



White Paper

DOMESTIC VIOLENCE AND THE ROLE OF THE HEALTHCARE PROVIDER.

The Value of Educating on Assessment and Intervention Strategies.

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DEDICATION PAGE

We dedicate this White Paper, *Domestic Violence and the Role of the Healthcare Provider: The Value of Educating on Assessment and Intervention Strategies* to the following people:

Anna Trautwein, RNC, of Saint Peter's University Hospital in New Brunswick, NJ, a pioneer in training healthcare providers on their role in screening and responding to victims of domestic violence. Anna began conducting these trainings more than twenty years ago, and has over thirty-five years of acute nursing experience. Examples of her efforts to recognize and meet the needs of victims of abuse began during her early career as a perinatal nurse when she encountered patients who were dealing with the consequences of domestic violence. She has been active in the community and at the state level with groups dedicated to improving awareness about and resources for victims of Domestic Violence including: the New Brunswick Domestic Violence Awareness Coalition, the New Jersey State Advisory Council on Domestic Violence and The New Jersey State Domestic Violence Fatality and Near Fatality Review Board, the latter for which she served as the Chair until 2010. There is no doubt in our minds that without Anna bringing both a focus and her wealth of experience to this issue in our community, that our Model Program and this White Paper would not have been possible. Her participation in this Model Training Program as a facilitator represents a partnership between Robert Wood Johnson University Hospital and Saint Peter's University Hospital, which was born out of the New Brunswick Domestic Violence Awareness Coalition, and is supported by the *Verizon Foundation*.

Kathleen Kelleher APNC, CBCN, DMH, NP, is a certified domestic violence specialist and OB/GYN Nurse Practitioner with an extensive background in Women's Health issues, currently at Chilton Hospital in Pompton Plains. Kathleen is also a pioneer in training healthcare providers on their role in screening and responding to victims of domestic violence. She coordinated the Domestic Violence Prevention Project at the University of Medicine and Dentistry of New Jersey and at Jersey Battered Women's Services with Howard Holtz, MD, from the late eighties to the mid-nineties. She also assisted with the development of one of the first hospital protocols on domestic violence with Regina Braham, CSW, and Howard Holtz, MD. She served on the New Jersey State Advisory Council on Domestic Violence for several years. She has facilitated some of the trainings of the Model Program this year as well, and we are extremely grateful to her for her contributions and expertise.

Mariam Merced, M.A., Director of the Robert Wood Johnson University Hospital Community Health Promotion Program, for her unwavering commitment to addressing domestic violence in our community for the last twenty years, and her advocacy and service to medically underserved and marginalized people in our community and beyond. Her vision helped to lead us to this work.

Dr. Sarah McMahon, and all of the faculty and staff at the Rutgers University School of Social Work's *Center on Violence Against Women & Children*, for their commitment to addressing violence against women and children, and for their support of our work.

All of the victims and survivors of intimate partner violence, whose experiences and lives we honor and remember. It is with them in mind that we work to address and prevent intimate partner violence.



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The mission of VAWC at the Rutgers University School of Social Work is to strive to eliminate physical, sexual, and other forms of violence against women and children and the power imbalances that permit them. This mission is accomplished through the use of multidisciplinary research, education, and training.

DESCRIPTION OF COLLABORATING PARTNER PROGRAMS

The following programs are dedicated to addressing the issue of violence against women in the New Brunswick, NJ local area and beyond. All three programs collaborated to make this paper possible.

ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL — COMMUNITY HEALTH PROMOTION PROGRAM

The mission of Robert Wood Johnson University Hospital is to improve the health, well-being, safety and security of the patients and communities served by providing the highest quality medical care; promoting and engaging in community outreach activities, and advancing research and medical knowledge to continually advance patient care.

The Robert Wood Johnson University Hospital Community Health Promotion Program (RWJUH CHPP) was created in 1991 to address health related challenges and institutional changes to improve access to care for the growing number of medically underserved minority communities in New Brunswick, NJ. Since its founding, the RWJUH CHPP has established strong working relationships and partnerships with community-based organizations, churches and community groups. These relationships allow the program to assist a large minority population in the city of New Brunswick, NJ to make healthy lifestyle choices and to improve their overall quality of life. Over the years, the RWJUH CHPP has been able to gain trust and respect from the community, and is valued as an integral resource for the most needy community residents.

CENTER ON VIOLENCE AGAINST WOMEN & CHILDREN

Founded in the Spring of 2007, the Center on Violence Against Women & Children (VAWC) has enjoyed tremendous success and growth under the leadership of Drs. Judy L. Postmus and Sarah McMahon. The mission of VAWC at the Rutgers University School of Social Work is to strive to eliminate physical, sexual and other forms of violence against women and children and the power imbalances that permit them. This mission is accomplished through the use of multidisciplinary research, education and training that impacts communities and policies in New Jersey, the U.S. and throughout the world. The Center engages partners from the academic, corporate, nonprofit and government sectors on research, education and training. More information about VAWC is available online at: socialwork.rutgers.edu/CentersandPrograms/VAWC.

NEW BRUNSWICK DOMESTIC VIOLENCE AWARENESS COALITION

The New Brunswick Domestic Violence Awareness Coalition (NBDVAC) is a conglomerate of community agencies in the New Brunswick, NJ area working to end domestic violence. The mission of NBDVAC is to partner to address the needs of victims of domestic violence and those who provide services to them in our community, promote healthy relationships, and to support the individuals, families, and the needs of the community through advocacy and education. The NBDVAC was formed in 2002 in New Brunswick in response to a large number of domestic violence murders in the area, with the idea of emphasizing prevention of domestic violence in addition to responding to it, and the need to collaborate to better address the issue in the community.

The idea to train local healthcare providers to assess, screen and intervene effectively with victims of domestic violence was born out of the Coalition; Coalition member Anna Trautwein, RNC, of Saint Peter's University Hospital spoke about it and she and Mariam Merced, Director of the CHPP at Robert Wood Johnson University Hospital, decided to do the first *Domestic Violence and the Role of the Healthcare Provider* seminar in March, 2012. Ms. Trautwein has been conducting education for healthcare providers on domestic violence for more than twenty years. The March 2012 seminar was attended by representatives of the *Verizon Foundation*, who saw the value in this innovative training, and invited RWJUH to apply for their current funding to expand the reach of the *Domestic Violence and the Role of the Healthcare Provider* model program, as well as our other initiatives.

Healthcare professionals face a myriad personal barriers, job-related barriers, and patient-related barriers that may hinder their ability to effectively identify and assist victims.

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OVERVIEW

Domestic violence, or intimate partner violence (IPV), is a pattern of assaultive and coercive power and control tactics used to emotionally, physically, sexually and/or economically abuse a past, current or potential romantic partner. This abuse is perpetrated in order to establish and maintain control over the victim. Onset may be gradual as abusers progressively isolate, intimidate, stalk, deprive and threaten to maintain power and control over their victims.¹

Intimate partner violence (IPV) is a major public health concern that affects four to six million relationships each year in the United States.² Victims of IPV experience devastating and life-changing physical, emotional, relational and financial consequences that often continue to affect them even after the abuse has stopped.

Victims are very present in the healthcare system.³ It is estimated that 24% to 54% of all women who visit emergency rooms have been abused during their lifetime,⁴ and it is suggested that victims utilize the healthcare system as much as 2.5 times as often as non-abused patients.⁵ The impact on the healthcare system that results from intimate partner violence is great. For this reason, healthcare professionals are uniquely positioned and can play an important role in addressing the issue of IPV.⁶ Healthcare professionals can address IPV by identifying victims, offering support and referring patients to community agencies.⁷

Since healthcare professionals are often “the first-line response” for many people who experience IPV, it is vital to have education, policies and protocols in place so that they can identify and record incidents of IPV and assist victims with getting the services and support they need.⁸ Unfortunately, healthcare professionals face a myriad personal barriers, job-related barriers and patient-related barriers that may hinder their ability to effectively identify and assist victims.⁹

In order to address the barriers that healthcare providers face, RWJUH CHPP, in conjunction with the New Brunswick Domestic Violence Awareness Coalition (NBDVAC) collaborated to provide a seminar entitled *Domestic Violence and the Role of the Health Care Provider*, and educated 330 healthcare providers between June 2012 and June 2013, including nurses, physicians, social workers and medical students, to recognize domestic violence, to screen patients, and to refer patients to community resources. The goal of the *Domestic Violence and the Role of the Healthcare Provider* seminar is to equip healthcare providers with the knowledge and resources necessary to provide services to abused men and women, and to allow them the opportunity to become more comfortable with screening their patients. During the three-hour sessions, healthcare providers are educated about the dynamics of abusive relationships and the clinical signs of abuse, which are important in addressing personal barriers healthcare providers experience when treating victims.

The program also addresses other personal and societal barriers such as prejudices and problems identifying with victims; institutional barriers such as lack of support, resources and collaboration with community agencies; and professional barriers such as lack of education, training and tools regarding IPV, all of which have been shown to hinder screening and services for IPV victims in the healthcare system. In addition, these medical professionals are exposed to a variety of screening methods allowing for significantly higher detection rates as suggested by researchers from both the social work and medical fields. By screening earlier and more effectively, victims may be aware of help and resources that are available.

1 The Family Violence Prevention Fund, 2010

2 Rodriguez, Bauer, McLoughlin & Grumbach, 1999

3 Sprague et al., 2012

4 CDC, 2003

5 Dolezal, McCollum & Callahan, 2009

6 Hamberger et al., 2004

7 Kirst, Zhang, Young, Marshall, O'Campo & Ahmad, 2012

8 Du Plat-Jones, 2006

9 Allen et al., 2007; Kirst, et al., 2012; Sprague et al., 2012; Tower, 2003

The hope is that this educational program for healthcare providers will be a model for other healthcare facilities on how to educate employees to identify, screen and to be resources to their patients who are survivors of violence.

The hope is that this educational program for healthcare providers will be a model for other healthcare facilities on how to educate employees to identify, screen and to be resources to their patients who are survivors of violence. When victims are restricted and controlled by their abuser, it may be that one of the few places they are able to go for help is to their healthcare provider. For this reason, the healthcare system has a vast opportunity to interface with victims, to support them and to be an ally to them. Healthcare providers are on the front line in the field of IPV whether they know it or not, and the goal of the *Domestic Violence and the Role of the Healthcare Provider* (DVRHP) model is to educate and equip them to identify victims within medical facilities, and to refer victims to services and resources that could potentially save their lives.

In the following paper, an overview of the dynamics of intimate partner violence will be introduced as well as evidence that an educational model for healthcare providers is beneficial in the field of IPV. Following, the format of the model program will be detailed as well as topics covered and evidence that the *Domestic Violence and the Role of the Healthcare Provider* model program has been successful. The terms “intimate partner violence” and “domestic violence” will be used interchangeably. The terms “victim” and “survivor” will be used interchangeably as well, because these are the terms that those who have suffered use, and because the health consequences of domestic violence are experienced by both victims and survivors.

Domestic violence, or intimate partner violence (IPV), is a pattern of assaultive and coercive power and control tactics used to emotionally, physically, sexually and/or economically abuse a past, current or potential romantic partner.

IPV RESULTS IN
2 MILLION
 INJURIES EACH YEAR
 IN THE U.S., 550,000
 REQUIRING MEDICAL
 ATTENTION

INTRODUCTION

Domestic violence is a major public health concern that affects four to six million relationships each year in the United States.¹⁰ Domestic violence affects individuals regardless of socioeconomic status, ethnicity, gender, sexuality or religious affiliation.¹¹ Domestic violence, or intimate partner violence (IPV), is a pattern of assaultive and coercive power and control tactics used to emotionally, physically, sexually and/or economically abuse a past, current or potential romantic partner. This abuse is perpetrated in order to establish and maintain control over the victim. Onset may be gradual as abusers progressively isolate, intimidate, stalk, deprive and threaten to maintain power and control over their victims.¹² Intimate partner violence affects both men and women and those in both opposite-sex and same-sex relationships.

Both men and women can be victims of intimate partner violence. However, statistics show that about 76% of identified victims are women and approximately 20-40% of women in North America¹³ experience domestic violence each year in the United States.¹⁴ This statistic is only representative of those who have reported the violence they have experienced and since IPV is underreported, the reality may be that the number of victims affected by domestic violence is much higher than this statistic indicates. Due to the fact that women make up the majority of victims of IPV and because the issue of gender-based violence has historically been primarily against women,¹⁵ this paper will focus specifically on female victims.¹⁶ However, it is recognized that men can be victims as well.

Victims of IPV experience devastating and life-changing health problems such as: depression, anxiety, STDs, HIV/AIDS, alcohol and substance abuse, diabetes, hypertension, post-traumatic stress disorder (PTSD), serious injuries and suicidal ideation, all of which can have long-term physical and emotional repercussions.¹⁸ IPV results in 2 million injuries each year in the U.S., 550,000

ABUSIVE, COERCIVE AND INTIMIDATION TACTICS ¹⁷	
EMOTIONAL	SEXUAL
Threats	Rape
Blackmail	Forced prostitution
Strict and petty rules	Forced pornography
Emotional neglect	Disregard for religious values around sexuality
Shaming	Disfiguring genitalia
Criticism	Lewdness or Forced Touching
PHYSICAL	FINANCIAL
Hitting	Controlling finances
Pushing	Withholding or restricting access to money
Shoving	Refusal to contribute to family expenses
Kicking	
Burning	

10 Rodriguez, Bauer, McLoughlin & Grumbach, 1999

11 Bradbury-Jones et al., 2011; Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011; Trautwein, 2012

12 The Family Violence Prevention Fund, 2010

13 Sprague et al., 2012

14 Rodriguez, Bauer, McLoughlin & Grumbach, 1999

15 CDC, 2011

16 New Jersey State Police, 2011

17 Center on Violence Against Women and Children [VAWC], 2013; Kramer, Lorenzon, & Mueller, 2004; Trevillion, Agnew-Davies & Howard, 2011

18 Allen, Lehrner, Mattison, Miles & Russell, 2007; Bradbury-Jones et al., 2011; Coker et al., 2000; Kramer Lorenzon & Mueller, 2004; Sprague et al., 2012

Abusive relationships gradually evolve into a stage of tension building, which is when the abuser exhibits blaming language, explosive anger and instigates many arguments.

IPV IS A GREATER **HEALTH BURDEN** THAN ANY OTHER RISK FACTOR—MORE THAN SMOKING OR EVEN OBESITY

requiring medical attention.¹⁹ This makes IPV a greater health burden than any other risk factor—more than smoking or even obesity.²⁰

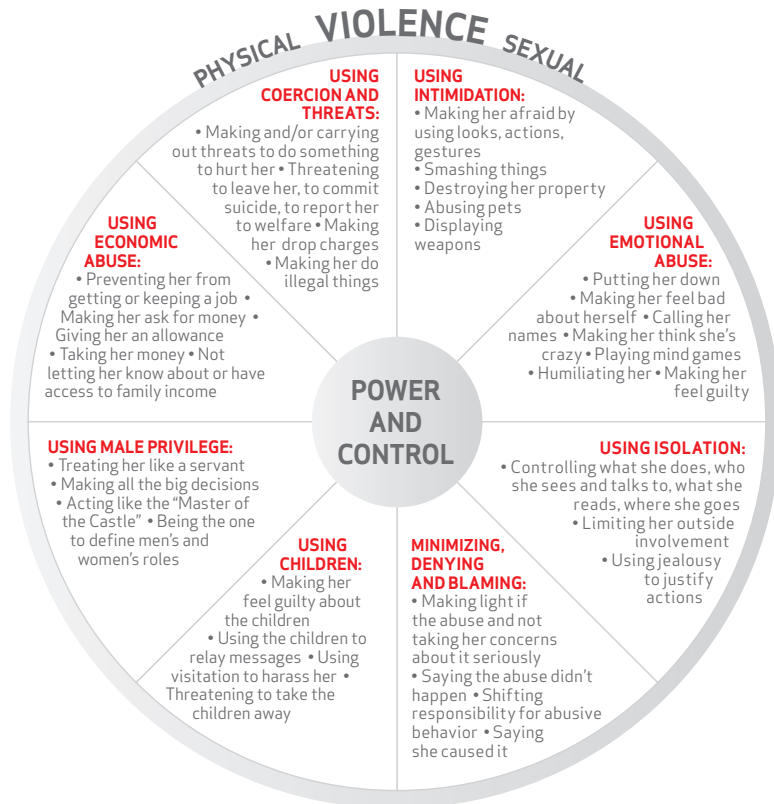
Intimate partner violence often occurs as a cyclical process known as the “cycle of violence.”²¹ Viewing abuse in this way has not been without controversy, but many who work with victims find that using this model can be helpful for the victims to recognize the patterns of abuse in their own experiences.

The beginning of the relationship is often described as calm, romantic, and some consider this the “honeymoon stage”. However, abusive relationships gradually evolve into a stage of tension building, which is when the abuser exhibits blaming language, explosive anger and instigates many arguments. Then, the tension building leads to an abusive incident(s). This abuse may be physical, sexual, emotional/psychological or financial, or a combination of these. Following the abuse, the abuser will often apologize, make excuses for their actions and promise it will never happen again. This phase is known by many as the “honeymoon/recapture” phase, as the abuser is seeking to regain the trust and control of the partner. Many abusers will make promises that they will change and will behave calmly for some time as the cycle moves towards tension building again.²²

Many abusive relationships go through this cycle at different paces and intensities, and not all relationships experience all aspects of the cycle. Abusers may use a variety of tactics to maintain power and control over their partners and may vary from threats, insults, intimidation, using children or pets, blaming, denial, minimizing, using male privilege to justify the abuse and degrade the partner, economic and emotional abuse, and isolating the victim from friends, family, coworkers and neighbors.²³ The Domestic Abuse Intervention Program in Duluth, Minnesota developed the **Power and Control Wheel** in order to help abused women to name and discuss abusive tactics they may have experienced.

POWER & CONTROL WHEEL

Figure 1. Domestic Abuse Intervention Programs, 202 East Superior Street, Duluth, MN, 55802, www.theduluthmodel.org



19 Centers for Disease Control and Prevention [CDC], 2003

20 Bradbury-Jones, et al., 2011

21, 21 Walker, 2006

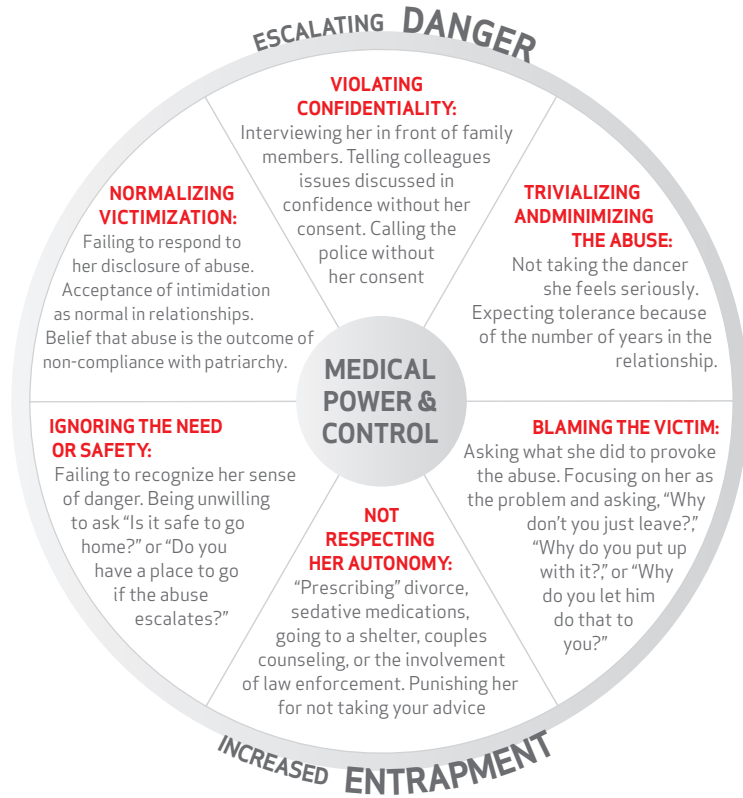
23 The Domestic Violence Project & National Center on Domestic and Sexual Violence, 2013

It is important for healthcare providers to be aware of the tactics used by abusers and to provide a safe and supportive place for victims to receive medical treatment. The goal should always be to increase safety and decrease isolation.

IN THE STATE OF NEW JERSEY, THERE WERE 10,124 DOMESTIC VIOLENCE OFFENSES FROM DATING RELATIONSHIPS IN 2011, WHICH ACCOUNTED FOR **14%** OF ALL DOMESTIC VIOLENCE OFFENSES IN NEW JERSEY FOR THAT YEAR

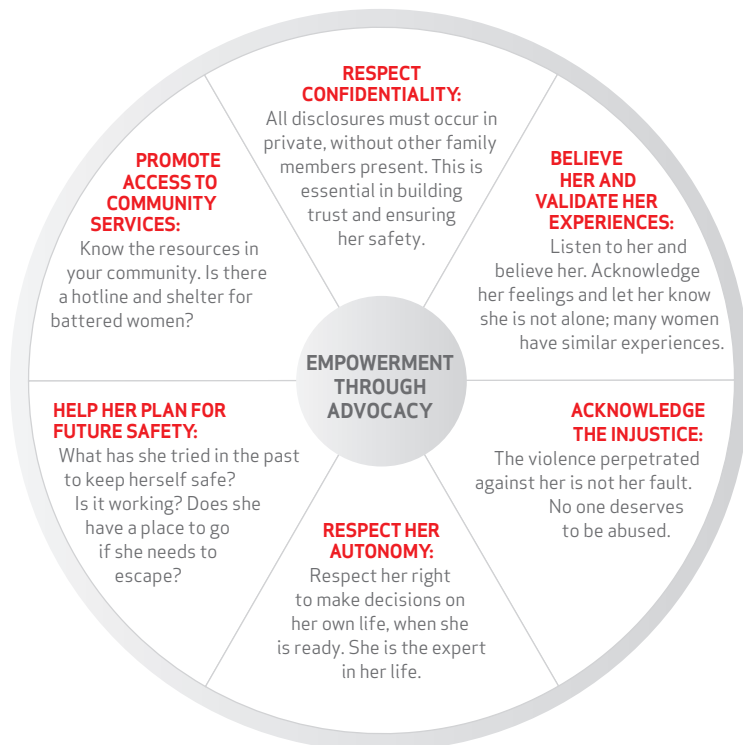
MEDICAL POWER & CONTROL WHEEL

Figure 2. Domestic Abuse Intervention Programs, 202 East Superior Street, Duluth, MN, 55802, www.theduluthmodel.org



ADVOCACY EMPOWERMENT WHEEL

Figure 3. Developed by: The Missouri Coalition Against Domestic Violence, www.mocadv.org. Produced and distributed by: National Center on Domestic and Sexual Violence, www.ncdsv.org



When working with victims, it is crucial to recognize that the abuser alone is responsible for the physical, emotional, psychological and financial injuries they have inflicted on their partner, and that the victim is never to blame.

It is important for healthcare providers to be aware of the tactics used by abusers and to provide a safe and supportive place for victims to receive medical treatment. The goal should always be to increase safety and decrease isolation. In order to do this, it is vital to protect each patient's confidentiality, to take each patient's experiences seriously, to respect each patient's autonomy, to value each patient's safety and to never place blame for the abuse on the patient.²⁴

Research shows that anyone may become a victim of intimate partner violence.²⁵ IPV can occur in early dating relationships as well as in late adulthood.²⁶ For example, in the State of New Jersey, there were 10,124 domestic violence offenses from dating relationships in 2011, which accounted for 14% of all domestic violence offenses in New Jersey for that year.²⁷ And, in the same year, elderly persons accounted for 4% of domestic violence offenses and 15% of domestic violence related homicides in New Jersey.²⁸ IPV affects those regardless of age, race, ethnicity, cultural background, sexual orientation, education level, religious affiliation and physical ability.²⁹

It is important to realize that the abuse is not caused by the victim's individual behaviors. Rather, many different factors related to community norms, societal norms and dynamics all contribute to intimate partner violence. The existence and perpetuation of strict gender roles and patriarchy is one factor which reinforces male domination and female subordination.³⁰ When these stereotypical gender roles are encouraged and supported through other cultural systems, it pressures men and women to act only within the prescribed roles. It is in this context that abuse, coercion and controlling behaviors are sometimes utilized by men as a mechanism to ensure that women remain in the subordinate position. Unfortunately, women are often blamed for the violence against them,³¹ and they are often socialized to base their self-worth on whether they are able to satisfy others, which further contributes to feelings of guilt and inadequacy when they are abused.³² Rather than holding abusers accountable for their violence and abusive actions, society shifts the attention and blaming towards the victim, asking why she stayed with her partner and what she did to instigate the abuse.³³

When working with victims, it is crucial to recognize that the abuser alone is responsible for the physical, emotional, psychological and financial injuries they have inflicted on their partner,³⁴ and that the victim is never to blame. Healthcare providers should remind their patients that abuse is not their fault and that abuse can happen to anyone to reduce feelings of stigmatization.

24 The Domestic Violence Project & National Center on Domestic and Sexual Violence, 2013

25 Bradbury-Jones et al., 2011; Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011
26, 27, 28 New Jersey State Police, 2011

29 Bradbury-Jones et al., 2011; Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011

30 Hunnicutt, 2009; Jasinsky, 2001

31 Berns, 2001

32 Bunch & Carrillo, 1992

33 Bjorkert & Morgan, 2010

34 Jasinsky, 2001

The Centers for Disease Control and Prevention (CDC) found that female victims of IPV have a higher prevalence of health problems that are long term such as: irritable bowel syndrome, diabetes, chronic pain, difficulty sleeping and asthma.

THE CDC
ESTIMATES THAT
4,450,807
WOMEN ARE
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EACH YEAR IN THE
UNITED STATES

IMPACTS OF INTIMATE PARTNER VIOLENCE

HEALTH IMPACTS

Intimate partner violence impacts survivors in nearly every aspect of their lives—their physical health, emotional health, employment, relationships with family and friends, potential use or abuse of substances and education—and the effects are likely to affect their lives beyond the period that they are abused.³⁵ The Centers for Disease Control and Prevention (CDC) found that female victims of IPV have a higher prevalence of health problems that are long term such as: irritable bowel syndrome, diabetes, chronic pain, difficulty sleeping and asthma.³⁶ In a study it was found that 69.7% of the victims who responded reported at least one health problem.³⁷ Those who have been abused are also more vulnerable to disease and health conditions³⁸ such as: heart disease, diabetes, back pain, strokes, mental illness and other common diagnoses. Abused women experience more health problems than non-abused women.³⁹ Further, these conditions often occur more frequently and more severely for victims than for those who are not abused.⁴⁰

The CDC estimates that 4,450,807 women are assaulted by their partners each year in the United States, and are afflicted with injuries ranging from scratches and bruises to broken bones, bullet wounds, knife wounds and death.⁴¹ Specifically in New Jersey, in 2011, there were over 70,000 domestic violence offenses, and 26% of domestic violence complaints resulted in injury.⁴² Fifty percent of women murdered by their intimate partners were treated in emergency rooms as a result of previous intimate partner violence.⁴³ Most women treated in emergency rooms after IPV had been treated for facial injuries, and 68% of domestic violence survivors were victims of attempted strangulation at least one time.⁴⁴

Victims of IPV are most likely to experience violence for the first time or to experience escalation in both frequency and severity of violence during pregnancy.⁴⁵ Pregnant victims are at increased risk of experiencing miscarriages, premature births and fetal injuries, and pregnant women are more likely to be murdered by their partners than to die of any other cause.⁴⁶ Research shows that intimate partner violence directed at pregnant women leads to low birth weight babies—a serious health problem for a newborn that can have life-long consequences.⁴⁷ Domestic violence has also been linked to forced abortions.⁴⁸

Women who are abused also experience increased reproductive coercion often resulting in many health problems.⁴⁹ Victims of abuse are more likely to be diagnosed with invasive cervical cancer and pre-invasive cervical neoplasia.⁵⁰ Many abused women do not have routine mammograms,⁵¹ and women who are abused are at increased risk for sexually transmitted diseases.⁵² In a study completed in 2000, it was found that 68% of women who were HIV positive had been abused as adults, 32% experienced sexual abuse in their lifetime and 45% experienced abuse after they were

35 Sprague et al., 2012

36 CDC, 2011

37 Kramer, Lorenzon, & Mueller, 2004

38 Bergman & Brismar, 1991; Coker et al., 2002; Dienemann et al., 2000; Follingstad, 1991; Letourneau et al., 1999; Stark & Flitcraft, 1995; Usta et al., 2012

39 McCloskey, Lichter, Williams, Gerber & Gantz, 2006

40 Dolezal, McCollum & Callahan, 2009

41 Chrisler & Ferguson, 2006

42 New Jersey State Police, 2011

43, 44 Chrisler & Ferguson, 2006

45 Chrisler & Ferguson, 2006; Du Plat-Jones, 2006; Usta, Antoun, Ambuel & Khawaja, 2012; Trevillion, Agnew-Davies & Howard, 2011

46 Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011; Usta, Antoun, Ambuel & Khawaja, 2012

47 Sullivan, Bryant, Robertson, Abel, Chang & Caughey, 2006

48 Usta et al., 2012

49, 50 Coker et al., 2000

51 Farley et al., 2002

52 Gielen et al., 2000; Letourneau et al., 1999

Fifty percent of women murdered by their intimate partners were treated in emergency rooms as a result of previous intimate partner violence.

IN NEW JERSEY,
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VIOLENCE OFFENSES
IN 2011

diagnosed.⁵³ In another study comparing diagnoses of STIs in non-abused women and abused women, 40% of abused women were diagnosed with one or more STIs as compared with only 18% of non-abused women diagnosed with at least one STI.⁵⁴

In addition, abused women are at a higher risk to abuse substances, even during pregnancy, than non-abused women.⁵⁵ And, they are at increased risk for poor nutrition and developing eating disorders,⁵⁶ to have heart and blood pressure problems,⁵⁷ and to struggle with mental health difficulties.⁵⁸ Women who are abused deal with the repercussions of their injuries, but also the longer-lasting effects of the psychological abuse causing poor self-esteem, feelings of betrayal, loss of trust, increased anxiety and heightened sensitivity and awareness.⁵⁹ Victims also have more sleep problems,⁶⁰ post-traumatic stress disorder (PTSD),⁶¹ panic attacks,⁶² anxiety⁶³ and depression⁶⁴ than those who were not abused. In fact, 76% of women diagnosed with depression also reported being physically or emotionally abused within their lifetime,⁶⁵ and abused women are at higher risk for suicidal ideation and completed suicide.⁶⁶ As a result of these emotional and psychological effects, about one fourth of abused women seek help from a mental health professional.⁶⁷

These physical and emotional effects that victims of abuse face last much longer than just the abusive incident or even the abusive relationship. The effects of abuse can be long-lasting and can have serious repercussions for a victim's lifelong health.⁶⁸ Victims may continue to experience somatic symptoms such as: low energy, poor sleep, headaches, hyper-vigilance, fatigue, pain, nightmares, racing heart and decreased immune functioning.⁶⁹ Many survivors of abuse are left with the physical consequences of a sexually transmitted disease, which could result in urinary tract infections, cervical cancer, infertility and sometimes even death.⁷⁰ Abused women are three times more likely to commit suicide, often have a lasting fear of intimacy and feel unable to trust men.⁷¹

These staggering rates of extensive health risks for survivors of abuse may lead to equally staggering mental health costs for victims⁷² at an average cost of \$1,775 more per year than non-abused women.⁷³ Victims average about 13 visits to mental health professionals resulting in over \$1,000 per victim per assault.⁷⁴ If women experiencing these health problems or those who are disabled are experiencing financial abuse, they may have many unmet healthcare needs, and often present the healthcare system with extensive costs due to their frequent visits to healthcare facilities.⁷⁵ It is estimated that 24% to 54% of all women who visit emergency rooms have been abused at some time during their lifetime,⁷⁶ and it is suggested that victims utilize the healthcare system as much as 2.5 times as often as non-abused patients.⁷⁷ The burden on health that results from intimate partner violence is noted to be the greatest risk factor for a person—even greater than cigarette smoking or obesity.⁷⁸

EFFECTS ON CHILDREN

The impact on the healthcare system goes even beyond the adult victim of abuse. When there are children in the home, they become victims as well. In New Jersey, children were involved or present during 31% of all domestic violence offenses in 2011, affecting over 21,500 children in just one year.⁷⁹

53 Gielen et al., 2000

54 Letourneau et al., 1999

55 Letourneau et al., 1999; Martin et al., 1996; Miller et al., 1989; Plichta, 1992

56 McNutt et al., Bostwick & Baldo, 1996

57 Follingstad, 1991

58 Chrisler & Ferguson, 2006; Coker et al., 2000; Dienemann et al., 2000; Kernic et al., 2000; Sprague et al., 2012

59 Chrisler & Ferguson, 2006

60 Dienemann et al., 2000

61 Coker et al., 2000; Sprague et al., 2012

62, 63 Kernic et al., 2000

64 Coker, 2002; Dienemann et al., 2000; Sprague et al., 2012

65 Kramer et al., 2004

66 Bergman & Brismar, 1991; Chrisler & Ferguson, 2006; Coker et al., 2002; Stark & Flitcraft, 1995

67, 68, 69, 71 Chrisler & Ferguson, 2006

70 Chrisler & Ferguson, 2006; Letourneau et al., 1999; Usta et al., 2012

72 Sprague et al., 2012

73 Hamberger et al., 2004

74 Chrisler & Ferguson, 2006

75 Bradbury-Jones, C. et al., 2011

76 CDC, 2003

77 Dolezal, McCollum & Callahan, 2009

78 Bradbury-Jones, et al., 2011

79 New Jersey State Police, 2011

Researchers have also found that children living in highly stressful households, including those with violent relationships, were at increased risk of developing acute mental health disorders for the remainder of their lives.

THE COST OF
DOMESTIC VIOLENCE
COULD BE AS MUCH AS
\$5.8
BILLION
PER YEAR

If children are witnessing the abuse, they are also at a high risk for medical and mental health problems as well as developmental challenges and difficulty developing healthy relationships.⁸⁰ Witnessing abuse has also been linked to impaired social competence, school achievement and both behavioral and cognitive functioning.⁸¹ Children whose mothers had experienced abuse may use healthcare more frequently and may experience long-lasting symptoms as a result of witnessing the violence, even after the violence had stopped.⁸²

There is reason to believe that screening children for witnessing domestic violence can be beneficial. However, healthcare professionals are encouraged to obtain training in order to gain a true understand of the issues. In 2011, nurses were urged to be aware of general and mental health problems that children may experience as a result of witnessing abuse such as: aggression, depression, low self-esteem, self-harming behaviors and abusing substances.⁸³ Researchers have also found that children living in highly stressful households, including those with violent relationships, were at increased risk of developing acute mental health disorders for the remainder of their lives.⁸⁴ These symptoms and behaviors may be evidence of adaptive behaviors that children develop in order to deal with the trauma that the abuse has caused.⁸⁵

It is important for all healthcare providers to recognize the barriers that survivors face when trying to leave and to know that women are actually at an increased risk of danger when they separate, file for divorce or an order of protection. Leaving with children even further complicates the victim's ability to remain safe.⁸⁶ For example, the increased risk of violence during an attempt to leave or seek help, threats from the abuser to harm the children or to involve child protective services, and child custody battles are some of the increased challenges that survivors may face.⁸⁷ Most importantly, it is crucial for healthcare professionals to screen mothers for intimate partner violence, and for pediatricians to be aware of the signs of witnessing abuse, and of its effects.⁸⁸ For more information about children who witness intimate partner violence, visit www.thegreenbook.info.⁸⁹

THE ECONOMIC IMPACT

In addition to the severe effects that IPV has on its victims and families, research has shown that domestic violence has extensive negative impacts on communities through direct and indirect costs that affect the economy and healthcare through homicide and suicide rates, and the general health of the public.⁹⁰ According to the Centers for Disease Control and Prevention (CDC), the estimated 5.3 million incidents of violence each year in the U.S. result in 2 million injuries per year and cost victims an average of \$2,665 for medical treatment for each incident. It is estimated that of these 2 million injuries per year, only 550,000 victims actually seek medical treatment and costs the U.S. about \$4.1 billion in direct medical and mental health costs.⁹¹

In addition to these costs, it is estimated that domestic violence is responsible for 8 million lost days of paid work each year, which equals over 30,000 full-time jobs.⁹² When indirect costs such as loss of productivity were accounted for, the cost of domestic violence could be as much as \$5.8 billion per year.⁹³ These estimates still do not account for home care visits, treatment for sexually transmitted diseases, terminated pregnancies, social services, women's shelter programs, financial assistance, medical and mental healthcare costs for children who witness abuse, foster care for children as a result of domestic violence as well as the cost of unmet medical and mental healthcare needs of those who do not receive services.⁹⁴ Also, abusers may not physically injure their partners, but by using tactics such as coercive control and emotional abuse, victims may be left with a multitude of injuries that are not physically visible. However, emotional abuse affects their mental, physical and emotional health. These types of injuries are often chronic, unnoticed, untreated and unaccounted for.

80 Fisher, 1999; Haight, Shim, Linn & Swinford, 2007

81 Fisher, 1999; Wolfe, Crooks, Lee, McIntyre-Smith & Jaffe, 2003

82 Rivara, Anderson, Fishman, Bonomi, Reid, Carrell, & Thompson, 2007

83 Norman, 2011

84 Rivera et al., 2007

85, 86, 87 Wolfe, et al., 2003

88 Siegel, Hill, Henderson, Ernst, & Boat, 1999

89 The Greenbook Initiative, www.thegreenbook.info

90 CDC, 2003; Tower, 2003

91, 92, 93, 94 CDC, 2003

Healthcare professionals face personal barriers, job-related barriers and patient-related barriers that may hinder their ability to effectively identify and assist victims of intimate partner violence.

AMONG VICTIMS WHO WERE MURDERED BY THEIR PARTNERS,

44%

WERE IN THE EMERGENCY ROOM LESS THAN TWO YEARS PRIOR TO THEIR DEATHS

ROLE OF HEALTHCARE PROVIDERS IN ADDRESSING INTIMATE PARTNER VIOLENCE

The impact of intimate partner violence on the healthcare system is significant. In a study completed in 2004, one in three women who presented to emergency departments reported experiencing physical or sexual abuse at some point in their lifetime, and one in seven women in emergency departments reported physical violence in the past year.⁹⁵ Women who are abused are more likely to be hospitalized⁹⁶ and to use outpatient care rather than preventative care.⁹⁷ Another study found that among victims who were murdered by their partners, 44% were in the emergency room less than two years prior to their deaths. In this same study, the 15 patients were in the emergency room a total of 48 times, about three times each.⁹⁸

Healthcare professionals have a unique opportunity to address IPV by identifying victims, offering support and referrals to community agencies and can play an important role in addressing the issue of intimate partner violence.⁹⁹ Victims present to a wide variety of healthcare professions such as emergency room physicians, orthopedic or trauma surgeons, family physicians, and specialists in obstetrics and gynecology,¹⁰⁰ and due to their constant patient contact, healthcare professionals are uniquely positioned to supportively and confidentially screen patients for victims.¹⁰¹ Since healthcare professionals are often “the first-line response” for many people who experience domestic violence, it is vital to have education, policies and protocols in place so that they can identify, record IPV and assist victims with getting the services and support they need.¹⁰²

Unfortunately, healthcare professionals face personal barriers, job-related barriers and patient-related barriers that may hinder their ability to effectively identify and assist victims of intimate partner violence.¹⁰³ In addition, the dynamics of IPV are complex, and it is often difficult to understand how it presents within patients. A patient may appear to be non-compliant and irresponsible when the reality is that her partner is preventing her from attending her scheduled appointments if he cannot escort her.¹⁰⁴ Patients may also present with chronic and persistent somatic complaints and have poor response to standard treatment methods.¹⁰⁵ IPV can be a hidden risk factor or contributing factor for many women’s health problems, but it is often unidentified due to the various barriers at play within the healthcare setting.¹⁰⁶

PERSONAL BARRIERS

Healthcare professionals often have personal barriers such as: attitudes and perceptions that domestic violence is a private issue, fear of offending their patient, fear of the patients’ abuser, a lack of understanding of abuse, lack of confidence or lack of training on screening techniques.¹⁰⁷ Personal barriers can play a huge role in determining whether or not healthcare providers screen patients for violence.¹⁰⁸ Those who have more positive beliefs about the value of screening and those who feel a sense of responsibility and commitment to policies around screening patients are much more likely to actually engage in screening practices.¹⁰⁹ In a study conducted in 2012, it was

95 Kramer, Lorenzon, & Mueller, 2004

96 Hamberger et al., 2004

97 Usta et al., 2012

98 Tower, 2003

99 Kirst, Zhang, Young, Marshall, O’Campo & Ahmad, 2012

100 Sprague et al., 2012

101 Hamberger et al., 2004

102 Du Plat-Jones, 2006

103 Allen et al., 2007; Kirst, et al., 2012; Sprague et al., 2012; Tower, 2003

104 Du Plat-Jones, 2006; Trevillion, Agnew-Davies & Howard, 2011

105, 106 Du Plat-Jones, 2006

107 Allen et al., 2007; Du Plat-Jones, 2006; Kirst et al., 2012; Sprague et al., 2012; Tower, 2003

108 Allen et al., 2007

109 Kirst, et al., 2012; Sprague et al., 2007; Tower, 2003

When healthcare professionals identify victims, they have a unique opportunity to create a bridge for patients to appropriate community agencies.

ABOUT
50%
OF HEALTHCARE
PROFESSIONALS
BELIEVE IT IS NOT THEIR
ROLE TO SCREEN FOR
INTIMATE PARTNER
VIOLENCE

found that 55% of healthcare professionals were uncomfortable talking to patients about abuse, and 23% were concerned for their own safety.¹¹⁰ In a similar study, it was found that a majority of healthcare professionals feared offending their patients who were not abused, and many were afraid of the reaction of the abuser toward themselves or toward the patient.¹¹¹ About 50% of healthcare professionals believe it is not their role to screen for intimate partner violence, 9% believe that abuse is rare and some even believe that abused women are to blame.¹¹²

INTERPERSONAL BARRIERS

Interpersonal barriers are the barriers that healthcare providers experience when they are interacting with their patients. These barriers are significant—particularly language and cultural barriers, misunderstanding about reasons that victims choose to stay with their abuser, and sometimes the perception that patients are difficult to screen when they are experiencing psychological difficulties.¹¹³ In order to address and reduce the presence of these barriers, it is important to educate and train professionals about the dynamics of abuse, how to effectively and sensitively identify victims, how to develop cultural competency, how to screen and refer patients for help and how to develop comprehensive policies and procedures within their practice settings.¹¹⁴ It is also important to note that although many professionals are worried about offending their patients by screening them, studies reveal that the majority of women actually want healthcare providers to ask them about abuse and reported that if asked directly, they would disclose.¹¹⁵ Even a majority of women who claim to feel uncomfortable when they are asked about intimate partner violence agreed that it is important to ask.¹¹⁶ Research also shows that routine inquiry about abuse is especially important for victims since 70-93% of victims do not know where to get help from community agencies or may not have the ability to safely seek help.¹¹⁷ When healthcare professionals identify victims, they have a unique opportunity to create a bridge for patients to appropriate community agencies specializing in addressing and protecting victims of IPV. However, it is crucial for these professionals to be educated and trained in order provide a safe and comfortable setting and to effectively and sensitively screen patients.¹¹⁸

ORGANIZATIONAL AND RESOURCE BARRIERS

Studies have shown that time constraints, inadequate resources and support, lack of referral sources and lack of adequate procedures for screening are all additional barriers healthcare professionals may face.¹¹⁹ In addition, over 68% of healthcare professionals lack knowledge, education and training about how to identify, screen and refer patients experiencing intimate partner violence.¹²⁰ The overall supportive nature of a healthcare organization, the existence of clear and comprehensive policies surrounding screening patients for abuse, as well as policies for referring and intervening for patients who disclose, also significantly impacts practitioners' ability and willingness to screen.¹²¹ Recently, many healthcare facilities have been moving toward utilizing Electronic Medical Records (EMR) systems to document and track patient records. This system does not allow for the narrative of victims' stories to be recorded and may not include a distinct map of the victim's body with which to record injuries, unless a request is made to the designer to include a body map. This may create another significant barrier to identifying victims.¹²²

110 Sprague et al., 2012

111 Hamberger et al., 2004

112 Sprague et al., 2012

113 Hamberger et al., 2004; Tower, 2003

114 Sprague et al., 2012; Tower, 2003

115 Rodriguez et al., 1999

116 Webster, Stratigos & Grimes, 2001

117 Kramer, Lorenzon, & Mueller, 2004

118 Webster, Stratigos & Grimes, 2001

119 Allen et al., 2007; Hamberger et al., 2004; Sprague et al., 2012; Tower, 2003; Trevillion, Agnew-Davies & Howard, 2011; Usta et al., 2012

120 Hamberger et al., 2004

121 Allen, et al., 2007

122 Trautwein, 2012

Structural changes, regular in-service education, institutional policies and physician training are all needed in order to sufficiently change clinical practice in regards to IPV.

TWENTY PEER-REVIEWED QUANTITATIVE STUDIES FOUND THAT

43-85%

OF FEMALE PATIENTS WERE IN FAVOR OF UNIVERSAL SCREENING FOR IPV

MODEL TRAINING PROGRAM

In order for healthcare professionals to take advantage of the unique opportunity that exists to address IPV within the healthcare system, it is important for providers to receive education regarding the dynamics of abuse, screening techniques and sources for referrals.¹²³ Education, supportive policies and intervention protocols must be in place for healthcare professionals to have a better opportunity to identify and record IPV and assist victims with getting the services and support they need.¹²⁴

Research has shown that primary care physicians are missing opportunities to detect domestic violence and intervene, as there are low levels of routine screening.¹²⁵ State policies regarding domestic violence protocols, training, screening and reporting vary. Forty-six out of fifty states do not have statutes regarding healthcare providers screening for domestic violence. Thirty-three states do have not statutes regarding training for any profession on domestic violence. New Jersey has neither statutes requiring healthcare providers to screen their patients for IPV nor requirements for healthcare providers to receive training on IPV.¹²⁶ Structural changes, regular in-service education, institutional policies and physician training are all needed in order to sufficiently change clinical practice in regards to IPV.¹²⁷

Despite the lack of state legislation and policy regarding the need for educating healthcare professionals about intimate partner violence, research has demonstrated a need for healthcare providers to screen and receive education to help them develop the necessary skills. Twenty peer-reviewed quantitative studies found that 43-85% of female patients were in favor of universal screening for IPV.¹²⁸

In order to educate healthcare providers in New Jersey and at the same time address the frustrations and barriers healthcare providers face, the Robert Wood Johnson University Hospital Community Health Promotion Program (RWJUH CHPP), in collaboration with the New Brunswick Domestic Violence Awareness Coalition (NBDVAC) and Anna Trautwein, RNC, of Saint Peter's University Hospital (SPUH), created a training model, *Domestic Violence and the Role of the Healthcare Provider*, which is funded by a generous grant from the Verizon Foundation who prioritizes addressing domestic violence as a major initiative. Between June 2012 to June 2013, 330 healthcare providers, including nurses, physicians, social workers and medical students have been trained to recognize domestic violence, to screen patients and to refer patients to community resources. The creation of this training model was prior to a recommendation that the U.S. Preventative Services Task Force issued in January 2013 recommending that primary care clinicians should routinely screen women of childbearing age (ages 14 to 46) for IPV and to refer those who screen positive to programs or support services.¹²⁹

Following each *Domestic Violence and the Role of the Healthcare Provider* seminar, participants were asked to fill out post-training evaluations. In these evaluations, participants indicated that this training was necessary and helped them to better understand intimate partner violence.

Some of the open-ended responses to the question “What is the most valuable thing that you learned from this training?” included:

- How important it is to assess all patients for domestic violence
- The depth of domestic violence and its many manifestations and consequences
- Strategies in approaching subjects with patients
- How to correctly ask my patients if domestic violence is something that they're suffering from

¹²³ Trevillion, Agnew-Davies & Howard, 2011

¹²⁴ Du Plat-Jones, 2006

¹²⁵ Rodriguez et al., 1999

¹²⁶ Durborow, et al., 2010

¹²⁷ Rodriguez, et al., 1999, p. 472

¹²⁸ Ramsay, Richardson, Carter, Davidson, & Feder, 2002

¹²⁹ Moyer, 2013

Victims may see healthcare providers for care for either routine or chronic conditions during the tension- building stage of the relationship more often.

HEALTHCARE PROVIDERS ARE EDUCATED ON WAYS TO EFFECTIVELY **SCREEN PATIENTS** FOR INTIMATE PARTNER VIOLENCE

- There is help out there
- We need to screen more
- Not to be judgmental of the victim
- DV affects everybody and there are a lot of resources available
- That anyone can be a victim of domestic violence
- Appropriate screening techniques/interventions
- Routine screening and compassionate verbal techniques can make a difference
- Healthcare workers can and should do more for DV victims
- Importance of screening in dental offices, PCP's, OBGYN's, etc.
- The increased incidence during pregnancy
- The entire program was very valuable

DOMESTIC VIOLENCE AND THE ROLE OF THE HEALTHCARE PROVIDER SEMINAR

Two highly qualified experts on intimate partner violence and women's healthcare facilitate the training program. Anna Trautwein, RNC, has over 20 years of experience providing domestic violence education programs to community and professional groups, including healthcare providers, and is currently the Women's Ambulatory Care Practice Administrator for Saint Peter's University Hospital in New Brunswick, NJ. Kathleen Kelleher APNC, CBCN, DMH, NP, is a certified domestic violence specialist and OB/GYN Nurse Practitioner with an extensive background in women's health issues, currently at Chilton Hospital in Pompton Plains, NJ. Both trainers have experience with survivors of IPV as well as extensive experience working with women in the healthcare setting as medical professionals.

The goal of the *Domestic Violence and the Role of the Healthcare Provider* seminar is to equip healthcare providers with the knowledge and resources necessary to provide services to abused women and to allow them to become more comfortable with screening all of their patients. During the three-hour training sessions, healthcare providers are educated about the dynamics of abusive relationships and the clinical signs of abuse, which are important in addressing personal barriers they may experience when treating victims. The facilitators review clinical and mental health manifestations of abuse.¹³⁰ In addition, healthcare providers are taught that victims often present themselves as individuals that are negligent of their health. Survivors may appear to delay in seeking healthcare, seek care sporadically, often go to the emergency room, have multiple healthcare providers and express an embarrassed, odd and evasive demeanor.¹³¹ Since nearly one in five women reporting IPV during the preceding year had partners who interfered with their healthcare, and over half of women with an interfering partner were abused in the preceding year, healthcare providers are also trained to be aware of signs in the partner which may confirm suspicions about abuse of the patient including: a partner's insistence to attend every healthcare appointment, to be present at all meetings and to determine the care received.¹³² These behaviors in a patient's partner may be indicative of coercive control and a means to prevent disclosure.¹³³

Healthcare providers are educated on ways to effectively screen patients for intimate partner violence. They are trained to use direct, indirect and framing questions,¹³⁴ and that developing a compassionate and trusting relationship with their patients is crucial in order to establish a safe environment for victims to report and seek assistance.¹³⁵ The quality of the relationship can either encourage or significantly hinder a victim's use of services.¹³⁶ Healthcare providers are also encouraged to acknowledge and protect the patient's right to autonomy, even if they choose to stay with the abuser. The *Domestic Violence and the Role of the Healthcare Provider* model program continually reminds healthcare professionals that their primary objective is to focus on increasing the safety of the victim, and decrease the victim's isolation, regardless of whether they are in or out of the relationship.¹³⁷

Participants in the seminar are taught that continuous screening is absolutely critical. Continuous screening provides increased chances for patients to build trust and rapport with the healthcare provider. It also communicates that domestic violence is unacceptable and an issue that the medical

130 VAWC, 2013

131 McCloskey, Williams, Lichter, Gerber, Ganz, & Sege, 2007

132 McCloskey et al., 2007

133, 134 Trevillion et al., 2011

135, 136 Bradbury-Jones, et al., 2011

137 Trevillion et al., 2011

Ideally screening should be done when the victim is in the tension-building phase of the relationship, before the violence occurs, when the victim is in anticipation of the abuse.

IT HAS BEEN FOUND
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FROM COMMUNITY
AGENCIES

field is striving to address. Healthcare providers are also educated about the fact that screening often occurs during the “wrong” part of the cycle of violence.¹³⁸ Most providers screen after the violence has occurred and the physical signs of abuse are apparent. Following the violence, the abuser will often apologize and make promises of change in order to redeem his actions. Disclosure is not likely to happen in this phase as the abuse has temporarily stopped and the victim may believe their partner will change. Ideally, screening should be done when the victim is in the tension-building phase of the relationship, before the violence occurs, when the victim is in anticipation of the abuse. Since the victim is often in fear of the next abusive incident, screening in this phase may lead to more disclosure. Victims may see healthcare providers for care for either routine or chronic conditions during the tension-building stage of the relationship more often.¹³⁹ For this reason, healthcare providers are encouraged to screen continuously, regardless of the presence of indicators, in attempt to reach a survivor when they are most likely to accept help.

Role-playing is used during the seminars to allow healthcare providers to become more comfortable with screening. Feedback from the post-training evaluations revealed that this activity reinforced what they had learned about the dynamics of abusive relationships and screening techniques.

Healthcare providers are taught to be aware of reporting laws and procedures. Mandated reporting laws vary from state to state. While reporting domestic violence is not required in New Jersey, injuries caused by a firearm, destructive device, explosive or weapon must be reported immediately.¹⁴⁰ Reporting is always required if children, disabled and elderly persons are abused. In Ohio, a failure to report serious injury is considered a misdemeanor and physicians are required to note known or suspected IPV in the patient’s records.¹⁴¹ Providers are encouraged to use the “Tell Before You Ask” approach which means that they should tell patients what they are required to report before asking patients about IPV.

All healthcare professionals should be aware of the elements of safety planning, and should be able to discuss these elements with their patients. Education on safety planning is especially important for providers reporting to law enforcement. Reporting will not take victims out of dangerous situations but may increase danger for the patient. Victims that are caregivers are faced with a difficult issue of leaving their children, family member or pets with their abuser.¹⁴² Providers are educated that the patient’s autonomy is critical, and that they should focus on empowering patients to make decisions in their own time and own way, but they must also be aware of what they are mandated to report by law, which varies from state to state.

Participants are encouraged to provide follow-up care and advocacy for patients that disclose about abuse they have experienced, when appropriate and agreed to by the patient.¹⁴³ By providing resources and documenting abuse in a chart, healthcare providers can become an ally to the patient. Providers should never pressure abused women to leave. Instead, they should offer patients options and resources. Pressuring patients to leave sets them up to feel inadequate once again, if they are not ready or believe it is not a safe time for them to do so. Women have reported not disclosing relative to their perceptions of safety for themselves or their children. Pressuring patients to leave a relationship can create feelings of shame and can potentially increase the patient’s isolation, because they may feel uncomfortable to continue seeing that provider if they remain in the relationship. Healthcare providers must recognize that leaving an abusive relationship is a process and not an event, and that danger often increases when a victim first leaves her abuser since abuse is about the abuser maintaining power and control. Domestic violence is often counter-intuitive. When the victim leaves, the abuser often escalates his/her tactics in order to regain control or punish the victim.

In addition to educating healthcare providers on screening techniques and providing resources to patients, information is provided to them about local and statewide agencies as referral tools. In New Jersey, agencies and resources include NJ Coalition for Battered Women and the NJ Statewide Domestic Violence Hotline, 1-800-572-SAFE (7233), as well as local non-profits that serve individual counties. It has been found that approximately 70-93% of abused women do not know how to get help from community agencies.¹⁴⁴ However, women who are referred to intimate partner

138, 139 Trautwein, 2013

140, 141 Durborow et. al., 2010

142 Bair-Meritt, 2010

143 Du Plat-Jones, 2006

144 Kramer, et al., 2004

Posting domestic violence awareness materials in doctor's offices and other healthcare facilities sends the message to patients that this is an important issue to address, and that this is a safe place to talk about it.

PROVIDERS
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ABUSED WOMEN

violence services by healthcare providers have been found to be nearly three times more likely to exit the relationship compared to women who did not receive such services.¹⁴⁵ Healthcare providers need to have adequate access to materials and resources regarding local hotlines, restraining order information and sexual assault support services in their office, and they are encouraged to post domestic violence awareness posters with hotline numbers. Posting domestic violence awareness materials in doctor's offices and other healthcare facilities sends the message to patients that this is an important issue to address, and that this is a safe place to talk about it. Providers are encouraged to make connections with professionals such as advocates and shelter staff who may serve as additional resources when needed.

Healthcare providers are reminded that domestic violence is prevalent in all cultures and that it is important to respect each patient's unique cultural background. Providers are encouraged to attend seminars on cultural competency and to learn about resources that are available for immigrants and women of various ethnicities and cultures. Language and cultural barriers pose an obstacle for abused women, so providers are also reminded that the New Jersey domestic violence hotline have access to a "language line" so they can communicate with survivors who speak any language. There are also specialized resources available in some areas for survivors with a specific cultural background, such as Manavi, which serves South Asian women in the New Brunswick, NJ area.

In New Jersey, Spanish-language materials are necessary for the large Hispanic population. According the 2010 US Census, 49% of the population in New Brunswick, where RWJUH is located, is of Latina/Hispanic descent. IPV is a major health problem for this population, particularly the Mexican population. The Mexican immigrant population is the largest subset of the Latino and Hispanic population in New Brunswick, and research has indicated Mexican immigrant women tend to suffer more severe abuse for longer periods of time than Anglo women.¹⁴⁶ Providers must develop cultural competency in order to effectively help abused women. The NJ Statewide Domestic Violence Hotline, 1-800-572-SAFE (7233), utilizes a language line for non-English speakers. The following table depicts types and samples of Routine Screening Questions. Providers are encouraged to rehearse or role-play these questions, and be prepared for any response.

ROUTINE SCREENING QUESTIONS		
DIRECT	INDIRECT	FRAMING
Use with heightened index of suspicion, and the presence of one or more increased risk indicators. Include regardless of how the issue of DV is initially raised.	In some clinical settings it may be more appropriate to begin inquiry with an indirect question before proceeding to more direct questions.	Effective to initiate conversation when it seems/ feels awkward to suddenly introduce the subject of abuse/violence, particularly when there are no obvious indications.
SAMPLE QUESTIONS		
DIRECT	INDIRECT	FRAMING
Do you (or did you ever) feel controlled or isolated by your partner?	You seemed concerned about your partner. Can you tell me more about that? Does he ever behave in ways that frighten you?	We now know that domestic violence is a very common problem. More than 30% of women in this country will report being abused by their partners. Has this ever happened to you?
Has your partner ever hit you or physically hurt you? Has he ever threatened you, someone close to you or made you feel afraid?	How are things going in your marriage? All couples argue, sometimes. Are you having fights? Do your fights ever become physical?	I don't know if this is a problem for you, but some of the women I (we) see are dealing with abuse in their relationships. Some are too afraid or uncomfortable to bring it up themselves, so I (we) have started to ask about it routinely."

145 McCloskey et al., 2002

146 Hancock, 2007

By providing resources and documenting abuse in a chart, healthcare providers can become an ally to the patient.

IN RESPONSE TO AN ONLINE SURVEY COMPLETED THREE MONTHS FOLLOWING THE TRAINING,

77.7%

OF RESPONDENTS SAID THEY FELT PREPARED TO PROVIDE SERVICES TO CLIENTS EXPERIENCING IPV AS A RESULT OF THE TRAINING

HOW TO RESPOND

- Ask kindly and non-judgmentally
- Be prepared for any response
- Prepare your response — verbal / non-verbal
- Listen
- Assist in safety planning
- Provide referrals
- Validate, validate, validate
- Keep a list with referral information handy
- Provide an opportunity to contact referral agency from your office/agency
- Consider using a Safety Assessment or Danger Assessment tool
- ASK and ASSIST in Safety Planning and promotion of Safety Behaviors
- Continue to Validate...

PROGRAM FEEDBACK

Our training has been overwhelmingly attended by nurses, but many other professionals attended, including physicians, social workers, nurse educators, mental health providers, medical school professors, hospital administrators and other healthcare providers.

This model training program has elicited an overwhelming positive response from participants. In response to an online survey completed three months following the training, 77.7% of respondents said they felt prepared to provide services to clients experiencing IPV as a result of the training. It is estimated, based on the 330 healthcare providers who attended the training and the data obtained from the 95 participants who completed the online survey, that approximately 5,355 patients/clients have potentially benefitted on a weekly basis from implementation of the *Domestic Violence and the Role of the Healthcare Provider* model education program. If it is estimated that an average of 5,355 patients/clients have benefitted per week, it can be further estimated this education for healthcare providers could potentially benefit approximately 278,491 patients/clients per year.

When asked “What is the most valuable thing you learned from this training?” in the post-training evaluation, responses included: learning the different methods of screening patients using direct, indirect and framing questions, clinical signs of domestic violence, importance of providing a trusting, comfortable environment and the different types of abuse. Many respondents also indicated that the hotline number and state agencies and resources were the most valuable thing learned from the training. One respondent answered that “[her] daughter was a victim and [she] asked all the wrong questions such as ‘why do you stay?’” Another respondent indicated that she was a survivor of domestic abuse and that the training reinforced the fact that the violence was not her fault and provided her with information on how to help other survivors. Another respondent indicated she was a future nurse and the training was important in order to incorporate the information learned into future practice.

Several participants in the training sessions provided personal accounts of how the training has positively affected their own increased ability to screen as a healthcare provider.

An obstetrics nurse who attended the training recalled:

“I definitely feel the training on DV was an asset to my profession personally and could be for so many others in the healthcare profession. When the red flags go up when doing an intake in OB, I have learned to be more patient and wait for the right time to ask about DV. Being able to provide that alone time with the patient, giving the [patient] the opportunity to verbalize freely makes a huge difference in the response.”

A hospital social worker who attended the training recalled:

“Shortly after your seminar, I had a patient who had relocated to this area due to Hurricane Sandy... Unfortunately, she had been a victim of domestic violence... [After attending] your Domestic Violence and Awareness seminar, I felt better prepared to respond to her needs. The resources and referral information was very helpful... The safety planning [was] very

Many respondents also indicated that the hotline number and state agencies and resources were the most valuable thing learned from the training.

patient friendly. The patient stated it was clear and easy for her to use... I felt the knowledge and resources I had acquired from your Domestic Violence and Education Awareness seminar assisted me in expediting much needed services. Thank you for assisting me in expanding my professional skills and enabling me to be able to better serve victims of domestic violence."

A Clinical Nurse Educator who attended the training recalled:

"In my previous role as a behavioral health nurse, we screened all patients for DV. I think that as a result of attending the training, the way that I would ask the required questions would be different. I also have a change in my thinking as to why would you stay in a situation where DV was taking place. I can now put the responsibility where it should be — with the abuser. I did recommend this seminar to others after attending, and I presented the webinar in a Nursing Grand Rounds forum at our facility."

A Registered Nurse who attended the training shared the following:

"I got a lot out of the webinar. I placed the 1-800-572-SAFE number in the bathroom and waiting room of my clinic. It was interesting to learn that many chronic health conditions that women face can result from or be exacerbated by the domestic violence. Since I live and work in a rural part of NJ, the webinar was a convenient format for me."

A Practicing Forensic Nurse who works as an Emergency Department Nurse Educator who attended the training shared the following:

"The nurse pocket cards included in the materials are a great idea that I have decided to duplicate and implement. I feel that all bedside nurses should attend this training because it is often a challenge for staff to understand the dynamics of abusive relationships. They would be more supportive of the patients who are victims if they got this clearly beneficial training. The safety planning information was also particularly helpful."

Model training programs such as Domestic Violence and the Role of the Healthcare Provider will educate and equip healthcare providers to identify victims using medical facilities, and to refer victims to services and resources that could potentially save their lives.

IN THE FUTURE,
WE HOPE TO
**EXPAND
OUR
ABILITY**

TO OFFER CONTINUING
EDUCATION CREDITS
TO SOCIAL WORKERS
AND DOCTORS,
AND TO SHARE THE
TRAINING IN A VARIETY
OF FORMATS AND
VENUES

CONCLUSION

Understanding intimate partner violence is often counter-intuitive. Healthcare providers face many of the same challenges around understanding domestic violence that society encounters. For those in the field of medicine, many are used to a top-down approach. Generally, healthcare providers tell the patient how to manage an illness and prescribe the necessary treatments and medication. The medical body of knowledge has been acquired from regimented, scientific study. However, knowledge about IPV has come directly from the men and women who are survivors or who are involved in the lives of victims and survivors who have bravely shared their stories. The experiences and stories of victims and survivors drive the methods and tools used today to address domestic violence. For this reason, it is important to preserve the survivors' stories, needs, experiences, and desires when addressing domestic violence.

Model training programs such as *Domestic Violence and the Role of the Healthcare Provider* will educate and equip healthcare providers to identify victims using medical facilities, and to refer victims to services and resources that could potentially save their lives. Education should also address the personal and societal barriers such as negative stereotypes and problems identifying with victims; institutional barriers such as lack of support, resources and collaboration with community agencies; and professional barriers such as lack of education, training and tools regarding IPV. In addition, medical professionals should be educated to screen patients in order to increase detection and intervention rates.

The goal of this model training program is not for providers to convince patients to disclose abuse. The goal is for providers to learn the tools in order to continually and consistently ask questions to screen patients for IPV, and to learn how to make patients feel comfortable, respected and safe to utilize healthcare professionals as resources and allies. It is important for healthcare professionals to recognize that leaving an abusive relationship is a process rather than an event, and to take the time to build trust and rapport with the patients while being mindful of cultural norms and cultural context. Asking the questions and planting a seed of reassurance is success. Hopefully by screening patients earlier and continuously, more survivors will get the support and help they need and increase their safety whether they leave or stay in the abusive relationship.

The 330 healthcare providers that were trained through this Model Training Program in New Jersey, *Domestic Violence and the Role of the Healthcare Provider*, have had the opportunity to develop their knowledge of the dynamics of IPV and to develop skills in order to identify, screen and support their patients who are survivors of abuse. This particular educational model for healthcare providers is hoped to serve as a model for healthcare facilities nationally. Part of our success comes from the fact that our trainers are highly regarded nurses themselves, so they speak the language of the trainees, and we were able to offer the nurses continuing education hours for attending the seminar. In the future, we hope to expand our ability to offer continuing education credits to social workers and doctors, and to share the training in a variety of formats and venues.

When victims are restricted and controlled by their abuser, sometimes one of the few places they are able to go for help is to their healthcare providers. For this reason, the healthcare system has a vast opportunity to reach victims, to support them and be an ally to them. Since victims suffer from chronic health conditions more than those who are not victimized, and screening during the tension-building phase of the cycle of violence can be a better time to screen than immediately after an incidence of violence, it is critical to increase healthcare provider's awareness of the connection between these issues, and give them the education and skills needed to respond effectively. Healthcare professionals are frontline workers in the field of IPV whether they know it or not. The overarching goal of this program is to equip them to make the positive impact they are uniquely placed to make in the lives of both victims and survivors of intimate partner violence.

As facilitator Anna Trautwein closes the seminar, she states that as a result of attending this model educational program, the hope is that healthcare providers will have a shift in their perspective, and

Victims may see healthcare providers for care for either routine or chronic conditions during the tension-building stage of the relationship more often.

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that they will begin to understand the importance of "...redefining the goals of routine screening, so that the act of compassionate asking in and of itself, rather than the outcome of disclosure, constitutes success."¹⁴⁸ That principle, in the context of this body of knowledge, can make all the difference in the field of healthcare addressing intimate partner violence.

APPENDIX

OTHER DOMESTIC VIOLENCE PROGRAMS AT RWJUH CHPP

In addition to the *Domestic Violence and the Role of the Healthcare Provider* training, RWJUH CHPP provides other community-level domestic violence programs.

1. New Brunswick Domestic Violence Awareness Coalition (NBDVAC)

RWJUH CHPP works in collaboration with the New Brunswick Domestic Violence Awareness Coalition (NBDVAC), a conglomerate of community agencies in the New Brunswick, NJ area working to end domestic violence. The mission of NBDVAC is to promote healthy relationships and to support the individuals, families and the needs of the community through advocacy and education. Previous campaigns and programs included: *Domestic Violence Has No Place In Our Community*, training of community-based organization, clergy and church members on domestic violence awareness issues, development of an educational bilingual guide for lay educators on domestic violence, training on domestic violence awareness for New Brunswick health educators, development of a domestic violence awareness theater project, "Love Does Not Hurt/El Amor No Duele," and a domestic violence protocol training for community-based organization.

2. 100+ Men Against Domestic Violence: Bystander intervention

In order to stop the cycle of violence against women, we must not only empower women but we must also educate men. Primary prevention is important in order to prevent violence before it begins. Based on this perspective, the "bystander approach" to intimate partner violence prevention is gaining popularity, as it enables all men the opportunity to help prevent violence. Effective IPV prevention programs must approach men not as potential perpetrators but as potential helpers, allies and bystanders.¹⁴⁹ The "100+ Men Against Domestic Violence" bystander intervention trainings include a curriculum to train men about domestic and dating violence, the impact of sexism and derogatory actions toward women, and how to be mentors in New Brunswick. This training was presented, this year, in a two-part session co-led by one male and one female facilitator with extensive backgrounds in the field of domestic violence.

3. Healthy Relationship Seminars

There are not many spaces in New Brunswick where young people can come together to talk about the issues of relationships. The "Healthy Relationship" workshops provide an atmosphere for teens and young adults to openly communicate about topics such as healthy relationships, conflict and signs of unhealthy relationships. This year the workshops were presented in both English and Spanish. Through a post-training evaluation survey, it was found that 90% of participants felt that the training better prepared them to handle conflict in relationships. Students and participants that have engaged in such programs demonstrate attitudinal and behavioral changes in regards to domestic violence.¹⁵⁰ It is the goal of this program to empower teens and young adults to confront their peers about abuse and to increase their knowledge of the dynamics of unhealthy relationships.

¹⁴⁸ Warshaw & Alpert, 1999, 619

¹⁴⁹ McMahon & Dick, 2011

¹⁵⁰ Cornelius & Resseguie, 2006

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