addition, among male victims who were made to penetrate a perpetrator, this was experienced first by;

- an estimated 15.3% at age 25–34 years and by
- an estimated 7.9% at age 35–44 years.

The case count for men reporting first being made to penetrate a perpetrator at age ≥45 years was too small to produce a statistically reliable estimate. In addition, the case counts for women reporting being made to penetrate a perpetrator during their lifetimes were too small to produce statistically reliable estimates for all age categories.

**Stalking**

Among female victims of stalking;

- an estimated 53.8% were first stalked before age 25 years, with
- an estimated 16.3% first experiencing this before age 18 years (13.5% at ages 11–17 years) and
- an estimated 37.5% at ages 18–24 years.
- In addition, among female victims of stalking, this was experienced first by an estimated 28.8% at ages 25–34 years, by an estimated 11.5% at ages 35–44 years, and by an estimated 5.9% at age ≥45 years.

Among male victims of stalking;

- an estimated 47.7% were first stalked before age 25 years, with
- an estimated 20.5% having first experienced stalking before age 18 years (16.2% at ages 11–17 years) and
- an estimated 27.2% having first experienced this at age 18–24 years.
- In addition, among male victims of stalking, this was experienced first by an estimated 21.3% at age 25–34 years, by an estimated 17.9% at age 35–44 years, and by an estimated 13.1% at age ≥45 years.

**Intimate Partner Violence**

Among female victims of contact sexual violence, physical violence, or stalking by an intimate partner;

- an estimated 71.1% first experienced these or other forms of intimate partner violence before age 25 years, with
- an estimated 23.2% having first experienced this before age 18 years (23.1% at age 11–17 years) and
- an estimated 47.9% at age 18–24 years.
- In addition, among female victims of contact sexual violence, physical violence, or stalking by an intimate partner, these or other forms of intimate partner violence were experienced first by
  - an estimated 20.7% at age 25–34 years,
  - by an estimated 5.9% at age 35–44 years, and by
  - an estimated 2.3% at age ≥45 years.

Among male victims of contact sexual violence, physical violence, or stalking by an intimate partner;

- an estimated 58.2% first experienced these or other forms of intimate partner violence before age 25 years, with
- an estimated 14.1% having first experienced this before age 18 years (14.0% at age 11–17 years) and
- an estimated 44.1% at age 18–24 years.

In addition, among male victims of contact sexual violence, physical violence, or stalking by an intimate partner, these or other forms of intimate partner violence were first experienced by;

- an estimated 26.7% at age 25–34 years, by
- an estimated 10.4% at age 35–44 years, and by
- an estimated 4.7% at age ≥45 years.

The results presented in this report indicate that a significant number and proportion of female and male United States adults have experienced stalking, sexual violence or intimate partner violence during their lifetimes or in the 12 months preceding the 2011 survey. Because of the broad range of short- and long-term consequences associated with these forms of violence, the public health burden of sexual violence, stalking, and intimate partner violence is substantial. The results provided in this report indicate that the burden of sexual violence, stalking, and intimate partner violence is not distributed evenly in the United States population.

Consistent with previous studies, the results suggest that women, in particular, are impacted heavily during their lifetimes. However, the results indicate that many men also experience sexual violence, stalking and, in particular, physical violence by an intimate partner. Although there are relatively smaller differences in the overall prevalence of physical violence by an intimate partner when comparing women and men, there is greater differentiation between women and men in terms of the prevalence of negative intimate partner violence related impact.

This suggests the need to look beyond the overall prevalence estimates when comparing the total burden of men's and women's intimate partner violence victimization.

Previous research indicates that:

- Characteristics, for example, frequency, severity, and impact, of women's and men's intimate partner violence victimization differ in ways that might not be reflected in overall prevalence estimates. However, any focus on differences between men and women should not obscure the fact that nearly 16 million men have experienced some form of severe physical violence by an intimate partner during their lifetimes and >13 million men have experienced intimate partner violence during their lifetimes that resulted in a negative impact.

The results also suggest that certain racial/ethnic groups experience a comparatively higher burden. Although statistical testing was not undertaken, an examination of the pattern of lifetime prevalence estimates suggests that multiracial and American Indian/Alaska Native women experience elevated levels for most of the types of violence examined in this report.

These findings are consistent with previous reports indicating that multiracial and American Indian/Alaska Native women are at greater risk for rape, stalking, and intimate partner violence. These findings underscore the importance of prevention efforts and services that address the needs of multiracial and American Indian/Alaska Native women.

Although previous research has suggested explanations for elevated rates of violence among American Indian/Alaska Native women such as elevated poverty, social and geographic isolation, and a higher likelihood of alcohol use by the perpetrator, little is known about why multiracial women are at greater risk for these forms of violence. Research is needed to identify risk and protective factors for violence victimization among multiracial persons.

**Stranger versus Acquaintance**

By definition, all victims of intimate partner violence knew their perpetrator; however, the majority of sexual violence and stalking victims also knew their perpetrators. Despite frequent depictions in the media of sexual violence and stalking perpetrated by strangers:

- Strangers were reported as the perpetrator by less than one fourth of stalking victims and by less than one fourth of victims of each form of sexual violence except noncontact unwanted sexual experiences.
- For stalking and for all forms of sexual violence except noncontact unwanted sexual experiences, two frequently reported perpetrators were intimate partners and acquaintances.

This pattern suggests that prevention efforts for sexual violence and stalking need to focus on preventing violent interactions between individuals who are intimate or are known to each other in another capacity.

Female victims of sexual violence and stalking reported predominantly male perpetrators, whereas for male victims, the sex of the perpetrator varied by the specific form of violence examined.

Male rape victims predominantly had male perpetrators, but other forms of sexual violence experienced by men either were perpetrated predominantly by women such as being made to penetrate a perpetrator or sexual coercion or were split more evenly among male and female perpetrators (for example, unwanted sexual contact and noncontact unwanted sexual experiences). In addition, male stalking victims also had a more even mix of males and females who had perpetrated stalking against them.

Prevention efforts should take into consideration that female sexual violence and stalking victimization is predominately perpetrated by men and that a substantial proportion of male sexual violence and stalking victimization (rape, unwanted sexual contact, noncontact unwanted sexual experiences, and stalking) also is perpetrated by men.

For each of the violence types assessed, ≥53.8% of all female victims and ≥47.7% of all male victims experienced their first victimizations before age 25 years, with many first experiencing victimization in childhood and adolescence. These findings suggest that primary prevention of sexual violence, stalking, and intimate partner violence should take place at an early age.

The Centers for Disease Control and Prevention (CDC) approach to the primary prevention of violence is in keeping with this finding. Specifically, the Centers for Disease Control and Prevention (CDC) supports:

- The development of safe, stable, and nurturing relationships and environments for children as a precursor to healthy parent-child relationships (CDC 2013).
- Healthy peer relationships among adolescents, healthy dating relationships among adolescents before their first experience with dating (see http://www.cdc.gov/violence prevention /DatingMatter); for more information.
- Also the engagement of bystanders to intervene before violence occurs.
- CDC also supports the development, evaluation, and widespread adoption of empirically supported teen dating violence prevention programs.

For example, the school-based Safe Dates program, which focuses on:

  - Enhancing conflict management skills and changing norms about dating violence, has been shown to prevent perpetration of physical and sexual violence as well as psychological aggression in teen dating relationships.

When peer, parental, and dating relationships are influenced early in life, healthy relationship patterns, behaviors and healthy social environments can be promoted while these behaviors are relatively modifiable. Therefore, adolescents can be equipped with healthier behaviors to use instead of violence within adult relationships.

In addition to the primary prevention efforts, secondary prevention is also vital. The results suggest that a substantial number of men and women also have experienced a range of negative impacts as a result of the intimate partner violence they have experienced.

Most notably, nearly

- 13.4% of women and
- 3.5% of men have been injured physically, and
- 9.1% of women and 4.8% of men have missed at least 1 day of work or school because of experiencing intimate partner violence.

Previous research has established that in addition to these near-term impacts, those who experience intimate partner violence are at greater risk for a range of long-term health consequences.

For the negative effects of intimate partner violence, sexual violence, and stalking to be mitigated, it is important to ensure that relevant services are available to victims. The findings in this report suggest that many adults are in need of these types of services as a result of intimate partner violence victimization.

During their lifetimes

- 6.9% of women and 1.6% of men needed medical services,
- 8.8% of women and 4.0% of men needed legal services, and
- 3.6% of women and 1.0% of men needed housing services (e.g., shelters).

Research is needed to examine the degree to which needed services are not being received and to determine whether any existing gap is attributable to services being unavailable, inaccessible, or inadequate, or to victims choosing not to use available services (CDC 2014)

**Domestic violence shelters**

Domestic violence shelters play a very important role in providing support and safety for the victims and their families. The shelters are vital to victims who do not have or lack access to other resources and those who feel that they have no other safe place to go where they can escape.

On September 15, 2011, 89% of identified domestic violence programs in the United States participated in the 2011 National Census of Domestic Violence Services. The results were published in the NNEDV report: Domestic Violence Counts 2011.
A 24-hour census of domestic violence shelters and services.

**Domestic Violence Shelters: Facts**

A survey of domestic violence services across the nation found that in a 24-hour period:

- 67,399 victims received assistance, from access to shelter services to counseling and support group referrals.

- 36,332 of the victims served were staying in a domestic violence shelter (NNEDV 2011).

The need for domestic violence shelters, however, exceeds the capacity and space. The 2011 survey found that of 10,581 requests for assistance that could not be met, 64% of those requests were for emergency shelter (NNEDV 2011).

National Network to End Domestic Violence (NNEDV) conducted a one-day, unduplicated count of adults and children seeking domestic violence services in the U.S. on September 12, 2012. This annual census documents the number of individuals who sought services in a single 24-hour period, as well as the types of services requested, the number of service requests that went unmet because of lack of resources, and the issues and barriers that domestic violence programs face as they strive to provide services to victims of domestic violence.

Some of the National Network to End Domestic Violence (NNEDV) 2012 results include:

- 64,324 Victims Served in One Day
- 35,323 domestic violence victims found refuge in emergency shelters or transitional housing provided by local domestic violence programs. In addition to a safe place to lay their heads at night, shelter residents were provided with a variety of comprehensive services.
- 29,001 adults and children received non-residential assistance and services, including counseling, legal advocacy, and children's support groups.
- 10,471 Unmet Requests for Services in One Day
- Victims made more than 10,000 requests for services, including emergency shelter, housing, transportation, childcare, and legal representation, that could not be provided because programs did not have the resources to provide these services.
- 65% of Unmet Requests Were for Housing Emergency shelter and transitional housing continues to be the most urgent unmet needs with 6,818 requests unmet.

Of the unmet requests, the following services were the most requested:

1. Emergency Shelter

2. Counseling

3. Attorney/Legal Representation

4. Transitional Housing

Programs were unable to provide services for various reasons such as:

- 42% reported not enough funding for needed programs and services.
- 30% reported not enough staff.
- 26% reported no available beds or funding for hotels.
- 23% reported not enough specialized services.
- 10% reported limited funding for translators, bilingual staff, or accessible equipment.

Safe Horizon is the nation's largest provider of residences for victims of domestic violence, offering adults and families safe havens after they have escaped violence. Safe Horizon operates nine shelters with more than 700 beds available in New York City, giving families both emergency shelter and long-term residences that provide more time for them to recover and rebuild their lives.

Safe Horizon offers comprehensive services that include:

- Counseling,
- Housing assistance,
- Life skills and Parenting courses,
- childcare
- Medical aid.

On September 10, 2014, NNEDV conducted a one-day unduplicated count of adults and children seeking domestic violence service in the United States. On September 10, 2014, 1,697 out of 1,916 (89%) identified domestic violence programs in the United States participated in the 2014 National Census of Domestic Violence Services. The following figures represent the information provided by these 1,697 participating programs about services provided during the 24-hour survey period:

- 67,646 Victims Served in One Day
- 36,608 domestic violence victims found refuge in emergency shelters or transitional housing provided by local domestic violence programs.
- 31,038 adults and children received non-residential assistance and services, including counseling, legal advocacy, and children’s support groups.

10,871 Unmet Requests for Services in One Day, of which 56% (6,126) were for Housing Victims made more than 10,000 requests for services; including emergency shelter, housing, transportation, childcare, legal representation, and more; that could not be provided because programs did not have the resources to provide these services.

The most frequently requested non-residential services that could not be provided were housing advocacy, legal representation, and financial assistance.

Cause of Unmet Requests for Help:

- 28% reported reduced government funding.
- 18% reported not enough staff.
- 18% reported cuts from private funding sources.
- 14% reported reduced individual donations.

Across the United States, 1,392 staff positions were eliminated in the past year. Most of these positions (76%) were direct service providers, such as shelter staff or legal advocates. This means that there were fewer advocates to answer calls for help or provide needed services (NNEDV 2014).

## FLORIDA'S DOMESTIC VIOLENCE LAW

Florida's domestic violence law enables you to work with the court system to stop the abuse. If you are a victim of domestic violence or if you have reason to believe you will become a victim, you may file a police report and request an Injunction for Protection Against Domestic Violence (IFP).

### HOW TO GET A TEMPORARY INJUNCTION FOR PROTECTION

Go to the Courthouse and ask for the Circuit Court Clerk's office. Tell them you want to apply for an Injunction for Protection. Complete the forms. Be as thorough and descriptive as possible. Mention all details, including dates of threats, bruises, weapons, drugs, alcohol, etc. If the abuser was arrested for abuse or may soon be released from jail, include this information. If you are pregnant and you are being abused, include this information also. What has happened most recently is what is most important.

• An official will ask questions to verify your petition, and you will be asked to swear that the facts in the petition are true.

• For safety reasons, you may furnish the Court with your address in a separate confidential filing.

• If you want the judge to order certain things such as custody of your children, child support or a batterer's intervention program for the abuser, you must request this in writing on the petition or the judge cannot provide the child support in the final order.

**WHAT ELSE YOU CAN DO TO PROTECT YOURSELF**

• Plan an emergency escape route.

• Keep money saved to use for your escape.

• See if a neighbor will give you emergency shelter.

• Make extra keys to the house and car. Leave them in a safe-and-secure place outside your residence.

• Keep extra clothes for yourself and your child / children with a friend, relative, or neighbor.

**WHAT TO DO IF THE INJUNCTION IS GRANTED AND THE ABUSER DOES NOT OBEY THE ORDER**

If you are in immediate danger, call 911. If you are not in immediate danger, return as soon as possible to the clerk's office where you filed the IFP, and complete a report of violation. This report is called an affidavit of noncompliance. Witnesses should also sign an affidavit.

• A hearing will be set, and the abuser will have to show why he or she should not be punished. You will have to go to court.

• If the judge finds that the abuser disobeyed the court order, the judge can put the abuser in jail by finding him/her in contempt. The judge may also issue other sanctions such as fines or changes in custody/visitation.

# CONTACT

| HOTLINE | Telephone # | TTY |
|---|---|---|
| National Domestic Violence Hotline | 1-800-799-SAFE (7233) | 1-800-787-3224 (TTY) |
| National Sexual Assault Hotline | 1-800-656-HOPE (4673) | |
| National Teen Dating Abuse Helpline | 1-866-331-9474 | 1-866-331-8453 (TTY) |

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