MASSACHUSETTS MEDICAL SOCIETY
COMMITTEE ON VIOLENCE
INTERVENTION AND PREVENTION

INTIMATE PARTNER VIOLENCE

The Clinician's Guide to Identification, Assessment, Intervention, and Prevention

Elaine J. Alpert, MD, MPH

5th Edition

CAMPAIGN AGAINST VIOLENCE®
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PREFACE

The Massachusetts Medical Society's Campaign Against Violence is pleased to release the fifth edition of its valuable guidebook on intimate partner violence. The guidebook's first edition, published in 1992, was designed for use by physicians and medical students in the Commonwealth of Massachusetts. Subsequent editions, published in 1997, 2002, and 2004, respectively, included relevant updates and revisions. The Massachusetts Medical Society (MMS) guidebook continues to be widely regarded by physicians and other clinical health care providers as being a key resource for up-to-date knowledge and practical advice about this important topic. Previous editions of the MMS guidebook have been adapted with permission for use in multiple states, including New York, Arizona, and Illinois.

The fifth edition represents a major rewrite of the guidebook. This edition contains major new features, including several new topics, customizability to geographic areas nationwide and potentially worldwide, and live-access Web resource links.

This guidebook describes the physician's role in screening and caring for patients at risk for abuse. However, other health care professionals come in contact with such patients, as well, and can thus benefit from the information contained in this guidebook.

Because physicians are often the first and sometimes the only professionals survivors of violence encounter, they can play a crucial role in breaking the cycle of violence and working toward prevention.

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Table of Contents

Introduction

This guidebook is designed to help physicians and other health care professionals improve their ability to respond to the needs of patients who have experienced intimate partner violence (IPV). Also referred to as domestic violence, spousal abuse, partner violence, battering, and numerous other terms, IPV has complex individual, social, and cultural underpinnings whose acute health effects and ongoing medical sequelae are encountered frequently in clinical practice.

Nearly every physician is called upon to care for patients who:

- Are at risk for intimate partner violence or other types of abuse in relationships
- Were exposed to abuse or its effects during childhood
- Are currently in an abusive relationship
- Or are coping with the long-term effects of past abuse

Knowing what to ask in order to "diagnose" IPV in the course of routine clinical care is a necessary skill in nearly every medical field and specialty. Even more important, however, is developing skills to assess, document, and intervene with sensitivity, compassion, and respect so this important health issue can be addressed optimally in the context of everyday clinical care. Addressing IPV also requires health professionals to practice in a trauma-sensitive and culturally informed manner, manage time and resources efficiently, and communicate empathically while maintaining appropriate professional boundaries. Finally, it is important to attend to the emotional needs and physical safety of both patients and staff at all times.

Because physicians and other health care providers are often the first and sometimes the only professionals survivors of violence encounter, they can play a crucial role in breaking the cycle of violence and working toward prevention.

The goals of this guidebook are as follows:

- To provide essential, up-to-date, referenced information and resources about intimate partner violence
- To describe the varied clinical presentations of intimate partner violence
- To recommend assessment and management strategies for identification and intervention
- To summarize resource and referral procedures for identified and at-risk patients
- To provide guidance regarding opportunities to engage in ongoing education, collaboration, and leadership in the field

Definition

Intimate partner violence (IPV) can be defined as a deliberate pattern of coercive control — with or without physically violent behavior — perpetrated by someone who is or was in a dating or intimate relationship with another person. The perpetrator and abused individual can be married, separated, divorced, or single, and can be male, female, or transgender. They may currently live together, they may have lived together in the past, or they may have never cohabited. IPV is but one component of the larger problem of family violence, which also includes elder abuse, child abuse and neglect, sibling abuse, and some forms of sexual assault.

Included within IPV is a broad spectrum of coercive behaviors:

- Actual or threatened physical attacks
- Sexual assault
- Psychological abuse (intimidation, threats, and systematic degradation)
- Economic control
- Social isolation
- Destruction of keepsakes, property, or personal possessions
- Spiritual abuse
- Abuse of animals/pets

These behaviors can occur in any combination, in sporadic episodes or chronically, and can extend over months, years, or even decades.

Physical violence tends to occur less frequently than other forms of abuse such as psychological abuse, social isolation, and threats — all of which are purposeful acts intended to reinforce control and dominance in the relationship by the perpetrator, or abuser. Physical assault, when it does occur, is usually preceded by one or more of the other forms of control listed above. Abused individuals tend to act in response to the overall pattern of intimidating behaviors rather than to a single episode or solitary event.

Some manifestations of IPV are considered criminal acts; for example, threats of physical violence, acts of physical violence, and sexual assault. Other types of abuse, such as the destruction of keepsakes and some forms of social isolation, may not be illegal per se, even though they can result in long-term and often severe adverse health effects. In this regard, IPV cases might come to the exclusive attention of the health care system, bypassing the legal and criminal justice systems altogether.

Data indicate that the vast majority of IPV survivors are women in heterosexual relationships. Men in heterosexual relationships, as well as both women and men in same-sex relationships and transgender individuals, can also be abused in relationships.

Background and Dynamics of the Abusive Relationship

STATISTICAL OVERVIEW

The following statistics highlight the pervasiveness of the problem of abuse in relationships. Published studies indicate IPV for the following demographics:

- Between two and four million women and 800,000 men per year in the United States[1,2]
- One in four women (lifetime prevalence)[2,3]
- Between one in four and one in eight women seen for general medical care in office or clinic practices (annual incidence)[4,5]
- Nearly one in five women seeking care for any reason in a hospital emergency room[6]
- One in four women who attempt suicide[7]
- One in twelve pregnant women during pregnancy[8,9]
- More than half of the mothers of abused children[10]

BEHAVIORAL DYNAMICS

Following are features that highlight key dynamics seen in many abusive relationships:

- An abusive act is rarely an isolated event. Violent behavior usually recurs and often increases in frequency and severity over time.
- Relationships that are abusive generally are not violent when they begin. Rather, they become increasingly so over time as the perpetrator enforces more control over the abused individual.
- Abuse in a relationship typically results from deliberate and purposeful actions on the part of the perpetrator rather than from an impulse disorder or anger management problem.
- Abuse is carried out to assert power and maintain control or dominance in a relationship.
- With rare exceptions, abusive behavior is directed exclusively at the intimate partner (and sometimes the partner's children or other dependents) and is well-hidden from others.
- Abuse can be physical, sexual, psychological, verbal, spiritual, and/or economic.
- Abuse is generally one-way, although survivors may strike back in self-defense.
- Although abused individuals may sustain life-threatening physical injuries, they often suffer less obvious effects that are just as debilitating.
- Abuse results from the abuser's behavioral choices, not from "problems" in the relationship. Therefore, addressing abuse requires altering the perpetrator's behavior rather than focusing on issues related to couples.
- When physical violence or threats are occurring in a relationship, anger management and couples counseling strategies are not only ineffective, but also can result in harm.
- Patients may be reluctant to disclose information about current or past abuse even when specifically asked because of embarrassment, shame, hope that the relationship will improve, or fear of retaliation by the perpetrator.
- Even when disclosure of abuse is prompted by a single, specific incident, an underlying pattern of coercive control often becomes evident.
- Those who are abused in relationships often don't "look battered." In fact, there may be no physical evidence of abuse at the time of your encounter with the patient.

- Especially following an episode of physical violence, the survivor may feel hopeful that caring behavior, apologies, and promises herald an end to the abuse and that the situation will improve.
- Many victimized individuals assume responsibility and internalize blame for their own abuse upon integrating specific and repeated messages of inadequacy from the abuser. Some survivors believe they deserve the abuse because of their choice of intimate partner.
- Internalization of blame and responsibility may be reinforced by societal, cultural, and media messages that tolerate or even promote negative stereotypes of abused individuals based on gender, race, or social class.
- Patients often believe that physicians and other health care providers do not know about or understand this problem, may not take the situation seriously, may not believe them, or even might assign blame to a patient disclosing abuse.

WHO IS AT GREATEST RISK?

Any person, anywhere, can be a victim of abuse. Intimate partner violence affects both women and men and cuts across all age, racial, ethnic, religious, educational, and socioeconomic strata. However, available research indicates that intimate partner violence does appear to be more prevalent in certain groups:[2,11]

- Women, particularly those who are single, separated, or divorced
- Individuals who have recently sought an order of protection, restraining order, or vacate order
- Adolescents and young adults
- Poor individuals, including those experiencing situational economic distress
- Individuals whose partners have experienced recent job loss or instability
- Those who abuse alcohol or other drugs or those whose partners do
- Women who are pregnant *and* have been previously abused
- Those whose partners demonstrate excessively jealous or possessive behavior

HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE

Multiple studies have indicated strong associations between IPV victimization and adverse health outcomes. In addition to physical trauma, survivors may present with a variety of other medical and social problems, including perceived poor general health, chronic pain, gynecological problems, gastrointestinal disorders, neurological problems, post-traumatic stress disorder, sleep disorders, anxiety, depression, suicidal ideation, alcoholism and other forms of substance abuse, smoking, and unwanted pregnancy.[12,13,14,15] Hathaway et al. also reported that women experiencing IPV have increased rates of health care utilization, indicating that survivors of IPV tend to cluster in health care settings, and thus are likely to be seen frequently by health care providers.

OBSTACLES TO LEAVING: WHY SURVIVORS STAY IN ABUSIVE RELATIONSHIPS

There are many reasons abused individuals find it difficult to leave their batterers.

Fear

The batterer may threaten to hurt or even kill his or her partner or take away or hurt the children if he or she attempts to leave.

Economic and Logistical Constraints

Batterers often control the financial resources of the household as well as access to telephones, car keys, and even medication and food, making it difficult for survivors to leave because they cannot independently support themselves and their children. Additionally, survivors may not know how to seek shelter or other resources for help and safety, and they may be afraid to ask.

Social Isolation

Abusers often make it difficult for their partners to communicate with friends and family. Isolation leaves the survivor psychologically dependent on the batterer as the sole source of social support. Over time, the batterer becomes the only person the survivor hears explaining what is happening — and why — within the relationship.

Feelings of Failure

Many abused individuals are made to feel by the batterer — as well as by others — that they are failures and they are responsible for having brought on their own abuse. They may view themselves as needing to figure out how to adapt or change in order to halt the abuse or fix what is wrong in the relationship. Survivors may also believe that their children deserve a two-parent family, even at the expense of their own safety.

Promises of Change

Your patient may believe the batterer's expressions of remorse about becoming abusive accompanied by subsequent promises that such behavior will never happen again. Some survivors also feel it is somehow their responsibility to change or redeem their batterers. While some abused individuals may want the relationship to continue, most are clear about wanting the violence to stop.

Prior Lack of Intervention

All too often, survivors of abuse are either blamed for the violence or not taken seriously by family, health care professionals, social service providers, and law enforcement authorities, leaving them feeling even more helpless and vulnerable.

PATIENT BARRIERS TO DISCLOSURE

In addition to the personal obstacles survivors face in leaving an abusive relationship, they may also be hesitant to disclose their abuse to anyone — including health care providers.[16,17]

Common barriers to disclosure in the health care setting include those that follow.

Fear

Many survivors fear that disclosure to health care providers might result in reports to child protective services, police, employers, or immigration authorities. Others voice concern that in a well-intentioned attempt to help, a health care provider might take matters into his or her own hands and broach the subject with the abusive partner, thus inviting increased danger from an abuser bent on retribution. Still others are apprehensive about disclosure because they fear loss of confidentiality if their medical records are accessed by others, including the perpetrator.

Shame

Survivors often feel ashamed about the abuse and want to avoid being stigmatized as someone who is a victim, weak, or unworthy in the eyes of their health care providers.

Assumptions about the Health Care System

Many survivors may perceive the health care system and its providers as being unwilling or unable to help. Other survivors, unaware of the now-documented connections between abuse and adverse health effects, don't want to "bother" a doctor with something they think isn't a strictly medical issue. Patients who belong to racial, ethnic, or sexual minorities in particular may perceive traditional health care settings to be out of touch with their own ethnic, religious, or cultural values and thus unable to understand the situation or provide respectful and culturally appropriate assistance. Finally, access to services other than emergency care is often restricted or completely unavailable for survivors who lack adequate health insurance.

▶ **Note:** in some states there are legal requirements that physicians report physical injuries resulting from intimate partner violence.

Language, Culture, and Religion

Abused patients may not know how to disclose because of language barriers and may fear loss of confidentiality when communicating through a translator. Cultural differences between physicians and patients may make even a well-intentioned response by a doctor less relevant to an abused individual's needs. Religious convictions and customs can also influence survivors to remain silent about abuse.

Immigration Status

Battered immigrants, both legal and undocumented, may fear being "turned in" by health care personnel. They may fear losing custody of their children or even deportation, which may result in being required to leave their children behind with the batterer.

Sexual Orientation

Survivors who are gay, lesbian, bisexual, or transgender may fear being shamed or outed if still closeted because of their sexual orientation. This issue keeps many such individuals out of the health care system entirely, especially if abuse is present and a dismissive, disrespectful, or even hostile response on the part of medical providers is anticipated as a result of disclosure.

Abuser Threats and Control

The abuser may accompany the patient to medical appointments and not allow the patient to be seen alone. He or she may also try to "control" the partner's health by not permitting medications to be taken as prescribed, by canceling appointments, or by unexpectedly interfering with medical visits, thus making the patient appear to be a "no-show" or non-compliant.

PROVIDER CHALLENGES TO PROVIDING EFFECTIVE AND SENSITIVE CARE

Some health care providers are reluctant to address intimate partner violence in the context of routine clinical care, citing the factors listed below and supported by seminal research by Sugg and others.[18] The work of Sugg and colleagues sheds light on the sensitivity of this issue as a health care topic and the importance of providing state-of-the-art, evidence-based education and training for physicians and other health care professionals.

The challenges listed below can be addressed by practicing according to the principles of routine, empathic, and trauma-sensitive care outlined later in this guidebook.

Discomfort with Confronting Issues of Violence and Abuse

Abuse can be an emotionally difficult topic to bring up and address. A physician or other health care provider may have personal knowledge of a situation affecting a family member or close friend, or the

physician may him- or herself be a survivor of child physical or sexual abuse, an adult survivor of violence, be struggling currently or recently with a coercive relationship, or may even be a perpetrator. Conversely, a clinician with no personal experience with violence, abuse, or victimization might find it difficult to relate to or empathize with his or her patients.

Feelings of Powerlessness

Physicians and other health care providers are trained to be helpers, fixers, and healers. Many clinicians feel powerless to be able to do anything definitive to help the patient, especially if the survivor decides to remain in the relationship or returns after having left. The frustration of not knowing what to say once a disclosure is made and of not seeing prompt or visible "success" can be an additional challenge, especially for physicians with limited experience addressing IPV in the clinical setting.

Personal Attitudes and Misconceptions about IPV

Issues that arise within a family or between spouses are often viewed as "private or family matters" that fall outside the realm of medical practice. However, addressing IPV is part of standard medical practice and should be treated not unlike other socially relevant issues in clinical practice.

Office Security and Personal Safety

Some physicians may be reluctant to intervene out of concern for their own personal security and the safety of their staff. Although reports of health care workers being threatened or injured by partners of abused patients are extremely rare, potential risks to office staff must be considered in any potentially volatile situation. Office staff should be trained on how to recognize and respond to IPV issues, including those related to patient privacy and confidentiality. Emergency procedures should be outlined and practiced in the office setting to prepare for potential, albeit rare, emergencies related to IPV.

Lack of Education or Expertise

Many younger physicians and nurses have received at least rudimentary training on IPV during professional school; however, paradoxically, this is a completely new topic for many seasoned clinicians. The multifaceted nature of this pervasive problem does not allow it to fit neatly within any one discipline, although sporadic educational offerings can be found at women's health, mental health, and behavioral health conferences and in related journals. This guidebook is designed to help fill some of the educational gaps for clinically practicing health professionals.

Time Constraints

Every health care provider is busy, with ever-increasing demands on clinicians' limited time. Time management will be addressed later in this guidebook.

SPECIAL POPULATIONS

Intimate Partner Violence and Pregnancy

Violence during pregnancy is a serious medical and public health problem, with the majority of published studies reporting prevalence rates ranging from 4 to 8%.[8,9] Recent data indicate that intimate partner violence is associated with a range of specific reproductive health risks such as unintended pregnancy; rapid repeat pregnancy; late or sporadic access to prenatal care; spontaneous abortion; elective abortion; intrauterine growth retardation; antepartum hemorrhage; premature labor; low birth weight infants; increased risk of injury, particularly to the breasts, abdomen, and genital area; unexplained pain; substance abuse; poor nutrition; and perinatal maternal death.[19] Indeed, intimate partner violence against pregnant women appears to be more prevalent than preeclampsia, gestational diabetes, and placenta previa,

conditions routinely screened for in prenatal care. In addition, homicide has been shown to be the most common cause of pregnancy-associated maternal death.[20]

The short- and long-term sequelae of abuse to the pregnant woman and her developing child can be far-ranging. Prenatal visits provide access to and continuity of care for pregnant women, and thus represent an excellent opportunity to conduct routine inquiry geared both to early detection and primary prevention of intimate partner violence. Patients should be routinely screened for new or ongoing intimate partner violence during each and every prenatal visit.

Adolescent Relationship (Teen Dating) Violence

Adolescents also may suffer from an array of abusive behaviors, ranging from verbal and emotional abuse to physical abuse, rape, and even homicide. Some teens are battered by people with whom they are in a dating relationship, while others are adolescent victims of parental abuse. Teens in dating relationships often confuse jealousy with love and lack experience and perspective regarding what behaviors constitute a healthy dating relationship. Striving for independence, abused adolescents may be especially reluctant to seek help from authority figures, including physicians.[21]

Clinicians should reassure teens about the confidential and supportive nature of the health professional–patient relationship. Physicians and other health care providers should screen adolescents for abuse as outlined on pages 16 to 18, remembering that the abuser may be a parent, other family member, boyfriend, or girlfriend. The teen's knowledge and behavior around violence, coercion, alcohol, drugs, and sexual activity needs to be assessed. An abused teen particularly needs to be told that the battering is not his or her fault and that help is available.

Bullying is a related issue that has gained prominence in recent years. This topic, while of critical importance to adolescent health, is beyond the scope of this guidebook.

Violence in Gay, Lesbian, Bisexual, and Transgender Relationships

Intimate partner violence in same-sex relationships appears to be as common as in traditional heterosexual relationships.[1,22,23] Many gay, lesbian, bisexual, and transgender (GLBT) individuals do not feel comfortable disclosing their sexual orientation to their physicians and are likely to be even more reluctant to disclose abuse. GLBT individuals who do disclose their sexual orientation to their physicians or other medical professionals are rarely asked about intimate partner violence. Barriers to inquiry include gender-related myths — for example, men cannot be victims of abuse, women are never batterers, and GLBT relationships are inherently "equal" because parties are of the same gender.

GLBT survivors of intimate partner violence encounter a spectrum of abusive behaviors similar to that of their heterosexual counterparts. Additional obstacles specific to GLBT survivors further reduce their opportunities to disclose and discuss abuse. These obstacles include homophobia and the resulting discrimination in society and among health care providers; potential social consequences of revealing one's sexual orientation, such as loss of children and other family relationships, job insecurity, and loss of community standing; fear of police inaction; and further discrimination. There also is a dearth of shelter space and support services for battered gay men, lesbians, bisexuals, and transgender individuals. Lesbian and bisexual women have the option of going to more traditional domestic violence programs that accept women, but staff at many of these programs may not be trained and/or sensitive to working with members of the GLBT community.

Transgender individuals face substantial barriers to accessing help because providers — and the public in general — often understand even less about gender identity and expression than they do about sexual orientation. Physicians should therefore approach screening, diagnosis, and treatment with special sensitivity to the difficult issues battered GLBT patients face.[24,25,26]

Violence in Diverse Cultures and Immigrant Populations

Intimate partner violence is prevalent in every culture and segment of society. Immigrants and other members of minority cultures are likely to face extra hurdles as they attempt to access available services to achieve safety for themselves, their children, and other dependents. Patients of different cultures may adhere to belief systems and traditions that make it harder for them to perceive their own danger, understand their right to live in safety, know their legal rights and options, or even speak to anyone about their situation. Those whose native language is not English may find it especially difficult to communicate with health care providers, advocacy services, and law enforcement. Regardless of their legal status, many battered immigrants are fearful of becoming homeless, losing their children, or being deported, should their abuse become known. Such individuals may not perceive the health care system to be one they can trust to help direct them toward safety and may therefore suffer in silence.[27]

Physicians and other health care professionals who are sensitive to the barriers and problems that immigrants and members of diverse cultures face can be in a better position to establish a relationship of confidentiality and trust with their patients — a crucial step toward both improved medical care and empowerment for those who are in danger.

Substance Abuse and Intimate Partner Violence

Substance abuse, including alcoholism, is frequently seen in association with intimate partner violence. Patients who abuse alcohol and other drugs are more likely to become abused in intimate relationships. Further, victimized individuals are more likely to abuse alcohol and to receive multiple prescriptions for tranquilizers, sedatives, and narcotic analgesics.[7] In fact, the abuse of alcohol and other substances is now seen as a not-uncommon maladaptive coping strategy in response to victimization, rather than as its cause.

Intervention goals for chemically dependent, battered patients should focus dually on sobriety and safety. For some, addiction treatment may be a necessary first step. For others, achieving safety may be necessary before participating in an addiction recovery program, as achieving sobriety may threaten the batterer's sense of control and place the survivor at risk for escalating violence.[28]

The success of safety planning can be compromised by ongoing drug use, and the success of addiction recovery can be impeded by continued violence. Therefore, the clinician should assess for intimate partner violence where there is evidence of substance abuse and screen for substance abuse where there is evidence of intimate partner violence. In addition, physicians and other prescribing health professionals should weigh carefully the risks and benefits of prescribing controlled substances for symptom relief in patients with chemical dependence.

Sexual Assault and Intimate Partner Violence

Rape and other forms of sexual assault are highly prevalent in society and are problems of significant medical, public health, and criminal justice importance. Sexual assault is often part of an abusive relationship, although underreporting due to embarrassment, self-blame, and fear make accurate prevalence figures difficult to obtain. The most recent national surveillance data are from the National Violence Against Women Survey (NVAW), conducted in 1995. Although far from current, these data reveal that one in six women and one in thirty-three men have experienced an attempted or completed rape at some time in their life. Further, 43% of rapes or attempted rapes of females and 9% of assaults on males are perpetrated by a current or former intimate partner (see *www.ncjrs.gov/pdffiles1/nij/210346.pdf*).[29]

Survivors of rape and sexual assault suffer from acute as well as chronic adverse health consequences. Short-term effects include direct trauma from sexual violence, such as vaginal or anal bleeding, bruises, scratches, and strangulation injuries. Rape survivors often experience profound feelings of isolation and dissociation in the immediate aftermath of a sexual assault. Long-term effects include chronic, recurring abdominal pain, headaches, changes in eating and sleeping patterns, binging and purging, anxiety, depression, post-traumatic stress disorder, and suicidal ideation or attempts. Survivors may struggle

with additional health consequences related to sexual assault, such as unwanted pregnancy and STDs, including HIV/AIDS. In addition to collecting physical evidence in cases of recent sexual assault (see "Documentation in the Medical Record," page 19), the physician or other health care provider should practice in a trauma-aware manner to offer validation, support, and appropriate referrals for legal services and supportive counseling.

It is essential for clinicians to act with particular honesty and sensitivity when working with patients who have been sexually assaulted and ensure that confidentiality and privacy are maintained to the fullest extent of applicable law. In the aftermath of an assault, patient responses can vary from intense distress to calm composure. Some survivors have difficulty trusting hospital personnel and the evidence collection process, which can take several hours to complete and can seem like yet another violation of bodily integrity. Thus, a trauma-informed approach emphasizing both sensitivity and patience is critical when examining or referring a patient for forensic evidence collection. Additionally, it is important to refrain from asking questions that might sound blaming or judgmental, such as "Why were you wearing that?" or "Why didn't you report this to the police?" Instead, provide support and encourage contact with a local rape crisis center and appropriate therapeutic and community-based services, even if an assault took place months or years ago. Approaches that are empathic and trauma-sensitive are integral to the recovery and reintegration process for survivors of sexual assault.

The Child Witness to Violence

An estimated 3.3 million children are exposed to family violence every year. Observing violence — including hearing it — can be as damaging to children as being abused themselves. Even very young children can be affected by family violence. Witnessing violence affects a child's ability to focus and learn in school, to form healthy peer relationships, and to develop normally. Many of these children have a distorted view of the world — one that is not hopeful, welcoming, or safe. They have a foreshortened, constricted view of their lives, in which they cannot picture themselves as adults, or see a future for themselves. Adolescents who grew up in homes where their parents are violent are more likely to be involved with substance abuse and dating violence. Young people who witness family violence are also at greater risk of being physically harmed themselves, especially if they attempt to defend or protect the victim, usually the mother, during an assault.[30,31]

Children, like adults, may find it difficult to talk to anyone about the violence in their lives, and thus become "silent victims."[32] Physicians and other pediatric care providers need to attend to children's needs for safety and security when assessing the extent and effects of their exposure to violence within the family. Interventions that help families achieve a stable and safe home environment play an important role in protecting all involved. Appropriate assessment and intervention can help children learn that violence perpetrated by anyone, especially by a family member or loved one, is wrong and unacceptable. Efforts such as these can serve as a crucial link to help children cope with and recover from the devastating effects of witnessing intimate partner violence.

The Link between Child Abuse and Intimate Partner Violence

Child abuse and intimate partner violence are closely linked. Children of battered mothers are up to 15 times more likely to be abused compared to the national average.[30] Between 40 and 59% of mothers of abused or neglected children are themselves battered, presumably by the same perpetrator.[10]

Violence is learned behavior. Although most abused and neglected children do not become victims or perpetrators as adults, research has shown that up to 75% of men in batterer intervention programs report having witnessed the abuse of their mothers or having been physically abused themselves as children.[33] Girls who have been abused or neglected or who have witnessed the abuse of their mothers may be more likely to be victimized in their own adolescent or adult relationships. Abused and neglected children are also at greater risk for exhibiting delinquent, violent, and criminal behavior, as well as long-term health problems.[34,35]

Disclosure of intimate partner violence may herald a particularly dangerous period for both the abused individual and any dependent children. Therefore, once disclosure is made, particular attention must be paid to the safety and well-being of the children and of others living in a home in which intimate partner violence is occurring. If a physician suspects that there might be physical, sexual, or emotional abuse or neglect of children, he or she, as a mandated reporter, is required by law to contact the child abuse hotline of the state in which the suspected abuse is occurring (see the "Hotline, Shelter, and Referral Resources" section for state-specific resource information). If a report to Child Protective Services (CPS) needs to be filed, the physician or other health care provider should inform the caseworker of his or her suspicion that the mother (or other caregiver) is also being abused. CPS can then consult with specialists in intimate partner violence to take action geared toward promoting the safety of both the adult survivor (usually the mother) and the children. In addition, the physician should communicate the decision to contact CPS and the reasons for doing so to the survivor. Such a conversation, although at times difficult to initiate, can help establish trust and promote safety for both the survivor and children.

Addressing family violence requires an understanding of the complex interconnections among child abuse and neglect, child exposure to violence, intimate partner violence, and the transmission of violent behavior from one generation to the next. Physicians and other health care providers are therefore in a unique position to protect children from child abuse and from subsequent dysfunction later in life by addressing violence across the life span.

Elder Abuse

Elder abuse encompasses physical, psychological, and economic mistreatment or neglect and may be intentional or unintentional. Physicians can be pivotal in the detection, management, and prevention of elder abuse.[36,37] Understanding the dynamics of elder abuse is critical to breaking the intergenerational cycle of abuse.

Some abused elders are mistreated in the context of dependency or infirmity. Others come to the attention of clinicians or other providers having been abused for years or even decades. Some elderly individuals exhibit signs and symptoms of current or past intimate partner violence. Patients no longer in acute danger can suffer long-term morbidity from chronic sequelae of past abuse. For elders living independently, fear of being placed in a nursing home and losing autonomy may limit disclosure of abuse.

Physicians who care for elders often have established and trusting relationships with their patients. Whenever feasible, physicians should work as members of multidisciplinary care teams. Physicians and extended care (home care) providers are in a position to observe behaviors and conditions related to abuse and neglect, which can lead to early intervention in at-risk patients. All health care professionals should remain mindful of their mandated reporter responsibilities as they evaluate elderly at-risk patients (see page 23).

The Adult Health Effects of Traumatic Exposures during Childhood

BACKGROUND

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to examine the links between childhood maltreatment and later-life health and well-being. The initial ACE Study, funded in large part by the U.S. Centers for Disease Control and Prevention and conducted in the Kaiser Permanente Health Care System (San Diego Health Appraisal Clinic) from 1995 to 1997, involved collection and analysis of data from over 17,000 outpatients.[38,39] Subsequent retrospective and now prospective data collection and analysis have resulted in a veritable treasure trove of data and insights that elucidate the range and depth of physical health, mental health, and social welfare effects during adulthood of adverse or traumatic experiences during childhood. Now in its tenth year, the prospective phase of the ACE Study is ongoing, and it is currently in the midst of additional data collection.

METHODS

As detailed on the CDC website (*www.cdc.gov/nccdphp/ace*), "Each ACE Study participant completed a confidential survey that contained questions about childhood maltreatment and family dysfunction, as well as items detailing their current health status and behaviors." Seven categories of adverse childhood experiences were assessed: three types of personal abuse (physical abuse, psychological abuse, and sexual abuse), and four types of household dysfunction (witnessing physical violence against a caretaker, substance abuse in a family member, a family member ever incarcerated, and suicide completion or attempts in a family member). Positive answers to these questions were then correlated to measures of adult risk behavior, health status, and disease.

FINDINGS

More than half of the respondents reported at least one adverse experience during childhood. A graded, or proportional, relationship was found between the number of adverse childhood experiences (the ACE score), the frequency of health risk factors for leading causes of death, and subsequent adult health and social welfare problems. To date, over 50 peer-reviewed articles have been published about the ACE Study and its implications for physical health, mental health, and social welfare in adults.

IMPLICATIONS

The ACE Study has ushered in a new era of inquiry and understanding regarding the dramatic adverse consequences of traumatic childhood experiences on adult health and social welfare and of the health effects of violence across the lifespan. The wealth of emerging evidence speaks to the importance of addressing trauma during childhood as a critically important underlying contributor to multiple adult health problems. Even more important, however, is that the ACE Study represents a clarion call for (1) enhanced attention on improving adult health by focusing on primary prevention of child physical and sexual abuse, (2) preventing domestic violence, (3) addressing substance abuse, and (4) promoting mental health in patients and their families.

Physicians who can identify both current and past victimization are in a better position to address current health problems that arise from past abuse and to foresee — and therefore potentially prevent — the occurrence of future health problems. As noted by Chamberlain, since many of the consequences of exposure to violence are not immediate and can occur decades after the trauma, there are multiple opportunities for prevention of adverse health outcomes over a patient's lifespan once a history of abuse is elicited[40] (see *http://new.vawnet.org/Assoc_Files_VAWnet/AR_AssessmentforExposure.pdf*).

In addition to the many peer-reviewed articles and chapters describing the ACE Study, an hour-long video presentation by Vincent J. Felitti, MD, co-principal investigator of the ACE Study, can be found at *http://gallery.me.com/avahealth#*100065.

Trauma-Sensitive Care

Patients who have been abused in family or intimate relationships may find medical encounters distressing and anxiety producing. Procedures such as gynecological exams and even seemingly innocuous encounters such as blood pressure checks and abdominal palpation can trigger intense reactions of anxiety, dread, and avoidance. In view of the documented prevalence of intimate partner violence and other forms of interpersonal violence and the paucity of visible signs or definitive disclosures in most cases, physicians and other health care providers should approach the care of *all* patients using principles of "trauma-sensitive" care, treating all patients as if they were potential abuse survivors.

Also known as trauma-informed care or trauma-aware care, trauma-sensitive care is, in many respects, the behavioral health equivalent of universal precautions for communicable diseases. Similar to routine precautions to prevent the transmission of blood-borne infections during medical procedures, clinicians who embody trauma-sensitive care assume the possibility of current or past abuse in all patients and act accordingly. Schachter et al.[41] outline nine principles of trauma-sensitive practice:

1. Respect
2. Patience (or taking time)
3. Rapport
4. Sharing information
5. Sharing control
6. Respecting boundaries
7. Fostering mutual learning
8. Understanding nonlinear healing
9. Demonstrating awareness and knowledge of interpersonal violence

Assessment for Abuse from a Lifespan Perspective

In 2004, the U.S. Preventive Services Task Force (USPSTF) published a controversial statement that there was insufficient evidence to recommend for or against routine "screening" for domestic violence.[42] Key experts in family violence research and scholarship countered that the USPSTF applied criteria that were designed for medical screening procedures — criteria that were too rigid and not appropriate for assessing the effectiveness of the complex act of physician assessment for IPV because of the difficulty fitting IPV into a traditional screening paradigm (even the USPSTF acknowledged this dilemma). For example, Lachs, in an editorial accompanying the USPSTF screening recommendation, writes that the standard model for disease screening performs poorly when assessing for a condition as complex as family violence, and that "for some conditions that clinicians regularly encounter [for example, family violence], robotic devotion to evidence-based medicine risks dehumanizing certain aspects of doctoring."[43]

USPSTF statements notwithstanding, leading medical organizations and family violence experts* continue to recommend that physicians and other health care professionals not only inquire about IPV in the course of routine care of all adolescent and adult patients, but also reconceptualize inquiry away from mere screening and toward encompassing a broader assessment of potential victimization across the lifespan. This new focus on lifespan assessment incorporates attention to the following factors:

- The neurobiology of traumatic stress
- Genetic and environmental risk and resilience factors
- Effectiveness of intervention and prevention strategies
- The appropriate role of physicians and other health care professionals in collaborative care
- Joint Commission standards and accreditation requirements

In its 2004 National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings, the Family Violence Prevention Fund summarized research on the

*Organizations that recommend routine inquiry for intimate partner violence include the Family Violence Prevention Fund, the American Medical Association, the American Academy of Pediatrics, and the National Coalition Against Domestic Violence.

benefits of routine assessment, stating that, "Universal and regular, face-to-face screening of women by skilled health care providers markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse."[44] A separate 2004 Family Violence Prevention Fund consensus statement, Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health,[45] describes routine inquiry about domestic violence as "a primary starting point to improve the medical practice approach to intimate partner violence… with a focus on early identification of all families and victims of intimate partner violence whether or not symptoms are immediately apparent."

Given the prevalence of IPV,[1] evidence that survivors of IPV are seen frequently by health care providers,[15] and research findings that abuse occurring at any age results in health problems that can extend decades into the future,[38,39] nearly every physician can expect to see patients who are either grappling with an abusive relationship or suffering from its intermediate or long-term health effects.

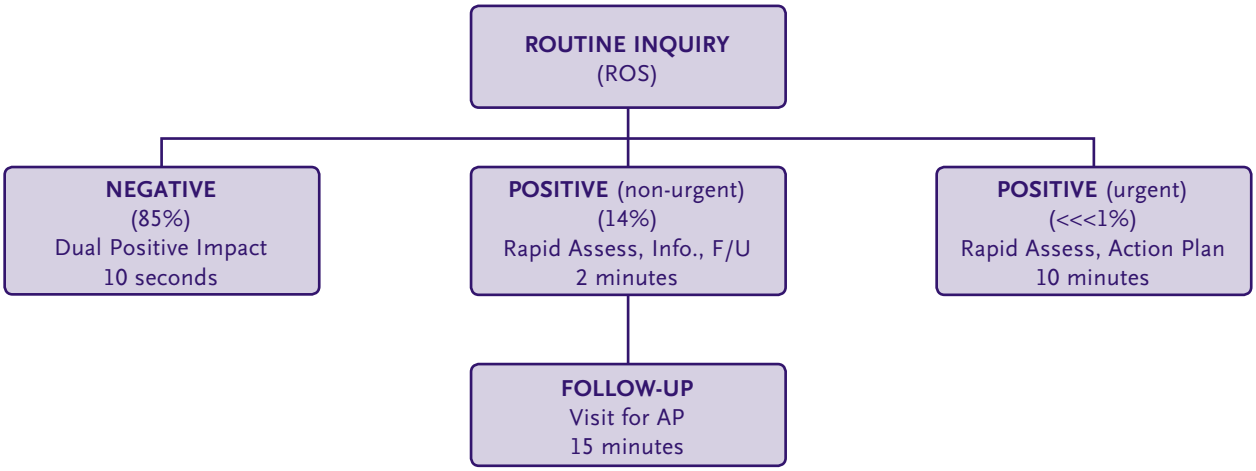
Time Management

Physicians may be reluctant to engage in inquiry and identification because they feel they have insufficient time to screen and respond given the multiple responsibilities and time constraints they face in daily practice. Judicious time management, however, should allow for both universal inquiry and targeted follow-up.

As can be seen in the flowchart (Figure 1A), physicians routinely inquire about common medical conditions such as angina pectoris. The physician generally asks, "Have you experienced pain, pressure, or discomfort upon exertion?" The likelihood of a positive response will, of course, vary depending on the patient mix and field of practice. Most patients, however, will answer "no" to this question. The question and its accompanying response normally take no more than 10 seconds of a physician's time, yet two important tasks are accomplished: (1) the physician is reassured that angina pectoris is not occurring or at least is rather unlikely, and (2) the patient becomes aware that should such symptoms arise, the physician is concerned, knowledgeable, and able to respond. Should the patient respond "yes" to a general inquiry about angina pectoris, however, the physician will engage in a series of questions designed to determine if

Figure 1A. Time Management in Office Practice

Example of a routine screening for common medical conditions, such as angina pectoris (AP)

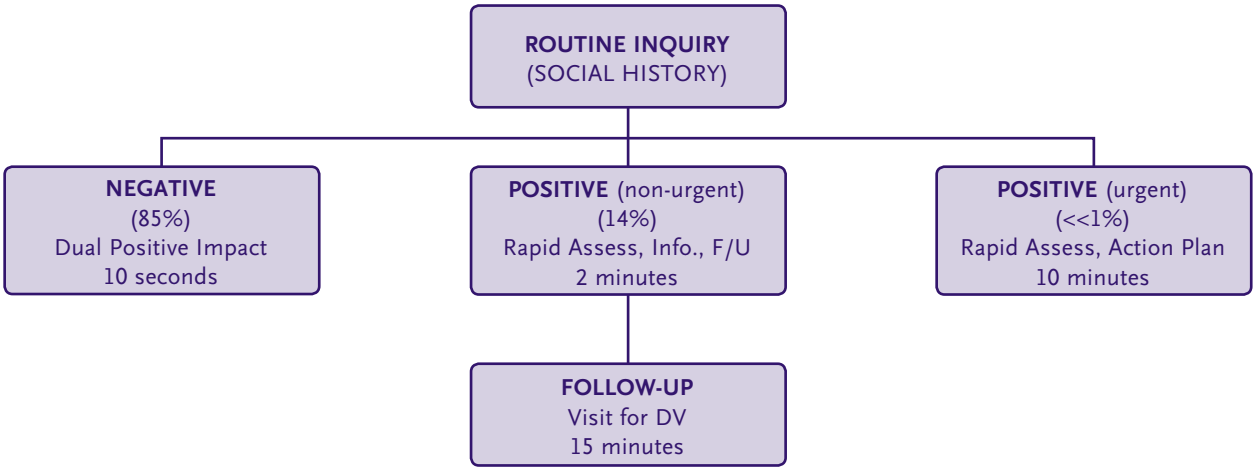


the condition is of new onset or unstable. Assuming this is not the case, the physician will likely place the patient on an aspirin and/or nitrate regimen, order an ECG and perhaps a stress test, and arrange to see the patient in follow-up. Such an encounter should take no more than two to three minutes. On rare occasion, a patient will present for evaluation of unstable cardiac symptoms or an emergent condition will be uncovered during the course of a more routine evaluation. In such a situation, emergency procedures will need to be instituted, which can take a moderate to substantial amount of time. Using the above logic, the average physician can inquire routinely about angina and manage his or her time wisely, using a targeted follow-up appointment to address a less-than-emergent problem in greater detail.

Similar logic can be employed in assessing for intimate partner violence (Figure 1B). As in the angina pectoris example above, asking about IPV (usually as part of the social history) should take no more than 10 seconds, yet it has a dually beneficial effect: the physician is reassured that the patient is not at risk for family violence (or that the patient, if affected, is not ready or able to disclose at that time), and the patient is made aware that the physician's office is a safe place, and that the physician is concerned, knowledgeable, and able to respond should IPV become an issue at any time in the future. A minority of patients has a past or current history of IPV. Most of these patients, however, despite dealing with difficult medical and social sequelae, are not in acute danger at the time of the physician visit. Should the patient disclose victimization, the physician should conduct a brief danger assessment, offer information including how to access relevant websites and hotlines, convey concern and support for the patient, and arrange to see the patient in follow-up to discuss the abuse and resource and referral options in greater detail. Similar to the case of stable angina pectoris above, such an encounter should encompass approximately two to three minutes. Only rarely will the physician be confronted with a patient in extreme danger or with emergent needs. In this situation, as in the case of new onset or unstable angina, a true medical emergency exists and urgent action will need to be taken.

Figure 1B. Time Management in Office Practice

Example of a domestic violence (DV) screening



Routine inquiry for IPV, therefore, should not add substantially to a physician's time commitments, and it may ultimately save time by allowing the physician to budget time prospectively while building trust and rapport.

CLINICAL PRESENTATIONS

Although those who are suffering from the acute or chronic effects of abuse access medical services more frequently than non-abused individuals, some patients may be hesitant to volunteer a history of abuse even to their primary care physicians. Survivors of IPV are more likely to disclose a history of abuse to their physicians if the clinician is perceived to be knowledgeable, nonjudgmental, respectful, and supportive.

Patients voice clear preferences in favor of their physicians taking the initiative to inquire as a matter of standard practice about violence and abuse during the course of a routine and emergency clinical encounter. The gender of the physician is not an important factor in the willingness of most patients to disclose or discuss abuse.[46,47]

Patients with a current or past history of abuse may show no obvious signs or symptoms of medical or psychiatric distress, underscoring the importance of routine inquiry by physicians and others on the interprofessional health care team. Some, however, may present with signs and symptoms, or "red flag indicators," including any of those that follow:

- *Physical trauma*: any acute injury, particularly lacerations, contusions, dislocations, fractures, head injury, or findings consistent with attempted strangulation (e.g., facial petechiae, laryngeal edema)
- *Gynecological problems*: sexually transmitted infections (including HIV/AIDS), rape and sexual assault, unintended pregnancy, rapid repeat pregnancy, abortion complications
- *Somatic symptoms*: headache, chest pain, abdominal pain, pelvic pain, fatigue, eating disorders, functional gastrointestinal disorders
- *Localized or generalized neurological findings*: altered mental status, seizures, motor or sensory deficits, memory problems
- *Behavioral/psychiatric problems*: anxiety, depression, hypervigilance, panic, dissociation during medical procedures, suicidal ideation or attempt, substance abuse
- *Social red flags*: frequent missed appointments, delayed presentation for care, seeming "non-compliance" with medical instructions
- *Partner red flags*: excessively attentive or jealous companion, partner who insists on accompanying patient into the examining room, partner who speaks for the patient or to whom the patient turns for approval when answering questions

The above list encompasses only some of the most commonly reported medical and psychiatric conditions associated with abuse. Patients who present with red flag indicators should be assessed routinely as described below. In addition, more probing questions, asked in a trauma-informed manner, may be indicated to elicit the underlying cause of the patient's distress.

PATIENT INTERVIEWING TECHNIQUES

All adolescent and adult patients should be queried routinely and periodically about IPV. The patient should be interviewed in private, without the partner, children, other relatives, roommates, or friends present. A history of previous trauma, chronic pain complaints, psychological distress, or other red flag indicators should be sought from direct history or from the medical record.

Before asking specific questions about IPV, it is best to frame inquiry as a routine component of everyday clinical practice. In addition to introducing the issue of violence in relationships by displaying posters, brochures, and help cards in the waiting room, examining room, and lavatories, the physician should introduce the issue using a simple framing statement. Sample framing statements include:

- Violence can be a problem in many people's lives, and so I now ask every patient I see about trauma or abuse they may have experienced in a relationship.
- Many patients I see are coping with an abusive relationship, so I've started asking about intimate partner violence routinely.

Once the issue is framed, a single question, asked routinely and nonjudgmentally in the course of the social history, can significantly increase the detection rate of IPV in the office practice and can allow your patient to feel safe in disclosing a history of abuse.

Here are some examples of questions that can be adapted as needed to individual practices:

- At any time, has a partner hit, kicked, choked, threatened, or otherwise hurt or frightened you?
- Has your partner or a former partner ever hit or hurt you? Has he or she ever threatened to hurt you?
- Every couple has conflicts — what happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights or make you afraid for your safety?
- I see patients in my practice who have been hurt or threatened by someone they love. Is this happening to you?
- Do you ever feel afraid of your partner?
- Do you feel safe in your relationship?

Should your patient disclose abuse in response to any of the above questions, or if you suspect battering without clear disclosure, asking the following specific questions in a safe and confidential setting can help you determine the extent of abuse and the possible risk to your patient:

- How were you hurt (or frightened)?
- Has this happened before?
- When did it first happen?
- How badly have you been hurt in the past?
- Have you needed to go to an emergency room for treatment?
- Have you ever been threatened with a weapon or has a weapon ever been used on you?
- Have you ever tried to get a legal order of protection against a partner?
- Have your children ever seen or heard you being threatened or hurt?
- Have your children ever been threatened or hurt by your partner?
- What have you tried to do to keep yourself (and your children or other dependents) safe?
- Do you know how you can get help if you are hurt or afraid?

It is helpful to ask adolescent patients questions such as these:

- Have you begun to date?
- Has your boyfriend/girlfriend ever threatened to hurt you or have you ever threatened to hurt him/her?
- Are you ever afraid of your boyfriend/girlfriend?
- Have you ever had a pushing or shoving fight with a boyfriend/girlfriend?
- Have you ever gotten hurt from a fight with a boyfriend/ girlfriend?
- Have you begun to have sex?
- Has anyone ever forced you to have sex when you didn't want to?
- Have you been able to confide in or talk to anyone else about this?

Caveats

As important as it is to ask the right questions, it is equally important to refrain from asking questions in a manner that might frighten or intimidate your patient, increase a sense of humiliation and shame about the abuse, or be interpreted as blaming the abused individual for the situation.

Here are some pitfalls to avoid:

- Most abused individuals do not identify themselves as victims or as battered *per se* because of the perception of helplessness, shame, and worthlessness associated with such value-laden terms. Therefore, avoid using terms like "victim," "abused," or "battered" when speaking with a patient. Instead, key into the patient's perspective by mirroring the patient's word choices, or alternatively, use words like "hurt," "frightened," or "treated badly."
- Do not inquire about abuse in the presence of the partner, friends, or family members.
- Do not break patient confidentiality by disclosing any information or discussing your concerns with the patient's partner — even if the partner is a patient of yours, too.
- Never ask your patient what he or she did to bring on the abuse.
- Do not ask your patient why he or she has not left the partner.
- A survivor may leave only to later return. If this is the case with your patient, avoid asking why he or she returned to the batterer.

PHYSICAL EXAMINATION

Be highly suspicious of intimate partner violence when any of these physical findings are noted:

- Any evidence of injury, especially to the face, torso, breasts, or genitals
- Bilateral or multiple injuries
- Delay between onset of injury and presentation for care
- Patient's explanation inconsistent with type of injury
- Prior use of emergency services on multiple occasions for trauma or other care
- Chronic pain symptoms where no etiology is apparent
- Psychological distress (e.g., anxiety, depression, sleep disorder, suicidal ideation)
- Evidence of rape or sexual assault
- Pregnant woman with any injury, particularly to the abdomen or breasts; vaginal bleeding; or decreased fetal movement

Intervention

GUIDING PRINCIPLES OF INTERVENTION

Once intimate partner violence is disclosed, the physician's role is to document, assess, and refer as indicated, keeping in mind four guiding principles of intervention developed by Warshaw et al. for the Family Violence Prevention Fund:[48]

Survivor Safety

Patient assessment, documentation, safety planning, communication, intervention, and follow-up must be conducted with the utmost concern for the immediate and long-term safety of the survivor and her or his dependent children. The physician should ask him- or herself, Is *what I am asking/doing/recommending going to help my patient become safer, or at least not place the patient at risk for further harm*?

Survivor Empowerment

The batterer's controlling and intimidating behavior restricts the abused individual's freedom to make informed, independent choices about his or her life. Facilitating the patient's ability to make his or her own choices is key to restoring a sense of purpose and well-being for survivors of intimate partner violence and can facilitate a patient's readiness to take proactive steps to end the violence.

Perpetrator Accountability

It is important to reframe the violence as occurring because of the perpetrator's behavior and actions, not the survivor's. It thus follows that the problem of violence in the relationship, and therefore the need to take definitive steps to end the violence, should be the perpetrator's responsibility. This guiding principle recognizes survivor safety as a priority and rejects victim blaming, problems "in the relationship," and other excuses offered by the offender as "explanations" for the violence.

Advocacy for Social Change

Physicians acting alone simply cannot meet all the needs of survivors of intimate partner violence. As health care professionals and systems grapple with the complex issues involved in understanding and responding to IPV, the need to collaborate with others in health care, as well as those in law enforcement, education, the faith community, the business sector, public policy, and society-at-large, becomes apparent. Physicians can be important partners in efforts to more effectively identify, and ultimately prevent, intimate partner violence.

PHYSICIAN ACTION STEPS

Once intimate partner violence has been disclosed, action steps by the physician include the following:

- Documenting findings in the medical record
- Assessing for danger and initiating safety planning
- Providing information, validation, and support
- Making referrals as appropriate
- Assuring follow-up

Documentation in the Medical Record

Document your findings carefully in the medical record. You may wish to draw a picture freehand or include a labeled photograph to supplement your written description. It is important to describe the patient's symptoms and signs accurately and indicate "domestic violence" or "intimate partner violence" as a finding, diagnosis, or problem when appropriate. The physician should obtain consent for photographic documentation from the patient prior to taking photographs.

Documentation in the medical record can be a source of invaluable information should your patient seek legal redress from the batterer. In addition, as vigorous criminal prosecution of domestic assault increases, accurate and legible medical records can often substitute for the physician's personal testimony in court.

Special Considerations in Documenting Sexual Assault: Forensic evidence can be collected up to five days after the crime occurs. Physical evidence that can be used for medical assessment and possible criminal prosecution should be obtained using a state-approved sexual assault evidence kit, which can be found in most hospital emergency departments. Unless the patient is unwilling or unable to present to the emergency department, the examination and evidence collection should be conducted in the emergency setting, not in the physician's office.

An increasing number of hospital emergency departments utilize the services of sexual assault nurse examiners (SANEs) who have specific training in forensic nursing, evidence collection, and crisis counseling. SANE programs have been shown to:[49,50]

- Enhance the proper collection of forensic evidence
- Facilitate provision of post-assault medical care (e.g., emergency contraception and HIV and other STD prophylaxis)
- Improve reporting to police and the subsequent filing of charges
- Increase conviction rates and yield longer average sentences for offenders
- Promote comprehensive community-based referrals for survivors
- Improve psychological recovery for survivors
- Challenge the social norms about rape

Increasingly, medically trained rape crisis advocates accompany SANEs to provide support, information, and follow-up guidance to survivors. Recent research has shown that compared to services by SANEs alone, SANE nurse/rape crisis advocate response pairs further increased the provision and quality of post-rape medical care, increased reporting to police, and improved patient perceptions of experiences with both medical personnel and law enforcement. Thus, while SANE services provide vital improvements in post-rape evaluation and care, SANE-advocate partnerships yield even greater incremental benefits.[51]

Should a patient who has been sexually assaulted contact the physician's office before presenting to the emergency department, he or she should be told to refrain from showering, bathing, or douching before presenting for forensic evaluation. Rape survivors should be instructed to put all clothes worn during the assault in a paper bag and bring them to the hospital for use, as appropriate, in evidence collection.

Danger Assessment and Safety Planning

Danger Assessment: Once a patient has disclosed being in a threatening or violent relationship, the physician can play an invaluable role in helping the patient assess risk level, initiating discussion about safety planning, and making referrals to appropriate services.

The most important determinants in assessing risk are the patient's level of fear and his or her own appraisal of both immediate and future safety needs. However, since patients may minimize or deny the danger of their situations, the following indicators of escalating risk should be explored with the patient:

- An increase in the frequency or severity of threats or assaults
- Increasing or new threats of homicide or suicide by the partner
- The presence or availability of a firearm
- New or increasingly violent behavior outside the relationship by the perpetrator

Safety Planning: To develop a safety plan, the patient's level of danger and the resources needed to flee suddenly must be addressed. The plan should include a place to go (friends, family, or emergency shelter) and other resources for daily living such as money, personal documents, car keys, and a change of clothing for the patient and his or her children. If an order of protection (restraining order) has been issued, your patient should carry a copy of it at all times. Inform your patient that local domestic violence programs provide free and confidential services and that trained advocates from these programs can provide information regarding the following:

- Legal rights
- Police and court procedures for protective orders
- Emergency shelter and safe house availability
- Support groups and other valuable support resources

Encourage your patient to call a local or statewide hotline or the National Domestic Violence Hotline at (800) 799-SAFE for further information. Provide a private, safe place for your patient to make the calls if at all possible. Such a call in no way commits the patient to a course of action, but can better inform and empower her or him to make educated decisions.

Quite often, the same information needs to be provided more than once.

Information, Validation, Support, and Medical Treatment

Patients who are coping with an abusive relationship need and appreciate information, validation, and support from trusted sources — especially from their physicians and other health care providers. Even when immediate results are not apparent, patient education efforts and supportive messages not only are valued, but also are remembered by patients as critical keys to safety and recovery.

Information: Here are some examples of helpful informational statements for patients experiencing abuse:

- Intimate partner violence is common.
- Physical violence is only one part of IPV.
- IPV usually increases in frequency and severity over time.
- Children can be affected by being (1) physically hurt and (2) witnessing or hearing abuse.

Validation: Validating statements include the following:

- There is no excuse for violence or abuse.
- You are not to blame.
- The abuse you have suffered is not your fault.
- No one deserves to be abused.
- You do not deserve to be hit or hurt. You deserve better.
- I understand how difficult this must be for you.
- You are not alone.

Safety: Here are statements that convey concern for the patient's safety:

- I am concerned about your safety and well-being.
- Help is available.

Follow-up: Statements that leave the door open for future encounters with the physician and others in health care include the following:

- You have choices.
- As your situation changes, I (or my office, hospital) will help you by providing information, support, and referrals.

Confidentiality: Statements about confidentiality are not only educational, but also can be of critical importance to patients. Throughout every patient encounter, it is also important to be honest about limits that may be imposed by applicable state reporting requirements. It is often helpful to make a clarifying statement such as this:

- What we discuss here is confidential. I will not discuss your situation with your partner or anyone else without your knowledge and consent, unless required by law.

Medical Treatment: Medical treatment in cases of intimate partner violence involves not only treating acute injuries, but also arranging primary care for patients who access medical care only for episodic complaints. Referral for mental health services may be indicated, but couples or marriage counseling is absolutely contraindicated if the situation is volatile or if violence is ongoing or active.

Resources and Referrals

The physician should review options with the patient and make appropriate referrals to community-based domestic violence advocacy and support services, mental health providers, legal advocates, social service providers, and others. Referrals should be offered in keeping with the patient's wishes, priorities, and cultural preferences.

For most complex conditions seen in the health care setting, referrals are made to medical or surgical experts with advanced medical training in a particular subspecialty. In contrast, referrals for patients experiencing intimate partner violence are generally made to domestic violence advocates and other non-medical experts. Making referrals to those outside of the formal health care system and relying on those whose expertise derives from practice-based evidence rather than evidence-based practice represents a new horizon for many physicians.

A local resource list can be a valuable asset for the practicing physician. Resource information should be compiled and kept updated for referral to the following services:

- Shelter services
- Legal assistance
- Services for children, elders, and other dependents
- Mental health counseling services
- Social welfare services
- Housing assistance
- Job training services
- Other referrals as appropriate to the individual situation

Mandated Reporting

Although there is no statute in Massachusetts requiring that domestic abuse against competent adult individuals be reported to authorities, there are circumstances in which physicians are required to make reports. If a physician has a reasonable basis to believe that a child, elder, or disabled patient is suffering as a result of abuse, the physician must report as outlined below.

When it is determined that a mandated report must be filed, a physician should explain to the patient the reasons for filing the report. Attempts should also be made to assist the patient in locating resources that will help ensure the safety of both the abused individual and at-risk family members if there is a fear of or reason to suspect retaliation by the perpetrator.

A physician who fails to comply with his or her mandated reporting responsibilities may be subject to disciplinary action, fines, or civil liability.

Questions regarding the legal aspects of mandatory reporting can be directed to the Massachusetts Medical Society, Office of General Counsel, at (781) 434-7520 or (800) 322-2303, ext. 7520.

CHILD ABUSE

Reports of suspected maltreatment of individuals under age 18 should be filed with the Department of Children and Families Child-At-Risk Hotline, (800) 792-5200.

ELDER ABUSE

Reports of suspected elder maltreatment (including self-neglect) should be filed by contacting the Elder Abuse Hotline, (800) 922-2275.

ABUSE OF DISABLED PERSONS

Reports of suspected abuse of individuals with mental or physical disabilities should be filed with the Disabled Persons Protection Commission at (800) 426-9009.

RAPE OR SEXUAL ASSAULT

In addition to the reporting requirements above, a physician attending, treating, or examining a survivor of rape or sexual assault must report the case at once to the Department of Criminal Justice Information Services and to the police of the town where the rape or sexual assault occurred. The physician must make this report regardless of the age of the patient and may not include the survivor's name, address, or any other identifying information. The report should describe the general area where the attack occurred.

The Patient's Role

The patient's role is to decide when it is safe to leave and when the economic and emotional resources to support that decision are in place.

The Physician's Role

The physician's role is to provide the patient with options, support, and resource and referral information in a manner that is caring, concerned, and nonjudgmental. Specifically, following disclosure, the physician should do the following:

- Reframe the abusive behavior as unacceptable and potentially criminal.
- Place responsibility for the violence unequivocally on the perpetrator.
- Validate the patient's courage and resilience in coping with the abuse that occurred.
- Document findings carefully and nonjudgmentally in the medical record.
- Assess for danger.
- Initiate safety planning.
- Diagnose and treat specific injuries and medical problems related to ongoing or past victimization.
- Diagnose and arrange treatment for psychological and behavioral problems in survivors and dependent children.
- Discuss safer sex practices and protection against sexually transmitted diseases and pregnancy, especially for patients who have been raped or who have experienced coerced sexual activity.
- When possible, avoid prescribing tranquilizers or other sedating psychoactive medications that could impair the survivor's ability to respond appropriately should she or he need to flee.

- Evaluate the need to file a mandated report to the appropriate agency for children and elderly or disabled patients.
- Refer the patient as appropriate to experts in the community who provide direct service to survivors of intimate partner violence. (Local, statewide, or national hotlines and domestic violence programs can be used as sources for referrals.)
- Assure follow-up for both the presenting complaint and comprehensive primary care.

A patient who remains in a dangerous or potentially dangerous relationship should not be labeled as a treatment failure or noncompliant. Choosing not to leave usually reflects the limited resources available to the survivor or her or his reasonable assessment of available options and safety needs.

Prevention

PRIMARY PREVENTION IN THE OFFICE SETTING

This guidebook's focus on intimate partner violence as a health care and public health issue is in keeping with the efforts of others who work to deliver the important cultural message that it is wrong — and against the law — to address conflict by using intimidation and violence. Physicians can communicate this message effectively in the course of routine office practice. When physicians and office staff model competence and concern about IPV, patients can more effectively face these difficult issues from positions of strength and resilience.

There are many ways to bring effective primary and secondary prevention into the office setting. Posters, brochures, and resource cards should be displayed prominently in waiting and examination rooms and in private areas such as bathrooms. Office staff should receive periodic in-service training about intimate partner violence, referral resources, protocols, and office safety procedures. Frank discussion with all patients about healthy relationships, respect for the autonomy of others, and nonviolent means to address conflict should be encouraged.

PHYSICIANS AS CHANGE AGENTS IN A LARGER COMMUNITY RESPONSE

The physician's job should not be restricted to the examining room or hospital ward. Physicians are respected in the community, their opinions are sought out and given great credence, and their influence as role models and community leaders is clear. Thus, it is crucial that physicians use their positions of leadership and respect by joining community coalitions; advocating for improved services, laws, and practices; and modeling respectful, nonviolent behavior. In short, physicians can very effectively "teach peace" in the course of their professional and personal activities.[52] The public health role of the physician as leader, advocate, and change agent is perhaps as important as the private health job of providing expert care for individual patients.

RADAR

The acronym RADAR summarizes action steps physicians should take in recognizing and treating patients affected by intimate partner violence.

Remember to ask routinely about IPV as a matter of routine patient care.

Ask directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview your patient in private at all times.

Document findings related to suspected intimate partner violence in the patient's chart.

Assess your patient's safety. Is it safe to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

Review options with your patient. Know about the types of referral resources in your community (e.g., shelters, support groups, legal advocates). See pages 29 to 37 of this guidebook for specific resource listings.

Although not part of the RADAR acronym, appropriate follow-up is helpful — if not essential — for both patient and physician. From the patient's perspective, when the physician follows up about intimate partner violence on subsequent visits, it reinforces caring, support, and trust, making ongoing communication more open and less stressful. From the physician's perspective, assuring follow-up reinforces the physician-patient relationship, makes subsequent patient care more efficient and satisfying, and also promotes ongoing physician education and expertise.

Legal Issues

Although physicians may not be directly involved in legal proceedings regarding intimate partner violence, it is important to know of their existence and purpose. Your role, when abuse is identified, is to refer the survivor to a trained advocate who will help her or him explore options, assist with safety planning, and make other appropriate referrals. Again, proper documentation in your patient's medical chart can provide invaluable information for any subsequent legal proceedings.

ORDERS OF PROTECTION (RESTRAINING ORDERS)

Under the Massachusetts Abuse Prevention Act (General Laws, chapter 209A), any person who is suffering from abuse by a present or former family or household member or by a dating partner may obtain an emergency, temporary, and/or permanent restraining order against the abuser. Abuse is defined by the statute as "(a) attempting to cause or causing physical harm; (b) placing another in fear of imminent serious physical harm; or (c) causing another to engage involuntarily in sexual relations by force, threat, or duress."

- Orders can be obtained through any district, superior, or probate and family court, as well as the Boston Municipal Court.

- Upon request, the survivor's address can be impounded and kept confidential from the abuser.
- The court may order the abuser to refrain from further abuse, to have no further contact with the abused individual, and/or to vacate and remain away from the survivor's residence and workplace. Any violation of such an order is a criminal offense, and police must arrest the abuser if they have probable cause to believe that such an order has been violated.
- The court may also issue orders awarding temporary custody and support of any children, as well as other orders deemed appropriate to a particular case. These orders are enforceable through civil contempt proceedings.
- A court may also order the immediate surrender of any firearms the abuser possesses, as well as the immediate suspension of any licenses or permits to possess firearms. Violation of such a surrender order is also a criminal offense.

Four types of orders of protection, or restraining orders, are available to a person seeking relief from abuse:

Emergency Restraining Order

When court is not in session, including at night and on weekends, an emergency restraining order can be obtained by calling the police who will then contact an on-call judge. The judge will determine if a substantial likelihood of immediate danger of abuse has been demonstrated, and if so, issue an emergency order. A formal complaint requesting a temporary order should then be filed by the victim when the court is next in session.

Temporary Restraining Order

When court is in session, a temporary restraining order (TRO) can be obtained by filing a complaint in the appropriate court to request protection from abuse. The victim must inform the judge of the nature of the abuse, the identity of the abuser, and indicate the kind of relief that is sought. Where a substantial likelihood of immediate danger of abuse has been demonstrated, a court may issue such an order without prior notice to the abuser.

Permanent Restraining Order

Upon issuance of a temporary restraining order and notice to the alleged abuser, a court hearing is scheduled within 10 business days, at which time the alleged abuser has an opportunity to present his or her version of events. After this hearing, if the judge determines that sufficient evidence of abuse has been presented, he or she may extend the order for an additional period of time up to one year. The order can be further extended thereafter as deemed necessary to protect the abused individual.

It is helpful for the survivor to be accompanied during this process by an advocate from a local battered women's program or other victim services agency, the district attorney's office, the court, or a friend or trusted family member.

All temporary and permanent restraining orders are now entered into the Massachusetts Domestic Violence Registry, where they can be accessed by judges and the police for future reference.

Harassment Prevention Order

Under the Massachusetts Act Relative to Harassment Prevention Orders (General Laws, chapter 258e), a harassment prevention order is available to those who have been stalked, sexually assaulted, or harassed, but do not have a substantial dating relationship with the harasser. A person may qualify for this type of order if (1) she or he is a target of three or more acts of harassment that are meant to and do indeed cause fear, intimidation, or destruction of or abuse to property; (2) she or he suffered one act of forced sexual relations; or (3) she or he is a victim of a crime that falls within a specific set of crimes as laid out in this law.

Under this law, the court may order the harasser to:

- Refrain from abusing or harassing the injured party
- Refrain from contacting the victim, unless authorized by the court
- Remain away from the sufferer's household or workplace
- Pay the person monetary compensation for the losses suffered as a direct result of the harassment

CRIMINAL COMPLAINTS

Most criminal complaints are initiated by the arrest of an alleged batterer by the police. However, a criminal complaint can also be sought through the clerk's office of the local district court. An abused individual filing for a restraining order must be provided with information about the availability of criminal complaint proceedings.

The criminal complaint process sends a clear message to the batterer that domestic abuse is considered a serious crime for which criminal penalties, including fines and a jail sentence, may be imposed. Upon conviction, an abuser may be required to take part in a batterer intervention program as a condition of sentencing.

It is important to note that, once a criminal complaint is issued, the local district attorney's office, and not the crime victim, has the responsibility and authority for the prosecution of the criminal case.

There are a variety of criminal charges that are often brought in domestic violence cases, including those that follow:

- Violation of a restraining order
- Assault
- Assault and battery
- Assault or assault and battery with a deadly weapon
- Breaking and entering
- Trespassing
- Threats
- Sexual assault
- Stalking

STALKING LAW

The Massachusetts Stalking Law (General Laws, chapter 265, section 43) provides that any person who "willfully and maliciously engages in a knowing pattern of conduct or series of acts" that seriously alarms or annoys a person and makes a threat intended to place the person in imminent fear of death or bodily injury shall be punished by a fine or imprisonment, or both. One purpose of the Stalking Law is to allow for prosecution of those batterers who are obsessed with their victims and continue to harass them even after the victim has ended the relationship.

While not every violation of a restraining order would qualify as stalking, a person convicted of stalking in violation of a restraining or vacate order is subject to a mandatory prison term of at least one year.

CHILD CUSTODY PRESUMPTION LAW

The Massachusetts Presumptive Custody Law (General Laws, chapter 208, section 31A), requires a court issuing a temporary or permanent child custody order to "consider evidence of past or present abuse toward a parent or child as a factor contrary to the best interest of the child." An abusive parent is defined as one who has committed either a pattern of abuse — including causing, attempting to cause, or placing the other parent or child in fear of imminent bodily injury — or a serious incident of abuse — causing, attempting to cause, or placing the other parent or child in reasonable fear of imminent serious bodily injury, including causing the other parent to engage involuntarily in sexual relations.

If the court finds sufficient evidence of abuse, the law creates a rebuttable presumption that child custody should not be awarded to the abusive parent. It is then up to the abusive parent to present sufficient evidence to rebut the presumption or prove that a custody award to the abusive parent would be in the child's best interest.

If ordering visitation to an abusive parent who has been denied custody, the court must provide for the safety and well-being of the child and the abused parent through supervision or other means.

Help for Physicians and Colleagues

Individual physicians and other health care professionals may themselves have been victimized as children or as adults or may currently be in an abusive relationship as a survivor or as a perpetrator. Those whose lives have been affected by abuse are urged to seek help from a hotline or direct service organization or from a trusted colleague, therapist, family member, or other source of support.

For emergency assistance, please call your local police or 911 (where available); a local domestic violence hotline; SafeLink, the Massachusetts statewide domestic violence hotline at (877) 785-2020; or the National Domestic Violence Hotline at 1-800-799-SAFE (7233).

Confidential referral for Massachusetts physicians and their families who are in need of help as survivors or as perpetrators can be obtained by calling Physician Health Services, a corporation of the Massachusetts Medical Society, at (800) 322-2303, ext. 7404, or (781) 434-7404.

Hotline, Shelter, and Referral Resources

As a health care provider, you may be the only professional a patient experiencing abuse encounters, so it is critical that you have the best available information for your patients.

This listing includes many, but not all, of the existing resources in Massachusetts that provide support and services for survivors of intimate partner violence. The Massachusetts Medical Society website, *www.massmed.org*, and the Jane Doe Inc. website, *www.janedoe.org*, contain additional information.

Web resources with a national focus are listed at the end of this section.

HOTLINE RESOURCES	
Massachusetts Statewide Domestic Violence Hotline (SafeLink)	(877) 785-2020
National Domestic Violence Hotline	(800) 799-7233 (SAFE)
Police Emergency	911

MASSACHUSETTS RESOURCES	
Statewide	
Jane Doe Inc. (information other than crisis services, Monday through Friday, 9 a.m. to 5 p.m.)	(617) 248-0922
Information (for phone numbers of local domestic violence shelters and services)	411
Victim Compensation and Assistance Division, Office of the Attorney General	(617) 727-2200
Asian Task Force Against Domestic Violence	(617) 338-2355
The Network/La Red	(617) 423-7233
Casa Myrna Vasquez 24-Hour Hotline	(800) 992-2600 (English/Spanish)
Mandated Reporting	
Elder Abuse Hotline	(800) 922-2275
Disabled Persons Protection Commission	(800) 426-9009
Department of Children and Families (Child Abuse)	(800) 792-5200
Legal Services	
Cambridge and Somerville Legal Services	(617) 494-1800
Greater Boston Legal Services	(617) 371-1234
Harvard Law School Battered Women's Advocacy Project	(617) 495-3139
Harvard Legal Aid Bureau	(617) 495-4408
Mass Legal Services	*www.masslegalservices.org*
Mass Legal Help	*www.masslegalhelp.org*
Services for Battered Men	
Violence Recovery Program	(617) 927-6250
Programa Contra Violencia	(617) 927-6460
Gay Men's Domestic Violence Project	(800) 832-1901

Services for the GLBT Community		
Boston Police, Liaison to the Gay, Lesbian, Bisexual Community		(617) 349-3307
Cambridge Police, Liaison to the Gay, Lesbian, Bisexual Community		(617) 349-3307
Gay Men's Domestic Violence Project		(617) 497-7317
Greater New Bedford Women's Center		(888) 839-6639
Lesbian/Gay/Bisexual Helpline		(617) 267-9001
Lesbian/Gay/Bisexual Youth Line		(617) 267-2535
Rape Crisis and Sexual Assault Services		
Boston and Route 128 Area		
Cambridge	Boston Area Rape Crisis Center	(617) 492-7273
Cambridge	Hotline	(800) 841-8371
North of Boston		
Beverly	North Shore Rape Crisis Center	(800) 922-8772
Lawrence	Women's Resource Center	(800) 400-4700
Lowell	Rape Crisis Services of Greater Lowell	(800) 542-5212
South of Boston		
Attleboro	New Hope	(800) 323-4673
Brockton	A New Day	(508) 588-8255
Fall River	Women's Center/SSTAR	(508) 675-0087
Cape Cod and the Islands		
Martha's Vineyard	Community Services/CONNECT	(508) 693-7900
Nantucket	A Safe Place	(508) 228-2111
West of Boston		
Amherst	Everywoman's Center	(888) 337-0800
Fitchburg	Rape Crisis Center of Central Massachusetts	(800) 870-5905
Framingham	Voices Against Violence	(800) 593-1125
Greenfield	NELCLWIT	(413) 772-0806
Marlboro	Rape Crisis and Wayside Victim Services	(800) 511-5070
Milford	Rape Crisis and Wayside Victim Services	(800) 511-5070
Pittsfield	Elizabeth Freeman Center	(413) 443-0089
Springfield	YWCA — DVSS	(413) 733-7100
Westfield	YWCA — New Beginnings	(800) 479-6245
Worcester	Rape Crisis Center of Central Massachusetts	(800) 870-5905

Victim Assistance Programs and Court Listings	
Massachusetts Office of Victim Assistance (MOVA) Directory	(617) 727-5200 *www.movahelpdirectory.org*
Barnstable County District Attorney's Office *District Courts: Barnstable, Falmouth, Orleans*	(508) 362-8103
Berkshire County District Attorney's Office *District Courts: North Berkshire, Pittsfield, South Berkshire*	(413) 443-3500
Bristol County District Attorney's Office *District Courts: Attleboro, Fall River, New Bedford, Taunton*	(508) 997-0711
Duke's County District Attorney's Office *District Court: Edgartown*	(508) 362-8113
Essex County District Attorney's Office *District Courts: Gloucester, Haverhill, Ipswich, Lawrence, Lynn, Newburyport, Peabody, Salem*	(508) 745-6610
Franklin County District Attorney's Office *District Courts: Greenfield, Orange*	(413) 586-9225
Hampden County District Attorney's Office *District Courts: Chicopee, Holyoke, Palmer, Springfield, Westfield*	(413) 748-8600
Hampshire District Attorney's Office *District Courts: Northampton, Ware*	(413) 586-9225
Middlesex County District Attorney's Office *District Courts: Ayer, Cambridge, Concord, Framingham, Lowell, Malden, Marlborough, Natick, Newton, Somerville, Waltham, Woburn*	(617) 494-4604
Nantucket County District Attorney's Office *District Court: Nantucket*	(508) 228-4642
Norfolk County District Attorney's Office *District Courts: Brookline, Dedham, Milford, Quincy, Stoughton, Wrentham*	(617) 329-5440
Plymouth County District Attorney's Office *District Courts: Brockton, Hingham, Plymouth, Wareham*	(508) 584-8120
Suffolk County District Attorney's Office *District Courts: Boston Municipal Court, Brighton, Charlestown, Chelsea, Dorchester, East Boston, Roxbury, South Boston, West Roxbury*	(617) 725-8653
Worcester County District Attorney's Office *District Courts: Clinton, Dudley, East Brookfield, Fitchburg, Gardner, Leominster, Milford, Orange, Uxbridge, Westborough, Winchendon, Worcester*	(508) 792-0214

Certified Batterer Intervention Services		
Boston Area		
Boston	Common Purpose	(617) 522-6500
Cambridge	Emerge	(617) 547-9879
Chelsea	Chelsea ASAP	(617) 884-6829
Norwood	Billings Human Services, Inc.	(781) 762-0060
Roxbury	Roxbury Comprehensive Community Health Center	(617) 541-3790
Somerville	Massachusetts Alliance for Portuguese Speakers	(617) 864-7608
Waltham	Middlesex Human Service Agency	(781) 894-6110
Cape Cod and the Islands		
Barnstable	Independence House	(508) 771-8572
Vineyard Haven	Martha's Vineyard Community Services, Inc.	(508) 693-7900, ext. 261
South of Boston		
Attleboro	New Hope	(508) 226-4015
Brockton	Brockton Family and Community Resources	(508) 583-5200
Fall River	PYCO	(508) 679-0962
Fall River	Family Service Association of Greater Fall River, Inc.	(508) 678-7542
New Bedford	The Community Center for Non-Violence: (508) 996-6600	
North of Boston		
Everett	Tri-City Mental Health	(781) 324-2218
Lynn	Project COPE, Inc.	(781) 581-9270
Malden	Tri-City Mental Health	(781) 324-2218
Methuen	Holy Family Hospital Family Violence Program	(978) 687-0156, ext. 4233
West of Boston		
Amherst	Men's Resource Center	(413) 253-9588
Athol	Clinical and Support Options, Inc.	(978) 249-9926
Framingham	Wayside Metrowest Counseling Center/Respect Program	(508) 620-0010
Milford	Community Counseling Center of Blackstone Valley	(508) 473-6723
Northampton	Cooley Dickinson Hospital/Dickinson Programs	(413) 586-8550
Pittsfield	Berkshire Batterer Intervention Program	(413) 445-9160
Springfield	Gandara Mental Health	(413) 846-0418
Springfield	New England Domestic Abuse Programs	(413) 263-3500
Worcester	PAVE/Spectrum, Inc.	(508) 797-6100
Worcester	Saint Vincent Hospital	(508) 798-6251

Certified Batterer Intervention Services (continued)		
Boston Area		
Boston	Casa Myrna Vazquez	(800) 992-2600
Boston	Renewal House	(617) 566-6881
Cambridge	Transition House	(617) 661-7203
Chelsea	Harbor COV	(617) 884-9909
Dorchester	Mary Lawson Foreman House of Casa Myrna Vazquez	(800) 992-2600
Jamaica Plain	Elizabeth Stone House	(617) 522-3417
Jamaica Plain	FINEX House	(617) 288-1054
Somerville	Respond	(617) 623-5900
South of Boston		
Attleboro	New Hope	(800) 323-4673
Brockton	Woman's Place/Health Imperative	(888) 293-7273
Brockton	Family and Community Resources	(508) 583-6498
Fall River	Our Sister's Place	(508) 677-0224
Fall River	Women's Center/SSTAR, Inc.	(508) 675-0087
New Bedford	Greater New Bedford Women's Center	(508) 996-3343 or (888) 839-6639
New Bedford	Hotline	(508) 999-6636
Norwood	New Hope	(800) 323-4673
Plymouth	South Shore Women's Center	(888) 746-2664
Quincy	DOVE (Domestic Violence Ended)	(617) 471-1234
Taunton	New Hope	(800) 323-4673
Cape Cod and the Islands		
Hyannis	Independence House	(800) 439-6507
Martha's Vineyard	Women's Support Services	(508) 696-7233
Nantucket	A Safe Place, Inc.	(508) 228-2111
North of Boston		
Haverhill	Women's Resource Center	(800) 400-4700
Lawrence	Women's Resource Center	(800) 400-4700
Lowell	Alternative House	(978) 454-1436
Malden	Respond	(781) 324-2221
Salem	HAWC (Help for Abused Women and Their Children)	(978) 744-8552
West of Boston		
Framingham	Voices Against Violence	(508) 626-8686
Framingham	Hotline	(800) 593-1125
Gardner	Women's Resources	(877) 342-9355
Greenfield	NELCWIT (New England Learning Center for Women in Transition)	(413) 772-0806
Holyoke	Women's Shelter/Compañeras	(413) 536-1628

Leominster	Women's Resources	(877) 342-9355
Northampton	Necessities/Necesidades	(888) 345-5282
Pittsfield	Women's Services Center	(800) 593-1125
Springfield	YWCA of Western Massachusetts — ARCH (Abuse and Rape Crisis Hotline)	(413) 733-7100
Waltham	REACH	(800) 899-4000
Webster	New Hope Inc.	(800) 323-4673
Westfield	YWCA — New Beginnings	(800) 479-6245
Worcester	Daybreak, Inc.	(508) 755-9030

SUPPLEMENTAL WEB RESOURCES

Many domestic violence organizations maintain a robust internet presence, primarily through websites and social networking. The resources below highlight a few key statewide resources for intimate partner violence. This list is not meant to be exhaustive.

Massachusetts Resources

Jane Doe Inc.

www.janedoe.org

Jane Doe Inc. (JDI) is a statewide membership advocacy organization of more than 60 community-based sexual assault, domestic violence, and dual programs across the Commonwealth. JDI works very closely with its member programs in order to understand the impact that domestic and sexual violence have on victims, their children, and local communities and improve options for their dignity, liberty, and safety. JDI works closely with its membership, state agencies, the executive and legislative branches of state government, other state and national advocacy organizations, and federal agencies and elected officials to integrate local, state, and national practices to end domestic and sexual violence.

Boston Medical Center Child Witness to Violence Project

www.childwitnesstoviolence.org

A counseling, advocacy, and outreach project based at Boston Medical Center that focuses on children who are bystanders to community and domestic violence

Asian Task Force Against Domestic Violence

www.atask.org

The mission is to prevent domestic violence and to provide hope to survivors. The Asian Task Force Against Domestic Violence (ATASK) staff speaks over 12 Asian languages and dialects and has a deep cultural understanding of our service populations. ATASK provides a multilingual helpline; an emergency shelter; outreach through trainings for local police and medical and dental providers; dating violence prevention sessions for youth in area schools; and communication with community members, service providers, and business owners about domestic violence in Asian families and communities. ATASK also offers a variety of programs and services including financial literacy, insurance, attorney referrals, representation through a legal advocacy program, and education through a Youth Empowerment Program and teen dating violence workshops.

Gay Men's Domestic Violence Project

www.gmdvp.org

The Gay Men's Domestic Violence Project, founded in 1994, is a grassroots, nonprofit organization providing community education and direct services for clients.

The Network/La Red

www.tnlr.org

Founded in 1989, The Network/La Red is a national resource and model for battered women's programs; batterer intervention programs; and gay, lesbian, bisexual, and transgender organizations beginning to address battering in lesbian, bisexual women's, and transgender relationships. The Network/La Red is a founding member of the Boston area GLBT Domestic Violence Coalition and a member of many national, state, and local coalitions, commissions, and boards.

Massachusetts Medical Society

www.massmed.org

The Massachusetts Medical Society (MMS) advocates for the shared interests of patients and the medical profession. Since 1992, the MMS Campaign Against Violence has provided leadership, policy support, and educational materials for both physicians and patients in the areas of intimate partner violence, child abuse and neglect, youth violence, sexual assault, and elder abuse.

Teen Action Campaign

www.seeitandstopit.org

This innovative teen dating violence prevention–oriented website was created by teens. It provides information, resources, and help for at-risk teens.

Mass Legal Help

www.masslegalhelp.org/domestic-violence/where-do-we-go-from-here

This site provides a self-help guide for survivors and domestic violence advocates.

Massachusetts Public Health Advisory

www.mass.gov/dph

On June 5, 2008, Governor Patrick signed a violence intervention bill making Massachusetts the first state to require health care providers to refer victims of violence to a variety of social services. At the same time the bill was signed, the Department of Public Health released a landmark public health advisory on domestic violence, the first time such an advisory was issued for a non-disease-related cause.

National Resources

Academy for Violence and Abuse

www.avahealth.org

The AVA is an academic and health professional membership-based organization dedicated to advancing health education and research on the prevention, recognition, and treatment of the health effects of violence and abuse.

Centers for Disease Control and Prevention: National Center for Injury Prevention and Control, Division of Violence Prevention

www.cdc.gov/ncipc/dvp/dvp.htm

Provides up-to-date information on research and statistics related to child maltreatment, intimate partner violence, sexual violence, suicide, and youth violence

FaithTrust Institute

www.faithtrustinstitute.org

The FaithTrust Institute provides training and educational resources for clergy, lay leaders, seminary faculty, chaplains, policy makers, and community advocates on the faith aspects of sexual and domestic violence.

Family Violence Prevention Fund

www.endabuse.org

This is the national health care resource center for family violence. The EndAbuse.org website has information and resources of value to researchers, advocates, survivors, and health care professionals.

Minnesota Center Against Violence and Abuse

www.mincava.umn.edu

An excellent resource providing access to research, education, and other violence-related resources

National Center for Children Exposed to Violence

www.nccev.org

A research and advocacy organization that addresses the consequences of exposure to violence in children

National Center on Elder Abuse

www.ncea.aoa.gov

The National Center on Elder Abuse (NCEA) is a national resource for elder rights, law enforcement and legal professionals, public policy leaders, researchers, and the public. The center's mission is to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

National Criminal Justice Reference Service

www.ncjrs.org

Features the latest statistics, facts, and articles on numerous criminal justice topic areas, including an "In the Spotlight" special section on family violence

National Domestic Violence Hotline

www.ndvh.org

The National Domestic Violence Hotline operates a 24-hour, toll-free, confidential hotline that provides support and information for survivors of abuse and for friends and family who are concerned about a victim. The hotline number is 1-800-799-SAFE (7233). There is a section for health care professionals who need assistance referring a patient as well as information on how to become more involved in creating a violence-free society.

National Coalition Against Domestic Violence

www.ncadv.org

The NCADV is dedicated to the empowerment of battered women and their children and therefore is committed to the elimination of personal and societal violence in the lives of battered women and their children.

National Institute of Justice: Bureau of Justice Statistics

www.ojp.usdoj.gov

Provides up-to-date information on research and statistics related to crime victimization including intimate partner violence

National Institute of Justice, Violence Against Women Office

www.ojp.usdoj.gov/vawo

The VAWO website provides up-to-date information for criminal justice practitioners, advocates, and social service professionals on interventions to stop violence against women. Recent research and promising practices regarding issues of domestic violence and stalking, batterer intervention programs, child custody and protection, sexual assault, and welfare reform are available.

National Network to End Domestic Violence

www.nnedv.org

Established in 1990, the National Network to End Domestic Violence, Inc., provides training and technical assistance to state coalitions against domestic violence, furthers public awareness of domestic violence issues, and advocates for federal legislation and funding to better serve victims of domestic violence.

Nursing Network on Violence Against Women International

www.nnvawi.org

The mission of the NNVAWI is to eliminate violence through advancing nursing education, practice, research, and public policy.

Partnerships Against Violence Network

www.padv.org

This website houses a virtual library of information about violence, representing data from seven different federal agencies.

Rape, Abuse and Incest National Network

www.rainn.org

The Rape, Abuse and Incest National Network (RAINN) is the nation's largest anti-sexual assault organization. RAINN operates the National Sexual Assault Hotline (1-800-656-HOPE) and carries out programs to prevent sexual assault, help victims, and ensure rapists are brought to justice.

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24-HOUR HOTLINES

National Domestic Violence Hotline (Nationwide)
(800) 799-SAFE

SafeLink, the Massachusetts Statewide
Domestic Violence Hotline
(877) 785-2020

INFORMATION AND REFERRAL IN MASSACHUSETTS

Jane Doe Inc., the Massachusetts Coalition
Against Sexual Assault and Domestic Violence
(617) 248-0922
(Monday through Friday, 9 a.m. to 5 p.m.)

FOR PHONE NUMBERS OF LOCAL SERVICES AND SHELTERS FOR BATTERED WOMEN AND MEN IN MASSACHUSETTS, CALL:

Directory Assistance
411

For Emergency Assistance
911

For additional resource information, see pages 29 to 37.

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