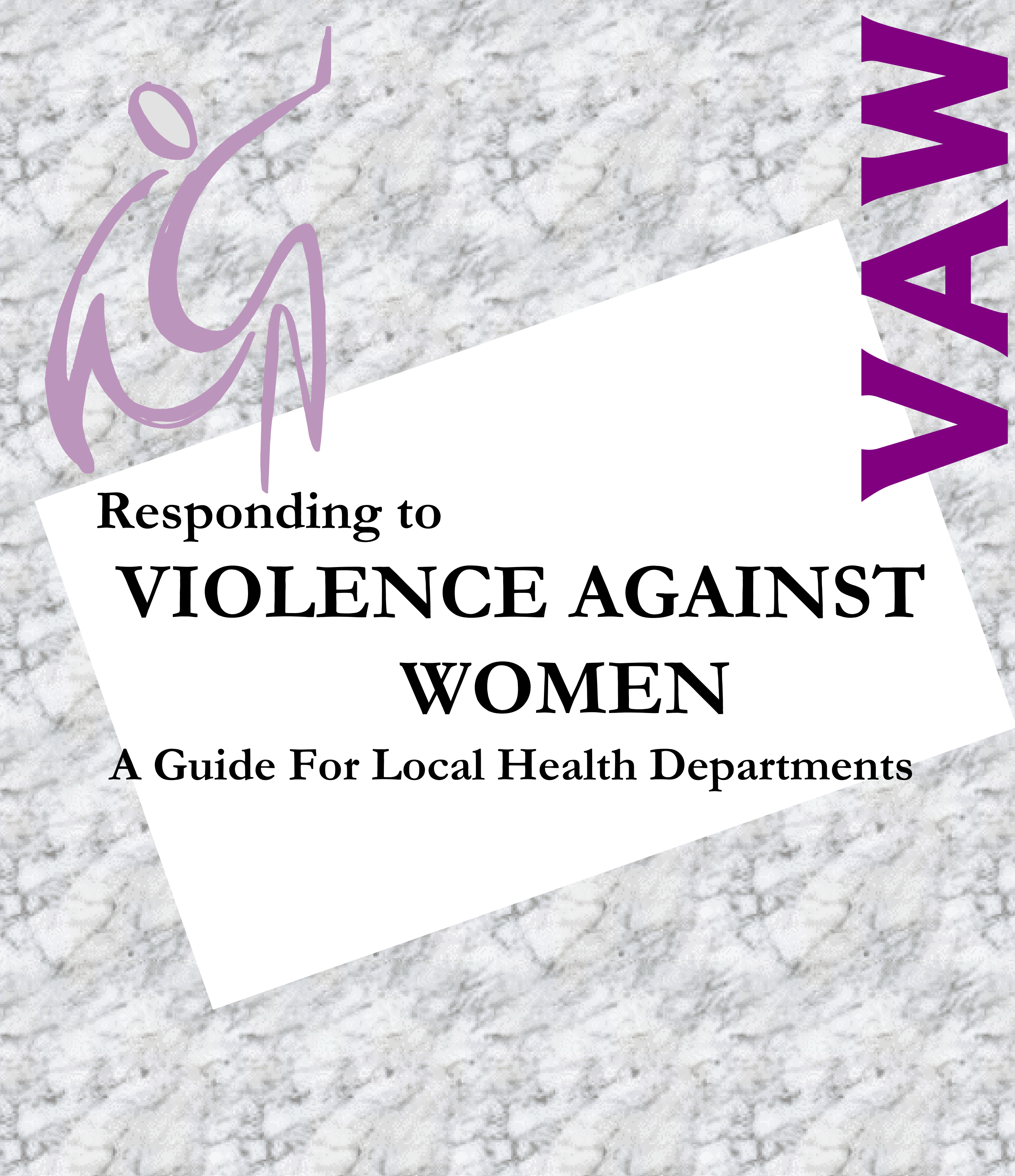

Responding to VIOLENCE AGAINST WOMEN

A Guide For Local Health Departments

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
INJURY AND VIOLENCE PREVENTION BRANCH

Responding to VIOLENCE AGAINST WOMEN

A Guide For Local Health Departments

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THE NC PUBLIC HEALTH ALLIANCE TO PREVENT VIOLENCE AGAINST WOMEN

The North Carolina Public Health Alliance to Prevent Violence Against Women (the "Alliance") is an interdisciplinary, interagency group that has been continuously active since its inception in 1994. The Alliance originally began as the Domestic Violence Coordinating Committee with membership primarily drawing from Injury Prevention and Women's Health in the NC Department of Health and Human Services as well as the NC Coalition Against Domestic Violence, the NC Medical Society, and the University of North Carolina Injury Prevention Research Center. Early projects included the first version of this resource, entitled *Responding to Domestic Violence: A Guide for Local Health Departments*, training packets and resources to be used in conjunction with the *Guide* during team training across the state, and the inclusion of questions in the NC PRAMS and NC BRFSS. The group changed its name to the NC Public Health Alliance Against Domestic Violence and expanded its membership in 1998.

More recently, a final change to the current name in 2001 reflected the Alliance's interest in expanding the scope of membership and topical areas addressed to a broader view of violence against women (VAW) to include sexual and other violence, and VAW-related issues for women with disabilities, child well being, and suicide. The revision of this *Guide* is one of the main projects Alliance members agreed to undertake. The contents have been updated and expanded to include information on sexual and other forms of VAW, and related information on issues in the context of VAW was added.

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INTRODUCTION

This resource, *Responding to Violence Against Women: A Guide for Local Health Departments*, updates and expands the scope of the earlier *Responding to Domestic Violence: A Guide for Local Health Departments*. This action was based on a decision by the Public Health Alliance to Prevent Domestic Violence in 2002. The Alliance, based on careful consideration and earlier discussions of mission and scope, decided that the time was appropriate to take a broader approach to addressing violence perpetrated against women. The timeliness of the decision was a critical factor in the ability for the Injury and Violence Prevention Unit to apply for and receive funding from the Centers for Disease Control and Prevention (CDC) for strategic planning and intervention for the prevention of violence against women by state health departments. The updating and dissemination of this Guide was the primary implementation activity for the CDC funding.

Following the CDC's funding priority areas, the Alliance decided to define the scope of violence against women to include domestic violence and sexual violence and to include the special populations of disabled women and children in homes with domestic violence. The Alliance further decided that the population of women to be targeted for planning and intervention should include adult women and adolescent females because adolescence is a period when much physical and sexual violence is initiated. Membership of the Alliance was expanded to include professionals and advocates representing the expanded focus areas, and the Alliance voted to change its name to the Public Health Alliance to Prevent Violence Against Women.

During this same period, the Women's Health Branch, Women's and Children's Health Section, received federal funding for its Northeastern Baby Love family violence prevention program. The family violence prevention grant activities called for increased screening for family violence, for training of health department and community agency staff, and specifically for updating *Responding to Domestic*

Violence: A Guide for Local Health Departments for use by the project and by health departments statewide.

This expanded Guide is a product of both grants, and will be presented to local health department personnel at a series of regional workshops during August and September 2004. During the workshops, the Guide's content will be presented following a public health approach that includes defining the problem and presenting clinic-based and community-based interventions for local health departments.

Part A: Violence Against Women: A Public Health Issue

Violence against women is not solely a social or legal issue, but a serious public health problem. Domestic violence and rape and sexual assault – common forms of violence against women – cause serious injury and death. The negative consequences can endure for many years and reach beyond the physical and mental health of abused women to include the health of their children and other members of society. Violence perpetrated against women affects all ages, races and ethnicities, religions, and socioeconomic status in both metropolitan and rural communities and diminishes the quality of life of the entire community.

Society as whole pays a price when violence against women is allowed to continue as generation after generation continues the cycle. Large amounts of resources are needed to address the short and long-term consequences, and billions of dollars are incurred en economic costs and lost productivity by both the offenders and victims. In a one-year period between July 2000 and June 2001, domestic violence agencies in North Carolina served 41,214 clients. Nationally domestic violence costs employers $3-5 billion each year[7].

It is critical that services are provided to victims of violence and to their children, both in an immediate crisis and through a longer period of healing from the trauma and making life changes to end the abuse. However, without a population-based approach to prevent the many forms of violence against women from being perpetrated, the problem will continue to grow. A public health approach that focuses on primary prevention will over time reduce violence against women and ensure that fewer women, children, and families experience the suffering it causes.

Part A of this Guide presents information to define and provide an understanding of violence against women using a public health perspective. Chapter 1 defines various forms of violence, its underlying causes, and typologies of perpetrators. Chapter 2 provides information to describe the magnitude and burden of the problem including its costs. Chapter 3 describes the impact of violence on various special populations of women.

CHAPTER 1

DEFINING VIOLENCE AGAINST WOMEN

The scope of Violence Against Women includes physical and sexual violence inflicted on women. The violence may occur in intimate relationships or be perpetrated by acquaintances or strangers. Included are the forms of violence commonly known as domestic violence, rape, and sexual assault and other types of abuse or aggression that may occur in conjunction with or separate from physical and sexual abuse. These include emotional abuse (also called psychological abuse), economic abuse, and stalking. Since most physical and sexual violence against women is perpetrated by intimate partners and acquaintances, this Guide will focus on the etiology of and response to these more common forms of violence.

This Guide's approach to violence against women includes the well-being of their children, especially if the children are exposed to the violence or are themselves abused. It also gives special attention to groups of women with risk markers for abuse and that present special considerations for intervention. These include women with physical and mental disabilities, pregnant women, adolescents, older women, women who use substances, women residing in rural areas, homeless women, African-American women, Latina women, military women, immigrant women, and those in same-sex relationships.

DOMESTIC VIOLENCE

Domestic violence is a pattern of coercive and abusive behaviors used by one current or former intimate partner against the other. The coerciveness of the behavior involves physical and sexual violence, threats of physical or sexual violence and psychological abuse. Power, control and the intimate context of the violence are fundamental components in understanding the nature of the problem and in developing effective interventions. Intimate partners include current spouses (including common-law spouses), current non-marital partners, former marital partners and former non-marital partners[158]. Domestic violence crosses all demographic boundaries as evidenced by its prevalence among heterosexuals, gay men, lesbians, bi-sexual, transgendered individuals and people from all cultures, races, occupations, religions and age groups.

Abuse Tactics

Batterers may use a variety of abuse tactics to dominate and maintain control over their partners. They may attempt to manipulate every aspect of their partners' lives. If unchallenged, men who batter learn that violence is an acceptable and effective way to resolve problems and get what they want. Various forms of abuse in combination or isolation of one another may comprise the abuser's store of tactics.

Physical Abuse

Physical abuse may include slapping, punching, choking, shoving, shaking, burning, or other actions that may or may not result in injury or trauma. Weapons including household objects, knives, or guns may be used. Sometimes the physical abuse may not cause physical injury, but may result in other health problems that may result from stress, sleep deprivation and poor nutrition.[193]

Psychological/ Emotional Abuse

Psychological or emotional abuse is defined as trauma caused by acts, threats of acts or coercive tactics.[158] This form of abuse is important because many women report that it is as harmful or worse than physical abuse they suffer. Behaviors regarded as psychologically abusive may include belittling or ridiculing the partner in front of others, insulting the partner, saying things to upset or frighten the partner, acting jealous and suspicious of the partner's friends and social contacts, and monitoring the partner's time and whereabouts.[130] Psychological abusers use many such verbal and nonverbal tactics to hurt or terrorize the victim.

Economic Abuse

Economic abuse may be considered a subcategory of psychological abuse since it serves many of the same functions and has some of the same emotional effects on its victims. It is distinguished by its focus on preventing victims from possessing or maintaining any type of financial self-sufficiency or resources and forcing material dependence on the abuser. Behaviors of economic abusers include the withholding money or access to money by the abuser, forbidding the partner's attendance at school or work, and interfering with the partner's job performance by harassing and monitoring work activities with frequent phone calls or visits to the workplace.[130]

Stalking

Stalking is defined as repeated visual or physical proximity, non-consensual communication, and/or verbal, written, or implied threats

directed at a specific individual that would arouse fear in a reasonable person. The victim must experience a high level of fear or feel that they or someone close to them will be harmed or killed by the stalker.[132] Results from the National Violence Against Women Survey indicate that many women who are stalked by intimate partners are stalked both during the relationship and after it ends.[175] Stalking behaviors may include the abuser secretly following and/or spying on the partner, standing outside the partner's home or workplace, leaving unwanted items for the partner to find, and verbally threatening the partner through telephone calls and messages, written or electronic correspondence, or in person.

Sexual Abuse

Sexual abuse may be used as a tactic by one partner to control another partner in the context of an intimate relationship and domestic violence in general. Sexual abuse of a partner may be used in conjunction with physical and other forms of abuse and is a means to control, punish, humiliate and degrade the victim. Between one third and one-half of battered women are raped by their partners, and sexual abuse often occurs in the most violent relationships.[14] The term "marital rape" generally refers to nonconsensual sex acts between a man and women who are husband/wife, ex-husband/wife, or a long-term intimate partner. Offenders often believe that marriage gives them ownership to the woman's body, entitling them to sex whenever they want it, regardless of the victim's wishes. Sexually assaulting a spouse is illegal in North Carolina.[21]

Abusers tend to sexually assault a partner when she is most vulnerable. For example, they will initiate an assault when a partner is asleep, pregnant, sick, intoxicated/otherwise incapacitated, or unable to call for help or physically defend herself because children or other people are nearby, and she does not want to expose them to the violence. Also, an abuser who knows that a partner was sexually abused as a child, and is therefore particularly vulnerable to its effects, may use this tactic.

Children and Exposure to Domestic Violence

Violence against women and violence against children occur in the same families 30 to 60 percent of the time according to published research. Although these studies use different methodologies and populations, they consistently report a significant level of co-occurrence.[178] The co-existence of domestic violence and child abuse and maltreatment is particularly harmful since studies suggest that the more types of violence children are exposed to, the less well adjusted they will be.[94] Young children can be overwhelmed by their exposure to violence, especially when both the victim and the perpetrator are well known and emotionally important to the child[145]. Children who witness domestic violence see and hear the violence and its effects, including the battered parent's injuries, and they live with the consequences of the violence that may include restricted funds and a lack of response to their basic needs. Children may believe they are the only ones who experience domestic violence. They often suffer physically, emotionally and psychologically from witnessing or being exposed to the violence.[178] Children who are both witnesses of their fathers' violence toward their mothers and victims of child abuse often experience the most profound adverse effects.[86]

Children from homes with domestic violence exhibit both more aggressive and delinquent behavior and more withdrawn, anxious behaviors in comparison to children from non-violent homes. They perform significantly below their peers in such areas as school performance, organized sports, and social activities.[104] These children's lives are further compromised by one or both parents with a reduced ability to parent while in the midst of a violent relationship. The impact on children who are exposed to domestic violence will be discussed further in Chapter 3.

Understanding Domestic Violence: The Power and Control Wheel

The power and control wheel on the following page depicts the range of abuse that battered women may endure. This wheel was developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, and is based on women's descriptions of their experiences with abuse. The wheel illustrates that power and control are at the core of a battering relationship. The behaviors listed in all the spokes of the wheel are tactics through which abusers maintain that control.

PHYSICAL VIOLENCE SEXUAL

USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.

USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons.

USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.

USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.

POWER AND CONTROL

USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles

USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.

USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away.

MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying she caused it.

PHYSICAL VIOLENCE SEXUAL

VIOLENCIA

FÍSICA

SEXUAL

USO DE COERCIÓN Y AMENAZAS

- Asustarla con amenazas de hacerle mal.
- Amenazarla con dejarla, con el suicidio o con denunciarla falsamente a la autoridad.
- Obligarla a retirar los cargos presentados contra él.
- Obligarla a cometer actos ilegales.

INTIMIDACIÓN

- Provocarle miedo a través de sus miradas, acciones y gestos.
- Destrozar objetos.
- Intimidarla rompiéndole sus cosas personales, maltratando a los animales domésticos, mostrándole armas.

ABUSO ECONÓMICO

- No dejarla trabajar o impedirle que mantenga su empleo.
- Obligarla a que le pida dinero.
- Darle una mensualidad.
- Quitarle el dinero.
- No informarle acerca de los ingresos familiares o no permitirle disponer de los ingresos.

ABUSO EMOCIONAL

- Hacerla sentir inferior.
- Hacerla sentir mal.
- Insultarla con apodos ofensivos.
- Hacerla pensar que está loca.
- Confundirla a propósito.
- Humillarla.
- Hacerla sentir culpable.

PODER Y CONTROL

PRIVILEGIO MASCULINO

- Tratarla como una sirvienta.
- No dejarla tomar decisiones importantes.
- Actuar como el rey de la casa.
- Definir los roles del hombre y de la mujer.

AISLAMIENTO

- Controlar lo que hace, a quién puede ver, con quién puede hablar, lo que puede leer, y dónde va.
- Limitarle su vida social. Utilizar los celos para justificar sus actos.

MANIPULACIÓN DE LOS NIÑO(A)S

- Hacerla sentir culpable por el comportamiento de los niño(a)s.
- Usar a los niño(a)s como intermediarios y mantener así el control.
- Usar las visitas con los niño(a)s para molestarla o amenazarla.
- Amenazarla con quitarle los niño(a)s.

MINIMIZAR, NEGAR, CULPAR

- Minimizar el abuso.
- No tomar seriamente la preocupación que ella tiene sobre el abuso.
- Negar que hubo abuso.
- Hacerla sentir responsable de la conducta abusiva.
- Decirle que ella lo provocó.

FÍSICA

SEXUAL

VIOLENCIA

Underlying Causes of Domestic Violence

Five theoretical models explaining domestic violence are described below. Each of these types uniquely defines domestic violence and presents diverse approaches to be taken to address the issue. Although each type has some explanatory value, no single framework fully explains why domestic violence occurs.

Domestic violence prevention strategies must include some understanding of the underlying causes as well as a vision of what constitutes a healthy, non-violent family. Despite their differences, all these theories share some common explanations and conclusions that can serve as a foundation for domestic violence prevention strategies.

- Domestic violence has been ignored as a major social problem until recently and remains poorly understood.
- Domestic violence is a complex problem impacted by multiple variables.
- Childhood trauma, either through exposure to violence or some other trauma, influences the likelihood of domestic violence.
- As long as domestic violence is condoned as accepted behavior by public attitudes and institutions, there is little chance of preventing it.[200]

Individual Psychopathology Model

This model explains violence in terms of qualities of the abuser, such as psychopathology, personality disorders, or drug/alcohol dependence. Psychological deficits, psychosocial problems (such as alcoholism), distorted interpersonal communication and other intra-individual abnormalities are considered causal factors for family violence. As the level of physical aggression increases, the psychopathological model asserts that there is a greater likelihood that some personality style, trait, or disorder will be associated with the physical aggression.

Some studies comparing men who abuse with men who do not abuse found a higher proportion of personality disorders among abusers. However, the majority of the abusers did not exhibit personality disorders. Other studies of male batterers show that witnessing domestic violence or being the victim of abuse undermines one's ability to trust and to regulate emotions and can result in hostile, dependent, insecure individuals with little ability to develop healthy relationships.[200]

Many reject the notion that mental illness in the abuser is an adequate explanation for violent behavior. Considering the wide prevalence of domestic violence in society, it is difficult to claim that 20% of American men have serious psychological problems. Research indicates that fewer than 10% of instances of family violence are attributable to personality traits, mental illness, or psychopathology.[70]

Psychotherapy is the recommended form of intervention according to this model. This model has received popular support because it is difficult to understand how a "normal" man could abuse his partner. Many people do not want to consider their own potential to abuse or even consider that some behaviors in which they engage could be violent or abusive.[70]

Social Learning and Development Theory

This perspective suggests that domestic violence is learned behavior that is modeled and rewarded, and supported by families and the broader culture. Analyses based on this theory focus on the ways children learn that aggression is an appropriate way to resolve conflicts, especially in intimate relationships.[54] Several studies have found that batterers are much more likely to have had violent fathers than non-batterers. Developmental research shows that early intervention with children from violent households may restore normal developmental processes, such as empathy and self-control, and minimize the risk of further harm caused by exposure to abusive adult models.[199]

Biological Theory

According to this theory, violent behavior is biological and organic and can be explained by genetics, biochemistry and changes in brain development due to trauma. Research has linked the trauma of early exposure to chronic violence to changes in a child's brain functioning that lead to violent behavior as an adult. Some researchers of biological theory believe that some abusive men have histories of head injuries that have affected their ability to solve problems and control impulsivity.[200, 157]

Couple and Family Interactions Theory

This theory suggests that domestic violence is rooted in the faulty interactions of a couple and family system, and that an individual's behavior cannot be addressed without understanding the context, characteristics, and dynamics of the familial relationship.[200]

Societal Structure Theory

According to this view, domestic violence is caused by an underlying power imbalance in society that focuses on patriarchy or male domination over women and children through physical, economic, and political control. Domestic violence reflects women's inequality in the culture and the reinforcement of this reality by various institutions.[29] According to this perspective, domestic violence cannot be adequately understood unless gender and power are taken into account[201] because the violence is used by the abuser to maintain the unequal balance of power.[195]

SEXUAL VIOLENCE

Sexual violence is a sex act completed or attempted against a victim's will or when a victim is unable to consent due to age, illness, disability, or the influence of alcohol or other drugs. It may involve actual or threatened physical force, use of guns or other weapons, coercion, intimidation or pressure. Sexual violence includes rape (or penetration) as well as intentional touching of the genitals, anus, groin, or breast against a victim's will or when a victim is unable to consent. It includes voyeurism, exposure to exhibitionism, or undesired exposure to pornography.[133]

Sexual assault is a crime of power, control, and violence that has a devastating impact on its victims. Anyone can become a victim of sexual assault regardless of gender, race, age, and economic status.

The most common form of sexual assault (77%) is by an acquaintance[77]. This occurs when a person known to the victim – a friend, co-worker, partner, or family member – forces unwanted sexual acts. It involves coercion, intimidation, threat of violence, or holding the victim down rather than physical violence. Rape in marriage is the most common completed rape and often involves multiple occurrences.

Statutory rape in North Carolina, except when the defendant is lawfully married to the offender, is consensual or nonconsensual vaginal intercourse or a sexual act with another person who is 13, 14, or 15 years old and the defendant is at least six years older than the person or another person who is 13, 14, or 15 years old and the defendant is more than four but less than six years older. The exception is when the defendant is married to the victim (NC GS 14-27.7A). Many of these victims may have given consent to sex, but under North Carolina law, consent is no defense for this crime.

Sexual assault by a stranger is the least common form of sexual assault. Adults and children are taught to be wary of strangers, when studies show that 77 % of completed rapes are by persons known to the victim.[77]

Children and Exposure to Sexual Violence

Children may be present or otherwise exposed to acts of sexual violence, and this exposure can have detrimental effects. Because most of the sexual violence children may be exposed to occurs between his or her parents or a parent and the parent's partner, much of this subject will be discussed in terms of domestic violence. In general, however, exposure to sexual violence in the home will likely cause similar effects as other forms of domestic violence.

Children may also be exposed to other forms of sexual violence, such as having a mother who is raped by someone other than a partner or ex-partner. A woman recovering from stranger or acquaintance rape and sexual violence may have difficulties with parenting due to the effects of the trauma. She may become increasingly fearful of being revictimized, may isolate herself or be depressed, may face a difficult recovery from physical injuries, and may use coping strategies that are harmful, such as using alcohol or other substances. Some women react to sexual violence and rape by overidentifying with their own sexuality and acting out in sexual ways. Also, if the perpetrator is known to the family, there may be the reality of further contact, and children may be at risk of being harmed just as the mother may be revictimized. They may create a hypersexualized environment, which can negatively effect children, particularly children who may themselves be developing sexually and looking for role models and norms of behavior as they explore their own identities. All of these difficulties of recovering from

sexual violence can impact a woman's ability to parent and can create a stressful environment for the entire family.

Tactics Used in Sexual Violence

Non-Domestic Violence

There is a wide variety of tactics used by rape and sexual violence offenders. They can be manipulative, using charm, making promises, offering gifts, or anything that lowers a potential victim's defenses. They may act really helpful and show concern for her safety until they can isolate her and take advantage of her vulnerabilities. Others may use physical violence and restraint, as well as threats of worse harm or death to get a victim to comply with demands.

Some rapists and sexual offenders use status or some other non-physical power they may have over a victim to have her cooperate. For example, they may be supervisors, respected members of a community or faith organization, or teacher. Others use their age to impress or manipulate younger children or adolescent girls. A large proportion of pregnant girls in their early adolescents have a partner they are "dating" who is several years older, even 5 to 10 years or more. Older offenders who are aware of the girl's age might use a sort of "grooming" process to normalize their behaviors and even make it sound special; however, depending on the age of an older offender, the age of the victim, and the difference in years between them, this may actually be statutory rape. They may use pornography as a tool, exposing the adolescent girl to such graphic images and then interpreting it as a teaching method. Often younger victims are made more vulnerable by the offender giving them drugs or alcohol, either with or without her knowledge or consent. There is a strong focus on gender roles, especially with a hypermasculine version of a man sharing his sexual prowess. The younger victim is then entrapped with threats of exposure, the offender telling everyone and ruining her reputation, or even making threats by using the illegality of the act (e.g., that she, too, will be convicted for participating if she discloses to anyone).

Many offenders, though not all, tend to work on "setting up" situations as they work towards committing an act of sexual violence. For example, they may secretly disable a woman's car and then offer help, or they may ask for assistance in finding something, etc. Part of most tactics is a scan for anything that may make a

person vulnerable, and these vulnerabilities are then used against a victim. Some offenders seem to act more impulsively without this kind of set up and planning.

For a better description of these tactics and how they may be used to understand the behavior of rapists, a researcher named Groth describe three basic typologies of rapists: the anger rapist, the power rapist, and the sadistic rapist[78]. Though originally proposed many years ago, by N. Groth these typologies are still accepted and useful for understanding sexual violence. All rape is primarily an aggressive act, and all rape includes characteristics of power, anger, and sexuality, but the offender types also have unique patterns based on which of these characteristics is dominant, how intensely each characteristic is felt and how the rapists express them[78]. These three basic types or categories of rapists grew out of observations of the patterns of assault used by convicted rapists and information shared by victims. The researchers then applied clinical expertise to better understand the psychodynamics involved with rape. The descriptions are generally still accepted today[78].

Each type of offender in Groth's three typologies has a particular profile and is more likely to use a certain collection of tactics, however, there is some overlap and an individual offender certainly may use any of the tactics described below during an act of sexual violence. It is also important to recognize the fact that this study, like most research on perpetrators of sexual violence, is unable to describe all rapists or sexual offenders. What we know about sexual violence perpetrators is really drawn from studying the ones who are somehow "caught" either by law enforcement and the justice system or in a therapeutic environment like a treatment center or in other social service agencies. Rape survivors have also contributed a great deal of knowledge by sharing of information with clinicians, law enforcement, and researchers despite their own trauma. Not all survivors talk about the rape or remember details, only 1 percent of the perpetrators of sexual violence are convicted for the crime, and few other perpetrators make it into some other form of treatment, therefore our knowledge and understanding of rape and rapists is fluid and subject to change. The vast majority of rapists still live in our communities and, most often, they are repeat offenders. Little is know about this large group of offenders that is "successful," i.e., not caught or otherwise officially identified. Because of this fact, we

do not have a complete picture, but what we do know can be useful as long as it serves as a general guide to understanding these behaviors.

Anger Rapist

This type of perpetrator uses sexual violence primarily as a means to express feelings of anger and rage[78]. About 30% of the offenders studied fall into this category. Anger rapists choose their victims based on availability and they are usually in the same general age group or older than the rapist. The anger rapists uses force, including brutal violence, and usually cause injuries to all or many parts of a victim's body. Often more force is used than is actually necessary to gain cooperation. Usually, no weapon is used. When a weapon is used, it is one of opportunity used more for hurting, rather than threatening, the victim. The episodes of rape may grow out of feelings of depression or anger and is spontaneous, impulsive, and unplanned, and they are usually over relatively quickly. The sexual violence is a means of lashing out against perceived "wrongs" or "put-downs" done towards the offender, despite the fact that the victim is not usually the original cause of the anger. Of ten these rapists have long criminal records that are filled with acts of aggression, in addition to the perpetration of sexual violence and rape.

Power Rapist

This category describes the most common type of rapist, and it includes the large group of offenders known as acquaintance or date rapists. Groth found that approximately 70% of his subjects fell into this category, which describes a rapist who commits sexual violence that is premeditated and usually preceded by persistent rape fantasies.

These acts of sexual violence are repetitive and may become increasingly aggressive over time. The power rapist is motivated by a psychological need for compensation, a means to feel powerful and counter deeply-held feelings of insecurity and inadequacy. These offenders are often described as being initially charming, though they also tend to be arrogant and narcissistic, thriving on and working to maintain other people's attention. In the course of the conversation they may repeatedly "talk over" the victim as they tend to focus on themselves, and return the conversation quickly to

themselves if it strays. They may be dismissive of what their potential victim says, or they may say belittling or disparaging things about others as a way to bolster their own images. Offenders discuss how others don't appreciate them to gain sympathy, although they also do convey a sense of entitlement and deserving better – better friends, jobs, things, family members and respect.

Victims are chosen based on vulnerability and tend to be around the same age or younger than the offender. Once they identify a potential victim as vulnerable, power rapists work to isolate her from others. Many victims report that they were sitting alone, withdrawn or depressed, or not really part of the group they may be with, a characteristic the offender looks for and then exploits. The power rapist will work to further isolate a victim by talking her into going to another location (for example, a different bar or club, or to get a cup of coffee or a meal). They often attempt to have the victim use drugs, especially alcohol, to increase her vulnerability. Other victims may have a disability, are already under the influence, or are by themselves, all things that can be exploited to increase vulnerability. The power rapist takes advantage of everything in order to manipulate the victim and complete a rape or act of sexual violence.

During a rape, the offender is usually anxious and may use a weapon carried to the crime scene for purposes of intimidation and threats to gain compliance, rather than for injuring the victim. Force is usually used only until the victim complies, but a victim who resists may inadvertently be injured. The power rapist speaks to give instructions and out of curiosity, often asking the victim personal questions and about their responses. The power rapist may hold the victim in captivity for a few hours, and the rape extends over a short period of time. If there is a prior criminal record, it will most likely show other crimes of exploitation, such as theft or robbery, nuisance calls, and other acts of sexual violence.

Sadistic Rapist

Sadistic rapists are motivated by eroticized aggression and symbolic control, elimination, or destruction of threat or temptation in order to regain psychological balance and equilibrium. About 5%

of Groth's subjects were part of this typology. Sexual violence perpetrated by sadistic rapists is premeditate and calculated, with the victim being a stranger who is chosen based on specific characteristics that are symbolic in nature. The victim is subject to ritualized acts such as bondage and shaving. If anger is also eroticized, the victim may be tortured and sexually abused over extended periods of time. During the sexual violence, the sadistic rapist is filled with intense excitement, and he uses language as a means to command, degrade, sometimes alternating between reassurance and threats. The offenses are typically compulsive, highly structured and ritualistic, and usually involve bondage, torture, and bizarre sexual acts. Weapons are used for capturing the victims, and many weapons or other instruments are used for restraining and torturing the victim. The sadistic rapist often holds the victim over extended periods of time for repeated episodes of violence, usually followed by disposal of the victim's body. If a sadistic rapist has a prior criminal record, it is most likely for bizarre and ritualistic offenses or other violent offenses. Many have no criminal record.

CHAPTER 2

THE MAGNITUDE AND BURDEN OF VIOLENCE AGAINST WOMEN

No comprehensive surveillance system for violence against women exists either for the United States as a whole, or for North Carolina in particular. However, data from national and regional studies that have examined various aspects of violence against women can provide some background information on the scope and nature of this important public health problem, though none provide a complete picture.

VIOLENCE AGAINST WOMEN IN THE UNITED STATES

Approximately 1.5 million women and 834,732 men are raped and/or physically assaulted by an intimate partner each year[176], and almost one-third of all US women are physically or sexually abused by a partner or ex-partner during their lifetimes[41]. Compared to men, women in the United States are less likely to become a victim of violent crime in general; however, women are between five to eight times more likely than men to be victimized by a partner or ex-partner[33]. In fact, nearly two-thirds of women who reported being raped, physically assaulted or stalked since age 18 say that they were victimized by a current or former husband, cohabiting partner, boyfriend or date[176]. Additionally, women between the ages of 19 to 29 were twice as likely as other women to experience violence perpetrated by a partner[176]. Adolescents aged 16-19 years old are 3.5 times more like than the general population to be victims of sexual assault, regardless of the perpetrator[126], and women under 25 years old comprise 83% of all female victims of rape[175]. One in seven adult women in the US has been forcibly raped at least once, but often repeatedly, in their lifetimes[101]. The most common perpetrator of a sexual assault (77% of the total) is an acquaintance of the victim[77].

Battering by a partner or ex-partner causes more injuries to women than auto accidents, muggings, and rape combined[169]. Women who are battered or raped by a current or former intimate partner are more likely to be injured than women assaulted by other types of perpetrator such as family members, acquaintances, or strangers[176]. Among women who are physically assaulted or raped by an intimate partner, one in three is injured, which means that each year more than 500,000 individual women are injured and require

medical treatment as a result of violence by an intimate partner or a former partner[176].

Every year in the United States, an estimated 5.3 million episodes of violent victimization by an intimate partner happen to women over 18 years old, and these episodes result in almost 2 million injuries, a quarter of which require medical care[132]. Only 35% of women who were injured during a rape and 30% of women injured by a physical assault received treatment for the injury[176].

While women can also be the perpetrators of violence against their partners, numerous statistics and surveys consistently show hat no matter which partner starts a violence episode, women are 7 to 10 times more likely than men to be injured during the intimate partner violence[154, 176]. Furthermore, women are between 7 to 14 times more likely than men to suffer from the most severe instances of physical assaults by an intimate partner[154, 176].

Women who are subjected to one type of violence by a partner are often subjected to other types of violence as well. For example, 48% of physically abused women also report sexual abuse, and over 84% who reported sexual assaults were also physically abused[151]. Between one-third to one-half of battered women are also raped by their partners, and sexual abuse in an intimate relationship characterizes the most violent relationships[14]. In fact, 14-24% of all women are forced to have sex at least once in their marriages[14]. The risk of rape does not end with a separation or divorce for many women, especially when a spouse or ex-spouse believes in entitlement to sex with his wife regardless of the relationship's status[14].

Women are not just at risk of injuries from partners and ex-partners, but they are also at risk for being killed by them. Approximately one-third of female homicides in the United States between 1981 to 1998 were committed by intimate partners or ex-partners, whereas only 5% of murdered men are killed by a partner or ex-partner[148, 154]. Also, of all homicides in the United States committed by an intimate partner, 72% occur to women[154].

Women with disabilities must cope with an even higher risk of being abused, and many of the challenges they face in daily life

often lead to more severe impacts and health consequences than other women face. Sixty-two percent of US women with physical disabilities reported having experienced emotional, physical or sexual abuse[140], yet women with disabilities often confront severe barriers in accessing services and health care; contend with multiple perpetrators, including partners, family members, and personal attendants or health care workers; and have usually experienced abuse for longer periods of time than abused women without disabilities[140, 202]. Adults with developmental disabilities are at four to ten times higher risk of physical and/or sexual assault than the general population[184].

Although only 27% of all U.S. homes include children under age 12, between 40 to 50 percent of female victims of intimate partner violence live in households with children under the age of 12[33, 154]. Approximately 3.3 million children are exposed to violence perpetrated by family members and directed towards their mothers or other female caregivers[8]. Furthermore, in 30 to 60% of families with domestic violence, men who abuse their female partners or ex-partners also abuse the children in the home[8, 53].

Almost two-thirds of women who experience rape at some point in their lives were first raped in childhood, and nearly one-third were raped for the first or only time before they were 11 years old[101]. Once raped, an individual has a higher risk of being raped again; therefore, childhood exposure to domestic violence and experiences of being victims of abuse and rape themselves can greatly increase women's risk of revictimization during adulthood[3].

Violence also occurs around the time of pregnancy, and it may, in fact, increase in frequency or severity during pregnancy for some women, while other women find that being pregnant is one of the few times that violence by a partner actually decreases[4]. Violence during pregnancy may, in fact, be more common than other conditions and health risks usually screened for during prenatal care. Most studies report between 4-8% of women experience violence while pregnant, while some studies suggest as many as 1 in 5 women are abused during pregnancy[68]. This wide range is largely due to the study population, methodology, and the nature of the questions asked. Adolescents experience an even higher rate of violence

around the time of their pregnancies and they often have numerous perpetrators including family members, partners or ex-partners, and friends[147]. In addition, many adolescent pregnancies result from statutory rape, since about two-thirds of the children born to teen mothers are fathered by men who are 20 years of age or older[47]. Adolescents between 15 to 17 years old who were forced to have sex were twice as likely as teens not forced into sex to be in a relationship with a partner 3 to 5 years older than them[46].

The consequences to the women and to the pregnancy can be moderate to severe; however, research results have not been consistent[149]. These consequences may be due to both direct and indirect effects and may include: late or no entry to prenatal care; inability to comply with medical recommendations during prenatal care; an array coping behaviors that are unhealthy, such as poor diet or the use of alcohol, tobacco, and other drugs; low birth weight and/or premature delivery; high levels of stress and depression during and after the pregnancy; and injury to the woman or the fetus, with miscarriage possible in severe cases[13, 119, 120]. Many of these mental and physical health effects can also greatly diminish a woman's ability to parent a newborn. Further information about the impact of violence against women around the time of pregnancy will be discussed in Chapter 3.

VIOLENCE AGAINST WOMEN IN NORTH CAROLINA

Based on survey results collected between 2000 and 2002, approximately 21% of women in North Carolina reported experiencing physical violence during adulthood (since turning 18 years of age). Among the physically assaulted women, 74% were victimized by their intimate partners, 21% by strangers, and 27% by acquaintances (note that these percentages sum to more than 100% because some women were victimized by more than one category of perpetrator)[116].

Information collected across the state over a number of years reported that 1066 women were murdered between 1988-1993,and in cases where the victim–perpetrator relationship was known, 70% of women were killed by their former or current intimate partners.

Furthermore, a history of domestic violence was noted by the Medical Examiner in 20% of the partner homicides[128]. Additionally, the NC Coalition Against Domestic Violence has collected anecdotal evidence about 74 domestic violence related homicides of women in 2002 and 68 in 2003[135]. Compared to other states across the nation, North Carolina had the sixth highest rate of domestic homicides in 2000[189]. In 2000, there were 81 female homicide victims. Of the 70 victims whose cases had information on the relationship of the offender, 91% of the female victims (or 64 out of 70) knew their attacker, and 2/3 of this number (or 43 women) were intimate partners or former partners of their attackers.

Domestic violence agencies across the state served 41,214 "primary," mostly adult victims, between July 1, 2000 and June 30, 2001, a 13% increase from the previous year. Although domestic violence affects women of all ages, races, and socioeconomic statuses, some common characteristics of victims served by programs during that year include: half were white; 95% were female; and 62% were between 18 and 44 years of age. Shelter was provided to 7,207 adults (17% of the total) and 8,187 children[137].

Between 1997 and 2000, nearly 10% of North Carolina women reported physical violence around the time of their pregnancies: almost 7% during the year before they became pregnant, 5.5% during their pregnancies, and just over 3% in the 3 to 6 months after giving birth[9].

Between 1999 and 2002, information collected from a statewide survey indicated that about 10% of NC women reported experiencing sexual violence after the age of 18. Of the sexually violated women, 51% were assaulted by intimate partners, 35% by strangers, and 37% by acquaintances (the sum does not total 100% because some women were sexually assaulted by more than one type of person)[116].

From July 1, 2000 through June 30, 2001 sexual assault programs across North Carolina served 5,964 primary victims, 3,977 adults and 1,987 children under age 18, representing a decrease of approximately 16% in the number of victims receiving services from

the previous year. Although sexual assault affects people of both genders, and all ages and races, there were some common characteristics of victims served by programs during that year. Fifty-nine percent of victims served were white, and 23 percent were black; half were under the age of 30; and approximately 8 percent were male. One-third (33%) of all sexual assault victims are children age 17 and younger, with 15% of victims under age 12. The majority of victims (68%) knew their assailant[138].

About 1 in 4 women in North Carolina reported having some form of physical, mental, emotional, or communication related disability during a 2000-01 survey. Women who identified themselves as having some form of a disability were almost 5 times as likely to report being sexually assaulted than women with no identified disability. Physical assault was not significantly different for women with or without a disability in this North Carolina survey[121].

COSTS OF VIOLENCE AGAINST WOMEN

There are numerous direct and indirect costs of violence against women, and these costs affect not only the women who experience the violence, but also their families, the health care system, businesses and other employers, and society as a whole. As a consequence of severe domestic violence, female victims are more likely than male victims to need medical attention and take time off from work; they also spend more days in bed and suffer more from stress and depression[134].

According to the CDC, every year, rape, physical assault, and stalking committed by intimate partners result in costs that total more than $5.8 billion[132], which can be divided into:

- Direct costs: $4.1 billion goes towards direct medical and mental health care services
- Indirect costs (among nonfatal cases): $0.9 billion is due to lost productivity, including almost 8 million days lost from paid work (the equivalent of 32,000+ full-time jobs) and almost 5.6 million days of lost household productivity
- Indirect costs (among fatal cases): another $0.9 billion is due to lost lifetime earnings

Other estimates of the annual direct medical costs of caring for abused women totaled about $1.8 billion. When direct medical costs and other costs such as lost productivity are totaled, domestic violence costs employers $3-5 billion each year, and sick leave, lost wages, and absenteeism cost yet another $100 million per year[7]. In a comparison of health plan usage, abused women generated around 92% more cost per year than women who were not abused[198]. Other costs to society include the increased need for and use of the legal system, law enforcement, social and community services, and lower economic advancement. Because many children who witness domestic violence and/or are abused grow up to further perpetuate this cycle as both perpetrators and victims of violence, the cost to society is further multiplied without effective intervention and prevention strategies[197].

Cost estimates specifically related to rape in the US (regardless of relationship between perpetrator and victim) indicates it is the most costly crime to its victims. Victim costs total $127 billion a year when such factors as their medical expenses, lost earnings, pain, suffering, and a loss of quality of life were considered[126]. The risk of developing Post-Traumatic Stress Disorder (PTSD) after a rape is between 50% and 95%[89]. Rape victims are over six times as likely to experience PTSD as the general population, and this often debilitating disorder can have long-term and far-reaching impact on a victim's ability to function in daily activities such as school and work, which can further impact her economic situation in the present and future[101].

VIOLENCE AND WOMEN IN THE HEALTH CARE SETTING

Women who have been abused by a partner comprise:

- Between 12-35% of women seen in emergency departments[134], and up to 54% of women seen in emergency departments have been threatened or injured by a partner at some time in their lives[2];
- Over a third (37%) of women seeking care from an emergency department for a violent injury[77];
- About 6 % to 23% (current or past year violence) and as many as 28% to 66% (lifetime prevalence) of all primary health care setting patients[102];

- At least 4-8% or higher of pregnant women seeking obstetric or prenatal care[68];
- 45 to 59% of mothers of abused children[65];
- Over half of women seen in a variety of mental health care settings (includes both current abuse and history of abuse)

Female primary care patients with a history of sexual abuse have an increased risk of physical symptoms, mental health issues, including eating disorders and suicidal thoughts or attempts, as well as a lower sense of health-related quality of life[48]. Victims of sexual assault are usually extremely concerned about their risk of developing HIV and other sexually transmitted infections and are often concerned about their risk of becoming pregnant from the assault. Often, a woman who has very recently been raped will go to a clinic and state that her purpose for the visit is a need for a pelvic exam or to be tested for pregnancy, HIV and other STIs without mentioning the rape. The need to ask every patient about violence at every clinic visit will be described in detail in Chapter 4.

CHAPTER 3

THE IMPACT OF VIOLENCE AGAINST WOMEN

CIRCUMSTANCES THAT MAY INCREASE RISK OF VIOLENCE IN POPULATIONS OF WOMEN

Women from all age, ethnic, racial, and socioeconomic groups are at risk for violence: the strongest risk factor for violence is simply being female. While this is an important fact to keep in mind, it is also true that many characteristics, or "risk markers," can lead to an increased occurrence of violence against women in certain circumstances. Risk markers should not be used to stereotype women who are seeking services. Treatment and care should be individualized, and interventions should be carried out in a culturally sensitive and responsive manner. However, factors such as health status, age, race, ethnicity, immigration status, and place of residence influence access to resources and therefore the abilities of women to respond to abuse. Many women are marginalized by several risk markers and have even more difficulty ensuring their own and their children's safety and accessing the services and care they need in everyday life. Domestic violence and sexual violence can make these everyday struggles almost insurmountable unless responsive, caring, and tailored interventions are in place. Several risk markers shared by many women in North Carolina are discussed below.

Pregnant Women

Although pregnancy should be a time of excitement and anticipation, for some women pregnancy can be a very frightening and dangerous period. As many as 324,000 women each year experience intimate partner violence during pregnancy[69]. Abuse may begin or increase during pregnancy, though some women do find temporary relief from violence during their pregnancies. For most women, abuse during pregnancy is associated with an increased severity and frequency of violence and with an increased risk of homicide[24]. The greatest risk factor for abuse during pregnancy may be abuse prior to pregnancy. One study found that 87.5% of women abused during pregnancy were abused prior to pregnancy as well[90].

When pregnant women were asked about their perceptions of the reasons they were abused by their partners, they identified several, including: (1) abuse had been part of the relationship before the pregnancy; (2) the abuser was angry and jealous toward the baby; and (3) the abuser was angry with the woman for not performing the roles and duties that he saw as necessary. Although, in

general, it seems that abuse by a partner tends to begin or become worse during pregnancy, some women also said that pregnancy has been a protective period from the abuse[27].

Adult and adolescent women who are victims of physical and/or sexual violence during pregnancy are also at higher risk for using alcohol and other substances, including tobacco. Substance use further threatens the women's health and can lead to poor birth outcomes and parenting problems if the substance use continues beyond birth[115, 117]. Adult women who experience psychological and physical violence are a bit more likely to use substances before pregnancy; however, women experiencing any form of violence during pregnancy, including psychological abuse, physical violence, and/or sexual violence were much more likely to use alcohol and illicit substances than women not experiencing violence during pregnancy[115]. It is important to address the use of substances along with the experience of violence among all pregnant women.

The consequences of abuse during pregnancy are not well understood, but they may be severe. Research results are not consistent, but many studies conclude that violence may be more common during pregnancy than many other conditions receiving much greater attention, including, preeclampsia, gestational diabetes, and placenta previa[149]. Effects of psychological and physical abuse on pregnancy outcomes may include increased risk for poor weight gain, infections, anemia, second trimester bleeding, lower birth weight, disruption of the pregnancy, injury to the fetus and elevated stress levels[146, 149]. Abused women also tend to begin receiving prenatal care later in their pregnancies than women who are not abused[124]. Unplanned pregnancies experienced by abused woman may result directly from sexual abuse and the inability to negotiate contraceptive choices[127]. Sexual violence may also lead to sexually transmitted infections, trauma related injuries, and numerous medical disorders that may seem unrelated such as gastrointestinal discomfort, heart problems, and chronic illnesses. All of these consequences can further compromise the health of pregnant women and may, in turn, adversely affect the fetus[156].

Poor health outcomes during pregnancy and birth may be related to increased stress and other psychopathology resulting from the violence; to actual physical effects of trauma related to physical and sexual violence; and to negative health behaviors women use to cope

with the violence such as using tobacco, alcohol, and other legal and illicit substances[149, 156].

Adolescents

Between 9% and 65% of adolescents have experienced some form of dating violence[173]. Both males and females between the ages of 12 and 19 years are at the highest risk of both perpetrating and becoming victimized by violence; however, as with adults, teenage girls report more severe and chronic violence, often coming from several perpetrators and resulting in worse injuries, than do teenage boys[33]. A large N.C. survey found that one-third of the questioned adolescents reported some type of victimization history, and 12% reported physical violence victimization[81]. Abusive adolescent dating relationships generally have a pattern of repeated violence that both escalates and increases in severity as the relationship continues, and the relationships often include more than one form of violence. Abuse in the relationships of teens is often intensified by the pressures, insecurities, and romanticism of adolescence. Furthermore, some adolescent girls are victimized by more than one partner or by several different types of perpetrators, such as intimate partners, parents or other family members, acquaintances and close female friends (this is particularly true for pregnant adolescents)[147].

Adolescents lack experience in making good decisions in intimate relationships. They often have trouble recognizing abuse and defining it as problematic in their lives. They may regard violence as a normal part of dating or may perceive jealous and controlling behavior as signs of love. They often do not have the knowledge or skills to prevent or respond to violence in their lives. Some female adolescents may believe in a more traditional role in which their status is dependent on attachment to a male partner. A teen may stay in an abusive relationship because she fears being without a significant other, or because her family or peers think he is such a “great guy.”

Lack of education and job skills leads many adolescents to believe that their only hope for a positive future is to maintain a relationship with a man, even if he is abusive. Tolerating occasional abuse may be perceived as a matter of survival or it may just be seen as part of normal life, especially if she has seen such behavior repeatedly modeled by older family members and neighbors.

Adolescents may feel they have no one to whom they can turn for help. Studies on dating violence show that many teens in violent relationships have not talked to an adult about their experiences with abuse[149].

Adolescent girls are more likely to experience sexual violence than their male peers and older men and women[101, 176], and they are also vulnerable to statutory rape and sexual assault. One study found that adult men age 20 or older father about two-thirds of children born to teenage girls nationwide[47]. Many of these victims may have given consent to sex, but under North Carolina law, consent is no defense for this crime. Victims of statutory rape face several concerns; including, the belief that they are in love with the offender; the need for legal advice about emancipation, permission to marry, abortion, adoption and parenting skills; and/or conflicting wishes of parents that can lead to further strife.

Preventing and confronting adolescent violence is important in preventing potential violence in future adult relationships and to better ensure the safety and well-being of all adolescents as they develop into adults. Despite the critical importance of preventing and intervening in dating violence and/or sexual violence, adolescents have fewer options and resources to escape abusive situations. For example, they lack financial means, cannot easily move or change schools to meet their needs, and are not protected by the Domestic Violence Act unless they have been married to or lived with the abuser. Also, legal complications may make shelters reluctant to admit abused teens.

Young Women

Among all women, those between the ages of 16 and 24 have the highest rate of intimate partner violence. In fact, women between the ages of 16 and 24 were three times as likely to experience intimate partner violence than women in other age groups. This finding regarding young women was consistent across racial line[57, 153].

Adolescents and college students are also most at risk for attempted rape, though many victims do not identify all forced sex acts as rape. The largest age group of rape victims is from age 18-29.

Almost two-thirds of these victims had a prior relationship with the rapist, but they were 7 times more likely to have been acquaintances (57%) as family members (8%)[77]. These victims often blame themselves for the assault because they might have been drinking, made a poor choice or decision along the way, or found themselves in a situation they unexpectedly could not control. In situations of acquaintance or dating violence in this age group, the offenders most often use coercion and intimidation to force sex acts, rather than physical violence.

The majority of rapes that occur on college campuses are acquaintance/date rapes; in fact, in a large study on college and university campuses across the nation, 84% of respondents who were raped knew their attackers, and 57% of the rapes happened while on a date[194]. The prevailing attitude on many campuses is if the victim was drunk or drugged, they were "asking for it." Widespread use of drugs and alcohol in many high schools and colleges can cause victims not to report their assaults for fear of being reprimanded or punished, especially if they drank alcohol before they were of legal age to do so. Although the media has labeled drugs such as Rohypnol and GHB as the date-rape drugs of the present, these are only two of at least 22 substances used to incapacitate an unknowing victim, and alcohol is still the number one drug used by far[108]. Almost all victims (97%) of drug-facilitated rapes seen in a hospital emergency department during a recent study were women[125]. Alcohol abuse increases the chance of a sexual assault attempt, and it increases the risk of a completed rape[185]. In addition, at least 45% of rapists were under the influence of alcohol and/or another drug at the time of the rape[20].

Older Women

The abuse of women is evident during all stages of life. While the prevalence of abuse by a partner decreases with age, older women are still at risk for domestic and sexual violence. Older women may have experienced a long history of partner abuse that has extended into old age, but such abuse also may begin later in life. Sexual assault still occurs against older women, though to a lesser extent than domestic violence or the risk faced by younger women. Of the 293,000 nationwide reports of elder abuse in 1996, there were 8,790 reported incidents of sexual assault[183].

There is a distinct difference between the responses and approaches taken by the elder abuse and the domestic violence fields toward reporting, intervention, and remedial assistance to victims. Although each field has developed a variety of strategies and services, neither has done much for older women who have been abused by their spouses or partners. Elder abuse has been defined largely as a problem resulting from the stresses of caring for frail, dependent elderly people who are living at home with family caregivers or in nursing homes. As a result, elder abuse prevention programs have concentrated efforts on relieving the caregiver's stress as a means of preventing violence from developing out of frustration and fatigue. The problem of elder abuse is much larger and more complex than caregiver stress.

Abuse in later life is an issue of power and control and many times elderly victims present with few of the red flags. Health care providers further endanger elderly victims by encouraging the victim to be more independent, believing the abuser's account that the victim is not competent or demented without doing an assessment, medicating victims rather than identifying the abuse and neglecting to discuss legal options. If the abuse is attributed to caregiver stress, the health care provider may contact an inappropriate community resource. They may contact a social service agency instead of law enforcement[16].

One study found that elderly victims were not likely to be more dependent than other victims of abuse but instead were more likely to be supporting the dependent abuser[150]. By focusing on those who are dependent due to frailty or incompetence and who may need protection from their adult children or caregivers, elder abuse advocates may be overlooking what may be a more prevalent problem - spouse abuse among older couples. Given the complexity of this issue,[16] screening is recommended for every female patient age 60 and over or female patients with disabilities.

Barriers that are unique to or are of particular importance to older abused women are listed below.

- Generational ties, spiritual and cultural values
- Elderly victim's fear of retaliation from caregivers
- Fear of being placed in a nursing home

- Risk of inappropriate nursing home placement
- Economic vulnerability
- Stigma of ending a long–term relationship
- Increased isolation due to decreased mobility
- Lack of awareness of needs of older abused women
- Little community outreach and public education aimed at older women and the need for specialized services to reach older women in their homes or senior centers.
- Difficulty of older women turning to younger women for help
- Need for specialized care not available at shelters

Older adult victims face additional barriers related to sexual violence, as many will not want to talk about being raped or otherwise sexually assaulted. It is important to be aware that older generations were brought up in a time when victim blaming and denial was commonplace. These elderly victims most often have internalized a great deal of shame and are more likely to fear that they will be sent away to a nursing home because family members may think they can no longer take care of themselves. In many instances, however, the offender is a caretaker and because the victim is dependent on him or her for most activities of daily life and for medical care, older adults will be less likely to report the crime.

Women With Mental and Physical Disabilities

The term "disabilities" covers a wide range of physical, psychological, emotional, cognitive, and communication difficulties. Disability also encompasses many types of chronic health conditions and impairments that may or may not be immediately apparent to a health care provider. Disability exists across all ages, ethnic groups, geographic regions, and socioeconomic status. The incidence of disability among all age groups is increasing as a result of improvements in medical technology, increased rates of chronic disease, and the aging of the population. Existing knowledge indicates that women with disabilities experience violence at similar or higher rates than women without disabilities and that the abuse often goes unrecognized[88]. Women in North Carolina who self-identified as having at least one disability on several annual surveys were at an increased risk of sexual violence than women who did not[121].

Abused women with disabilities face many obstacles to receiving help for any form of violence they experience. The isolation and dependence that many people with disabilities experience makes them particularly vulnerable to physical and sexual abuse. These factors also make reporting abuse or calling for assistance extremely difficult. A disabled woman's confidence in her ability to live independently may be undermined by victimization. Women with disabilities are often taught to be compliant[45]. Particularly, people with cognitive disabilities are reinforced for compliant behavior and are dependent on others for many of their basic needs. These factors have the potential to increase the risk of victimization. A woman with a disability may fear, with reason, that she will lose daily living assistance, housing, or her independence. The stigma, shame, isolation, and denial that prevent many victims of abuse from seeking services are even more pronounced among women with disabilities who often perceive most of their problems as a result of the disability.

Women, with and without disabilities, can feel powerless against violence. Women with disabilities often lack opportunities to develop and understand their own sexuality and do not have opportunities to develop other social skills and a positive self-concept. Some express feelings of helplessness to prevent abuse and have the attitude of submission. This reflects the perceptions of disempowerment for women with disabilities. The numerous environmental and attitudinal barriers that women with disabilities regularly face can be viewed as stressors or forces that also cause feelings of defeat[139, 141]. There is increased perceived vulnerability as people view the physical, mental, and emotional limitations of women with disabilities. This perception of defenselessness makes women with disabilities easy targets for violence and abuse.

Another critical risk factor is the lack of economic independence. Women with disabilities share the problems of low wages and occupational segregation faced by women without disabilities. Lack of economic independence may contribute to a sense of powerlessness and is connected to the cycle of poverty and downward social mobility.

Societal devaluation and insensitivity toward people with disabilities form a backdrop that impacts attitudes, beliefs, services, and

resources. This devaluation contributes to the perceived defenselessness and powerlessness of women with disabilities, which is further compounded by inadequate, inappropriate, and inaccessible services. Many shelters do not have the trained staff or physical facilities that are accessible to women with mobility, hearing, vision, or mental disabilities. For example, women with disabilities may need accessible transportation, TTY and sign language interpreters, a ramp, alternate formats of written materials, and other types of accommodations to address their needs. Two recent surveys, one of domestic violence agencies and one of sexual violence agencies (rape crisis centers) across North Carolina found that these services are often not available and staff do not feel adequately prepared or able to serve the myriad needs of women with disabilities[190, 191]. Shelter rules, such as participating in housekeeping, are geared toward non–disabled women and may need to be modified on an individual basis for a woman with a disability. Even if a shelter is physically accessible, attitudes of staff and volunteers may lead women with disabilities to feel burdensome.

Rural Women

Women living in rural areas are not typically considered to be at increased risk for domestic violence. Rural life is generally perceived as being healthier and safer when compared to city life, and rural families are thought to be more wholesome and intact.
However, rural areas are not immune from the problems of domestic and sexual violence. Abused women living in rural areas face several obstacles to receiving help. A recent publication by the National Sexual Violence Resource Center[111] focused on sexual assault against women living in rural areas and the many associated barriers to reporting the crime and to receiving assistance, including:

- Lack of anonymity
- Greater physical isolation
- Informal social controls (i.e., unwritten cultural rules and norms such as prioritizing family reputation above personal justice)
- Distrust of outside assistance
- Perceptions of sexual assault (i.e., acceptance and seeing sexual violence as “just the way it is”)
- Concern for family continuation and survival

- Concerns accessing human services due to lack of experience using them or lack of convenient access
- Other barriers, such as size and configuration of the community, language barriers, ethnic codes, perceptions of local law enforcement, etc.)

Beliefs in subordinate roles for women exist throughout U.S. culture but may be especially pervasive in rural areas. Not only do many women have these beliefs, but also neighbors and relatives with these beliefs may be less understanding and supportive of an abused woman. Support for families to stay together may come from the whole rural community including neighbors, friends, churches, and police and may negatively affect abused women. Community members may encourage her to "be a better wife," or remind her that she "made her bed and now must lie in it." Law enforcement officers may know the couple and may prefer to mediate rather than arrest the abuser.

Violence against women is pervasive and hidden in rural localities due to physical or geographical isolation. Many victims do not have access to a vehicle, and public transportation does not exist in rural areas. A woman may be several miles from the nearest assistance, and she may be unwilling to walk so far because she may not be able to take her children with her. Often there are no neighbors nearby to hear her screams during an assault by the abuser. Law enforcement agencies frequently must cover large areas with few officers. As a result, they might take more than an hour to respond to a call for help.

Anonymity is uncommon in many small communities, making lack of privacy another barrier faced by rural women. An abused woman may be at increased risk if her abuser discovers that she has revealed the abuse. Women are frequently afraid to use available services (medical or social) because friends and relatives may work in the hospital or social service agency or may see them in the waiting room. Lack of anonymity inhibits many women from calling the police. Friends and acquaintances may serve on the police force. Police calls and arrests are often printed in the local newspaper, and rural residents often have police scanners in their homes to listen to police calls. Many rural women feel that, if they decide to leave their partner, they must leave the town and make a fresh start.

In addition, resources for abused women in rural areas are often limited. North Carolina's 100 counties have only 90 domestic violence and sexual assault programs. Although many of these programs serve several counties, the distance may be too great for a abused woman to reach the facilities available to them. Law enforcement agencies usually will not cross the boundaries of their jurisdiction. If shelter is not available in her county, officers may not be able to transport her to a shelter. A lack of childcare and affordable housing for single mothers is also a barrier. Employment may be hard to find, especially if some people in the town do not believe her accusations and doubt her integrity.

Factors that may increase rural women's risk for abuse include the presence of weapons in the home and the seasonal nature of many rural–based occupations. Hunting weapons and loaded guns are usually common and accepted in rural households. Abusers often use firearms to terrify and threaten victims. For women whose partners work in agricultural occupations, bad weather can intensify the effects of physical isolation and increase time spent together, leading to increased exposure and opportunity for the abuse to occur.

Homeless Women

Studies have shown a correlation between domestic violence and homelessness[19]. Usually, homeless women with children are fleeing a domestic violence situation. For example 50% of homeless women with children are escaping abusive situations[203]. Also, women experience homelessness because of eviction and domestic violence whereas men were more likely to be homeless because of unemployment or substance abuse[80]. Women with limited resources find themselves among the homeless population due to lack of affordable housing, long waiting lists for assisted housing and shelters that are filled to capacity. An estimated 32% of requests for shelter by homeless families were denied in 1998 due to lack of resources[186]. Adequate provision of emergency shelter provides safety to women and children who are experiencing violence. Policies and laws that support affordable housing, living wages and other supportive services are essential to decreasing homelessness among this population.

Women who are homeless are also at an increased risk of sexual violence, and may turn to prostitution as a means to support themselves and their children. Very often, runaway youth are fleeing from sexual violence in their homes and find themselves on the street and homeless, as well as vulnerable to further sexual and physical violence.

African American Women

Research is inconclusive about the incidence of abuse among black women. Studies document both higher and lower rates of abuse reported by black women as compared to other racial groups[124, 147, 192]. Nearly one-third of African American women experience intimate partner violence (IPV) in their lifetimes compared with one-fourth of white women[176]. Although similar proportions of black and white women are likely to be abused, their response to the violence, and society's response to them, may be different. Black women may find it harder to leave a abuse relationship than white women because of fewer options for a marital partner and on average black women have lower incomes than white women. Black women may remain silent about the violence, not from an acceptance of violence as a cultural norm but from a sense of racial loyalty[23]. Some black women may attribute their abuse to the displaced aggression of the black male. They may believe that the black male's anger toward the white system for his inability to assume or maintain economic and other social roles typically assigned to the male in this society is turned against black women, a less threatening and more available target. Women with such beliefs may resent the white system of racial and economic oppression, which they may view as having contributed to their abuse[40].

Race related stereotypes may influence a black abused woman's willingness to ask for help. Black women may feel that reporting the abuse will not help them. Many black communities have had negative experiences in depending on the criminal justice system to protect them from abuse or to intervene on their behalf. The response time of police to domestic violence calls may be unduly slow. The police may treat the abuser less harshly than they would treat the abuser of a white woman. Blacks have also been shown to receive harsher punishment than do whites for domestic violence–

related homicides[23]. Some black women may also believe that domestic violence programs are established for white abused women. This perception may stem from the fact that the abused women's movement, including the establishment of shelters, had its roots in the women's movement. Many women of color felt estranged from that movement, perceiving that it primarily represented the interests of white women.

Studies examining service utilization indicate that black women may be more reluctant than white women to seek counseling, to go to a shelter, or to obtain assistance from human service professionals. However, they may be more likely to turn to medical services, their extended family or other informal sources of help[40]. For more information on domestic violence and women of color, contact the North Carolina Coalition Against Domestic Violence, which has a caucus for women of color (see Resources in Appendix 3).

Latinas

Latinas are the second largest minority and the fastest growing population in North Carolina. The definition of the term "Hispanic" is debated. In this Guide, "Hispanic" is defined as: "of or pertaining to the language, people, and culture of Spain, Portugal, or Latin America." Many of the Latinas in N.C. are foreign born and vary in levels of acculturation.

The National Crime Victimization Survey found that Latinas and non–Latina women were about equally vulnerable to violence by an intimate[10]. One study found no significant differences between Latina–American and Anglo–American women in the severity and frequency of abuse but did find differences between the two groups in their attitudes towards abuse and their perceptions of what constitutes abuse[181]. Latina-American women perceived fewer types of behaviors to be abusive and exhibited a more tolerant attitude toward wife abuse than did Anglo–American women. Latina women's differing interpretations of abuse may influence their willingness to leave an abusive relationship.

Abused Latina women's access to assistance may be limited. In general, Latinas have lower levels of education, lower incomes, and are less likely to have insurance, to speak English fluently or to utilize health care services[182]. Since few domestic violence program staff or law enforcement officers speak Spanish, Latina women may

have difficulty asking for help from them. They may be less likely to drive a car or to support themselves economically. All of these factors contribute to a abused woman's ability to receive help.

Latinas have traditionally placed great emphasis on family as the primary social unit and support system. Traditional Latina families are patriarchal with special authority given to the elderly, parents, and men. Sex roles are clearly delineated. The man assumes the role of the primary authority figure and the woman assumes the traditional role of wife and mother and is subordinate to the husband. The wife's economic dependence on the husband and the notion of male machismo have been suggested as being related to abuse in Hispanic families[181]. In the Latina family, individual needs often are subordinated to family unity and strength. For the abused woman, this often means tolerating abuse for the sake of keeping the family together. Many Latina women avoid discussing their problems outside the extended family. Abused Latina women may refuse to confide in health care providers or experience difficulty in asking for help outside their cultural group.

Religion also affects the response of many Latina women to abuse. Catholicism, the predominant religion for Latinas, considers the maintenance of the family to be of primary importance[180]. For more information on domestic violence among Hispanics, contact the North Carolina Coalition Against Domestic Violence, which has published *A Guide Addressing Domestic Violence in the Latino Community* (see Resources in Appendix 3).

Immigrant Women

The term "immigrant" as used in this Guide refers to all persons living in the U.S. who are not born as U.S. citizens, including legal immigrants, refugees, and undocumented persons. Abused immigrant women are largely invisible and out of reach of helpful services. Immigrant women who are not proficient in English may be unable to access many of the resources available to abused women. In addition, the human service system may be difficult for many immigrant women to understand. They may not have equivalent types of services or service providers in their country of origin. Many immigrant women may also have had negative experiences with police in their country. Abused immigrant women may be

fearful that they, their abusers, or their children may be deported if they call the police. For these reasons, abused immigrants may be unwilling to turn to law enforcement for help.

An immigrant woman may have difficulty acclimating to living in the U.S. The culture in the U.S. is more direct than many other cultures. Values of modesty, respect, and indirectness in communication that are prevalent in many other cultures may inhibit an immigrant woman from discussing her abuse. She may be separated from her extended family on whom she may have always relied. Many abused women feel a great sense of loss when their relationship ends. For an immigrant woman, the sense of loss may be compounded by her separation from her family and cultural roots.

Often, immigrant women may be more economically dependent on their partners than non–immigrant women. Relatives in their homeland may be dependent on her partner for financial support as well. A abused immigrant's economic dependence may be exacerbated by the impact of immigration laws concerning employer sanctions and hiring practices, as well as immigration law and regulations which make her ineligible for most forms of public assistance or income entitlement programs. Legal immigrants must meet tougher income standards for many programs. Undocumented immigrants are not eligible for many programs.

Immigrant women who rely upon their husbands to obtain legal alien status are especially vulnerable to abuse. Without legal status, the wife is subject to deportation, a fate that could lead to her being separated from her children and to her children falling into the custody of the abusive husband[16]. For additional information, see Project Esperanza information in Appendix 3.

Lesbians, Gays, Bisexual and Transgender (LGBT)

Abuse in same-sex relationships has been defined as "that pattern of violent and coercive behaviors whereby a lesbian seeks to control the thoughts, beliefs or conduct of her intimate partner or to punish the intimate for resisting the perpetrator's control over her"[85]. According to this definition, the dynamics of abuse among same sex partners are the same as abuse among partners of the opposite sex. Like male abusers, lesbians who batter seek to achieve, maintain and demonstrate power and control over their partners. Lesbian victims

of abuse also may have the same physical and psychological symptoms as women in heterosexual relationships[84].

Victims of sexual assault that are lesbian, gay, bisexual, or transgender (LGBT) experience the same range of emotions–shock, fear, guilt, shame, vulnerability, post traumatic stress disorder, and self blame–as heterosexual victims. However, it is important to remember a sexual assault victim from the LGBT community will have a different set of concerns than a heterosexual victim. A common misconception is that that being lesbian, gay, bisexual, or transgender causes someone to sexually assault, this is not true.

Some concerns may include:

- not being taken seriously or having their experience minimized;
- having to explain how it happened in more detail than one would ask a survivor of opposite-sex assault;
- increasing people's homophobia or being seen as a traitor to their community if they tell their story to straight people;
- being treated in a homophobic manner by the police, the hospital, rape crisis center, and others;
- and/or having to reveal their sexual orientation for the first time.

Also, it is important to remember that due to homophobia, individuals within the LGBT community are targeted for sexual assault. Approximately ten percent of hate crimes against gay men and lesbians include sexual assault[42].

This percentage may be even higher, since it is sometimes difficult for lesbians to discern whether they were attacked because of being identified as a lesbian or simply as a woman. Health care providers need to be aware in taking patient histories that answers to common questions may seem contradictory or not as expected.

If an abused lesbian is not known publicly as a lesbian, she may be reluctant to discuss her abusive relationship[16]. Lesbians fear the homophobic reactions of people in the abused women's movement, and the health, social service, mental health, and legal systems. Her partner may threaten to expose her sexual orientation if she talks

about the abuse, and she may fear losing her friends, custody of her children or her job as a result. Since many people view homosexuality as mental illness or a dysfunctional way of life, a abused lesbian may be unwilling to talk about the abuse for fear of having her community and herself further criticized.

Abused lesbians may experience little support. If a abused lesbian's support system is shared with her partner, she may have no one to whom to turn. Members of the lesbian community may have idealistic views of lesbian relationships, leading them to deny the existence of abuse among lesbian couples[71]. They may be unwilling to admit that women are capable of hurting other women.

Lesbians also face barriers with domestic violence programs. It is sometimes difficult for women who work with abused women to admit that women themselves can be abusers. Many within the abused women's movement view abuse as the direct result of sex role inequality in heterosexual relationships. The notion that one woman would batter another woman contradicts the feminist gender–politics analysis that abuse is a consequence of male privilege and power in society. Finding safe shelter may be difficult for lesbians because women are usually automatically trusted within the shelter system. Domestic violence program workers traditionally assume that any woman who comes for help is a victim, and that a woman's story should not be questioned. When a lesbian requests services, there is no simple way to know that she is, indeed, the victim. Anywhere the abused lesbian can go, her partner can go as well. Lesbian abusers have been known to contact shelters seeking a place to stay, and identify themselves as victims[71]. In cases in which there has been mutual verbal or physical abuse, shelter or advocacy staff may feel ill–prepared to assess which partner is "most eligible" for services.

Health care providers who recognize indicators of abuse are likely to assume that the abuser is a male partner. The abuser herself may accompany the victim to the emergency room or the doctor's office in the guise of providing support, but in fact she is exerting control over the victim as she seeks medical service. A lesbian's sexual orientation may be included as a part of her permanent medical record, subject to review by future health care providers.

Abused lesbians may face difficulty in accessing the legal system. The N.C. Domestic Violence Act, discussed in Appendix 1, does not provide protection from same–sex intimate partner violence. Since many people believe that women are not capable of doing serious physical harm to others, judges and law enforcement may not treat a “cat fight” among women as seriously as an assault on a woman by a man. In some instances, police officers have arrested the victim instead of the perpetrator if they perceive the victim as being “more masculine”[71].

For more information on domestic violence and lesbians, contact the North Carolina Coalition Against Domestic Violence, which has a caucus for lesbians (see Resources in Appendix 3).

Military Women

Military women include women who are in the military themselves as well as women married to men who are in the military. Some studies have suggested that military families may be at greater risk for spouse abuse, possibly due to the military’s legitimization of violence[113, 162]. Military families relocate frequently, leaving a woman more socially isolated and sometimes without a social system to turn to for help. A study that compared violence against wives between a sample of military and civilian families in a community found more spousal violence in the military families than in the civilian families[44]. Another survey of military women found that 24% of women under the age of 50 and 7% of those aged 50 or older reported domestic violence in the past year.[131]

North Carolina is highly impacted by violence against women in the military due to the large presence of military personnel from all branches of service. Between June and July 2002, there were five domestic homicides at Fort Bragg, North Carolina. A military investigation found marital discord, significant amounts of time away from home for military personnel, inadequate time for family integration, and unpredictable work schedules as contributing to the homicides. There is also a prevailing attitude among military personnel that seeking counseling services is detrimental to one’s military career[59]. After a documentary by the television news program “60 Minutes”, on domestic violence in the military, the Family Violence

Prevention Fund initiated dialogue with the Department of Defense. As a result, the Defense Task Force on Domestic Violence was created in 1999 to help the Secretary of Defense prevent domestic violence. The Task Force has released several reports and recommendations since its creation. One of the most important recommendations is that the Department of Defense should create a military culture that does not tolerate domestic violence, hold offenders accountable, provide confidential services to victims and training for commanding officers and law enforcement to improve their response to violence in military families[60].

All major military bases in North Carolina have domestic violence programs, including treatment programs for abusers. Despite the military's efforts to address domestic violence, an abused military woman or wife of a military man may seek treatment for injuries or conditions resulting from the abuse from private providers or health departments rather than the military, so that information about the abuse does not enter the military medical record.

IMPACT OF VIOLENCE AGAINST WOMEN

In addition to the increased direct and indirect costs associated with required social services, medical care, legal and judicial response, reduced productivity, and numerous other costs, domestic violence, rape and sexual assault, and other forms of violence against women have further devastating consequences for women, their abusers and rapists, children, and society as a whole. These consequences include negative impacts to physical and mental health and to the emotional well being of individuals and families[36, 38, 110, 155].

The range of emotional, psychological, and health effects battered women experience has been well documented. These consequences may be present in victims of past violence, as well as current victims. Since each woman experiences a unique set of circumstances, each woman will be affected differently.

Rape and sexual assault also have a devastating impact on victims. Many women live the rest of their lives with feelings of fear, guilt, shame, vulnerability, disorientated, anxiety, confusion and blame for the crime by our society. Some survivors may also feel helpless, depressed, embarrassed, powerless and possibly even suicidal. While survivors commonly experience these feelings, each person will have a unique response to the assault.[3]

Emotional Effects

Fear

Fear is an overriding emotion many abused women feel. An abused woman may be constantly afraid of what the abuser may do to her and her children. She may feel unable to act because of this fear and sees few options available to her and her children that will protect them whether they remain with or leave the perpetrator. The fear can take many forms, including: fear of further injury or death at the hands of the perpetrator; fear of being stalked and found if she leaves the perpetrator; fear of embarrassment or humiliation if others discover the abuse; fear of not being able to protect and provide for her children, especially if she leaves the relationship; fear of losing her children to Social Services intervention; etc. Also, many women who have been sexually assaulted live with fear, guilt, shame and vulnerability for the rest of their lives. In fact, women who are rape victims are 7 times more likely to be raped again, so this fear of further violence is not unfounded[3].

Anger

Some women may be able to target their anger at their abusers or the person who raped/sexually assaulted them. Others may internalize the anger, which can sometimes lead to guilt and self–blame, self-destructive behavior, self-inflicted injury, and even suicide or attempted suicide.

Guilt

Guilt can be directly related to the woman's misdirected anger at herself. In response to her belief that "she got what she deserved," a women experiencing intimate partner violence may feel that she contributed to the severity of the situation and that the abuser's behavior is her fault. Women who experience rape and sexual assault may also question themselves and their actions around the time of the assault and attach feelings of guilt to their own behavior rather than acknowledging that a rapist is always at fault.

Embarrassment

Social norms around abuse are such that women feel shame for being abused. Abused women may feel as though they should have known better than to be with an abusive partner and may question their own judgment. Women who have been raped and/or sexually assaulted also live with the embarrassment of having their bodies

violated, exposed, and used without consent. After a sexual assault, receiving needed medical care, including physical examinations, and disclosing the experience to law enforcement often requires women to repeat the narrative of events numerous times in various locations and to different people, both male and female, which can lead to further embarrassment. This can be a significant barrier to reaching out for medical or legal/law enforcement assistance and can also prevent women from following through with recommendations if they do seek assistance.

Psychological Effects

Domestic Violence. Women's psychological reactions to domestic violence are much like those of rape victims and other trauma victims[18]. The primary difference is that, for a battered woman, the violence is ongoing and usually intensifies over time. For this reason, abused women have been compared to prisoners of war. Domestic violence is a continuous traumatic experience and, like many other forms of trauma, it takes a considerable psychological toll on its victims. Effects of trauma are exacerbated by the fact that the aggressor is someone they may love and trust, and on whom they may depend emotionally and financially. Battered women often describe the psychological trauma as more painful and damaging than the physical trauma of their partner's assaults[166].

Rape and Sexual Assault. Rape and other forms of sexual violence lead to significant psychological effects during and immediately after the assault and for a considerable length of time afterwards. The severity of sexual violence is determined by the victim's reaction to the violence, not by the actions of the aggressor, and each survivor reacts in unique ways[144]. Reactions to sexual violence also have been described by the term *rape trauma syndrome*, which includes a wide range of reactions (see below).

Decreased Self-Esteem

Battered women may develop low self–esteem as a result of chronic victimization[87, 171, 174]. One study found that, as the frequency, form, and consequences of physical aggression increased, the level of self–esteem decreased[31]. Some battered women demonstrate their lowered self–esteem by believing that they do not deserve or are not worthy of better treatment by their intimate partner or by the systems

designed to help them[50]. Survivors of sexual violence, whether perpetrated by an intimate partner, acquaintance or, stranger, often encounter decreased self-esteem, also. The rape or assault occurred against the survivor's will and this may leave her feeling somewhat powerless or without control. The survivor may also become more uncomfortable with her own sexuality and body as a means of coping with the sexual trauma she experienced.

Helplessness

Learned helplessness is the process by which a woman learns that she cannot predict the outcome of a specific behavior. Many men batter with no definite pattern that a woman can identify and use to predict the next outbreak of abuse. Thus, an abused woman is at the mercy of her abuser's mood fluctuations and outbreaks of temper. Likewise, sexual violence often occurs unexpectedly, and victims are often unable to safely stop perpetrators from raping or assaulting them, which may lead to feelings of both paranoia and being helpless to protect themselves from further sexual violence in the future.

Doubts About Sanity

As a result of the constant verbal and emotional abuse perpetrators of domestic violence inflict on their partners, some women think they are losing their sanity. The isolation an abused woman experiences leaves her with few people who can confirm her sanity, which is constantly being attacked by her abuser.

Stockholm Syndrome

The Stockholm syndrome describes the phenomenon in which hostages are known to defend their captors or become emotionally involved with them. This syndrome has been applied to women whose abuse is perpetrated by intimate partners or ex-partners and it arises when threats and other emotional abuse are followed by periods of kindness, which can provide hope and allow the victim to deny the traumatic situation[75]. Both the threat to survival and being isolated by the abuser have been found to contribute to the development of this syndrome.

Post-Traumatic Stress Disorder (PTSD)

PTSD is commonly associated with war veterans but also can result from experiencing or witnessing abuse[63]. Domestic violence, rape and other forms of sexual violence, and childhood sexual abuse are among the most common causes of PTSD in women. PTSD is characterized by: (1) persistent re–experiencing of the traumatic event (often through nightmares and flashbacks); (2) avoidance of activities related to the trauma; (3) indifference to surroundings and detachment from others; (4) signs of increased arousal (insomnia, irritability, exaggerated startle response); and (5) difficulty concentrating or remembering[72, 161, 166].

PTSD has been documented in 45 to 85% of women seeking refuge at shelters for abused women[88, 196]. The more extreme the abuse and chronic trauma, the more pronounced are the PTSD symptoms. Women experiencing PTSD as the result of domestic violence most commonly exhibit symptoms such as hypersensitivity, avoidance, intrusive thoughts and depression[76].

Since reliving past trauma can be just as vivid and frightening as the original traumatic event, and because survivors of past or more recent and ongoing sexual and domestic violence often have no control over these episodes, they may experience severe psychological distress and even fear that they are "going crazy." Symptoms of PTSD can have a debilitating effect on every aspect of a woman's life. It can make it difficult to impossible to function at work, attend school, or even leave her home and socialize or carry out the activities of daily life. It is important for health care providers to understand the typical constellation of symptoms so that they can provide the woman comfort and reassurance that no matter how strange or uncontrollable symptoms of PTSD may be, they are a very common part of surviving sexual violence and overcoming past or ongoing domestic violence.

Abused Woman Syndrome. The collection of psychological symptoms commonly seen in victims of ongoing, repeated abuse makes up the Abused Woman Syndrome. The syndrome is a subcategory of PSTD. These symptoms assist the abused woman in surviving or coping with the abuse she experiences on an ongoing basis. Abused women will exhibit different symptoms depending on their past and current experiences including their history of abuse, mental health, and support systems.

PTSD is also a common occurrence in victims of rape, sexual assault, or child sexual abuse. In fact, rape victims are more than six times as likely to experience PTSD as people who do not have a history of rape[101]. Research has found that women have between a 50% to 95% chance of developing PTSD after being raped[89]. PTSD can persist in various forms and with different intensity for many years after the initial trauma, even if that trauma has stopped. For example women may suddenly remember childhood sexual abuse committed on them when a "trigger" sets off a long–ago suppressed memory of it, and they can react with chills, uncontrollable shaking and fear, panic attacks, and other physical and psychological effects.

For example, they may be with a sexual partner who has physical features that are similar to their childhood abuser or who exhibits a behavior or gesture during sex that is reminiscent of abuse from years ago, even if the current sexual context is not one of force or violence. Another trigger particularly relevant fort health care providers is a physical exam, particularly a reproductive health or pelvic exam that includes close body contact. The trigger may set off an extremely vivid memory, or even a sense of re-experiencing the original trauma, complete with really emotions, fear and terror, as well as other sensations such as visual and other sensory hallucinations recalling the trauma.

Rape Trauma Syndrome. This terminology for a particular form of PTSD is currently not in common use, but over the past few years it was frequently used to describe the myriad feelings and psychological effects of rape and sexual violence on victims of all ages. Most practitioners now refer to PTSD and its symptoms when discussing the effects of rape and sexual violence.

Depression

One study that assessed women in a abused woman's shelter for depression diagnosed major depression in 37% of the women[196]. Estimates of clinical depression among battered women usually range from about 1 in 10 to about 1 in 3 of all battered women[28].

Depression in abused women has been associated with other life stressors that often accompany domestic violence such as childhood abuse, other daily stressors, having many children and forced sex with a partner[26].

As mentioned earlier, 25% of white women and 50% of black women who attempt suicide have been reported to be abused women[160]. In a study surveying more than 3,000 women at 32 colleges and universities in the U.S., 30% of the women who identified in the study as rape victims contemplated suicide after the incident[194].

Substance Use

Many abused women turn to alcohol and other drugs to help them cope and escape the reality of intimate partner violence[26]. Abused women are more likely to use alcohol and other drugs than women who are not abused[98, 117, 118]. The use of alcohol, illegal drugs, and prescription medications by abused women may increase their risk of serious injury, morbidity, and death[164].

Domestic violence and substance abuse have been found to be strongly associated. A North Carolina study of substance abuse revealed that victims of violence are more likely to smoke cigarettes, drink alcohol, and use drugs both before and during pregnancy than non–victims[118]. Data from the 1985 National Family Violence Survey on the experiences of women who were either married or cohabitating with a man have shown that women who drink heavily or use drugs were more likely to be victims of abuse. However, the authors noted that most of the physical abuse occurred in the absence of the use of alcohol or other drugs by the victim[98].

Although a strong association has been found between substance use and domestic violence, no evidence exists that substance use by the woman causes the violence. One explanation for the association is that abused women turn to alcohol and other drugs in order to cope with the physical and emotional pain, fear, and loss of power associated with being in an ongoing abuse relationship.

Substance use has serious potential consequences for abused women. If an abused woman is diagnosed with or treated for substance abuse, she may lose custody of her children to the abuser if he is the father. The isolation, low self–esteem, and poor financial situations many abused women experience may be further intensified if they are substance abusers. These factors make leaving more difficult and dangerous for abused women.

The strong relationship between abuse and substance use, and the serious health consequences of both for abused women, indicate the need for dealing with both the substance abuse and the violence concurrently. However, barriers exist to helping women with both problems. Domestic violence and substance abuse programs have different views of the relationship between domestic violence and substance abuse and consequently have different models of treating these two problems. Abused women's advocates, in general, believe that abuse is an intentional act by the abuser, which is not caused by the substance abuse of the woman or the abuser. They also believe that abused women abuse substances in response to the abuse. In contrast, the traditional view of substance abuse counselors has been that the substance abuse is a disease process, beyond the control of the addict, which causes dysfunctional behaviors including abuse[12]. Therefore, they believe that treating the substance abuse of the addicted abuser will end the violence. This approach may prolong the elimination of the violence. However, in recent years, there has been a shift to offer specialized services for women. The long–term requirements for effective substance abuse treatment also contrast sharply with the short–term safety and emergency care focus of most domestic violence programs.

Many substance abuse programs do not address the needs of abused women. Most residential substance abuse treatment programs cannot accommodate children. An abused woman may be unwilling to be separated from her children or to leave them with the abuser while she receives treatment. She may have no viable alternatives for leaving the children safely. Also, many substance abuse programs either do not identify violence as a treatment issue, or they recognize the violence as an issue secondary to substance abuse[12]. Treatment models used by substance abuse programs that require substance abusers to give over power and control over their lives are inappropriate for abused women who already have limited power and control. These models inappropriately reinforce abused women's beliefs that they are powerless and that they may be partly responsible for the violence because of their roles as "enablers" or "co-dependents"[164].

Likewise, many domestic violence programs do not address the needs of women who are substance abusers. Substance abusing

women who seek safety at abused women's shelters may be denied access because of substance use. Many domestic violence service providers do not have the expertise to identify substance abuse in abused women and manage the individual and programmatic issues substance abuse raises. The domestic violence movement has been reluctant to bring up issues such as substance abuse for fear that others will use this to blame abused women for their predicaments.

Social and Economic Effects

The following are some of the social effects that many abused women experience.

- isolation from friends, family, and service providers
- severe economic hardships following separation or divorce
- loss of custody of the children
- no financial safety net later in life

Physiological Effects

Injury

Abuse may be the single most common cause of serious injury to women. Abuse may account for one half of all serious injuries among women seen in the emergency department[2, 170]. In one study of abused women, 43% of abused women had presented to emergency departments six or more times for abuse–related injuries. However, in most cases, the victimization history underlying these injuries was never identified by responding health care providers because women may not present with obvious trauma[152, 170].

The types of injuries sustained by abused women tend to differ from those of other causes. Typical injury patterns related to abuse include contusions or minor lacerations to the head, face, neck, breast, or abdomen. In contrast, unintentional injuries are more likely to involve the periphery of the body. Abused women are also more likely than accident victims to have multiple injuries. Female primary care patients with a history of sexual abuse have more physical and psychiatric symptoms and lower health-related quality of life than those without previous abuse[48]. Refer to Chapter 2 for further discussion of violence –related injuries and their costs to society.

Increased Risk for Disease and Reproductive Health Problems

Because an abuser's effort to exert control over his partner often extends into their sexual relationship (e.g., refusing to use a condom, forcing sex), an abused woman may be at increased risk for:

- HIV/AIDS
- pelvic inflammatory disease
- recurrent vaginal and urinary tract infections
- sexually transmitted diseases
- unwanted pregnancy
- reproductive decision-making and contraceptive use[127]

Increased Risk for Chronic Health Problems

Abused women have more somatic complaints[96, 100] and significantly more medical problems for which they sought treatment than do non-abused women[79]. Between 40 to 60% of female clients that visit health care providers for evaluation of chronic headaches, irritable bowel syndrome, and chronic pelvic pain have a history of past or ongoing physical or sexual abuse[49, 51, 179]. Somatic complaints may result from actual physical injuries that produce prolonged pain or dysfunction. Some health problems that abused women may experience are listed below.

- abdominal and gastrointestinal complaints
- anemia
- atypical chest pain
- chronic pain
- chronic headaches
- decreased concentration
- dizziness
- fatigue
- back pain
- hypertension
- pain during intercourse
- recurring central nervous symptoms including fainting and seizures
- irritable bowel syndrome
- muscle aches
- palpitations
- sleep and eating disorders

Impact on Children

Living in a home where domestic violence is present is detrimental to children. There are three areas of concern that emerge when considering the effects of intimate partner violence on children. The first concern is the effects of trauma a child experiences as witnesses of violence. Each year thousands of American children witness intimate partner violence within their families. Witnessing violence is a risk factor for long-term physical and mental health problems, including alcohol and substance abuse, being a victim of abuse and perpetrating intimate partner violence.[64, 172]

The second concern is the co-occurrence of domestic violence and child maltreatment in the same family. The Center for Disease Control and Prevention reports a review of studies on the co-occurrence of intimate partner violence and child abuse found that that in about 50% of the families in which the mother is being abused, the children are also being abused, either by the intimate partner of the mother or by the mother.[32] Another review of 31 studies on the co-occurrence rates of domestic violence and child maltreatment found the prevalence to be between 30-60 % in most of the studies.[53] Children can be primary victims of domestic violence in the following ways: physical injuries from direct physical abuse while trying to protect their mother by getting in the middle of the assault on their mothers, physical abuse from the abuser and the abused adult in the household and neglect from the primary caretaker who is usually the mother.

Below are some of the many effects that exposure to domestic violence can have on children.

- excessive aggressiveness, anger, or fearfulness
- belief that violence is a legitimate means to resolve conflict
- alcohol or drug abuse
- emotional problems
- suicide
- low self–esteem
- guilt for loving the abuser
- belief that they are responsible for the abuse

- academic difficulties
- isolation from helping systems, other children, or family members
- frequent moves and changes in schools
- running away from home
- becoming child abusers or abusers (boys) or abused women (girls) as adults
- excessive fighting, bullying, lying and cheating
- injuries while trying to protect their mother
- physical ailments related to stress including headaches, abdominal pains, peptic ulcers, rheumatoid arthritis, asthma; eating disorders.

The third concern related to domestic violence and child maltreatment is the lack of a coordinated response from social service agencies. Historically, these agencies hold different views about who should be held accountable for the child maltreatment. Child protective service agencies have been accused of working from a child-centered perspective by holding the abused mother accountable because she has failed to protect the child by allowing the child to remain in an injurious environment Domestic violence advocates have been accused of providing women-centered services at the expense of protecting children.[11, 112] One author notes, "failure to develop a multidisciplinary coordinated approach to addressing domestic violence and child abuse has led to myopic policies that do not promote the safety of victimized parents and their children simultaneously."[34]

In North Carolina, the Child Well-Being and Domestic Violence Task Force was formed in 2002 to address domestic violence and child maltreatment in our state. The Task force adopted the following principles: enhancing a parent's safety enhances the child's safety, domestic violence perpetrators may cause serious harm to children, domestic violence perpetrators and not their victims should be held accountable for their actions and the impact on the well-being of the adult and child victims, appropriate services tailored to the degree of violence and risk, should be available for adult victims leaving, returning to or staying in abusive relationships and for child victims and perpetrators of domestic violence., children should remain in the care of their non-offending parent whenever possible and when the

risk of harm to the children outweighs the detriment of being separated from non-offending parents, alternative placement should be considered As a result, legislation has been introduced to address temporary custody in the *ex parte* hearing and to criminalize the act of serious assault in the presence of a child[136].

Impact on Society

The effects of domestic violence on society include:

- increased crime
- increased costs associated with law enforcement, social services, incarceration, judicial system, health care and counseling
- costs to business through lost wages, sick leave, and absenteeism
- increased insurance costs
- perpetuation of the intergenerational transmission of violence
- decreased quality of life through homelessness, chemical dependency, and poverty

RISK FACTORS

Risk Factors for Being Abused

Studies have been unable to identify specific conditions or risk factors that contribute to the likelihood a woman will be abused. Psychological portraits of abused women are difficult to interpret because it is difficult to know whether personality traits were present before women were abused or whether these traits have developed as a result of the victimization. It is difficult to identify risk factors for sexual assault victims because all women are considered vulnerable. However, certain factors may contribute to or increase the woman's vulnerability to experiencing violence.

Marital Status

Married women may be less likely than single, separated, or divorced women to be abused by a male intimate partner. Separation or divorce may actually increase a woman's risk of being abused. Divorced women were twice as likely to report physical violence and separated women were 2 to 3 times more likely to report past or current physical violence.[39]

Pregnancy

Some research has indicated that pregnancy is a time of increased risk for abuse. In some cases, however, pregnancy may offer some protection against abuse.

Age

Age is inversely related to acts of domestic and sexual violence. Younger women are more likely to be abused than older women.

Length of Marriage

Marital violence can occur at any stage of a marriage, but newer marriages appear to have the highest risk of wife abuse. No information is available on the association between the length of the relationship of non–married couples and domestic and sexual violence.

Power Balance

Families in households where the decision making is shared have been found to be less violent than those in homes where all the decisions are made either by the wife or the husband[70].

Violence in Family of Origin

Women who experience violence in their family of origin may perceive violence as normal part of intimate relationships. Women with a father who physically or emotionally abused their mother were at a significantly increased risk of intimate partner violence[39].

Risk Factors for Being an Abuser

An overview of risk factors for being an abuser is presented. These risk factors have been found to be associated with domestic violence; however, men who batter come from every age, race, class, religion, profession and educational level. An abuser may exhibit some or none of the risk factors mentioned below. Above all, what men who batter have in common is that they exert power and control over their partners.

Violence in Family of Origin

Men who have experienced violent childhoods are more likely to assault their wives than are individuals who have not experienced childhood violence[70, 97]. Those who observe their parents use vio-

lence are more likely to grow up to be abusive partners. Some studies have found that if a man was abused by his parents as a child, he is more likely to be severely violent in his marriage[e55, 161, 163]. A literature review found that witnessing parental violence as a child had a somewhat stronger effect on becoming an abuser than being abused as a child[93].

Socioeconomic Status

Several studies of marital violence have shown that spousal violence is more likely to occur in low income, low socioeconomic status families. Poor men have fewer resources to cope with the stressors that are associated with poverty[97]. However, wife abuse is not confined only to low income, low status families. Much of the violence in middle– and upper–class families is kept secret[70]. Wife assault is more prevalent among men with lower incomes and less education[93]. One of the main factors associated with wife battery is the employment status of the husband. Unemployed men have rates of wife assault that are almost double the rates for employed men[70]. Status inconsistency and status incompatibility are also related to marital violence. If a man's educational background is considerably higher than his occupational attainment or if a man has less education and a lower status job than his wife, he is more likely to be an abuser[70].

Violence Toward Children

Studies consistently show that about half of the men who abuse their wives also abuse their children[70, 161]. Most of these studies define violence toward the children as more severe than a slap or a spanking.

Substance Abuse

High rates of alcohol use or alcoholism have been found among abusers. Researchers who looked through several studies found that nearly 60% of abusers were chronic alcohol abusers or alcoholics[177]. Alcohol abuse is associated with severe domestic abuse[17, 52, 55, 73, 167]. A review of the literature on substance abuse and domestic violence found that 25 to 50% of domestically abusive men had substance abuse problems[83]. However, there does not appear to be a relationship between the length of sobriety and a decrease in abuse[168]. Alcohol

use is also associated with sexual assault. In fact, one-half of all sexual assaults are committed by men who have been drinking[1]. However, it is important to remember that blaming the abuser's substance use for his abusive behavior and sexual violence inappropriately removes responsibility from the abuser.

Generalized Aggression

Although many abusers are violent only to their partners, men who severely assault their partners are more likely to be violent outside the home than either men who do not assault their partners or who commit "minor" assaults against their partners[55, 73].

Personality

Some abusers have been found to have low self–esteem. A remark or comment that might not affect someone else may be interpreted as a slight, insult or challenge to many of these men. Abusive men have also been described as feeling helpless, powerless and inadequate. They have been labeled as sadistic, passive–aggressive, addiction prone, pathologically jealous and dependent[70].

Warning Signs

Certain behaviors can serve as warning signs for potentially abusive men. The following are some of those warning signs[91].

Jealousy. An abuser is often intensely jealous of his partner. He may claim that his jealousy is his way of expressing his love. In fact, jealousy may be a sign of mistrust and possessiveness. He may question his partner excessively about her activities and the people with whom she spends time, accuse her of infidelity, and stalk her.

Controlling Behavior. An abuser has a strong desire to control his partner, which in early stages may appear to be his way of offering help and support. His control over his partner can include taking over decisions about finances and other family matters, what his partner wears, with whom she socializes, and her career choices.

Too Serious Too Soon. An abuser will often show excessive interest and desire for a relationship soon after he and his partner become involved. He may pressure the woman to commit to him,

often wanting to cohabitate or marry. Typical expressions of love early in the relationship include, “You’re the only one I’ve ever felt this way about” or “I just can’t live without you.”

“Jekyll and Hyde” Personality. An abuser may exhibit a “Jekyll and Hyde” personality by acting charming and loving toward his partner in public and being violent and ruthless in private. He may also exhibit this type of personality by fluctuating between both types of behavior in public and private. This “Jekyll and Hyde” personality not only confuses his partner about who he is and what his intentions are but makes convincing family and friends about his abusive nature more difficult.

Part B: Violence Against Women: A Public Health Response

Violence against women is becoming widely recognized as a public health problem. Effective responses must become a public health priority. Earlier responses to domestic and sexual violence focused on the most immediate needs of victims by advocates, health care providers and community service agencies. While this emphasis continues to be needed, a new focus on prevention – preventing the violence before it occurs is needed. In the forefront of shaping this emerging focus in all areas of violence prevention is the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention[74]. State and local health departments nationwide are challenged to lead efforts to make prevention a priority. A number of public health, medical and other professional organizations have named the response to violence against women as a priority. Their recommendations cover a range of topics such as the need to screen for domestic and sexual violence; actions to take when violence is identified as a problem for a patient; and guidelines for establishing agency protocols for a uniform and comprehensive response. Table 1 presents details on these recommendations.

TABLE 1

Professional Organization	Selected Position Statements and Recommendations
American College of Obstetrics and Gynecology (ACOG) (http://www.acog.org)	• Recommends that physicians screen all patients for intimate partner violence (with guidelines on timing provided) • Recommends that physicians screen all patients at every visit for sexual assault; consult state laws for reporting requirements
American Medical Association (AMA) (http://www.ama-assn.org)	Provides detailed, very comprehensive guidelines. Examples: • All physicians should be trained about family and intimate partner violence through undergraduate and graduate medi cal education and continuing professional development • Routinely screen all patients for history of violence – if positive history, assess and discuss safety before patient leaves the office and refer to appropriate medical and community resources • Within the larger community, urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence • Supports preparation and dissemination of information to maintain and improve skills needed by all practicing physicians involved in providing care to rape victims

Organization	Position
	• Supports function and efficacy of rape victim services, encourages rape crisis centers to continue working with local police to help rape victims, and encourages physicians to support the option of having a rape victim counselor present while the victim is receiving medical care
American Medical Women's Association (AMWA) (http://www.amwa-doc.org)	Supports that all health professionals become: • Trained/ encouraged to ask all patients about domestic violence • Trained/ encouraged to practice the necessary privacy and safety precautions to protect victim from perpetrator • Encouraged to give referrals to hotlines, shelters, and other community resources which may be required by the victim • Trained to assist victim in developing safety plan or refer to another professional for this activity. Declares concern with problem of rape and encourages: • Objective, factual, and public education regarding problem of rape and its therapy • Highest of medical treatment given to sex crime victims • Development of responsive medical, counseling, and support services for rape victims
Society for Social Work Leadership in Health Care (http://sswlhc.org/html)	Provided Standards of Care for domestic violence, child abuse and neglect, and elder abuse.
National Association of Social Workers (NASW) (http://www.naswdc.org)	• Supports universal screening of all clients for DV; expansion of agency programs to include services for victims and perpetrators • Assistance, rather than punishment for "failure to protect" for non-offending custodial parents • Use of shelters and support services for undocumented women in children in violence family situations
American Nurses Association (ANA) (http://www.nursingworld.org)	• Supports education in skills to prevent VAW, assess women in health care and community settings, and conduct research on VAW • Through knowledge and clinical skills nurses can assess, intervene and prevent sexual and domestic violence. • Support coordinated, interdisciplinary, community-based response

Organization	Recommendations
American Association of Colleges of Nursing (http://www.aacn.nche.edu)	Recommends all bachelor's level and higher nursing educational programs should teach: • About the scope of the problem of violence, esp domestic violence • Skills to assess, identify, and document abuse & its effects • How to provide interventions, esp. for women, elders, and children • The recognition of cultural components • Legal and ethical issues in treating and reporting • Activities to prevent domestic violence
American Academy of Nurse Practitioners (http://www.aanp.org)	• Encourages health care providers to identify, treat, and properly refer all victims of sexual assault and of child, elder, and domestic violence • Advocates use of national guidelines for assessment, identification, and referral of violence victims • Supports violence prevention content in educational programs for all health care providers

The public health approach to violence against women is unique, yet complementary to providing crisis services to individuals in need. Its approach emphasizes "primary prevention," or the reduction of the incidence of a problem before it occurs in a population. The public health approach is defined by a four-part; science based approach to health problems.[106]

1. Collecting data on the magnitude of the violence problem; descriptions of what the problem looks like among various populations, and the consequences of violence at various levels of society;
2. Conducting research to determine causes of violence, protective and risk factors for violence, and factors that may be modified in order to prevent violence;
3. Using information from Step 1 and Step 2 to design, implement, monitor, and evaluate interventions; and
4. Implementing promising programs in a variety of settings and sharing information with others through various dissemination channels so that promising practices can be replicated efficiently and effectively.

As a protector of the health of local communities, local health departments in North Carolina can take a key role in a larger and broader public health oriented response to violence against women in the community. The local health department can assume a lead role to assure that all components of a public health response are in place in the community, with needed services provided not only by the health department, but by many other community agencies and organizations.

Chapter 4 provides guidance to health department staff of all disciplines as they respond to individual women and families. Chapter 5 guides the health department to assume various community roles in organizing coordinated responses to violence against women and leading a community focus on prevention.

CHAPTER 4

THE CLINICAL RESPONSE TO VIOLENCE AGAINST WOMEN

The rationale for local health departments to develop a protocol to identify and assist women clients who have been victimized by violence is explained in this chapter. The principles that should be addressed and the components that should be included in any clinical intervention are provided in detail.

RATIONALE

Studies of domestic violence prevalence have found between one-fifth and one-third of women seen in health care settings are battered[65]. Also, women with a history of sexual violence are more likely than other women to have eight or more doctor or health care visits in the past year[151]. Most women who have experienced any form of violence do want to tell someone about it even though they are reluctant to broach the subject themselves, and medical providers are the most common professional group women say they want to talk to about the violence[82]. Also, women who experience domestic or sexual violence, whether by a partner, an acquaintance, or a stranger, are more likely to experience both acute and chronic medical ailments that prompt them to seek care.

Often, women with physical or mental health concerns resulting from violence will not seek community services that specifically respond to domestic and sexual violence, but they will go to a health care provider for symptom based relief (for problems such as chronic headaches, pain, gynecological problems, etc.). For example, 95% of sexual violence survivors do not access services initially at rape crisis centers or with a mental health therapist[105], but many do seek some form of medical care. Even in domestic violence cases when a partner is so controlling that a women is essentially isolated and unable to seek most community services, the partner will usually not bar her from seeking health care for herself or for a child. Therefore, the health care system is a means to reach and assist large numbers of women victimized by violence, and health care providers have unique opportunities to assist and positively impact women's and children's lives. In order to provide assistance to battered or sexually violated women, health care providers must be able to identify them and assess their individual needs. Thus, identification is the first step of a response to VAW.

Local health department clinics should routinely ask all women about domestic and sexual violence and provide assistance to women identified as battered or sexually violated. Because women may go to the health department repeatedly for prenatal care and periodically for other types of care, health department providers have opportunities to build relationships with women and to identify and assist women whose lives have been affected by violence. Services in local health departments reach a large number of women in the state, and the providers are ideally suited to provide interventions to women who need them and education about violence to all women regardless of past or current experiences of violence. By making the discussion of domestic and sexual violence a routine part of clinical interaction, women who may not have experienced violence during initial visits will know they can seek assistance at the health department if they are victimized at some point in the future.

Health care providers currently have no legal obligation to assess women for domestic or sexual violence; however, they do have an ethical responsibility to address these issues. Women experiencing violence use health services more than non-abused women, and effective intervention in health care settings may be the only opportunity to intervene and support victims[26, 38]. Treating a woman effectively necessitates that health care providers not only treat the physiological and psychological symptoms and consequences of current and past domestic and sexual violence, but also address the violence that is the root of many of the problems she experiences. Bandaging her injuries or referring her to a counselor for her depression without acknowledging the violence in her life will do little to help the client in the long run. When the direct provision of specific services needed by women and their children is not feasible, it is imperative that health departments know how and where to access these services in the community, build relationships with providers in other agencies, and consider memoranda of understanding (MOUs) or other protocol agreements with community agencies that can provide such services.

Health care issues related to domestic violence

Battered women should be identified in order to avoid prescribing harmful or inappropriate therapies. For example, some health care providers prescribe medications for battered women, usually pain medications or mild tranquilizers, which are contraindicated for

abuse victims. Battered women are already at an increased risk for suicide, depression, and drug or alcohol abuse, and some medications may further increase their risk. Furthermore, some drugs may hamper the victim's alertness, making her more vulnerable to assault and less able to leave the relationship. Furthermore, domestic violence victims who may rely on an abusive partner or caregiver to carry out their treatments or to assist with medications may be placed at further risk when the abuser withholds, alters, or otherwise manipulates the treatment as a means to control the battered partner. Discussing this possibility and alternative options of health care with battered women can be effective ways to minimize risk

A health care provider's response to a battered woman may affect the woman's self–respect and dignity. Ignoring the partner abuse can reinforce feelings of humiliation and compound damage already done to the battered woman's sense of self–worth. By not responding to abuse, health care providers may also inadvertently reinforce the actions of the batterer. If no one intervenes, batterers will presume that there are no restrictions on or consequences to their actions. Conversely, a comprehensive and appropriate response to the abuse can not only lead to beneficial health care and prevent harmful practices, but it also can affect the woman's perceptions of herself, her situation, and her ability to make changes in her life to improve safety for herself and her children. A provider who implies that the woman is "the problem" will reinforce the messages she receives at home. In contrast, the health care provider who says things like "no one deserves to be hit" and "you are not to blame" will be giving different and crucial messages.

Failing to diagnose domestic violence may contribute to the woman's sense of entrapment. Often when battered women seek help, the seriousness of the abuse may be dismissed or minimized. She may be blamed or provided misinformed advice. As the woman becomes increasingly isolated from her support network, the health care provider may be the only person with whom she can speak openly and confidentially about the abuse. A battered woman already may have faced barriers in seeking help and resistance from her family, friends, and other service providers, and consequently may not feel free to broach the subject with her health care provider. She may be hesitant to talk about the abuse unless the health

care provider clearly shows interest, concern, and a willingness to support her. Therefore, it is the health care provider's responsibility to initiate the discussion of domestic violence. Battered women need to be heard and believed, and just as importantly, their choices and decisions need to be respected, as they are the only ones who know all the circumstances of their lives. Healthcare providers must set realistic goals and not gauge success by whether a patient leaves an abusive relationship. The main goal for health care providers needs to be asking the patient about domestic violence and providing her with information, support, and tools she needs to make her own decisions about her future.

Health Care Issues Related to Sexual Violence

Women with a history of sexual abuse and violence also tend to have feelings of low self-esteem and self-worth, shame, guilt and a fear of disclosure. This is particularly true when the response of a health care provider seems unpredictable and the consequences of disclosure may lead to further trauma and lack of control over what happens in her life. It is extremely important to create an atmosphere of support and understanding around the discussion of rape and sexual violence victimization. Asking about a history of sexual abuse in a client's lifetime as well as asking about any recent episodes of sexual violence are critical parts of each visit between patient and health care provider. The main goal for health care providers needs to be asking the patient about the sexual violence and providing her with information, support, and tools she needs to make her own decisions about her future. This includes respecting her need and right to make a personal decision about whether she wants to prosecute a rapist or undergo the forensic "rape kit" examination for evidence. If done properly and without judgment, asking about sexual violence can provide a safe environment for women to discuss their experiences, to receive assistance, and to regain a better understanding of their experiences along with a healthier sense of self worth. It can also empower women and rebuild the sense of self-determination that sexual violence destroys.

Women who were raped a few days or weeks before a clinic visit may seek specific types of medical care without volunteering information about the rape. They may seek testing for pregnancy and sexually transmitted infections (STIs) including HIV, care for any injuries sustained during the rape, or care for more diffuse symptoms

such as pain, generally not feeling well, headaches, gastro-intestinal discomfort, etc. By asking directly about sexual violence, the provider can address fears surrounding pregnancy and STIs/HIV and provide information about prophylactic treatments, answer questions, and refer them for mental health care or counseling, advocacy and crisis support services, and an examination by specially trained Sexual Abuse Nurse Examiners (SANE) that is specifically designed to collect evidence to prosecute the perpetrator if she wishes to pursue a criminal case (a "rape kit").

PRINCIPLES FOR AN EFFECTIVE CLINICAL RESPONSE TO VIOLENCE AGAINST WOMEN

The following principles should be incorporated into all aspects of clinical violence intervention.

Create a safe environment for discussing violence

Make women feel comfortable discussing the violence in their lives. Displaying posters and information on domestic and sexual violence in waiting areas, examining rooms, and bathroom facilities sends the message that domestic and sexual violence are unacceptable and that you are open to discussing these issues. In turn, this may make women feel more comfortable discussing their own needs and problems stemming from the violence in their lives when they interact with health care providers. Providing information in private areas also gives the patient a safe and discreet opportunity to read about the issues or copy down or take contact information without anyone knowing she is doing so. This is especially important for reaching patients who are not ready or willing to discuss these issues with you. In order to be inclusive and welcoming to all clients, a wide variety of materials should be available and on display. Such materials should include messages that:

- target and address different age groups
- are written in culturally competent ways to reach women of many racial and ethnic backgrounds
- use language that is inclusive of heterosexual and same sex partners
- discuss the needs of women who were raped or sexually violated by perpetrators other than partners and ex-partners
- provide specific information for women with disabilities
- provide enough information for women to be able to seek help on their own or with the clinic staff

Screen Women in Private

Screen women for domestic and sexual violence in private, away from their partners, family, or friends and other clients, so that their responses remain confidential, and so that they feel less inhibited. Many abusive men intimidate their partners and threaten to harm them or their children if they disclose the abuse or episodes of sexual violence to anyone, thereby isolating them from all sources of help and support. To assure that women are assessed alone, the clinic should consider a policy that all women must be seen alone initially before anyone can join her in the examining room. By setting a universal standard for all clients, it will be less likely that an abusive partner of a client who is asked to remain in the waiting area will feel singled out and turn their anger upon staff or the client.

If a woman does not speak English, do not rely on her children, family, or friends (and especially not her partner) to translate during the assessment. Since Spanish speakers are becoming increasingly prevalent in North Carolina, it is important for all health care providers to seek out information about translators and other resources in the community and to consider hiring some bilingual staff. When working with a client who has a disability, recognize that a personal attendant may also be her abuser; however, the client has the right to request the attendant's presence throughout the exam. It is important to find a way to ask the client in private whether she wishes to have the attendant with her, and inform her that sensitive questions will be asked that may be uncomfortable to answer in front of the attendant. If a woman is deaf or hard of hearing or has difficulty communicating, arrange for interpreter services. Again, when possible, it is important to seek out information on community resources and make it available to all staff in order to meet the needs of women with communication or physical limitations before a client presents with an immediate need for such services.

Confidentiality should be safeguarded in the following ways: patient's chart should be placed where the abuser and other unauthorized persons do not have access to it; case discussions should be held in private; documentation should go in the patient's chart and not on other family member records; phone calls or mail should not be directed to the patient's home to discuss abuse without permission from the patient[16]. Inform patients about the confidentiality policy as well as any exceptions to confidentiality before asking questions.

Screen all Women

Screening for domestic and sexual violence should be institutionalized as a normal standard of practice. It is most effective when carried out in sensitive and culturally competent ways[25]. Screening only certain women and not others gives the impression that the provider is singling out women due to assumptions and prejudices based on characteristics such as socioeconomic status or race. In fact, unrecognized personal biases may indeed mean that women at risk will be missed if every patient is not screened. Screening all women conveys the message that domestic and sexual violence are important health concerns and can happen to any woman. It can set the foundation for a woman to see the health department as a resource if she should become a victim of domestic or sexual violence in the future. Since domestic and sexual violence screening includes education about violence and models of healthy relationships, and response options for battered and sexually violated women, screening all women can serve as a form of primary prevention. Due to a strong relationship between violence against women and child maltreatment, screening for domestic violence may also reveal child abuse and can serve as a means to protect children from further harm by the perpetrator, either through direct abuse and neglect, unintentional injury of the child while battering his or her mother, or through the trauma children experience when exposed to violence perpetrated against their mothers.

All adolescent females aged 14 or older should be screened as a routine part of their care[56]. If it becomes apparent that an adolescent younger than 14 is sexually active or in an intimate relationship, she should also be screened for sexual and partner violence.

Because providers often do not assess for domestic and sexual violence, many women are not accustomed to being asked about violence. Women may be surprised if you ask questions about abuse without explaining why you are asking them. Before screening a woman for battering and sexual violence, explain that the assessment is now a part of routine care because it is such an important health concern that effects so many women and children. Begin asking questions about domestic and sexual violence with framing statements such as, "Because domestic and sexual violence are such a problem, I ask all my clients…" This is discussed in more detail and with more example framing statements on Pages 84-85.

Screen Women at Every Visit

Women who initially do not disclose their experiences with domestic violence or sexual violence may later choose to discuss it. A woman may not admit domestic or sexual violence the first time she is asked because she may be embarrassed, may not trust the provider, or may be afraid of the abuser or rapist. Also, since abuse may begin at any time and a rape or sexual assault may occur at any time, a woman who has not been battered or raped at one health department visit may begin experiencing a form of violence by the time of her next visit. When assessing women for domestic violence or sexual violence, tell them that this health issue is significant enough to be raised at each visit and that it is OK if their replies differ from what they previously told you or others.

While this is an important principal, it is also equally important to recognize that there are times that screening a women at every visit is inappropriate due to safety, privacy, or other concerns. Do not screen women if:

- you cannot assure you can ask her questions alone and in a private location
- if you have immediate concerns about the safety of your client, the health department staff, or yourself if you do screen; or
- if you cannot secure an interpreter for non-English speakers, or a communication device or sign language interpreter for women with communication disabilities

In these cases, make a note in her chart that she was not screened at the current visit and schedule to do so at a follow-up appointment. Ensure that any assistance from an interpreter or communication device is available for this next visit.

Build Trust with the Women

Inform women that anything they tell you will be kept in confidence and honor this promise. Also, before asking about abuse and violence, tell women that the only exceptions that require you to report what she says include revelations of a desire to hurt herself or another person and incidents of abuse and neglect committed on a minor by someone in a caregiver role. If the patient is a minor, tell her that you are obliged to report any physical and sexual abuse she

discloses to you if it has been perpetrated by a caregiver, such as a parent or family member. (Refer to Appendix 1 for further information on legal guidelines.) As she tells her story, remain calm and supportive. Maintain eye contact, validate her experience, and let her know that abuse and sexual violence are never her fault. Do not react in horror or minimize her situation. Do not seek to verify the patient's information of abuse or sexual violence with her companion, whether a spouse, a partner or some third person. Do not confront the batterer about his treatment of your client.

Listen to and Believe Women

Listening to and believing a battered or sexually violated woman are the most important things you can do for her. An abuse or sexual violence victim may have experienced frustration in previous attempts to seek help from law enforcement officers, family, or clergy. Alternatively, she may never have discussed her abuse or experience of sexual violence with anyone. You may be the first person to whom she has revealed the abuse or violence or the first to believe her.

Prescribe Medications with Caution

In treating a battered woman, remember that the source of her problems is the batterer, not her mental state. Recognizing this, do not simply prescribe tranquilizers or sedatives. Research has shown these drug types to be common choices for treating battered women[170]. Focusing on her depression or anxiety, without acknowledging the battering or sexual violence, leads to treating the symptoms rather than the cause of her problems, and it can incorrectly giver her the message that her problems are within herself only. Medication may also make her drowsy or not alert, thus making carrying out a plan to receive assistance difficult by impeding her ability to drive, concentrate on work, or care for her children[91]. Some women may use these medications for suicide attempts, a real concern for domestic and sexual violence victims since they are at higher risk for depression and suicidal thoughts or attempts.

Provide Sensitive Support

For cases that involve domestic violence, there are three crucial messages that you should tell a battered woman: (1) You don't deserve to be abused; (2) There are many women in your situation; and (3) There are sources of help available to you. Many battered

women would like to tell someone about the violence in their lives and would benefit from knowing that their situation is not uncommon and that resources are available. As a result of the batterer's constant attempts to isolate her and the extent to which this problem is hidden in our society, a battered woman may feel as though she is the only person in the world in her situation. She needs to know that battering affects many women's lives and that she is not to blame for her situation. Furthermore, she needs to hear that battering is her partner's problem and not a result of anything she has done[16]. No one deserves to be battered. Rather, she and her children have the right to live without the fear of violence.

For women who have experienced sexual violence, it is important to remember that individuals may be traumatized or may have symptoms of PTSD (post traumatic stress disorder). Other clients for whom the trauma of sexual violence is not as immediate or as salient may still be consumed with shame and embarrassment about their experiences. Either way, a physical exam, especially one related to reproductive health or requiring the health care provider to touch the client, may be extremely uncomfortable, fear-inducing or even almost unbearable, and may be the "trigger" that reminds her about a past experience of sexual violence. She may begin to relive the trauma and need careful reassurance in addition to referral for rape crisis services. A recent rape victim can be offered the option of calling a local rape crisis center for assistance and to have an advocate meet her at the clinic.

It is important to remember that women who live with violence want the violence to end but may not want to end the relationship or be in a situation where they want to or are ready to leave their abusive partners. Women benefit from a helpful and concerned professional whose advice may be "planting the seeds" of change[50]. Sharing your concern, building trust, and providing information will create an environment that is conducive for women to return to when they need further assistance or are ready to make changes in their lives. Respect women's decisions regardless of what they may be, so that she regains power over her own life and is comfortable returning for future health care and assistance.

Maintain the Safety of Clients and Staff

Safety is one of the most important needs of battered women. Victims of rape and sexual assault also have safety needs as they may have been threatened by their attacker and may have experienced stalking.

In–Clinic Protection

Tips for maintaining safety within the clinic include:

- Note any suspicious behavior that may indicate a domestic violence case (e.g., a person hovering over or restraining a female client; verbally or physically abusive behavior towards a woman or children).
- Have a policy that all clients are to be seen alone (at least during the first part of a visit).
- Designate a person to whom suspicious behavior should be reported.
- Develop a liaison or agreement with law enforcement to ensure the safety of the victim, family, and staff.
- Call law enforcement to accompany the woman out of the clinic, if necessary.
- If there is reason to believe there may be a violent incident in the clinic, call security or law enforcement.
- Ask clients about current restraining or protection orders, and find out who is not allowed to be in proximity to a client in case that person comes to clinic.
- Always ask each client for safe ways to contact her by telephone and by mail, even if it is not at her residence, and ensure that this information is updated at each visit and clear to any staff member who may look in the chart or make contact with her.

Home Visit Protection

Tips for maintaining safety while performing home visits include:

- Tell colleagues where you are going and when you expect to return. If you are uncomfortable going alone, take someone with you.
- Position yourself near an exit so that you may leave quickly if difficulties arise.
- Keep a cellular phone in your car so that you can call to confirm the appointment and can easily call for help if necessary.

BARRIERS TO IDENTIFYING AND INTERVENING IN VAW

Barriers for Women

Health care providers face numerous barriers to identifying and assisting battered women and women who were sexually violated. These barriers include factors related to the women, the health care providers, and the health care system.

A victim may be reluctant to identify herself because she:

- feels ashamed or humiliated
- blames herself for the domestic or sexual violence
- fears she will be judged and blamed for the domestic violence, rape or sexual assault
- fears institutionalization
- fears she will lose the person who provides her personal care
- fears she may lack credibility (Many people who have cognitive, speech, or other disabilities are stereotyped and considered not to be credible. This is also true for young women and adolescents, sex workers, and people with substance use problems, mental health issues, cultural or linguistic barriers, etc.)
- fears she won't be believed
- fears she will be treated differently or not respected after disclosing
- fears for her personal safety and the safety of her children
- has had bad experiences when she has disclosed abuse and sexual violence in the past
- feels that she has no control over what happens in her life or that she will be taken advantage of again
- hopes that the batterer will change (as they often promise to do)
- believes that her injuries are not severe enough to mention
- wants to protect her abusive partner, caregiver, or family member because of emotional or financial dependence
- fears that her children will be taken away from her
- fears that she will not receive assistance after disclosing

The psychological trauma a woman experiences from domestic and sexual violence may:

- prevent her from seeking medical attention
- lead her to cling to her partner, despite the abuse
- lead her to avoid all examinations, especially pelvic exams, if she has been raped, sexually assaulted, or sexually abused
- make it very difficult for her to leave her house to carry out any activity due to severe depression and/or fear

- lead her to dysfunctional activities, such as using alcohol and other substances, as a way to deal with stress and depression, which could cause further fear of disclosure
- lead sexual assault victims to become hypersexualized, pursuing a number of casual sexual encounters, and this could be a barrier to seeking services due to fear of being stereotyped or blamed for the assault

In cases of domestic violence, in order to isolate and maintain control over the woman, a batterer may:

- restrict her use of health services, or
- insist on accompanying her to her appointments
- withhold medication, assistive devices such as walker, canes, wheelchairs, etc.
- withhold personal care
- withhold disability benefits/money
- withhold access to communication (telephone, interpreters, TTY, etc.)
- withhold access to transportation
- withhold access to official documents needed for some forms of health care (insurance card, Medicaid card, etc.)

Barriers for Health Care Providers

Many health care providers lack understanding of domestic violence and/or sexual violence. They may:

- believe that women deserved or asked to be abused by a partner or that women must want the abuse otherwise they would not stay in the relationship
- believe that women deserved or asked to be raped or sexually assaulted because they dressed a certain way, drank too much or used substances, dated someone not well known or went somewhere with a stranger, etc.
- define domestic and sexual violence as solely social or legal problems rather than as a public health problem
- fear discussing domestic and sexual violence because they do not know what to do once a client has disclosed
- view domestic violence as a personal, private, family matter that falls outside the purview of medicine, and rape as a legal or law enforcement matter once immediate physical and medical issues are treated
- feel that direct questions about domestic and sexual violence may be perceived as intrusive, out of place, or inappropriate

- know the batterer or sexual violence perpetrator or members of his family, and therefore may feel uncomfortable discussing the abuse or sexual violence or may not believe the woman if she discloses

Health care providers may experience frustration when they:
- give advice their clients do not follow
- are unable to “cure” the violence or some of its effects
- are unable to influence their clients’ behavior towards healthier decisions
- ask about domestic and sexual violence, and the client denies the experiences or changes her replies to questions between visits

Many health care providers may not have adequate skills to:
- manage associations with their own history of domestic or sexual violence, making it more painful to discuss their clients’ experiences
- deal with the woman’s reaction to being questioned about abuse, which may include anger, depression, or suicidal thoughts
- cope with the realization that domestic and sexual violence are not rare, nor confined to certain groups, meaning that the providers themselves or people close to them could become victims
- ask about domestic and sexual violence on a continuing basis without experiencing secondary trauma or even job “burnout,” due to overly identifying with victims, not appreciating their own emotional vulnerabilities or taking time for self-care, and not having or reaching out to an understanding support network

Barriers for the Health Care System

Barriers also exist within the institution responsible for health care:
- Providers often are limited in the amount of time they are allowed to spend with each client; therefore, they may not bring up domestic or sexual violence because they fear the discussion and response may be very time consuming.
- Providers may fear retaliation by the batterer in cases of domestic violence.
- Providers may fear having to testify in court if they ask about domestic or sexual violence.
- Medical and nursing schools typically do not provide adequate instruction on identifying and assisting battered women and victims of sexual violence.

- Many health care institutions do not have policies and procedures on assessing or responding to domestic and sexual violence.
- Some women have lost or been denied their health insurance because of domestic violence. Providers may fear that, by identifying battered women, they may be putting these women at risk of losing their coverage.

COMPONENTS OF AN EFFECTIVE CLINICAL RESPONSE TO VIOLENCE AGAINST WOMEN

The main components of a clinical intervention that should be included in protocols for domestic violence and sexual violence are:

1. Screening to Identify current or past domestic or sexual violence.
2. Assessment of risk and needs for the client and her children.
3. Interventions – Providing referrals and assistance.
4. Documentation of the domestic or sexual violence.
5. Follow up with the client.

The processes through which the health care provider can fulfill these responsibilities are discussed below.

Unless otherwise noted, much of the following clinical response, including descriptions of components, suggested questions, and documentation procedures has been adapted from the publication National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings produced by:
The Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
(415) 252-8900
TTY (800) 595-4889
September 2002

Any misrepresentation or misinterpretation of the National Consensus Guidelines was done inadvertently in the process of adding in other resources used to provide more complete information the authors wished to convey.

Before women can be assisted with issues related to domestic and sexual violence, they must be identified. Battered women and women who experienced rape or other forms of sexual violence are often willing to report their abuse to health care providers, especially when providers probe sensitively for this information and ask frank questions.

COMPONENT 1: IDENTIFY CURRENT OR PAST DOMESTIC OR SEXUAL VIOLENCE ("SCREENING")

There has been some controversy recently about screening women for domestic violence with the main question being: "Does screening women for domestic violence and providing an intervention and follow up services make her safer?" Despite the fact that it seems to make common sense that asking questions about domestic violence and providing referrals along with other medical interventions and assistance, safety planning, and follow-up care is the ethical thing to do and appears to be beneficial, researchers have not found strong evidence to support or to debunk this claim. Since this is such a strongly debated issue, it is important to touch on the differing perspectives for a better understanding of why this Guide along with many other professionals and organizations stand by the need to ask women about domestic violence in their lives and the lives of their children.

One perspective is that asking women about domestic violence does not have enough evidence either supporting or disproving its effectiveness; therefore, it should not be promoted as standard care along with other evidence-based medical interventions. Most recently, the U.S. Preventive Services Task Force (USPSTF) released a new Recommendation Statement on screening in March of 2004 which said they, "…found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of their children, of women for intimate partner violence, or of adults or their caregivers for elder abuse"[187].

In response to this Recommendation Statement, the Family Violence Prevention Fund reviewed the USPSTF's findings and strongly urged a reexamination of the evidence that pertains only to intimate partner violence and to reassess the process of asking women about violence as a behavioral assessment rather than a "medical screen" in order to better evaluate the actual potential for risk reduction for women and a public health benefit[62]. Other

medical professionals further challenged the USPSTF Recommendation Statement, claiming its view is too narrow, the review included errors, and several studies actually do find many benefits for battered women who are identified and assisted by health care providers, as well as other professionals[61]. Other leaders in various fields agreed:

- The Executive Director of the Association of Women's Health, Obstetric and Neonatal Nurses, said "AWHONN strongly urges nurses to take the time to ask their patients whether they are safe in their homes. This screening is every bit as important as screening for heart disease, breast cancer, or cervical cancer and should be an integral part of routine health care."[61]

- In an editorial that was published along with the USPSTF's Recommendation Statement, a physician noted "Sometimes humanity trumps evidence." … "What proof is required?… Our patients and families are suffering, and the relief of suffering is among our mandates."[107]

- The AMA President-Elect stated, "We stand by our existing policy of routine inquiry about abuse." "Our experience confirms what common sense tells us: When doctors and other health care providers talk to patients about domestic violence and offer referrals and help to those who are victims, battered patients are more likely to take steps to protect themselves and their children. It would be a tragedy if any provider stopped inquiring about family violence as a result of this new recommendation"[61].

How Do You Ask About Domestic and Sexual Violence?

Some guidelines to follow when asking about domestic violence include:

- Ask the woman about her situation in your own words in order to be natural and empathetic.
- Ask about the domestic and sexual violence in person rather than by using a written questionnaire. Studies have found that women are up to four times more likely to report the abuse when they are asked in personal interviews than when they are asked in written questionnaires[122, 143].

- Ask directly about the violence. The manner in which questions are phrased will influence the woman's response.
- An abused woman may have internalized the myths about battered women and may not consider herself a "battered woman." Asking indirectly about "conflict in the home" will only reveal a portion of battered women.
- Similarly, women who were raped or sexually assaulted may not view coercive behaviors as sexual violence or certain sexual acts as "rape" or "sexual assault."
- Any general questions about "stress" or "problems" should always be followed by more specific, simply-worked questions about threats of violence and physical violence. There are also more standardized screening tools that can be used in clinical practices. Suggested ways to phrase these questions and examples of screening and assessment tools are provided later in this chapter.
- Allow the woman to document the episodes and types of abuse or sexual violence that have occurred monthly or weekly on a calendar. Documenting the incidents on a calendar can help her see patterns of violence more clearly.

It is important to begin the screening process with some framing questions to provide context for why you need to ask personal questions and to allay defensiveness that might result from feeling singled out for questioning. Some example screening questions include:

- "Because violence is so common in many people's lives, I've begun to ask all my patients about it."
- "I am concerned that your symptoms may have been caused by someone hurting you."
- "Because pregnant women (or adolescent women) are at special risk, we screen all pregnant women (or adolescent women)."
- "I ask all my female clients if they are in an abusive relationship or have an association with a person who is abusing them."
- "Since I will be your doctor we need to have the best sort of working partnership. It would help if you could answer my questions about your sexual history"[66]

- "I don't know if this is (or has ever been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely."
- "I know we just met and yet I have to ask you all these personal questions. Let me explain why. We need to find out why you have these symptoms, and answering these questions can help us figure this out."[66]
- "I ask all of my patients this question because it is important to me to know what has gone on and what is going on in their lives. For instance, someone can be traumatized by witnessing or experiencing violence…"[66]
- "In order to understand your medical problems better it would be helpful if we could discuss other things that are going on or have happened to you in the past that would affect your health…"[142]

Once you have introduced your topic, it is time to ask about domestic and sexual violence by using one of the existing tools provided below, modifying one of these tools, or developing your own with the guidelines provided in this section. A complete screening should ask questions about both current and past or lifetime domestic and sexual violence. Whenever a woman says she is being battered or she has been sexually victimized by a partner or someone else, it is critical to screen for the well being of any children who may have been exposed to the violence or victimized themselves.

Examples of Existing Screening Tools

The following examples of tools to identify battered and sexually violated women have been developed for health care providers. Some of these tools also include assessment questions. Health department staff can choose the tools that best suit their needs and that best meet the needs of the women they serve, or they can create their own tool. Using tools that have already been developed may be simpler and more effective than developing a tool. Although several of these tools were developed to screen pregnant women, they can be adapted for use with all women.

Tools Developed or Modified by NC Health Departments

Gaston and Wake County Health Departments and the Coastal Area Health Education Center (Coastal AHEC) in conjunction with the New Hanover County Health Department each developed a screening tool for use with their clients. These tools were all reported to be successful in identifying more women who needed domestic violence related services; however, it is unclear if any county health department is currently using any of the following tools. If these tools are adopted, add questions specifically about sexual violence and about children living in the home or otherwise exposed to violence against their mothers.

Gaston County Health Department Screening Tool

The Gaston County Health Department revised the Abuse Assessment Screen for use in their clinics. This tool is on pages 87-88. They began using this tool in January 1993 to screen pregnant adolescents and then began to screen all pregnant women; however, it is not clear whether it is still in use at any health department. The advantage of using this tool is that it has already been adapted for a health department setting. This expanded version can be used to assess pregnant women three times (during pregnancy counseling, mid term, and post–partum). This tool also asks about other factors associated with domestic violence such as age and the woman's and batterer's use of drugs and alcohol. Additionally, the tool includes general questions about sexual violence and asks for the relationship of the perpetrator to the patient. Therefore, it can be used to ask about sexual abuse in a domestic violence relationship as well as sexual violence committed by others, but adding more questions related to sexual violence would be helpful. The form allows providers to document referrals made and a safety plan developed.

DV Safety Assessment

Client Label:

Marital Status M___ S___ Sep___ D___ W___
EDC_________

	A. Pregnancy Counseling	B. Mid (27-32weeks) Assessment	C. Post Partum
A. Since becoming pregnant, have you received threats of abuse (which you believe will happen), been frightened and intimidated repeatedly, been hit, slapped, kicked or physically hurt by someone? B. Since pregnancy counseling, have you received ? C. Since mid-assessment, have you received .... ? **KEY:** C=client P=perpetrator B=both Mark the area of injury on body map 1 = Threats of abuse, including threats of weapon use. 2 = Slapping, pushing; no injuries and/or lasting pain. 3 = Punching, kicking, bruises, cuts and/or pain. 4 = Beating up, severe contusions, burns, broken bones. 5 = Head injury, internal injury, permanent injury. 6 = Use of weapon; wound from a weapon.	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?
A., B., C. Before becoming pregnant, but within the last year, have you received threats of abuse (which you believe will happen), been frightened and intimidated repeatedly, been hit, slapped, kicked or physically hurt by someone? (If answered yes to this question, do not ask again) **KEY:** C=client P=perpetrator B=both Mark the area of injury on body map 1 = Threats of abuse, including threats of weapon use. 2 = Slapping, pushing; no injuries and/or lasting pain. 3 = Punching, kicking, bruises, cuts and/or pain. 4 = Beating up, severe contusions, burns, broken bones. 5 = Head injury, internal injury, permanent injury. 6 = Use of weapon; wound from weapon.	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?
A. Within the last year, has anyone forced you to have sex/has anyone sexually assaulted you? B. Since pregnancy counseling, has anyone ...... ? C. Since mid-assessment, has anyone .... ? C=client P=perpetrator B=both	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?	Yes___ No___ relationship age___ # of times no yes alcohol/drugs who - C P B ?
Comments	weeks gestation___ Date___ Screener Clinic Area	weeks gestation___ Date___ Screener Clinic Area	# of weeks since delivery___ Date___ Screener Clinic Area

(Adapted McFarlane 1992) GCHD - Revised 4/94

DV Safety Education
(Red Flags–Referral Options–Community Resources–Safety Plan)

Red Flags:	A. Pregnancy Counseling	B. Mid (27-31) Assessment	C. Post Partum
1. (Safety, Control) A. Do you feel safe in your own home? (no one is worried about my safety or warned me that my partner makes them feel unsafe?) B. Since pregnancy counseling, do you still feel safe in your own home? (your sense of safety at home has not changed? C. Since mid-assessment, do you still feel safe in your own home?	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
2. (Isolation, Jealousy) A. Does your partner keep you from friends, family, coming to the health department, going to school, or other appointments? B. Since pregnancy counseling, has your partner become possessive, needs to be with you or know where you are all the time? C. Since mid-assessment has your partner stopped you from seeing certain people, or has made infidelity accusations that are not true?	Yes___ No___	Yes___ No___	Yes___ No___
3. (Witness Violence) A. Growing up did you see your mother being threatened, hit, slapped, kicked, or physically hurt by your father, stepfather, or her boyfriend?	Yes___ No___	X	X
4. A. Have you ever left home because of domestic violence? B. Since pregnancy counseling, have you left home because of DV? C. Since mid-assessment, have you left home because of DV?	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
5. A. Has your partner ever been violent to your children? B. Since preg. counseling, has your partner been violent to your children ? C. Since mid-assessment, has your partner been violent to your children ?	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
6. A. Have you ever received medical treatment for injuries caused by DV? B. Since pregnancy counseling, have you received medical treatment . . . ? C. Since mid-assessment, have you received medical treatment . . . . . . ?	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
Comments:			
Referral Options: a. Immediate access to shelter or police	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
b. Shelter information and access at later date	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
c. Referral to counseling (Individual) Health Depart., Mental Health, Family Service, Other (Support Group) Family Service, Mental Health, Shelter, Other	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
d. Returning to family/partner, with follow-up appointment	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
e. Referral to court system, magistrate, police, hospital, other legal services	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___
Comments:			
Community Resource Information Given: Referral Agency's Brochure, General Brochure with Phone Numbers, Important Phone Numbers Brochure, Safety Card, Warrant Brochure, Other Brochure			
Safety Plan Discussed:	Yes___ No___ N/A___	Yes___ No___ N/A___	Yes___ No___ N/A___

Coastal Area Health Education Center (AHEC) Tool

A briefer version of the Abuse Assessment Screen that asks only about abuse during pregnancy, was developed by the Coastal AHEC for a study on battering during pregnancy[43]. It is unclear if this tool is currently in use in any health department setting. Maternity Care Coordinators conducted this assessment three times during pregnancy. This assessment does not address other factors related to domestic violence such as substance abuse. It also does not ask about sexual violence by partners or by other perpetrators. If this tool is used, other questions about sexual violence need to be added.

Questions and response codes	1st MCC contact Date:	2nd trimester contact Date:	3rd trimester contact Date:
(1st) Have you been hit, slapped, kicked, or hurt during pregnancy?	No___ Yes___ (continue)	No___ Yes___ (continue)	No ___ Yes ___ (continue)
(2nd/3rd) Have you been hit, slapped, kicked, or hurt since the last time I asked you?	How many times? ___ Who hurt you? ______ ____________________	How many times? ___ Who hurt you? ______ ____________________	How many times? ___ Who hurt you? ______ ____________________
Use numbers to code responses How they hurt you / Where hurt 1=Threats of abuse / 1=Extremeties 2=Slapped, shoved, pushed / 2=Back 3=Hit, punched, kicked / 3=Breasts 4=Beaten / 4=Genitals 5=Stabbed or cut / 5=Face/Head 6=Shot with a gun / 6=Abdomen 7=Sexual abuse	How did they hurt you? _________ (enter #s) Where did they hurt you? _________ (enter #s)	How did they hurt you? _________ (enter #s) Where did they hurt you? _________ (enter #s)	How did they hurt you? _________ (enter #s) Where did they hurt you? _________ (enter #s)

Wake County Department of Health's Screening Tool

Wake County Human Services developed the following screening tool for domestic violence and substance abuse among pregnant women; however, it is not clear if it is currently in use[118]. The questions that screen for domestic violence are provided below. Note that the question about sexual violence can be used both for domestic violence and for sexual violence by other perpetrators.

1. Have you (ever) lived with, or been in a relationship with, someone who made you feel unsafe at times?

Before this pregnancy (ever)?	Since you've known you're pregnant?
0 No, never felt unsafe	0 No, never unsafe
1 Yes, felt unsafe	1 Yes, felt unsafe
(Age first time______Years)	
(Age last time______Years)	

2. Have you (ever) been hit, slapped, kicked or otherwise physically hurt by someone? (If yes, specify relationship of perpetrator to client. Exclude playful rough-housing.)

Before this pregnancy (ever)?	Since you've known you're pregnant?
0 No, never felt unsafe	0 No, never unsafe
1 Yes, felt unsafe	1 Yes, felt unsafe
(Age first time______Years)	
(Age last time______Years)	

3. Have you (ever) been forced to have sexual activities with anyone? (If yes, specify relationship of perpetrator to client.)

Before this pregnancy (ever)?	Since you've known you're pregnant?
0 No, never forced	0 No, never forced
1 Yes, forced (specify by whom _____)	1 Yes, forced (specify by whom_____________)
(Age first time______Years)	
(Age last time______Years)	

Baby Love Plus Family Violence Project Tool for Maternity Care Coordinators (MCCs)

The following tool was developed for use in the maternity care clinics of the Northeastern region of North Carolina. It has been in use since 2003 as part of an expanded Baby Love Program[114]. This tool asks about both domestic and sexual violence and includes options for responding with non-partner abusers or perpetrators of sexual violence. In the original project, a Maternity Care Coordinator (MCC) screen the patient for violence at the initial visit that include a positive pregnancy test or the first time the patient comes in for prenatal care, followed by other similar tools used during post-partum visits at 6 weeks, three months and six months. All women who say they have experienced domestic and/or sexual violence at any of the visits in which they are screened are referred by the MCC to the Domestic Violence Specialist, a specially trained social worker who conducts more in-depth assessment with the clients and ensures they receive indicated interventions and referrals as options.

MCC SCREENING DURING PREGNANCY (1-10-03 version)

PATIENT ID#: ______________________________ CLINIC/SITE: ______________________________

PATIENT NAME: ________________________________ ________________________________
(First) (Last)

ADDRESS: ____
(Street) (Town, State, Zip)

TELEPHONE: ________________________________ WEEKS GESTATION: ____________________

TODAY'S DATE:_______/_______/_______ PRACTITIONER: ________________________________
(Month Day Year)

Many women experience violent or upsetting incidents during their lives, including emotional abuse, physical violence, and sexual violence. These behaviors can be done by many persons, including relatives (parents, etc.), boyfriends/girlfriends, spouses/husbands/partners, acquaintances, and strangers.

1. Has anyone been emotionally mean/abusive to you (such as calling you names, swearing at you, breaking your possessions, threatening to hurt you)…

During the year before this pregnancy?
0 No
1 Yes (1ST INITIAL(s): _______________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

Since you've known you're pregnant?
0 No
1 Yes (1ST INITIAL(s): ____________________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

2. Has anyone hit, slapped, kicked or otherwise physically hurt you (EXCLUDE MUTUAL PLAYFUL ROUGH-HOUSING)…

During the year before this pregnancy?
0 No
1 Yes (1ST INITIAL(s): _______________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

Since you've known you're pregnant?
0 No
1 Yes (1ST INITIAL(s): ____________________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

3. Has anyone used force to make you have sex or unwanted sexual contact…

During the year before this pregnancy?
0 No
1 Yes (1ST INITIAL(s): _______________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

Since you've known you're pregnant?
0 No
1 Yes (1ST INITIAL(s): ____________________________)
(RELATIONSHIP(S): __)
(STILL IN RELATIONSHIP(S)? _____)

4. Have you seen/spoken with anyone (including police officers, lawyers, domestic violence or rape crisis professionals, nurses, doctors, social workers, etc.) because of some type of emotional hurt or violence…

During the year before this pregnancy?
0 No
1 Yes (AGENCIES/PERSON (S))
(DATE(s) of contact)

Since you've known you're pregnant?
0 No
1 Yes (AGENCIES/persoN(S))
(DATE(s) of contact)

_____ Further violence assessment is NOT indicated
______ Further violence assessment is indicated (patient reported "yes" to any of the above questions, or clinical opinion indicates need for more detailed assessment.)

If indicated, further assessment will be completed by:
____ MCC

____ Social Worker/ DV Specialist

***____ Other** (SPECIFY)*

National Screening Tools

Abuse Assessment Screen

The Abuse Assessment Screen[123] screens for physical abuse and sexual abuse. It is provided in English and in Spanish on pages 94-95. It has been tested for validity and reliability. In one study, this tool revealed one in six pregnant women was abused[124]. Read the questions to the woman while holding the tool in a manner that the woman can easily see the questions as you read. If she reports abuse, hand her a pen or pencil and ask her to mark the areas on the body map where she was abused. Together score each abuse incident using the six-point scale.

FIGURE 1 A. ABUSE ASSESSMENT SCREEN

1. **WITHIN THE LAST YEAR,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

   If YES, by whom?

   Total number of times

2. **SINCE YOU'VE BEEN PREGNANT,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

   If YES, by whom?

   Total number of times

MARK THE AREA OF INJURY ON THE BODY MAP SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

SCORE

1 = Threats of abuse including use of a weapon ________

2 = Slapping, pushing; no injuries and/or lasting pain ________

3 = Punching, kicking, bruises, cuts and/or continuing pain ________

4 = Beating up, severe contusions, burns, broken bones ________

5 = Head injury, internal injury, permanent injury ________

6 = Use of weapon; wound from weapon ________

If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR**, has anyone forced you to have sexual activities? YES NO

   If YES, by whom?

   Total number of times

Developed by the Nursing Research Consortium on Violence and Abuse.
Readers are encouraged to reproduce and use this assessment tool.

FIGURE 1 B. ENCUESTA SOBRE EL MALTRATO

	SI	NO
1. **DURANTE EL ÚLTIMO AÑO**, fué golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien?	SI	NO

Si la respuesta es “SI” por quien(es) ___________________

Cuantas veces?

	SI	NO
2. **DESDE QUE SALIO EMBARAZADA,** ha sido golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien?	SI	NO

Si la respuesta es “SI” por quien(es) _____________________

Cuantas veces?

EN EL DIAGRAMA, ANATÓMICO MARQUE LAS PARTES DE SU CUERPO QUE HAN SIDO LASTIMADAS. VALORE CADA INCIDENTE USANDO LAS SIGUIENTE ESCALA:

GRADO

1=Amenazas de maltrato que incluyen el use de un arma ________

2=Bofeteadas, empujones sin lesiones fisicas o dolor permanente ________

3=Moquestes, patadas, moretones, heridas, y/o dolor continuo ________

4=Molida a palos, contusiones several, quemaduras, fracturas de huesos ________

5=Heridas en la cabeza, lesiones internal, lesiones permanents ________

6=Uso de armas; herida por arma ________

Si cualquiera de las situaciones valora un numero alto en la escala,

	SI	NO
3. **DURANTE EL ÚLTIMO AÑO**, fué forzada a tener relaciones sexuales?	SI	NO

Si la respuesta es “SI” por quien(es)

Cuantas veces?

AMA Guidelines for Domestic Violence Screening

The American Medical Association has developed an unstructured list of guidelines to follow to screen women for domestic violence[65]. These guidelines have not been adapted to health departments. However, they are probably more familiar to physicians than other types of guidelines because they are endorsed by the AMA. Therefore, if physicians are the ones who will be screening women in your health department, consider incorporating these guidelines. If using this tool, it is important also to incorporate a screening tool that asks about sexual violence occurring in contexts other than domestic violence and to ask about the exposure of any children in the home to the violence or to direct abuse or neglect by the abuser.

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all disagree at home. What happens when you and your partner disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

Women's Experiences with Battering (WEB) Scale

In contrast to the Abuse Assessment Screen, the Women's Experiences with Battering (WEB) Scale does not measure only observable discrete events, but instead measures the gendered nature of battered women's experiences[165]. This tool was developed based on findings from focus groups with battered women and known-groups surveys with battered and nonbattered women. It can be administered in an interview or as a questionnaire to fill out. This

tool tends to identify the feelings women experience in a relationship with domestic violence rather than on the specific behaviors used by batterers. If this tool is used, other tools should also be incorporated to ask about injuries, the presence of children in the home, and sexual violence.

Women's Experience with Battering Scale (WEB-Scale).

Description of how your partner makes you feel	Agree Strongly	Agree Somewhat	Agree a Little	Disagree a Little	Disagree Somewhat	Disagree Strongly
1. He makes me feel unsafe even in my own home	6	5	4	3	2	1
2. I feel ashamed of the things he does to me	6	5	4	3	2	1
3. I try not to rock the boat because I am afraid of what he might do	6	5	4	3	2	1
4. I feel like I am programmed to react in a certain way to him	6	5	4	3	2	1
5. I feel like he keeps me prisoner	6	5	4	3	2	1
6. He makes me feel like I have no control over my life, no power, no protection	6	5	4	3	2	1
7. I hide the truth from others because I am afraid not to	6	5	4	3	2	1
8. I feel owned and controlled by him	6	5	4	3	2	1
9. He can scare me without laying a hand on me	6	5	4	3	2	1
10. He has a look that goes straight through me and terrifies me	6	5	4	3	2	1

Directions:

To score this scale, add the responses for items 1 through 10. The score range is 10 to 60. A score of 20 or higher is a positive screening test for battering.

American College of Obstetricians and Gynecologists (ACOG) Screening Tools

Since the mid-1980s, The American College of Obstetricians and Gynecologists (ACOG) has recognized that domestic violence and sexual violence are serious problems with many effects on the health of women and their children. Over the past two decades, ACOG has released a number of technical bulletins, medical recommendations, and position statement on various aspects of violence against women. In addition, ACOG has developed screening tools both for domestic violence and for sexual violence.

ACOG Screening Tools—Sexual Assault

ACOG recommends that physicians screen ALL patients at every visit for sexual assault. To help physicians with this difficult process, ACOG has developed tools to screen for sexual assault[6]:

Screening teens for rape and sexual assault can be conducted by making a statement and asking the following questions:*

"Because sexual violence is an enormous problem for women in this country and can affect a woman's health and well being, I now ask all my patients about exposure to violence and about sexual assault."

1. Do you have someone special in your life? Someone you're going out with?

2. Are you now—or have you been—sexually active?

3. Think about your earliest sexual experience. Did you want this experience?

4. Has a friend, a date, or an acquaintance ever pressured or forced you into sexual activities when you did not want them? Touched you in a way that made you uncomfortable? Anyone at home? Anyone at school? Any other adult?

5. Although women are never responsible for rape, there are things they can do that may reduce their risk of sexual assault. Do you know how to reduce your risk of sexual assault?"

*Consult your state laws for child abuse, child sexual assault, and statutory rape reporting requirements.

ACOG Screening Tools—Domestic Violence

ACOG recommends that physicians screen ALL patients for intimate partner violence[5].

For women who are not pregnant, screening should occur:

- at routine ob-gyn visits
- family planning visits
- preconception visits.

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

Screening should occur:
- at the first prenatal visit
- at least once per trimester, and
- at the postpartum checkup.

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

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

- Within the past year — or since you have been pregnant — have you been hit, slapped, kicked or otherwise physically hurt by someone?
- Are you in a relationship with a person who threatens or physically hurts you?
- Has anyone forced you to have sexual activities that made you feel uncomfortable?"

The S.A.V.E. Tool for Screening for Sexual Assault

The Florida Council Against Sexual Violence (FCASV) has developed an entire protocol named SAVE for how to screen for sexual violence, as well as how to evaluate, educate and refer a client who has been victimized[66]. Some of the framing statements suggested as ways to approach the topic were listed on Pages 84-85 with other examples. The specific screening questions the SAVE tool uses to ask about sexual violence are:

- "Have you ever been touched sexually against your will or without your consent?"
- "Have you ever been forced or pressured to have sex?"
- "Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?"
- "Do you have control over whether you use contraception when you have sex?"[142]

International Planned Parenthood Foundation (IPPF)

The IPPF has developed a tool that includes domestic violence and sexual violence[95]. One unique feature of this tool is the question specifically asking women about sexual violence during childhood. [Please note: for consistency of language, every incident of the term "Gender Based Violence" was changed to "Violence against Women" and the abbreviation "GBV" was changed to "VAW." Otherwise, the text as not been altered from the original.]

Sample Stamp for Client Intake Form to Record Information on VAW

Date: ___/____/____
In risk?: Yes ☐ No ☐
Accepted help?: Yes ☐ No ☐

	Ever	Last 12 months	Partner √ = yes
PSY			
PHY			
Sx			
CSA			

Date: the date the screening tool was used with the client.

In risk: denotes whether the woman is in immediate risk as per her answer to the safety question ‘Will you be safe when you return home today?’

Accepted help: Did the client accept a referral?

Ever: mark if the client has experienced the particular kind of violence at any given point in her life.

Last 12 months: mark if the client has experienced the particular form of violence in the last 12 months. This is what IPPF/WHR defines as current experience of violence.

Partner: mark if the aggressor of the violence was the client’s partner.

The four categories of VAW, defined by the working group based on existing definitions in the literature and on the experience of affiliates, which can be specified using this tool:

PSY: psychological violence
PHY: physical violence
SX: sexual abuse
CSA: denotes a history of childhood sexual abuse

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SCREENING TOOL

CASE NUMBER:________________DATE:________________

NAME OF COUNSELOR:________________________________

Introduction:

Since abuse and violence are so common in women's lives, we have begun asking these questions of all women who come to ________________________________(name of organization).

Psychological/emotional violence in the family

1. Have you ever felt harmed emotionally or psychologically by your partner or another person important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, etc.)*
   If Yes, › when did this happen?__________________________
   By whom?____

Physical violence

2. Has your partner or another person important to you ever caused you physical harm? (Examples, hitting, burning or kicking you?)*
   If Yes, › when did this happen?__________________________
   Who did it?____

Sexual violence

3. Were you ever forced to have sexual contact or intercourse?
   If Yes, › when did this happen?__________________________
   By whom?____

Sexual violence in childhood

4. When you were a child, were you ever touched in a way that made you feel uncomfortable?
   If Yes, › when did this happen?__________________________
   By whom?____

Safety

5. Will you be safe when you return home today?

Each organization can work out its own examples and description of acts of physical violence to ensure that they are culturally relevant.

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Exposure of Children to Domestic and Sexual Violence

Most screening tools do not ask about the presence of children in the home where domestic violence occurs, nor do they ask specifically whether children have witnessed any act(s) of domestic violence or sexual violence by someone known or not known to the victim or to the child. It is important that you include the following questions into routine screening whenever a woman says she has been abused by a partner or has been a victim of sexual violence:

1. Are you worried that your children may have heard or seen some of the abuse?
2. Have your children been abused or hurt themselves?
3. IF YES to either question #1 or 2, then ask: Would you like the children to receive counseling, medical attention, or other services? [You may need to probe to make sure the client knows what sorts of services she may be able to access for her children].
4. If YES to question #2, a referral DSS, Child Protective Services is required if a child is being abused. It is important to note the NC Division of Social Services has adopted a Domestic Violence policy that is in place statewide. Some of the goals of this policy are that all family members will be safe from harm, the non-offending parent/adult victim will receive services to protect him/herself, and that the alleged perpetrator will be held responsible for abusive behavior.

   All families referred to DSS are screened for domestic violence. In counties that have adopted the Multiple Response System (MRS), the screening is conducted in the initial contact. If a health department is referring or reporting the abuse of children in a domestic violence situation, it's important that the person initially contacting DSS report and explain the domestic violence and have it recognized and considered from the beginning of the investigation.

Develop your own identification tool

In addition to the tools previously mentioned, there are several questions suggested in the literature for use in screening women for domestic and sexual violence. These questions have been grouped according to the issue they are determining. Develop a personal repertoire of abuse-related questions that are comfortable and natural.

A thorough screening tool should address each of these five issues.

1. Physical abuse
    - I noticed you have a number of bruises. Could you tell me how they happened? Did someone hit you?
    - Sometimes when I see an injury like yours, it's because somebody hit the patient. Did that happen to you?
    - Have there been times during your relationship when you have been hit, punched, kicked or hurt in any way? Are you in such a relationship now?
    - Have there been times during your relationship when you and your partner have had physical fights?
    - Has you partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
    - Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
    - Many clients tell me that they have been hurt by someone close to them. Has this ever happened to you?
    - When there are fights at home, have you ever been hurt or afraid?
    - Sometimes when others are over-protective or jealous—as you describe—they react strongly and use physical force. Is this happening in your Situation?
    - Do you have guns in your home? Has your partner ever threatened to use them when he was angry?
    - I'm concerned that your symptoms may have been caused by someone hurting you. Has someone been hurting you?
    - It looks like someone hurt you. Tell me about it.
    - Have you ever been scared to go home? Are you scared now?

2. Emotional abuse
    - Do you feel equal to your partner?
    - Who makes the decisions in your relationship?
    - Do you ever feel bossed around by your partner?

- What happens when you disagree with your partner?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education.

3. Sexual assault
   - Has anyone ever forced you to do something sexually that made you uncomfortable?
   - Has your partner/anyone ever force you to have sex or perform sexual acts against your will?
   - Has your partner/anyone ever forced you to have sex when you didn't want to?

4. Abuse during pregnancy
   - Ask any of the questions listed above to a pregnant woman.
   - Preface the above questions with "While you were pregnant,…"

5. Child abuse and Exposure of Children to Domestic and Sexual Violence

   Inform the woman that you will have to report any child abuse or neglect committed by a caregiver to the Department of Social Services before asking these questions. [NOTE: Refer to the previous section on page 104 for more information on the exposure of children to domestic and sexual violence.]

   - Are there children involved in the abuse?
   - Is he violent to the children?
   - Are children present or otherwise exposed to violence in the home?
   - Have your children seen someone sexually assault you?
   - Have your children seen someone physically or emotionally hurt you in any way?

COMPONENT 2: ASSESSMENT OF RISK AND NEEDS FOR THE CLIENT AND HER CHILDREN

Once a woman has been identified as experiencing domestic or sexual violence, assess her immediate safety and her risk for future violence, her coping mechanisms, health status, and then determine her referral needs. The assessment should provide the foundation for whatever service is planned. Encourage the woman to discuss her particular situation in detail, including exactly what has been occurring, its frequency, and her emotional feelings and reactions. Listening to the woman's experiences may be difficult, but describing her situation is an essential step in helping her recognize the serious and dangerous nature of her relationship.

Areas to assess:
- safety and lethality
- coping mechanisms

Safety and Lethality

First, make sure that the victim is safe in the clinic setting. The Family Violence Prevention Fund has questions to be considered regarding the victim's immediate safety__. These questions were originally created to relate only to domestic violence, but some may be may be modified to apply more generally in cases of sexual violence. Suggestions for modification follow certain questions in parentheses.

- Is the victim's partner here now or likely to return? (Is the person who raped or sexually assaulted you here now or likely to return?)
- What would she like you to do if her partner tries to get her to leave the healthcare setting? (What would she like you to do if the person who raped or sexually assaulted her tries to get her to leave the healthcare setting?)
- Does she want you to call security or the police?
- Does she want to leave the clinic with her partner?
- Does she want to keep hidden and then find a shelter? (Or another safe place?)
- Does she need to call someone to pick up her children?
- Does she have a protective order? If so, does she want the abuser arrested if he shows up?
- Does she think it would be better to go home with him at this time?
- Does she need to be home by a certain time in order to avoid further abuse?

Next, for cases of domestic violence, assess for risk of serious injury or homicide by the batterer. Ask the patient to describe current and prior patterns of abuse. Asking questions about safety can help make it clearer to the victims that she is in danger. Ask women about the following factors which may increase their risk for further abuse or homicide: access to weapons, threats, substance abuse, violence in other situations, controlling behavior, and plans to leave. These factors have been found to be associated with severe abuse and partner homicide, but they are not predictive of whether she will be a victim.

Danger Assessment Tool

The Danger Assessment is an instrument developed to use in assessing the potential for homicide by a partner or ex-partner[24]. The questions on this form are based on research identifying factors associated with partner homicide. The assessment form has been tested for internal consistency, test-retest reliability, and construct validity. The items in the scale are not ranked by severity. Although it is unknown if some items indicate more risk than others, the instrument may be used to assist the woman in objectively evaluating her safety in her current relationship. The Danger Assessment is scored by totaling the number of items that have been answered "yes." Pregnant abused women have been found to score higher on the Danger Assessment than abused women not abused during pregnancy. Part B of this assessment is provided in English and Spanish. To introduce the assessment, read or paraphrase the paragraph that precedes the questions to the woman. Show the woman the results and encourage her to make her own assessment of her risk of homicide.

FIGURE 2A. DANGER ASSESSMENT

Several risk factors have been associated with homicides (murder) of both batterers and battered women in research that has been conducted after the killings have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The "he" in the question refers to your husband, partner, ex-husband, ex-partner or whoever is currently physically hurting you).

PLEASE CHECK YES OR NO FOR EACH QUESTION BELOW.

YES	NO		
________	________		
_______	______	1.	Has the physical violence increased in frequency over the past year?
_______	______	2.	Has the physical violence increased in severity over the past year and/or has a weapon or threat with a weapon been used?
_______	______	3.	Does he ever try to choke you?
_______	______	4.	Is there a gun in the house?
_______	______	5.	Has he ever forced you into sex when you did not wish to do so?
_______	______	6.	Does he use drugs? By drugs I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs, heroin, or mixtures.
_______	______	7.	Does he threaten to kill you and/or do you believe he is capable of killing you?
_______	______	8.	Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
_______	______	9.	Does he control most of all of your daily activities? For instance, does he tell you whom you can be friends with, how much money you can take with you shopping or when you can take the car? (If he tries, but you do not let him, check here .)
_______	______	10.	Have you ever been beaten by him while you were pregnant? (If never pregnant by him, check here .)
_______	______	11.	Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")
_______	______	12.	Have you ever threatened or tried to commit suicide?
_______	______	13.	Has he ever threatened or tried to commit suicide?
_______	______	14.	Is he violent outside of the home?

________ TOTAL YES ANSWERS

THANK YOU. PLEASE TALK TO YOUR NURSE, ADVOCATE OR COUNSELOR ABOUT WHAT THE DANGER ASSESSMENT MEANS IN TERMS OF YOUR SITUATION.

Note: From Campbell, J. (1986). Nursing assessment for risk of homicide with battered women. ***Advances in Nursing Science, 8(4), 36-51.***

FIGURE 2B. EVALUACION DE PELIGRO

Varios factores de riesgo han sido asociados con homicidios (asesinatos) en ambos el abusador o la mujer abusada en estudios realizados despues de haber ocurridas las muertes. No podemos predecir que sucederá en su caso, pero me gustaría advertirle del peligro de homicidio en situaciones de abuso severo y que usted se de cuenta de cuantos factores, de riesgo se aplican en su situación. (En las siguientes preguntas cuando hablamos de "él" nos estamos refiriendo a su marido, compañero, ex-marido, ex-compañero o quienquiera que la este actualmente dañando la fisicamente.)

Por favor marque SI o NO a cada una de las preguntas que siguen abajo.

SI	NO	
________	________	1. ¿Ha aumentado su compañero la violencia física durante el año pasado?
________	________	2. ¿Ha aumentado la severidad de violencia fisica por su compañero durante el año pasado y/o ha sido amenazada con un arma o ha sido un arma usada de usted?
________	________	3. ¿Ha tratado él de asfixiarla?
________	________	4. ¿Hay alguna arma de fuego en su casa?
________	________	5. ¿La ha forzado el a tener relaciones sexuales en contra de su voluntad?
________	________	6. ¿Usa él drogas? Por drogas me refiero a "exitantes" o afetaminas, "speed," polvo de angel, cocaina, crack, drogas de la calle, heroína, o mezclas.
________	________	7. ¿La amenaza él con matarla o cree usted que él es capaz de matarla?
________	________	8. ¿Se emborracha él todos los dias o casi todos los días? (Refierase a la cantidad de alcohol.)
________	________	9. ¿Controla él la mayoria de sus actividades diarias? Por ejemplo, le dice él quienes pueden ser sus amistades, o cuanto dinero puede llevar cuando va de compras, o cuando puede usar el coche?
		(Si él trata, pero usted no to deja, marque aqui .)
________	________	10. ¿Ha sido usted golpeada cuando estaba embarazada?
		(Si no ha estado embarazada de él, marque aquí .)
________	________	11. ¿Es él violento, o constantemente celoso de usted? Por ejemplo le dice él: "Si no eres mia no vas a serlo de nadie."
________	________	12. ¿Ha usted amenazado o ha usted tratado con suicidarse?
________	________	13. ¿Ha tratado o amenazado él con suicidarse?
________	________	14. ¿Es él violento fuera de la casa?

________ **TOTAL DE RESPUESTAS SI**

GRACIAS. POR FAVOR HABLE CON SU ENFERMERA, ASESOR LEGAL, O CONSEJERO SOBRE LO QUE LA EVALUACION DE PELIGRO SIGNIFICA EN SU CASO.

Develop Your Own Assessment Tool

Elements of a thorough assessment include questions on risk factors for further abuse, women's coping mechanisms, and special needs of battered women. Examples of questions that address each of these elements are provided.

Ask women about factors that may increase their risk for further abuse, being raped or sexually assaulted again, or homicide. Samples of questions that inquire about specific risk factors are provided below.

These questions may be adapted as needed.

1. Access to weapons
   - Does he have or use a weapon?
   - Is there a gun or another weapon in the home?

2. Threats
   - Has he threatened to hurt or kill you or your children?
   - Has he threatened you or your children with a weapon?
   - Does he know where you live or other ways to find you?

3. Substance abuse
   - Does your partner use drugs or alcohol? If so, how often?
   - You mentioned your spouse uses drugs/alcohol. How does your spouse act when drinking or on drugs?

4. Violence in other situations
   - Is your partner violent outside the home?
   - Does your partner fight physically with other people?

5. Controlling behavior
   - Do you feel that your partner controls your behavior too much?
   - How are decisions made or conflicts resolved at your house?
   - Is your partner extremely jealous? If so, what does he do when he gets jealous?
   - Does your partner consistently control your actions or put you down?

6. Her plans to leave
   - Do you have a plan to leave?
   - Have you told him that you plan to leave the relationship?

7. Her concerns about safety
   - Are you afraid of your partner?
   - Are you afraid of the person who raped you?
   - Do you feel that you are in immediate danger?
   - What do you think will happen between you and your partner in the near future?
   - Are you expecting a violent attack in the near future?
   - Are you afraid for the safety of your children?

Women's Coping Mechanisms

Ask about the mechanisms the woman uses to cope with the domestic or sexual violence to determine specific mental health needs she may have.

1. Substance abuse

   Alcohol and other drugs can reduce women's abilities to make rational decisions and can also be used for suicide attempts.

   - Do you use drugs or alcohol? If so, how often?

2. Suicide attempts or threats

   Many women think about suicide; however the situation becomes urgent if a woman has formulated a plan to commit or attempt suicide. People with a suicide plan typically will act on it in the near future.
   - Have you ever threatened or attempted suicide?
   - Has your partner ever threatened or attempted suicide?
   - Do you think about suicide? If so, do you have a plan to commit suicide? [If the patient threatens to kill herself or her partner, call for an emergency psychiatric evaluation.]

3. Women's special needs

   Finally, ask the woman what she thinks she needs to end domestic violence or to recover from sexual violence.

COMPONENT 3: INTERVENTIONS PROVIDING REFERRALS AND ASSISTANCE

Enabling battered and raped or sexually violated women to take control of their own lives at a pace that is comfortable for them should be central to the process of assisting them[92]. In cases of domestic violence, a battered woman is often forced to give up even the smallest decisions to the wishes and whims of her batterer. In cases of rape and sexual assault, control over her own body and its integrity was taken from the victim. Thus, a battered woman or a victim of rape or sexual assault must be allowed to make decisions and take action for herself if she is to reclaim control of her own life. Discussing the abuse or violence with the provider may be her first opportunity in quite a while to express her own desires and needs. Developing a plan should be done with the woman, not for her. The health care provider should not become another controller in her life. The process of setting her own goals and making decisions about her personal life may be lengthy but is essential to assist her in developing independent strength. It also will make it more likely that she will follow through with the plan.

Plan Strategies to Meet the Needs of Battered Women

A battered woman can take steps to protect herself and her children. Plan strategies for meeting a the client's crisis and long–term needs with her[92]. Focus on the needs and the barriers that she identifies.

A battered woman may need specific information and practical help in the areas of finances, housing, job training, career opportunities and childcare. A battered woman may have substance abuse problems, which should be treated. She may need therapy or a battered women's support group to help her cope with the anger, sadness, lowered self–esteem, fear, feelings of being different from others, depression, lack of trust, anxiety, and feelings of powerlessness and hopelessness that are caused by victimization. When making a therapy referral, select a therapist who is skilled in working with domestic violence victims. Refrain from referring a battered woman to couples counseling because this type of counseling cannot be successful unless the woman can speak freely during the counseling session without fearing retribution once the couple leaves the therapist's office. Finally, ask her if she needs help finding information about legal options open to her for protecting herself and her children, for seeking compensation, seeking custody of the children, or prosecuting a domestic abuser or a rapist.

Low-income women are likely to have had a longer history with the social service system than middle-income women. This experience could mean that low-income women are more likely to be disillusioned with the manner in which the system operates, but they also may have a better understanding of how the system operates. In making referrals, be aware of the limits of services for the poor and especially for battered women and be realistic in explaining what agencies have to offer and the difficulty of getting what is promised.

Provide the patient information on community responses. Resources exist in nearly every community that can assist her in taking steps and coping with all aspects of domestic and sexual violence recovery and healing. Community resources can help victims find shelters, offer counseling and support groups, help develop a safety plan, explain legal options, and link victims with legal advocates and other sources of assistance. Consider how the information and referrals will be given to the woman. Some of the options for providing referrals and information about resources include the following.

- Develop a resource directory that can be used to provide information on community resources. Make sure the directory includes resources specifically for women with disabilities, women with immigration concerns, language barriers, and other needs already discussed. Keep this directory in the rooms where women are seen.

- Place brochures or pamphlets about domestic and sexual violence in discrete places, such as the restroom, so women who do not wish to reveal their experiences with violence will be able to receive information. This material will also suggest to the female client that the health department is sensitive to her situation and is a safe place to discuss her experiences.

- Distribute small, pocket–sized cards with listings of general community resources that include services for battered women and for sexually violated women. The cards should be a size that allows them to be easily hidden in a woman's purse or billfold. Also, they should include information on a variety of

community resources unrelated to domestic and sexual violence so that the batterer and others will not immediately suspect that the information is targeted to battered or sexually violated women if the card is discovered. Supplying these cards to all women seen in health department clinics is a means of providing needed information to battered and sexually violated women regardless of whether they choose to reveal their experiences.

Develop a Safety Plan

The assessment should determine the level of danger a woman faces. A woman in a domestic violence situation may face the greatest danger when she attempts to leave the batterer. If she decides to stay with the batterer, she still will need a safety plan so that she will be able to escape in the event of a subsequent abusive incident. Two sample safety plans that you may use or adapt are provided below. The first, on page 116, is a checklist. The second, on pages 119-125, is a more thorough, but lengthy tool. A battered woman may not feel comfortable taking the second tool home with her because it may be difficult to keep from the batterer. Provide the woman enough time to complete it, and then keep it in her medical record. Review the safety plan at each visit to determine if the woman's situation has changed and to provide her an opportunity to update the plan.

Ask the woman to examine her personal support structure to identify people who can help her make plans for the present and the future. If she is not at risk for homicide or suicide, then discuss with her how she will manage and which people she will rely upon for help. If she is too afraid to return home, then explore with her the possibilities of staying with a friend or a relative or at a shelter. If she has children, make sure she takes her children with her whenever possible. If she leaves her children with the abuser, he might claim that she abandoned them in future legal proceedings.

At every visit, collect information about currently safe ways to contact her for follow-up appointments. Ensure that information she considers currently is clearly marked in her chart so that no staff member tries contacting her there.

Assisting battered women is a challenge for health care providers. Help should be centered on each woman's needs and must also deal with the underlying causes of the abuse. Providers may become

frustrated when a woman returns to her batterer or does not follow the service plan developed by the provider. A battered woman faces many barriers to leaving the batterer that many people find hard to understand. Yet, no one wants the battering to stop more than she.

Support Her Decisions

Leaving an abusive situation, taking legal action, or seeking counseling are actions that require time, energy and planning[103]. Weeks, months, or even years may pass before she gets the strength, courage, and resources to leave. Her decisions may appear to be non–productive or even destructive. Nevertheless, support her decisions because she knows her situation best and she must be allowed to determine her own future[91]. If a battered woman says that she cannot leave the batterer, tell her:

- I am afraid for your safety;
- I am afraid for the safety of your children;
- It will only get worse; and
- I am here for you when you are ready to leave.

In the case of women who were sexually violated, it is important that you respect her decision about whether or not she wishes to prosecute her attacker.

SAFETY PLAN: DOMESTIC VIOLENCE

For battered women, the following suggestions may be helpful in developing her safety plan.

When preparing to leave:

- Decide where you will go when you leave.
- Make arrangements for a place of refuge before you leave. Determine who would be able to let you stay with them or lend you money. If possible, do not stay with a male friend. This may be used against you in divorce or child custody proceedings.

- Open a savings account and/or a credit card in your own name to start to establish or increase your independence. Think of other ways in which you can increase your independence.

- Agree upon a coded message with friends and family to signal your departure.
- Rehearse departure with children.
- Plan to depart at a time when batterer is not present in the home.
- Hide money, an extra set of house and car keys, and a bag with extra clothing.
- Have available the following items:
  Social Security numbers (his, yours, and the children's)
  Rent and utility receipts
  Birth certificates (yours and the children's)
  Driver's license
  Bank account numbers, checkbook, and ATM card
  Insurance policies
  Marriage license
  Valuable jewelry
  Important telephone numbers
- Review your safety plan as often as possible in order to plan the safest way to leave your batterer.

Safety in the Home

To protect yourself during violent incidents:

- In the event of an argument, try to stay away from the bathroom, kitchen, bedroom or anywhere else weapons might be available and try to stay in a room or area where you have access to an exit.
- Confide in a neighbor about your problem with domestic violence. Ask the neighbor to call the police if violence begins.
- Remove weapons from the house.
- Advise children to stay out of the conflict and instruct them in ways of contacting police.
- Devise a code word to use with your children, family, friends, and neighbors when you need the police.
- Change the locks on your doors as soon as possible after he leaves. Buy additional locks and safety devices to secure your windows.
- Discuss a safety plan with your children for times when you are not with them.
- Inform your neighbors and landlord that your partner no longer lives with you and that they should call the police if they see him near your home.

Safety in the Workplace and in Public Places

- Inform your children's school, day care, etc. about who has permission to pick up your children.
- Inform someone at work about your situation, including office or building security. Provide a picture of the batterer if possible.
- Arrange for a co–worker or answering machine to screen your telephone calls.
- Leave your workplace in the company of a co–worker.
- Use a variety of routes to go home.
- Change the time when you shop and choose different stores and banks.

Name: ________________________________
Date: ________________________________
Review dates: __________________________

Personalized Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I may not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

Step 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may employ a variety of strategies.

I can use some or all of the following strategies:

A. If I decide to leave, I will ______________________________. (Practice how to get out safely. What doors, windows, elevators, stairwells or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them (place) __________________________ in order to leave quickly.

C. I can tell ______________________and ______________________about the violence and request they call law enforcement (911) if they hear suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact law enforcement (911) and the fire department. My local fire department number is ______________________.

E. I will use ____ as my code word with my children or my friends so they can call for help.

F. If I have to leave my home, I will go __________________________________.

G. I can also teach some of these strategies to some/all of my children.

H. When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as ________________________. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)

I. I will use my judgement and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done strategically in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with ________________so I can leave quickly.

B. I will keep copies of important documents or keys at ______________________.

C. I will open a savings account by ______________________ to increase my independence.

D. Other things I can do to increase my independence include: ________________
____.

E. The domestic violence program's crisis line number in my area is ______________________. I can seek shelter, help in court, emotional support, and referrals to community resources by calling this crisis line.

F. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill the following month will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave. I could also purchase prepaid telephone cards or cell phones which the batterer would not be able to trace back to me.

G. I will check with ____ to see who would be able to let me stay with them or lend me some money.

H. I can leave extra clothes with _______________________________________.

I. I will sit down and review my safety plan every ___________________________ in order to plan the safest way to leave the residence.
____ (domestic violence advocate, friend, or relative) has agreed to help me review this plan.

J. I will rehearse my escape plan and, as appropriate, practice it with my children.

Step 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, and electrical system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/ apartment.

F. I can install an outside lighting system that lights up when a person is coming close to my house.

G. I can teach my children how to use the telephone to make a collect call to me and to ___________________ (friend/minister/family member/other) in the event that my partner abducts the children.

H. I can call my local telephone company and ask that my phone number be changed to an unlisted number.

I. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I inform about pick–up permission include:

_________________________ (school)
_________________________ (day care staff)
_________________________ (baby sitter)
_________________________ (relative)

J. I can inform ______________________ (neighbor),______________________ (pastor), and ____________________________ (friend) that my partner no longer resides with me and they should call law enforcement (911) if he is observed near my residence.

Step 4: Safety with a Domestic Violence Protective Order (DVPO, also know as a 50B Order or Restraining Order). Many batterers obey DVPO's, but one can never be sure which violent partner will obey and which will violate DVPO's. I recognize that I may need to ask law enforcement and the courts to enforce my DVPO.

The following are some steps that I can take to help enforce my Domestic Violence Protective Order:

A. I will keep a copy of my DVPO ____________________ and _____________________ (locations). (Always keep a copy of your DVPO on or near your person. If you change purses, that's the first thing that should go in. Always keep a copy at home and at work.)

B. I will give a copy of my DVPO to law enforcement agencies (including police departments and sheriffs departments) in the county where I live and in the county where I work.

C. I will give a copy of my DVPO to _______________,______________________, and ____________________. (Always give a copy to all people and/or places that the abuser has been ordered to stay away from, i.e. day care centers, schools, churches, family residences, etc.)

D. There should be a county registry of DVPO's that all law enforcement agencies can call to confirm the validity of the DVPO. I can check to make sure that my order is in the registry. The telephone number for my county registry of DVPO's is _____________.

E. For further safety, if I often visit other counties in my state where family and friends live, I will register my DVPO in the following counties______________________, _____________________ and ___________________________.

F. I can call the local domestic violence program if I am not sure about B, C, D or E above.

G. I will inform my employer, my minister, my closest friend and __________________ that I have a DVPO in effect.

H. If my partner destroys my DVPO, I can get another copy from the Civil Clerk's office at the courthouse located at ____.

I. If my partner violates the DVPO, I should call law enforcement (911) immediately to report the violation. (If law enforcement finds the abuser near you, they should arrest him immediately. Show them a copy of your DVPO.)

J. If my partner violates the DVPO, I can file a Motion to Show Cause in District Court with the Civil Clerk of Court located at ____________________________________.

I can also charge the abuser for all the crimes he commits in violating the order by going to the Criminal Magistrates' office located at _______________________________.

K. If law enforcement does not help, I can contact my domestic violence advocate or attorney, who can help me file a complaint with the police department or sheriff's department.

Step 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and co–workers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor and __________________________ at work of my situation.

B. I can ask ____________________________ to help screen my telephone calls at work.

C. When leaving work, I can____.

D. When driving home, if problems occur, I can ______________________________.

E. If I use public transit, I can ____.

F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G. I can also ____.

Step 6: Safety and drug or alcohol consumption. The outcomes of using drugs and alcohol can be very hard on a battered woman, may hurt her relationship with her children, and put her at a disadvantage in other legal actions with her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol consumption, a woman needs to make specific safety plans.

If my partner or I use drugs or alcohol, I can increase my safety by the following:

A. If I am going to consume, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety. (Not applicable to women recovering from alcohol or other drug addiction.)

B. If my partner is consuming, I can ____.

D. To safeguard my children, I might ____________________________________.

Step 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources, and to avoid hard emotional times, I can do some of the following:

A. If I feel down and ready to return to a potentially abusive situation, I can ____

B. When I have to communicate with my partner in person or by telephone, I can ____

C. I can try to use "I can..." statements with myself and to be assertive with others.

D. I can tell myself, ____" whenever I feel others are trying to control or abuse me.

E. I can read ______________________________________ to help me feel stronger.

F. I can call ___________________________________,__________________________ and _______________________________ as other resources to be of support to me.

G. Other things I can do to help me feel stronger are _________________________ and ____.

H. I can attend workshops and support groups at the domestic violence program or ____________________________ or _____________________________ to gain support and strengthen my relationships with other people.

Step 8: Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

When I leave, I should take:

Identification for myself
Children's birth certificates
My birth certificate
Social Security cards
Money
Checkbook, ATM card
Credit cards
Keys: house, car, office,
Medications
Welfare identification
Work permits
Green card
Passport(s)
Divorce papers
Bank book and statements
Insurance papers
Small saleable objects
Address book
Pictures
Jewelry
Items of special sentimental value
Medical records—for all family members
Lease/rental agreement, house deed, mortgage payment book
School and vaccination records
Children's favorite toys and/or blankets
Driver's license and registration

Telephone numbers I need to know:

Domestic violence crisis line _______________
County registry of DVPO's_________________
Criminal Clerk of Court ___________________
Supervisor's home number_________________

Plan Strategies to Meet the Needs of Victims of Sexual Violence

Victims of sexual violence may need immediate crisis referral or more long-term assistance and counseling to help her cope with her feelings, to work through the effects of the violence, and to recover from the trauma of rape. Getting in touch with a nearby rape crisis center is an excellent option for finding individual counselors skilled in the needs of raped women and for finding support groups specifically for a survivor of sexual assault, if she wishes to pursue this option. Since sexual violence victims are at increased risk for eating and body dysmorphic disorders, they may need medical intervention and counseling. A victim of sexual assault may need specific assistance to recover from PTSD, which can linger for a long time after the assault and cause severe disruption to her daily routine and life plans.

Maintain information about rape crisis centers in the area as well as toll-free telephone numbers that she can use to get specific information or to ask questions she may have. When referring to an individual counselor, it is important to provide names of counselors with experience working with victims of rape and sexual violence, as well as with PTSD, if necessary. Such names and contact information should be prepared and placed in each exam room before working with a client needing the information. Include information about legal services she may wish to pursue and other available community services such as substance abuse and alcohol treatment, the sexual violence coordinator at local law enforcement offices, transportation assistance, etc.

If she was very recently raped, a woman may wish to go through a "rape kit" exam for collection of evidence. Maintain information about how to contact area nurses who are certified as SANE (sexual assault nurse examiner) providers, as well as which local hospitals or other facilities participate in this program. Refrain from conducting unnecessary physical examinations if she plans to pursue an exam with a SANE as she may be re-traumatized each time she undergoes an exam. Offer to contact a rape crisis center to have an advocate sent over to accompany her or to meet her for the rape kit exam. Assure her that she may pursue any health care or medical need at the health department regardless of whether she follows through with the rape kit.

COMPONENT 4: DOCUMENT THE DOMESTIC AND SEXUAL VIOLENCE AND ITS EFFECTS

Thorough and accurate documentation of the health care provider's findings is critical to assisting battered women and victims of sexual violence. Medical records are legal documents that can be used as evidence to substantiate the abuse or sexual assault in legal proceedings[129]. In cases of domestic violence, many women have failed in their attempts to obtain legal action against their abuser, to gain custody of their children, or to prove a case of self–defense because they had no tangible proof of their abuse. Likewise, in cases of sexual violence that a victim may wish to prosecute, documented information about what the patient says about the assault, injuries sustained during the assault, and other effects she may be experiencing as a result of the assault are critical components of successful court cases. Health care providers who treat a battered or sexually assaulted woman's injuries and record the extent, cause and circumstances of the injuries in her medical record are providing an important service to her by giving her the evidence she may need. In addition, this documentation can supply the information necessary for assuring continuity of care by future providers who may be responsible for a woman's care. If a woman's current provider leaves or transfers her to another provider within the health department, exact notes describing her situation will assist the subsequent provider in recognizing possible cases of abuse or re-victimization in cases of sexual violence. However, as with all medical records, the records of a woman identified as battered or as a victim of sexual violence are confidential and should not be seen by anyone who is not her provider unless they are subpoenaed or the woman gives her written consent for a release. The written consent should not broadly permit release of information, but should, instead, note exactly which providers or other professionals should receive exactly what type(s) of information from exactly which visit(s) noted in the chart.

What to Document

It is important to document what the client tells you about the circumstances of violence in her own words, if possible; however, avoid statements that are pejorative, judgmental or may be interpreted incorrectly. Avoid recording long descriptions and quotes by the woman which deviate from the actual abuse or incident(s) of sexual violence (e.g., "He gets jealous when I spend time with my friends). Avoid recording subjective data that could be used against the woman (e.g., "He's right — I should spend less time with my

friends and more time with the kids," of "I was sexually attracted to him and agreed to go back to his place.").

Relevant History

1. Chief complaint – why did she come in today? What is her present illness or medical need?

2. Details of battering by a partner or sexual violence by anyone and its relationship to the reason she came in.

3. Any concurrent medical problems possibly related to the abuse or sexual violence

4. For currently battered women:
   - Social history, including relationship to the abuser and the abuser's name.
   - Patient's statement about what happened, not what led up to the abuse (e.g., "boyfriend John Smith hit me in the face" not "patient arguing over money")
   - Include date, time, and location of the incident, if possible
   - Patient's appearance and demeanor (e.g., "tearful, shirt ripped" not "distraught").
   - Any objects or weapons used in an assault (e.g., knife, iron, closed or open fist)
   - Patient's account of any threats made or other psychological abuse
   - Names or descriptions of any witnesses to the abuse

5. For recently sexually assaulted women –
   - Offer referral to the nearest SANE and explain the role of the SANE
   - If patient refuses, provide information/referral, then proceed to document relevant history as above.

Results of Physical Exam

- Findings related to violence, including neurological, gynecological, mental status exam, if indicated
- If there are injuries, (present or past) describe the following:

- record her statement verbatim as much as possible regarding the cause and circumstances of any injury (record in her medical record her explanation for injuries by writing: "Client states....")
- the length, width, depth, shape, color, and location of the wounds (these characteristics assist in determining the age and type of wound and the probable cause of the injury)
- If she states that the injuries resulted from battering or from sexual violence, ask her about: the instrument, weapon, or body part used to injure her.

Describing and Documenting Injuries

Characteristics of injuries to be documented are provided below and are adapted from Butts (1994)[22].

Location

The exact location of each injury should be noted in relation to fixed body landmarks and standard anatomical regions in a detailed narrative. Anyone reading the description should be able to locate easily a particular injury in relation to other injuries and to the body as a whole.

Age

The age of a bruise can be approximated by its color. Bruises less than 24 to 48 hours old are generally red–blue, and then turn deep blue to purple. Within one to three days they begin to show green–brown discoloration that initially occurs at the margins. The color change progresses to yellow moving from the outer toward the inner part of the bruise until the bruise is healed. Most bruises heal within one to three weeks depending on their size and location. Larger bruises take longer to heal than smaller ones. Bruises in less vascular areas, such as lower extremities, take longer to heal than those in more vascular areas, such as the face. Swelling generally reaches its maximum during the first 12 to 24 hours of an uncomplicated injury and then it begins to dissipate. A swollen, red–blue bruise indicates a relatively recent blow, whereas a blue–red flat bruise with green–brown margins is several days old. Bruises at various stages of healing may indicate multiple episodes of battering.

Type and Cause

The type and cause of an injury can also be inferred from its characteristics.

- *Lacerations* are breaks in the skin and tissue. A laceration with irregular margins or abraded edges results from the crushing or tearing forces of a blow to the body or from the body striking a hard object or surface. These wounds occur most commonly when the skin is crushed between underlying bone and a hard object or surface. Lacerations may show patterns indicating the type of object that caused the injury.

- *Incised wounds* are lacerations produced by sharp objects. Incised wounds have sharp, clean margins and lack the scraping, abrading, or bruising seen in other types of lacerations. Tissue tends to be cut cleanly for the full depth of the wound and no interconnecting tissue bridges are present. In assaults, knives are the most common cutting agents, but glass or sharp bits of metal may produce cuts also. A stab wound is an incised wound that is deeper than it is long.

- *Human bite marks* usually cause an elliptical bruise in which individual tooth marks may or may not be visible. Breaks in the skin are rare with human bites but are typical of animal bites.

- *Abrasions or scrapes* are caused by tangential contact with an object. The direction of the movement between the area of skin injury and the causative object or surface is often apparent.

- *Burns* should be described in terms of the degree of burn (first, second, or third degree) indicating the depth of tissue trauma. Note the size, shape, and pattern of the burns. Patterns can provide information about the cause of the injury. By noting the exact shape of the burn, it may be possible to reconstruct how it occurred and whether it was intentionally inflicted. Burns resulting from a cigarette, iron, radiator, or stove elements can often be distinguished. The presence of "pour patterns" from hot liquids should also be noted.

Patterns of Trauma

A pattern of injuries distributed over the head and neck, the front of the torso, and areas that later can be concealed by a one piece bathing suit or other clothing should signal possible abuse to the provider. Unintentional injuries are more likely not to be patterned. Accidental injuries in the home very rarely result in black eyes, signs of strangulation, bite marks, or missing clumps of hair[30]. The recognizable imprint of an object in a wound raises the likelihood that the injury was inflicted. The shape of a bruise or a laceration gives an indication of the object that inflicted the wound. Elongated objects striking the body tend to produce elongated bruises. Thin tubular or rod–like objects may produce parallel bruises because the rounded surface striking the skin forces blood laterally, leading to hemorrhage at the margins rather than directly at the point of impact. Thus, for instance, looped cords often leave distinctive curving parallel bruises that clearly point to the nature of the striking object. Hand slaps, belts, and other objects with specific surface features may produce clearly recognizable pattern injuries. Bruises can take the shape of fingerprints, hand prints, or other weapons or objects.

Laboratory and other Diagnostic Procedures

If a woman indicates that she is being abused or has been a victim of sexual violence, determine if she is pregnant, since pregnancy may be an important factor in her future decisions.

Record results of any lab tests, X-rays, or other diagnostic procedures and their relationship to the current or past abuse.

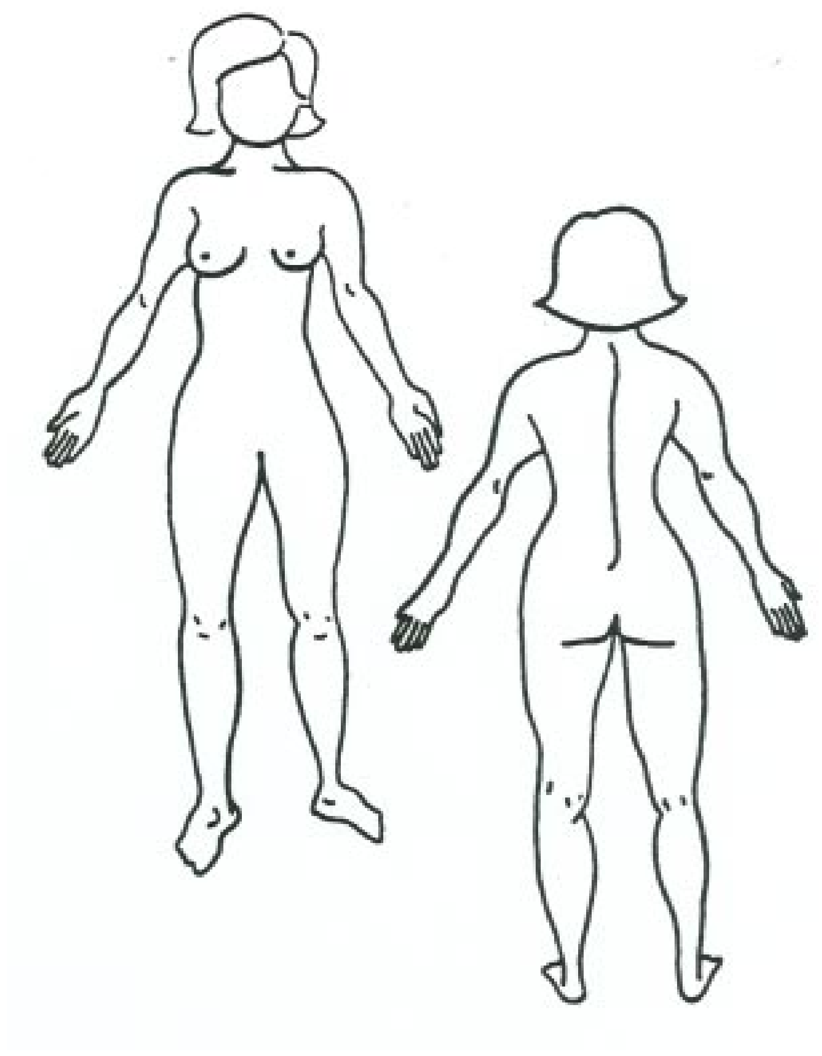
Methods of Documentation

Screening Tools

The screening and assessment tools provided on pages 87-88 also can be used to document the injuries and abuse. If the client did not disclose domestic or sexual violence, document the fact that a screening was done, but the client did not disclose. If you suspect domestic or sexual violence, document your reasons for concerns (i.e., patient presents with indicators of abuse”).

Body Map

Injuries can be marked on the body map provided below as a supplement to the narrative description of the client's injury or condition.



Body Chart

Another tool that can be used is the body chart. This chart allows for more detail about injuries than the body map. A sample body chart is provided below.

	Contusions	Lacerations	Abrasions	Bites	Burns	Fractures	Loss of Function	Painful Areas
Head								
Ears								
Nose								
Cheeks								
Mouth								
Neck								
Shoulders								
Arms								
Hands								
Chest/ breasts								

Photographs

Photograph any injuries. While written documentation can be challenged in court, photographic documentation is difficult to dismiss. Photographs also overcome or compensate for the inadequacies of written descriptions and the observer's memory. Even if the woman does not want to take legal action at the present time, she will have the photographs if she decides to take action later. Polaroid offers special cameras and a training program for photographing injuries including those sustained internally from rape and sexual assault.

Photograph a woman's injuries only after obtaining her informed, signed consent. A sample of a consent form is provided on page 135. Informed consent involves more than obtaining a signature on a form. All procedures should be explained clearly, more than once if necessary, so that the woman can understand what you are doing and why.

Photographs should accurately reveal the extent of all injuries. To adequately capture the size and shape of the injuries, the plane of the back of the camera should be parallel to the plane of the wound. Photograph each individual injury, first at a sufficient distance from the body to include recognizable anatomic landmarks that will locate the injury, then close enough to show detail. Also, each injury should be photographed to include the woman's face so that her identification can be confirmed. Include a scale, such as a ruler, in a close–up photograph to demonstrate the size of an injury. A scale also allows for comparisons between the wound and an object or weapon, and for preparation of life–size photographs for one to one correlations.

Mark photograph on the back with the names of the woman and the examiner, the woman's medical record or client number, and the date the photograph was taken. Each shot should be taken twice so that the woman and the provider have similar copies of photographs. The provider's copy should be kept in a sealed envelope in the woman's medical record. Either give the second set to the woman or mail it to a safe address that she provides.

Consent to Photograph

The undersigned hereby authorizes ______________________________________ and the attending physician to photograph or permit other persons in the employ of this facility to photograph __________________________________ while under the care of this facility, and _________________________________ agrees that the negatives or prints be stored in the client;s medical record, sealed in a separate envelope, so that they may be used later for evidence. These photographs will be released only to the police or the prosecutor when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

____
Date

____
Client's Signature

____
Witness

____
Client's Parent or Legal Guardian

____
Street Adress

____
City State Zip Code

Obtaining Evidence for litigation

Obtain permission from the woman to obtain personal items (e.g., torn clothing) and explain that collecting evidence will be helpful if she later decides to press charges. Also, explain to the woman that the collection of evidence does not obligate her to prosecute the batterer.

In order for physical evidence of the abuse to be admissible in court, the "chain of evidence" must be established. The custody of any evidence collected must be accounted for from the moment of collection until the moment it is introduced in court so that there is no doubt that the evidence came from the victim. Thus, a standard procedure should be adopted for collecting and preserving such evidence so that there can be no question regarding its authenticity. Suggestions for gathering evidence from physical and sexual abuse victims are provided below.

Evidence of Physical Abuse or Injuries

Physical evidence including weapons and damaged clothing may be collected to support the woman's allegations of domestic or sexual violence. Any item of evidence should be placed in a container labeled with the nature and source of its contents, the woman's name, her identifying number, the name and the initials of the collector, and the date of the collection. In order to prevent the loss of fibers or of other trace evidence, clothing and other evidence must be sealed in paper or cardboard containers. Plastic containers seal in moisture, making it possible for bacteria to destroy quickly any unstable biological fluid evidence. Containers should be sealed with tape or stapled and then placed in a safe location, preferably a locked drawer. Anyone who handles the evidence items should label them with his or her initials to ensure that the item remained safe while in his or her care and to document to whom it went next. This procedure should be handled in such a manner that the individual transferring the items can state that their condition at the time of transfer was the same as when collected. The same person who collected the evidence should witness its removal so that the collector can note that the evidence was not tampered with or damaged prior to being turned over. Any break in the "chain of evidence" may make an item unusable or inadmissible in subsequent legal proceedings. Keeping the chain as short as possible (i.e., having evidence

handled by as few people as possible) will minimize the chance that something will happen to the evidence and will reduce the number of individuals who will need to testify regarding the chain.

If law enforcement officials are present during the evidence collection, the items can be turned directly over to them. This action should be noted on the medical record. When no law enforcement representative is available, the items must be preserved until they can be turned over. There is no medical or legal reason for a law enforcement representative to observe the actual collection of evidence. Maintaining the "chain of evidence" during the examination requires no outside assistance and can be strictly the function of the attending medical personnel.

Evidence of Sexual Abuse

The North Carolina State Bureau of Investigation provides kits to gather evidence of sexual assault ("rape kits"). As soon as the evidence is collected, the kit should be sealed with tape and kept refrigerated until it can be given to law enforcement officials. The kit will then be sent to a state lab for analysis. Because the only purpose of collecting evidence for a Rape Kit is future prosecution, it is extremely important to find training on the proper way to use the kits to prevent destroying evidence or breaking the chain of evidence, threby rendering thekit unusable in court. Contact NC CASA (see Appendix 3) for information on this and on finding a qualified Sexual Assault Nurse Examiner (SANE) in your area.

For women referred to other facilities for the collection of evidence, there are funds available through the Rape Victims Assistance Program for the collection of the evidence and the treatment of the woman's injuries. The Rape Victims Assistance Program pays health care facilities up to $1,000 to collect the evidence. A woman may be eligible for further compensation, which pays up to $20,000 for treatment of injuries, if she cooperates in the prosecution of her assailant and meets other requirements. See Appendix 3 for further information on this program. Please refer to the end of Appendix 1 for information regarding your duty to report sexual violence in N.C.

Document Referrals

Document the plans and referrals made with the client for the following:

- Treatment of injuries and correlating conditions
- Counseling and education about violence
- Assistance with safety plan
- If law enforcement officials are called to escort the woman or provide other assistance, name of officer(s) involved and action taken:
- Referrals made to: (list specifically)

COMPONENT 5: FOLLOW-UP WITH THE CLIENT

Follow up is an important, yet often neglected, step in domestic and sexual violence intervention. Discussing the violence with the woman again lets her know that the abuse or incident(s) of sexual violence is being treated seriously and informs the health care provider about the woman's additional needs. Offer to schedule at least one additional visit with the woman to give her additional opportunities to talk. Health visits may be among the few opportunities a battered woman has to get away from the batterer and for sexual violence victims to speak to someone who will believe them, take them seriously, and not make judgments. Scheduling more visits also lets the woman know that battering and sexual violence are problems that should be taken seriously. If she is not willing to schedule another appointment to discuss the battering or sexual violence, make a note in her medical record that she should be screened for both types of violence again at her subsequent visits. At each of those subsequent visits review the medical record and ask about current and past episodes of domestic and sexual violence.

Questions to ask, when relevant, during follow up include:

- Has the battering continued or escalated?
- Has the person who raped or assaulted you made further threats? Has that person raped or assaulted you or attempted to rape or assault you again?
- What is your current assessment of your danger?
- What have you decided to do about the abuse?
- Have you contacted domestic violence programs or other agencies for help? If so, what were the results of the contact?
- Have you contacted rape crisis centers or other agencies for help? If so, what were the results of the contact?

- Are you receiving counseling or other services now?
- Do you need additional referrals?
- Does the safety plan need to be revised?
- Is there a protective order in place or are you pursuing one?
- Are you pursuing other legal options?

Also, it is important to convey your continued interest in her safety and the safety of her children as well as concern about her well being. Therefore, follow-up visits are opportunities to communicate your concern and ask the following questions to assess safety and coping or survival strategies:

- "I am still concerned for your health and safety."
- "Have you sought counseling, a support group, or other assistance?"
- For battered women: "Has there been any escalation in the severity of frequency of the abuse (by your partner)?"
- "Have you developed or used your safety plan?"
- "Have you told any friends or family members about the violence?"
- "Have you talked with your children about the abuse and what to do to stay safe?"

Then, it is important to reiterate the options available to the patient and that you and the health department staff continue to be resources she can access for assistance.

SPECIFIC RESPONSES WITHIN VARIOUS SERVICES/ CLINICS OF THE LOCAL HEALTH DEPARTMENT

The information discussed here incorporating domestic violence intervention into various health department clinical services was adapted from work done by Ussery[188]. Possible indicators of domestic violence commonly seen with specific clinical services and screening and assessment questions that apply to these services are provided.

Maternity Clinics

The association between domestic violence and pregnancy is discussed in Chapter 3. Women may be more likely to seek help for battering during pregnancy as a result of concerns about the fetus' safety. For many battered women, pregnancy is the only time appointments with health care providers are allowed. For these women, the visits to the maternity clinic may provide the only opportunity to ask for help.

Domestic violence indicators seen in maternity clinics

- late and/or sporadic access to prenatal care
- divorce or separation during pregnancy
- vaginal bleeding
- self–induced or attempted abortion
- injury to breasts and/or abdomen
- increased alcohol or drug abuse
- miscarriage
- low maternal weight gain
- short inter–pregnancy interval
- poor nutrition
- premature labor
- depression, or unhappiness about pregnancy

Suggested questions

- Since your pregnancy began, have you been hit, slapped, kicked or otherwise hurt by someone?
- How is your partner handling your pregnancy?

Sexually Transmitted Disease (STD) Clinics

As mentioned earlier, the vast majority of domestic violence victims are women and the majority of perpetrators are their male partners. However, domestic violence has been found in a substantial number of gay and lesbian relationships. Since many of the male clients seen in STD clinics are in same sex relationships, screen males for domestic violence as well. None of the identification and assessment tools provided have been pilot tested on men, so their validity and reliability for screening men is not known.

Battered women may be at an increased risk of sexually transmitted diseases (STDs) because they risk abuse when they refuse sex or demand the use of a condom. Batterers who are promiscuous may put their partners at an increased risk for STDs. Similarly, women who test positive for STDs are at an increased risk of violence. Some treatments for STDs require that the client abstain from intercourse for up to a week to ten days. This may be difficult for a battered client who is not able to negotiate sex with his or her partner. As a form of control, battered women are sometimes forced into prostitution by their partners. These women are at risk of violence and STD (including HIV) infection from their partners and sexual clients.

Include domestic violence questions in both pre– and post–test counseling. Continue any intervention that has been initiated in any follow–up appointments with clients. When the client returns to hear the results of medical tests, ask about his or her sense of safety. Clients who are suspected victims of abuse but have not yet disclosed the abuse may feel comfortable doing so at follow–up appointments. After repeated visits to the same health care provider; the health care provider may feel that he or she has reached the level of trust and familiarity necessary to discuss her situation.

Inform clients of the necessity to contact their past sexual partners. Although contacting partners of clients with STDs is always done without giving the names of infected clients, discuss with them the potential consequences of this notification including an assessment of any potential violence. Discuss options to reduce the potential for violence during the notification process.

Domestic Violence Indicators seen in the STD clinics

- recurrent STDs or HIV infection
- evidence of the exchange of sex for money or drugs
- evidence of intravenous drug use
- frequent vaginal and/or urinary tract infections
- injuries to genitalia, breasts, and/or abdomen
- complaints of vaginal discomfort with no evident physical cause
- reluctance to identify sexual partners
- noncompliance to treatment regimens

Suggested questions

- How often is having sex expected as a way to make–up for a fight?
- What kind of contraception or disease protection do you use? How often? When you do not use protection how often is that someone else’s decision?
- What is it about the method of contraception or protection that you use that made you choose it?
- In what ways does stress in your relationship(s) effect your sexual life?
- How often are you encouraged by someone else to have sex with other people?

Family Planning Clinics

Reproductive health is one area of the batterer's control that often remains undetected by the couple's family and friends. Many batterers try to control the form of contraception, if any, the couple will use and often do not warn their partner of the existence of a sexually transmitted disease. For these reasons, the battered woman's choice of contraception may be critical. If she gives you reason to believe that she is not allowed to use contraception consistently, suggest a form that does not require daily attention, or one that cannot be detected (for example, Depo–provera). Also, urge women to use contraception such a condoms or contraceptive foam that may provide protection against STDs.

Domestic Violence Indicators Seen in Family Planning Clinics

- frequent vaginal and/or urinary tract infections
- recurrent STDs, or HIV infection
- injuries to genitalia, breasts, and/or abdomen
- evidence of noncompliance with treatment regimens
- complaints of vaginal discomfort with no evident physical cause

Suggested questions

- Do you and your partner use contraception consistently? Does your partner ever prevent or discourage you from using it?
- Why does this form of contraception appeal to you?

WIC Services

WIC staff may see women who are not following their diet recommendations. The anxiety battered women feel as a result of living with abuse can interfere in a woman's ability to eat a healthy, consistent diet. Also, a batterer may restrict his partner's access to food as a means of exerting his control over her. Staff in WIC clinics should review signs of domestic abuse during pregnancy.

Domestic Violence Indicators seen in the WIC Services

Domestic violence indicators seen in WIC services

- not being able to obtain WIC foods
- evidence of homelessness
- low birth weight infants
- failure of baby to thrive despite availability of WIC foods

- low maternal weight gain
- short inter–pregnancy interval
- evidence of drug/alcohol abuse

Suggested questions
- Who does the grocery shopping for your family? Does your partner ever accompany you to the store?
- Are meal times ever disrupted because of family crises?
- Who decides what you will do with your time?
- How is your family reacting to the baby (or pregnancy)?
- Who makes the decisions about what foods you or your family will eat?

Child Health Clinics

The impact of domestic violence on child health is discussed in Chapter 3. Because domestic violence has a serious impact on the health of children and child abuse is often present along with domestic violence, child health clinics providers should be familiar with the various indicators of child and partner abuse. Before the mother will speak honestly about the abuse she and her child have experienced, you may need to assure her that admitting that she and her children are victims may not jeopardize her parental rights.

Suspected child abuse must be reported to the Child Protective Services division of the county Department of Social Services (DSS). The client should be told of the need to report so that she can plan immediate safety precautions if she fears her partner's reaction. Strongly encourage the woman to report the child abuse herself so that she will be seen by DSS as a cooperating parent. As mentioned previously, NC DSS has adopted a domestic violence policy which is in effect statewide. They are in the process of training staff about domestic violence and pilot testing a multiple response system that is less punitive to non-offending parents while holding batterers accountable for the violence.

Domestic Violence Indicators Seen in Child Health Clinics

When these cues are detected and subsequent intervention is initiated for the safety of the mother, questions about the safety of the children should always follow.

- frequent pediatric visits
- visits for seemingly insignificant complaints

- late evening or night visits
- canceled appointments
- child suffering from sleep disorders, anxiety, and/or depression
- mother with obvious injuries
- evidence that the child has rarely been seen by the same professional more than once

Suggested questions

- Does your partner have access to the children?
- Are weapons available to your partner?
- Has he ever removed or threatened to remove the child from your care?
- Has your child ever tried to run away?
- Has your partner ever touched or spoken to your child in a sexual way?
- Has your child ever tried to hurt him/herself or pets?
- Has your partner ever hurt of threatened to hurt your child?

TIPS FOR WORKING WITH SPECIAL POPULATIONS

Listed below are clinical interventions that can be used with the special populations.

Adolescents

- Include information on domestic violence in school health clinics
- Include domestic violence protocols in school health clinics
- Include information about sexual violence in school health clinics
- Include sexual violence protocols in school health clinics

Disabled Women

- Consult, with the woman's permission, with the health care or mental health providers treating her for her disabling condition to understand her needs and abilities.
- Assist in securing safe housing. Organizations that serve people with specific disabilities may be able to assist in locating suitable shelter. Many mental health centers in North Carolina operate "crisis homes" that are appropriate shelters for mentally disabled women who are abused.
- Let the woman tell her story through her own method of communication, such as gestures. Allow her to use her own words

to describe body parts or experiences. If she cannot easily speak, encourage her to draw, where appropriate, or to write her experience or type an account on a computer.

Older Women

- Provide home visiting nurses to the shelters.
- Encourage older women to develop a buddy system. Having a buddy who will check on the woman daily will help decrease her isolation.
- Find alternatives to battered women's shelters for abused elderly women.
- Refer abused older women to Adult Protective Services.
- Coordinate in-home domestic violence support services for older women who either have health concerns or are extremely reluctant to leave their homes. (Caution: In–home visitation may increase the victim's danger.)

Rural Women

- Create networks for women by helping them identify those in whom they can confide and from whom they can get support and assistance.
- Protect the woman's privacy. In rural health departments, staff may know the woman or someone in her family. Discussing the woman's situation with others without her permission will cause her to lose trust in you and may endanger her safety.

Substance Abusing Women

- Create an atmosphere of trust and acceptance.
- Screen women identified as battered for substance abuse.
- Screen women identified as substance abusers for domestic and sexual violence.
- Relate women's drug use to issues of power, control, and safety
- Address the safety of women prior to referral to treatment programs for substance abuse

African American Women

- Realize that African American women may be more willing to turn to informal sources of help than to police, domestic violence programs, or other human services. Ask the woman where she feels most comfortable going to receive help.
- Acknowledge racism as a barrier to African American women seeking or receiving assistance.

Latina

- Inform the Latina who is concerned about breaking up her family how the children are affected by domestic violence.
- Explore each woman's definition of domestic or sexual violence to plan and intervene effectively.
- Provide an interpreter for Latinas who do not speak English proficiently. Do not ask their children or anyone else who accompanied them to interpret.
- Have bilingual/bicultural materials available.
- Consult and provide referrals to organizations that serve the Latina population.
- Include members from the latina community in planning domestic and sexual violence interventions.

GLBT Clients

- Do not record the gender of the batterer/sexual violence perpetrator or the sexual orientation of the victim in the medical record without the patient's explicit consent.
- In cases of partner violence, assess violent or abusive incidents carefully if there is a question of mutual battering. Often, violence that appears mutual at first involves discreet incidents with a clearly identifiable victim and abuser. Over the course of the relationship, it may be possible to identify one partner as the member of the relationship who uses the violence to exert control over the other partner.
- Screen all patients for domestic and sexual violence in private. Recognize that the friend or partner who insists on accompanying the patient may be the batterer or the person who raped or sexually violated the patient.
- Use gender neutral language when asking about partners, abuse, and sexual violence. For example, ask "Has your partner ever hurt you?" rather than asking, "Has your husband or boyfriend ever hurt you?" This will provide the GLBT individual the opportunity to discuss the partner abuse or sexual violence without revealing his/her sexuality.

Immigrant Women

- Inform immigrant women that everyone is eligible for emergency medical care regardless of immigration status.
- Refer the woman to Legal Services to find an attorney who is knowledgeable in the areas of both immigration law and domestic and sexual violence law.

- Ask the immigrant woman if she understands the referrals you provide her. If not, explain how these services operate.
- Provide an interpreter if the woman is not fluent in English.

Military Women

- Use caution in referring a military woman to a military domestic violence program, especially if confidentiality is dubious.
- Encourage military women to report domestic or sexual assaults to local law enforcement in addition to the military police. The assaults may not become a part of the rapist's or batterer's criminal record if they are not reported to local law enforcement.

HEALTH DEPARTMENT STAFF ROLES

All professionals within the health department should play an active role in responding to women who experience domestic and sexual violence. Clerical staff, security staff, social workers, nutritionists, clinicians, health educators, and administrative personnel all have the opportunity to provide support to battered and sexually violated women.

Clerical Staff

The clerical staff, often the first persons in a professional setting a woman will see, should be aware of the behavioral cues of domestic and sexual violence. Examples of behaviors that could indicate domestic violence include: the woman repeatedly canceling appointments; her partner canceling her appointments; her partner accompanying her into the clinic and remaining close to her; and her partner answering questions directed to her. If battering is suspected, they should alert the provider whom the woman will see of the possibility.

Security Staff

Security staff can help to ensure privacy and safety for the victims of domestic and sexual violence; however, many health departments do not have a security staff. If a security officer witnesses threats, abusive behavior and/or violence in the parking lot or waiting area of the clinic, he or she should alert the appropriate health care provider that the woman may be a victim of violence. Security should be called if a female client's partner refuses to allow her to be interviewed in private. This should be a last resort, however, because it may increase the risk of retaliation against the woman. Staff should call law enforcement whenever they question the safety of a situation.

Social Workers

Social workers have expertise in psychosocial assessment and service planning with health department clients. They should play an active role in identifying and treating victims of domestic and sexual violence. The psychosocial assessment routinely done by social workers is an opportune time to screen for domestic and sexual violence. Once a woman has been identified as a violence victim, a social worker should ask her questions regarding her sense of safety, her knowledge of available local resources, and her future plans. Then the social worker can make a safety plan with her, which is discussed in more detail beginning on page 116. Social workers also should be familiar with community resources in order to make appropriate referrals.

Nutritionists

Nutritionists provide dietary counseling to WIC clients and clients with other health concerns. Often nutritional services are either the point of entry into the health department for many women, especially pregnant women, or are the only health services women seek. Therefore, in order to develop a comprehensive protocol for screening women for domestic and sexual violence, nutritionists must be involved. They should include screening for domestic and sexual violence as a routine part of their client assessments. Nutritionists typically assess clients eating behaviors and substance use. They should be aware of the possibility of abuse or sexual in a woman's life as a factor associated with these issues.

Clinicians

Clinicians include nurses, nurse practitioners, physician assistants, physical therapists, and physicians. Clinicians should be aware of the physical, emotional, and psychological consequences and indicators of domestic and sexual violence. They should accurately document any violence in the client's medical record. Clinicians can screen women for domestic and sexual violence while conducting the standard interview for the medical record. While the client is answering questions about her family's medical history and her health, she may feel comfortable addressing the issue of violence she has experienced. This will also help her to understand that abuse is a health issue that deserves the care and attention of a health care provider.

Health Educators

Health educators have skills in assessment, organizing, planning, and evaluation that can all be applied to form the health department's clinical and community response to domestic and sexual violence. Health educators can provide leadership in assessing the health department's and community's efforts to assist women victimized by domestic and sexual violence. Health educators can play a key role in establishing linkages between the health department and other community agencies that serve women and in developing community initiatives (see Chapter 5 for further information on developing and working with community responses to domestic and sexual violence. They can also be instrumental in training staff on domestic and sexual violence related issues.

Administrators

Administrators' support is essential. Administrators can allocate resources and set health department policy needed for the health department to take action against domestic and sexual violence. They can initiate or establish clinical protocol for responding to domestic and sexual violence. They can also serve as a link between the health department and other community agencies that serve women, especially in establishing memoranda of understanding (MOUs) to assist with comprehensive care of women experiencing violence.

CHAPTER 5

THE COMMUNITY BASED RESPONSE TO VIOLENCE AGAINST WOMEN

A community based response to violence against women should be two-fold:

1) assuring that a coordinated system of services are available for women victimized by domestic and/or sexual violence and for their children if needed in order to end the violence and mitigate its consequences, and
2) placing a strong focus on preventing violence before it occurs.

Local health departments have an obligation to promote and protect the health of the community, including the impact of violence. Health departments throughout North Carolina have successfully developed and implemented community based approaches to various public health problems, and have the skills to lead and/or support community efforts to prevent the occurrence and reoccurrence of violence against women.

What health departments can do

- *Define and describe the problem of violence against women*

Staff can identify sources of state and local data to describe the problem in a public health context, including the magnitude and complexity of the problem, the burden on individuals and the burden on the community. There are several resources that can help you find relevant local and statewide data, inlcuding a collection of databases that include variables about violence against women[15] and a collection of statistics relevant to rape and sexual assault[21].

- *Raise awareness in the community*

Health departments are experienced in creating and communicating health messages. These same strategies of communication can serve to inform the community at all levels (individuals, institutions organizations) of the problem of violence against women and the community response that is needed. Awareness education can be a powerful prevention strategy when it is designed to create a community-wide attitude of intolerance of violence against women.

- *Advocate for policies to prevent violence against women.*

Public health workers understand the impact of policy in improving the health status of the community and are experienced advocates for policies that protect the public health. This experience can strongly support community efforts to assure that effective policies guide the work of all community agencies and services as they respond to individual incidents of violence. Policy can be an effective tool for prevention, especially if community policies strongly focus on accountability of the perpetrator.

- *Maintain a focus on prevention.*

The field of violence against women lacks research and program models that are truly primary prevention in nature. Promising approaches are broad efforts to address, inform, and educate the public about violence in order to encourage nonviolent behavior. Education should focus on nonviolent problem solving and redefining role models. It includes education of children and adolescents in the classroom and other community settings. Violence against women is a social problem that must be addressed at all levels of social life[74]. The health department is unique among community based agencies because of the public health focus on prevention. Health department staff can keep collaborators aware and focused on prevention through all aspects of community level work. Using state and national public health resources, the local health department can always be on the lookout for promising interventions, and assist the community to develop the resources to implement and evaluate these programs.

EXAMPLES OF COMMUNITY BASED RESPONSES TO VIOLENCE AGAINST WOMEN

In the following sections are descriptions of several North Carolina community based programs and strategies for responding to and preventing violence against women. Two program models are presented, the Coordinated Community Response for domestic violence and the Sexual Assault Response Team to respond to rape and sexual assault. Many of these programs are either in place or being established in many North Carolina communities. In some locations, the health departments are active partners, while in others health departments have yet to join the effort. These types of pro-

grams offer opportunities for health departments to become involved or take a lead role in community-based intervention. Examples of these community-based strategies are described below in order to generate ideas about how health departments can become involved in existing community responses, or organize such efforts where they do not exist.

Coordinated Community Responses

In North Carolina, many local domestic violence programs have organized Coordinated Community Responses (CCRs). A list of those programs is at the end of this chapter. According to the definition of the Centers for Disease Control and Prevention (CDC), a CCR is "a geographically defined effort, representing diverse sectors of a local community to address domestic violence and integrate collaboration and primary Prevention strategies in coordination with a recognized domestic violence agency or program."[32] CCRs address the adequacy and coordination of community services and policies that address domestic violence and implement prevention programs in the community. Local health departments are critical members of a CCR, and should be instrumental in organizing such a group if one does not exist in the community.

Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)

The purpose of DELTA is to stimulate the development and implementation of activities to prevent intimate partner domestic violence that can be integrated into coordinated community responses.[32] These activities to prevent domestic violence are referred to as prevention enhancements and are defined as population-based and/or environmental/systems level services, policies and actions that prevent domestic violence from initially occurring and require a community level process to identify and implement.

In 2002, the North Carolina Coalition Against Domestic Violence received funding from the Centers for Disease Control and Prevention to implement DELTA. Through a competitive process, four local domestic violence programs were selected to receive DELTA funds to implement prevention enhancements in their communities.

Albemarle Hopeline, Elizabeth City (serving Pasquotank and Chowan counties)

The Pasquotank-Camden Community Response Team (DVCCR) is working to prevent first-time intimate partner violence. The DVCCR is working in two school systems and in the community at large, targeting the military, faith, legal, health and Hispanic communities. Through education and awareness of healthy relationships, the project hopes to see an improvement in the future lifestyles of residents of the Albemarle area. The DVCCR sponsors a series of Lunch-and-Learn sessions for various community groups, and is planning workshops on healthy relationships and prevention education at the US Coast Guard training center. The Safe Dates curriculum is slated to be presented in three middle schools. This CCR has quickly gained significant community recognition and support and learned that a group of concerned citizens can build momentum toward community change.

Domestic Violence Shelter and Services, Inc., Wilmington (serving New Hanover County)

This CCR (EVOLVE Wilmington! Encouraging Values and Opportunities for Living in a Violence-free Environment) was launched with a Community Call to Action Press Conference, after which thirty CCR members were recruited. That number has since doubled, and, after training was conducted for the CCR Team, it was divided into five Community Action Teams (CATs) to address the five priority populations of DELTA: business, education, faith, neighborhoods, and health/mental health to strategically plan projects that will involve those groups; for example, the Business CAT is planning to host a county-wide Domestic Violence in the Workplace Summit. The *Safe Dates* curriculum has been presented in high school and middle schools, and is planned for after-school and community-based programs.

Thirtieth Judicial District Domestic Violence and Sexual Assault Alliance, Inc., Waynesville (serving Haywood, Jackson, Macon, Clay, Cherokee, Graham, and Swain counties)

This project is focusing prevention efforts on the faith-based community and on youth with the teaching of the "Youth Relationships" program that focuses on the prevention of intimate partner violence. At the end of the 18 two-hour sessions, the youth create and complete a project. A goal of the project is to teach the "Youth Relationships" program in all local high schools.

The Coalition for Family Peace, Chatham County, North Carolina

The Coalition for Family Peace was established in 1997 as a coordinated community response (CCR) to prevent and reduce intimate partner violence in Chatham County. From five initiating organizations (Chatham Hospital, Chatham Primary Care, Family Violence and Rape Crisis Services, the Siler City Police Department and the UNC Department of Family Medicine), the Coalition has grown to a membership of 136 individuals representing 44 organizations including health care, the justice system, human services, the faith community, businesses and community members.

The Coalition has five task forces that identify, plan for, implement, and support the development of activities for Intimate Partner Violence (IPV) prevention and intervention. The task forces focus on the following areas: Community Awareness, Criminal Justice, Hispanic Community, Provider Training, and Victim Services. The work of the task forces is coordinated by the Board of Directors that meets monthly. The coalition members meet quarterly to learn about current issues related to IPC, provide input on the direction of the Coalition, hear about the work of the task force and give feedback from the community. Because of this structure, the community and the task forces guide the CCR.

Some accomplishments of the Coalition for Family Peace include the following:

- Worked with area law enforcement agencies to develop an Interagency Domestic Violence Unit, with uniform domestic violence protocols and one officer coordinating all the domestic violence cases;

- Provided victim services, outreach and awareness to the rapidly-growing Latino community;

- Developed batterer intervention programs in English and Spanish;

- Provided training to more than 250 community professionals in working with domestic violence in their own settings;

- Worked with Chatham Hospital to develop a focused response to violence against women, including training of all Emergency Department nurses in forensic examination and dedication of a private examination room for these patients, and universal screening of women over age 14 for IPV;

- Offered training, outreach and joint initiatives with the faith community, partnering with them to increase the community's effectiveness in providing domestic violence intervention;

- Developed funding for legal representation resources for victims in civil settings;

- Developed increased services for children exposed to domestic violence, both through this project and in collaboration with the Chatham County Partnership for Children's Safe Start Project;

- Obtained funding for a supervised child visitation and safe exchange program; and

- Developed and implemented a comprehensive IPV prevention plan.

From the beginning, the Coalition for Family Peace has strived to be representative of Chatham County's culturally diverse community and worked to increase services to underserved populations. The Coalition has been a leader in North Carolina in the development of culturally appropriate and bilingual services for the Latino community. The Coalition's Hispanic task force is predominately Latino, holds its meetings in Spanish and focuses on community awareness and outreach to the Latino community. They have defined the services appropriate to their own community and have helped to significantly increase awareness of domestic violence issues and services in that community.

The Coalition has also worked to engage the African American community in development of prevention and outreach services. In recent years, the African American Outreach Coordinator has worked through African American churches and local community groups to raise awareness and recruit participants for the coalition

and its task forces. The Coalition's basic IPV training has included a unit on cultural issues from the beginning. Additionally, since Chatham is a rural county, the Coalition for Family Peace has provided outreach to the rural portions of their community using non-traditional means to reach its most isolated areas.

The Coalition has been flexible and innovative in its efforts to prevent and reduce IPV. One example is the first project undertaken by the Hispanic Task Force. They decided that the community needed a soccer team at the local high school. They found sponsors, identified a volunteer coach and met with the school administration to get it set up. This project has increased the credibility of the Hispanic Task Force and the coalition in the Latino community, provided an opportunity for Latino boys to be involved in sports familiar to them, and has given the Coalition a forum for reaching them as well. Sometimes the most direct path is not the best path for working in communities.

SART (Sexual Assault Response Teams)

A Sexual Assault Response Team (SART) is a multidisciplinary interagency team of individuals working collaboratively to provide services for the community by offering specialized sexual assault intervention services. Teams are specialized to fit the needs of each community and generally have goals of increasing reporting and conviction of sexual assaults and countering the experience of sexual trauma with a sensitive and competent response.[109]

Sexual Assault Response Teams have evolved from the Sexual Assault Nurse Examiner (SANE) programs that began in the late 1970s with the recognition by medical professionals, particularly female nurses, that the services provided to sexual abuse victims were inadequate. Victims of sexual assault in hospital emergency departments competed unsuccessfully with the critically ill or injured for staff time. Doctors and nurses were often insufficiently trained to do medical-legal exams, and many lacked the ability to provide expert witness testimony as well. The SANE programs were developed from within medical facilities to provide a more timely response by specially trained nurses with expertise in forensic evidence collection.[109]

Sexual Assault Nurse Examiners (SANEs) typically work as a part of a Sexual Assault Response Team (SART). The Team can vary in its makeup and coordination of activities, but usually includes a rape crisis advocate, law enforcement personnel, a prosecutor and the SANE. The SART concept includes crisis intervention and long-term counseling, investigation and evidence collection, and a more sensitive initial medical response to rape victims.[109]

Pitt County SART, Pitt County, North Carolina

Several years ago, Pitt County agencies serving victims of sexual assault recognized the need for improved communication and collaboration, and a system of response to sexual assault where all victims receive the same comprehensive services regardless of where they enter the system. In 1996 the Pitt County District Attorney's office received grant funding to develop the county's first county-wide protocol for responding to sexual assault. A committee was formed with representatives from agencies that respond to the needs of sexual assault victims:

- Rape victim advocate
- Law enforcement personnel including a communications dispatcher, a responding officer, a law enforcement advocate and an investigator
- Medical personnel including a forensic nurse examiner or a nurse and physician
- Judicial personnel including an assistant district attorney and a victim/witness assistant

The committee called itself the Sexual Assault Response Team (SART). Their first focus was to better understand victims' needs and the services provided by each agency. They met regularly to learn about their various agencies, develop protocols, and organize the multidisciplinary response. During this process, the SART engaged in very intense discussions because of the different opinions and practices of the member agencies. However, the determina-

tion to better serve sexual assault victims was the driving force in this collaboration to write and rewrite a comprehensive protocol that included all resources in the community for victims of sexual assault and their families. After almost two years, the SART members signed off on the final version of the Pitt County Rape Response Protocol.

The Protocol contains the roles and responsibilities for each agency, and established a blueprint that guides the victim through the system and avoids re-victimization. Through this process the SART will achieve its goal of providing a collaborative, interdisciplinary team response to provide services that ensure a transition from victim to survivor for every individual whose llife is impacted by sexual violence.

An example of how this process works may begin with the victim entering at the hospital. The charge nurse is respondible for calling team members. When the responding law enforcement officer makes contact, he/she only establishes in a sexual assault has occurred, no details are exchanged at that time. The advocate, investigator, and medical personnel (forensic nurse examiner) meet with the responding officer to be briefed before entering the victim's room. The advocate enters the victim's room, introduces him/herself and explains the process of the team approach. The victim is given the right to refuse any or all members. Then the team enters the room for the detailed interview. The investigator usually leads the interview and incorporated all necessary questions. The advocate's reason for being present is to support; therefore, he/she does not take notes or ask questions. Medical personnel fill out the State Bureau of Investigations (SBI) rape kit forms during this interview. The investigator then briefs the victim on his/her next step and leaves the room so that the rest of evidence gathering for the kit can be performed. Medical personnel meet any of the victim's medical needs that are apparent. The victim is given a Pathway Booklet that contains a list of team members and their telephone numbers, other resources that may assist them, and information about crime.

From the start, the Pitt County SART has recognized the need for ongoing training to keep the team and other agency and community members. The REAL Crisis Center received a grant to expand the SART by establishing monthly meetings with an educational program, additional trainings, and community outreach. The program has trained other counties on establishing SARTs, and has established an e-newsletter. The Pitt County SART has assisted hundreds of victims on their road to recovery.

	A	E	F	H	I	J	K	L	M
1	CCR Name	First Name	Last Name	Address	Address	City	State	Zip	Phone
2	DV Advocacy Council - Alamance County	Gary	Ander	Family Abuse Services	PO Box 2192	Burlington	NC	27215	336-226-5982
3	Success and Families Programs - Alexander County	Leigh	Milstead	DSS - Alexander Co.	604 7th St Southwest	Taylorsville	NC	28681	828-632-1080
4	Beaufort Co. DV Task Force	Patricia	Dorn	Options to DV/SA, Inc.	PO Box 1387	Washington	NC	27889	252-946-3219
5	The Asheville/Buncombe Coalition for Prevention of Family Viol.	Janet	Harvey	Mediation Center	189 College St.	Asheville	NC	28801	828-251-6401 ext 18
6	Burke Co. Task Force on DV	Michelle	Newman	Options, Burke Co.	PO Box 2512	Morganton	NC	28680	828-438-9444
7	SAVE Task Force - Caldwell County	Tracy	Pyle	Caldwell Co. Sheriff's Dept.	2351 Morganton Blvd	Lenoir	NC	28645	828-758-2324
8	Catawba Professional Response to DV	Laurie	Suttles	First Step DV Program	17 Hwy 70 SE	Hickory	NC	28602	828-322-1400
9	Coalition for Family Peace - Chatham County	Kathy	Hodges	Coalition for Family Peace	PO Box 961	Siler City	NC	27344	919-742-7320
10	DV Task Force-Cumberland County	Elizabeth	Keever	District Court Judge	PO Box 363	Fayetteville	NC	28302	910-678-2901
11	DV Prevention Organization - Dare County	Temple	Heggie	Outerbanks Hotline	PO Box 1417	Manteo	NC	27954	252-473-5121
12	Davidson Co. DV/SA Task Force	Stacy	Sosebee-West	Family Services of Davidson Co.	PO Box 607	Lexington	NC	27293	336-243-1628
13	Davidson Co. DV/SA Task Force	Michelle	Garkusha	Family Services of Davidson Co.	PO Box 607	Lexington	NC	27293	336-243-1628
14	Duplin Co. Task Force on DV	Dee	Beddingfield	Sarah's Refuge, Duplin Co.	PO Box 368	Warsaw	NC	28398	910-293-3467
15	Domestic & Sexual Violence Task Force	Dina	Helderman	Durham Crisis Reponse Center	PO Box 52028	Durham	NC	27717	919-403-9425, x22
16	Advocay Council on DV - Edgecombe and Nash	Linda	Hawkins	My Sister's House	PO Box 7665	Rocky Mount	NC	27804	252-462-0366
17		Karol	Rivera	My Sister's House	PO Box 7665	Rocky Mount	NC	27804	252-462-0366
18	Multi-disciplinary Team - Franklin County	Danielle	Hill	Safe Space, Inc.	PO Box 240	Louisburg	NC	27549	919-497-5599
19	DV Community Council - Forsyth County	Sharee	Fowler	Family Services Shelter	610 Coliseum Dr.	Winston-Salem	NC	27106	336-722-8173
20	Gaston County DV Prevention Council	Cathy	Cloninger	Shelter of Gatson Co.	330 N. Marietta St.	Gastonia	NC	28052	704-866-3826
21	Harnett County DV Co DV Task Force	Tonya	Gray	Safe in Harnett Co.	PO Box 728	Lillington	NC	27546	910-814-4500
22	30th Judicial District DV-SA Alliance	Sybil	Mann	30th Judicial Alliance, Haywood Co.	307 Broadview St., PO Box 554	Waynesville	NC	28786	828-454-5082
23	Task Force on Family Violence - Henderson County	Tonya	Blackford	Mainstay, Henderson Co.	125 South Main Street	Hendersonville	NC	28792	828-693-3840
24	DV Task Force - Hertford, Bertie, Gates and Northampton	Judge	Kwasikpui	Northampton Co. Court House		Jackson	NC	27845	252-534-1785
25	Family Abuse Services Team - Iredell County	Patty	West	My Sister's House	Po Box 5217	Statesville	NC	28687	704-872-4045
26	DV Task Force - Johnston County	Keri	Christensen	Harbor	PO Box 1903	Smithfield	NC	27577	919-934-0233
27	Lee Co. DV & SA Task Force	Susan	King	Haven	310 N. Steele St., PO Box 3191	Sanford	NC	27331	919-774-8923
28	DV Task Force - Lenoir County	Susan	Mock	Lighthouse Program	PO Box 1678	Kinston	NC	28503	252-522-7272
29	Madison County Family Violence Task Force	Donna	Gregory	Helpmate	PO Box 457	Marshall	NC	28753	(828) 649-2582
30	McDowell County DV Task Force	Megan	Fields	Family Services of McDowell Co.	PO Box 1572	Marion	NC	28752	828-652-8538
31	DV Advocacy Council - Mecklenburg County	Morgan	Dow Cromwell	Youth and Family Services	700 E. Stonewall St., 6th Floor	Charlotte	NC	28202	704-336-2986
32	Family Violence Task Force - Montgomery County	Carol	Albright	Crisis Council	PO Box O	Troy	NC	27371	910-572-3749
33		Cathy	Harris	Crisis Council	PO Box O	Troy	NC	27371	910-572-3749
34	Sandhills Coalition Against Domestic Violence	Jerri	Bourne	Friend to Friend, Moore Co.	295 Hardee Brach Road	West End	NC	28327	910-947-3333
35	DV Network - Pitt County	Diana	Lucas	Family Violence Program, Inc.	PO Box 8429	Greenville	NC	27835	252-758-4400
36	DV Advocacy Council - New Hanover	Crystal	Moore	DV Shelter and Services	PO Box 1555	Wilmington	NC	28402	910-343-0703
37	DV Prevention Council-New Hanover	Stephanie	Wertlake	DV Shelter and Services	PO Box 1555	Wilmington	NC	28402	910-343-0703
38	DV Task Force - Robeson	Alfreida	Ricardi	Southeastern Family Violence Ctr.	PO Box 642	Lumberton	NC	28359	910-739-8622
39	DV Task Force - Richmond	John	Webster	Richmond Community College	613 McDonald Ave	Hamlet	NC	28345	910-582-7100
40	Elder Domestic Task Force - Rockingham	Angie	Boles	Rockhingham	PO Box 16	Wentworth	NC	27375	336- 342-3331
41	General Task Force - Rockingham	Cynthia	Pugh	Rockingham	PO Box 16	Wentworth	NC	27375	336-342-3331
42	Rowan County DV Task Force	Karen	Barbee	Salisbury Police Dept.	132 East Liberty St.	Salisbury	NC	28144	704-638-4463
43	Victim Advocacy Case Review Management Team - Sampson	Elwood	McPhail	UCARE, Sampson Co.	PO Box 761	Clinton	NC	28328	910-596-0931
44	DV Task Force - Wake	Adam	Hartzell	Interact	612 Wade Ave	Raleigh	NC	27605	919-828-7501
45	Regional Task Force- Watagua, Alleghany, Ashe & Avery	Jennifer	Herman	OASIS, Watagua Co.	PO Box 1591	Boone	NC	28607	828-264-1532
46	Wayne Co. Task Force on DV/SA (No Longer Exist)	George	Marsh	Lighthouse of Wayne Co.	PO Box 1581	Goldsboro	NC	27533	919-736-1313
47	SAFE, Inc. - Wilkes	Kathleen	Humphrey	SAFE, Inc.	PO Box 445	Wilkesboro	NC	28697	336-838-9169
48	Pasquotank/Camden DV CCR Team	Kathy	Nielsen	Albermarle Hopeline	PO Box 2064	Elizabeth City	NC	27906	252-338-5338
49		Janet	Leary	Albermarle Hopeline	PO Box 2064	Elizabeth City	NC	27906	252-338-5338
50	Wilson County CCR Team	Leslie	Spencer	Wesley Shelter	PO Box 1426	Wilson	NC	27894	252-2912344
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APPENDIX 1

LEGAL GUIDELINES

Many healthcare providers have expressed concern about their lack of knowledge of legal issues for battered women and legal issues pertaining to their intervention with battered women. Undoubtedly, many battered women are also unaware of the legal options available to them. These legal issues for battered women and healthcare providers are discussed in this section.

As a healthcare provider, you can provide some basic information about the legal options for battered women. However, urge battered women to seek legal counsel with a professional or to call a domestic violence program or women's organization, because specific procedures and policies vary throughout the state. Also, variation exists among judicial districts in terms of the sensitivity of judges, magistrates, and law enforcement officers and in terms of some of the procedures to obtain and enforce protective orders. Professional legal counselors and advocates in domestic violence and sexual assault programs can discuss the alternatives with a battered woman.

A. Laws affecting battered women

North Carolina has civil and criminal laws that protect and assist battered women. A battered woman may pursue either civil or criminal proceedings, or both at the same time, depending on her needs.

1. Civil laws

Civil law concerns the violation of a person's individual legal rights and seeks restitution for this violation or protection from further violations. Examples of civil actions in the area of domestic law include separation or divorce, and child custody or property division decisions. The Domestic Violence Act also contains civil remedies for battered women. These civil actions are presented in more detail below. If a woman decides to pursue any of these options, she may want to consult with an attorney. The domestic violence program in your community may be able to recommend attorneys who specialize in these areas and who are sensitive to the needs of abused women. Many domestic violence programs have court advocates who are able to guide women through the legal system.

a. *North Carolina Domestic Violence Act*

In 1979, the North Carolina General Assembly passed the Domestic Violence Act-Chapter 50B of the North Carolina General Statutes. This act informs batterers that the consequences of their actions are great, and that they have much to lose by resorting to violence. The act provides domestic violence victims and law enforcement officers with options that were not previously available without the assistance of a privately retained attorney. It also contains provisions expanding the arrest powers of officers responding to domestic violence and mandates the action of law enforcement personnel in specific situations. In addition, it enables domestic violence victims to receive protective orders and the custody of property and children for up to one year.

(1) Provisions of the Domestic Violence Act

(a) Law enforcement response

This act requires law enforcement officers to take the following actions.

- Remove the batterer from the home and help the battered woman return to the home.
- Assist in an emergency situation. However, law enforcement officials are not required to respond to a call when multiple complaints are made from the same person within a 48- hour period.
- Advise the woman about domestic violence programs in the community.
- Transport the woman to appropriate facilities, such as a hospital (if she is injured) or to a battered women's shelter.
- Accompany the woman to her residence to remove needed personal items.
- Arrest the batterer if he violates certain provisions a Domestic Violence Protective Order.

The law allows law enforcement to arrest the batterer without a warrant for most domestic violence crimes.

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(b) Domestic Violence Protective Orders

Domestic Violence Protective Orders issued by a judge may be granted for a fixed period of time, not to exceed one year. A District Court Judge has several possible types of relief that he or she may grant in a Domestic Violence Protective Order. The Judge may utilize only one, or a combination of the following provisions.

Prohibit abusive behaviors.

- Order the batterer not to assault, threaten, abuse, follow, harass or interfere with the victim or her children either in person or on the telephone.
- Order him to stay away from her home, her workplace, her school, the children's school and daycare, or any place where she is seeking shelter.
- Prohibit him from purchasing a firearm.
- Order him to attend an abuser treatment program

Provide for financial security and custody of property and children.

- Require the batterer to pay his partner's legal costs and attorney's fees.
- Allow the battered woman to live in the home where she had lived with her partner and order him to move out and not return to the home.
- Provide her and her children with suitable housing if she and her children have no place to go.
- Give her possession of personal property such as clothing and household goods except for his personal clothing, toiletries and tools of trade.
- Give her possession and use of the car.
- Give her custody of the minor children and order the batterer to pay child support.
- Order him to provide temporary financial support to the battered woman if the two are married.

Special Notes on Domestic Violence Protective Orders for Battered Immigrants

Orders should forbid the batterer from withdrawing an immigration application already filed on behalf of the victim an/or contacting the INS.

Orders can require access to, or copies of, any documents supporting the victim's immigration application, such as the following: (1) the victim's work permit, ID card, passport or documents filed with the INS: (2) the batterer's passport, certificate of naturalization, green card, social security card, birth certificate; 3) the marriage certificate, weddings photos, rent receipts, utility bills and income tax returns; and (4) children's school record and birth certificates. If some of these documents are unavailable, the batterer can be order to provide the relevant information to assist in locating these records.

Orders can require the batterer to sign a prepared FOIA (Freedom of Information Act) so that the battered immigrant can access records from INS.

Orders can require that children's passport be relinquished to the victim.

DVPOs should be available to victims who choose not to separate from their abusers since immigration benefits do not require separation. (Capps 2003).

(2) Obtaining a Domestic Violence Protective Order

A woman can seek a Domestic Violence Protective Order (DVPO) if a male partner, with whom she has cohabitated, has a child in common, or with whom she has been in a dating relationship threatens to kill her, threatens her with a weapon, attempts violently to break into her home, beats, strikes, or injures her, engages in any other behavior that puts her in fear of serious bodily injury or continued harassment that inflicts serious emotional

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distress, or does any of these things to her children. This act also allows same sex couples who live or have lived together to be give a protective order. The law allows men to receive protective orders against their female partners if the above conditions are met. Although obtaining a DVPO without the assistance of an attorney is possible, the woman should hire an attorney if she thinks the batterer will hire a lawyer or will try to get custody of the children. Most domestic violence programs can help women through the process of obtaining a DVPO.

Three steps are required to receive a DVPO. Step 1 is to file papers for a Domestic Violence Protective Order at the office of the Clerk of Superior Court. Step 2 is to attend an ex parte hearing for a temporary protective order that lasts until the next hearing. Ex parte means that a complaint can be filed and a hearing take place without the defendant (i.e., the batterer) being present or notified. Step 3 is to present evidence at a second hearing within ten days for the permanent (one-year) Domestic Violence Protective Order.

(a) Step 1: Filing the papers

The forms for requesting a protective order are available at the Clerk of Superior Court's office in each county and at most local domestic violence programs and battered women's shelters. Obtaining the forms at a domestic violence program is advantageous because many programs have advocates who can guide the women through the process. The completed forms then are filed with Clerk of the Superior Court at the local courthouse in the county where either the woman or the man is presently living or staying. There is no charge for filing the papers or having the sheriff's department serve them. The form is available from the Clerk of Court. In filling out the forms, the woman must request an ex parte hearing if they want one.

(b) Step 2: Ex parte hearing for a temporary protective order

The Clerk of Superior Court will schedule an ex parte hearing with a district court judge within 72 hours after the papers are filed. This hearing will be in the county where the papers are filed. This may take place just after she files the papers and may only last a few minutes. The woman must demonstrate to the judge that she and/or

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her children are in serious and immediate danger. She may not be required to produce much evidence. However, she should present anything that would help convince the judge that she needs court protection, including her testimony, the testimony of other people, a record of the abuse, and any other evidence (for example, photographs of injuries or torn or bloody clothing.) If the judge rules in her favor, the judge will sign a temporary protective order that which becomes effective at the time of the hearing. The batterer is served the temporary protective order by the sheriff's department, and it will be in effect until the second hearing in district court. If the judge refuses to sign the ex parte temporary order, the victim may still secure a permanent domestic violence protective order at the second hearing, with all parties present. In some counties, magistrates may issue ex parte orders when judges are not available.

After the ex parte hearing, the courtroom clerk will assign a date and time for the hearing for the permanent order and will give the woman a copy of the ex parte temporary order. The clerk will then deliver copies of the papers, or will have the woman deliver the copies, to the sheriff for service on the batterer. The woman also should take a copy of the ex parte temporary order to the police department of the city in which she resides. If she does not reside within the limits of any particular city, it is not necessary for her to deliver an extra copy of this order to any police department.

(c) Step 3: Hearing for a Domestic Violence Protective Order

The second hearing, which is for the DVPO (also called a permanent protective order), will be held about ten days after the ex parte hearing. If the woman will not be able to attend the hearing, she should call the clerk's office in advance to try to reschedule the court date. Three major consequences may result if she misses the hearing. First, the case will be dismissed, and she will not receive the permanent protective order. Second, the woman may lose credibility with the judge. The judge may not take the woman's future attempts to obtain a protective order seriously. However, if the batterer was notified of the hearing and does not appear, the judge can still issue a permanent protective order (DVPO). If the sheriff has not notified the batterer of the hearing by the date of the hearing, the hearing will be postponed and the temporary protective order will stay in place until he is notified.

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At the second hearing, the woman must prove that her domestic partner physically abused or threatened to abuse her or her children or place her in fear of injury. She should focus on incidents of actual physical abuse or threats of physical abuse. It will be very important for her to explain why she is currently in fear for her or her children's well-being. She must convince a judge that she needs protection and each item for which she has asked in the complaint such as child custody, support, and possession of her home or car. Therefore, she should bring any evidence she has collected including documentation of the abuse in her medical record.

Before the hearing, the victim should ask any witnesses who saw the abuse or her injuries to testify at the hearing. Since some witnesses may not come without a subpoena that orders them to appear and testify, she may have to file subpoenas. Subpoena forms may be filed at the local Clerk of Superior Court's office, for a $5 fee. She should practice what she will say before going to court because the judge, the defendant, or the defendant's lawyer may ask her questions.

The order of events at the hearing is as follows. Certain steps may be omitted depending on whether either the woman or the man have witnesses or lawyers.

(1) The battered woman will tell her side of the story and present her evidence.
(2) The batterer, his lawyer, or the judge may question her.
(3) Her witnesses, if any, will testify.
(4) He, his lawyer, or the judge may question them.
(5) He will tell his side.
(6) She, her lawyer, or the judge may question him.
(7) His witnesses will testify.
(8) She, her lawyer, or the judge may question them.
(9) After hearing both sides and considering at all the evidence, the judge will decide whether a permanent protective order should be granted.
(10) If the judge rules in her favor, the judge will sign the DVPO listing the provisions covered by the order.

A copy of all protective orders or agreements should be given to both the woman and the defendant and to the police or sheriff's department where each resides. Although the DVPO is called a permanent protective order, it is in effect only for up to one year. However, the order can be extended if the woman continues to be in serious and immediate danger.

(3) Enforcing the protective order

If the batterer enters the woman's home, threatens her after being ordered not to do so, or violates the order in any way he can be charged with the criminal misdemeanor of violating a protective order or can be found in civil contempt of court. The woman should keep a copy of the protective order with her at all times, keep copies at her home and at her workplace, and be sure her local sheriff or police department has a copy. If the batterer violates the order, the woman should call the sheriff or police immediately to tell them that the batterer is violating the DVPO, and that they need to come to arrest him. Once the police verify the DVPO, they will arrest the batterer for violating the order, seek a warrant for his arrest or inform her how to get a warrant for his arrest. If the judge determines that he violated the order, he can be jailed, fined or placed on probation for the crime. To have the batterer held in contempt, the woman must fill out a form at the Clerk of Court's office seeking a show cause order for contempt. Notice will be sent to the batterer and a judge will hold a hearing to determine whether to hold him in contempt.

b. Absolute Divorce (N.C.G.S. § 50-6)

An absolute divorce means dissolution of the marriage, and once granted by a court, both parties are free to remarry. The most common ground for divorce is separation of the parties for at least one year. Separation means that the parties must have lived apart for the entire year. The parties do not need a court document to establish a separation. If the parties reconcile and then separate again, the one-year period begins on the date of the second separation. Isolated acts of sexual intercourse between the parties will not affect the statutory requirement of one year's separation.

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Either party can initiate a divorce action after separation of one year. The divorce complaint must be filed in the county where the plaintiff lives or in the county where the defendant lives. One of the parties must have been a resident of North Carolina for at least six months preceding the initiation of the action. Parties are usually represented by attorneys in divorce proceedings.

Be aware that unless resolved by agreement, all rights to division of marital property and alimony may terminate upon divorce if not preserved in the divorce judgment, or filed before the divorce. Otherwise, any remaining issues should be reserved for future resolution by the court.

c. Divorce from Bed and Board (N.C.G.S. § 50-7)

In North Carolina, a spouse can petition the court for a divorce from bed and board, which is essentially a court-ordered separation. In order to petition the court, one or more of the following grounds must exist:

- abandonment (i.e., if either person leaves without a good reason and does not plan to return)
- maliciously turning out of doors (i.e., forcing a spouse to leave)
- cruel or barbarous treatment that endangers the life of the other spouse
- offering indignities to the other spouse as to render her condition intolerable and life burdensome (e.g., humiliation, insults)
- excessive use of alcohol or drugs
- adultery (i.e., sexual intercourse with someone other than your spouse)

d. Alimony (N.C.G.S. § 50-16)

Alimony means payments for the support and maintenance of a spouse, either in lump sum or on a continuing basis, that is ordered by the court or agreed to in a separation agreement. The spouse requesting alimony must be a "dependent spouse." A dependent spouse is one who is actually substantially dependent upon the other spouse for his or her maintenance and support OR is substantially in need of maintenance and support from the other spouse.

Any claims for alimony must be made before the parties are divorced. The court looks at a variety of factors in determining the amount of alimony, including earnings, accustomed standard of living, and length of the marriage.

Alimony payments cease if the dependent spouse remarries, the supporting spouse dies, or the dependent spouse cohabitates with someone as if married. In addition, either spouse may seek a modification of alimony through the courts at any time after the divorce by showing a substantial change of circumstances. An award of alimony is enforceable by contempt proceedings in the court. Finally, it is possible to obtain an award of attorney's fees in actions for alimony, whereby the supporting spouse is ordered to pay reasonable attorney's fees for the benefit of the dependent spouse.

e. Equitable Distribution (N.C.G.S. § 50-20)

"Equitable distribution" refers to the division of marital property between spouses who are divorcing. The first step is determining what is marital property. "Marital property" includes all real and personal property acquired by either spouse during the marriage and before the date of separation, excluding all separate property. "Separate property" is NOT subject to equitable distribution and includes all real or personal property acquired before the marriage or acquired by gift or inheritance during the marriage.

Once the court determines what is marital property, the next step is to value the property. The final step is determining the division of marital property. The law presumes that an equal division of marital property is equitable, i.e. each party is entitled to 50% of the marital property. However, it is possible for one party to receive more than half of the marital property if certain factors are present.

Parties may agree to a division of property in a separation agreement or the court can order a division. A party must assert a claim for equitable distribution before a divorce decree is entered or all rights to a share of the marital property will be lost.

f. Separation Agreements

A separation agreement is a voluntary agreement between spouses that settles such issues as alimony, division of property, custody and child support. The agreement is binding as a contract on all matters except those relating to children. A court can modify provisions related to child custody and support. A party not performing as agreed to in the agreement can be held in breach of contract.

In order to enter into a separation agreement, the parties must be living separate and apart at the time of signing the agreement or immediately thereafter. The agreement must be in writing and witnessed by a notary public. Each party should obtain the advice of an attorney before signing a separation agreement. Even if the parties are in mediation (which is not recommended in domestic violence situations), each party should have his or her own attorney review the agreement before signing.

g. Child Custody (N.C.G.S. § 50-13.1)

Custody of children can be agreed to in a separation agreement or can be ordered by the court. A court always has jurisdiction over custody matters and can modify a custody arrangement.

Custody includes both legal custody and physical custody. Legal custody refers to a parent's right to participate in making decisions about the child's welfare. Physical custody refers to the living arrangements of the child(ren). The custodial parent is the one who has physical custody of the child(ren). The court can order either sole custody (one parent) or joint custody (shared by both parents).

The non-custodial parent will almost always have a right to visitation with the child(ren). It is very important in domestic violence situations for any visitation arrangements to be specifically spelled out by the court, including a neutral place for exchange of the child(ren).

Custody decisions are based on the best interests of the child(ren). There is no longer a presumption that it is in a child's best interest to be in the custody of his or her mother. However, the party that has been the primary caretaker will have a stronger case in

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obtaining custody. Domestic violence is a factor to be considered by the court in awarding custody.

NOTE: A battered woman may be able to obtain temporary custody of her children in certain situations as part of a DVPO under NC General Statute Chapter 50B.

h. Child Support (N.C.G.S. § 50-13.4)

Parents are legally obligated to support their children. A custodial parent may seek child support payments from the non-custodial parent at any time. North Carolina has established presumptive guidelines for determining the amount of child support.

Child support payments terminate when the child reaches 18 or is otherwise emancipated, unless a child is attending secondary school, in which case child support may continue until graduation or age 20, whichever occurs first.

A woman may seek child support through her local child support enforcement office, a division of the Department of Social Services in each county in the state. Services are provided regardless of income level. Individuals receiving Temporary Assistance to Needy Families (TANF) (referred to in North Carolina as Work First)are automatically referred to the local child support enforcement office and are required to cooperate with the child support office to obtain child support which reimburses the state for the Work First benefits. An exception to this requirement is if the woman can show that she would be in danger from an abusive parent if she were required to disclose information with regard to seeking child support. Individuals not receiving public assistance may receive services upon payment of a small application fee.

Child support payments are made directly to State Collection. Individuals receiving public assistance must assign a portion of the right to receive support directly to the State of North Carolina.

North Carolina provides for income-withholding for the payment of child support. In addition, child support can be enforced through contempt proceedings. A non-supporting parent may face criminal charges and imprisonment.

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i. Temporary Restraining Order (Civil Procedure Rule 65)

If a woman does not meet the requirements for obtaining a DVPO under Chapter 50B, she may be able to obtain a temporary restraining order (TRO) under Rule 65 of the North Carolina Rules of Civil Procedure. In order to receive a temporary restraining order, it must be shown that immediate and irreparable injury, loss, or damage will result to the party requesting relief before notice can be served on the other party and a hearing held. A TRO is very limited in nature in that it only lasts for ten days. After ten days a woman may be ale to obtain a permanent injunction. A woman will generally need an attorney to obtain a TRO and a permanent injunction.

2. Criminal laws

Criminal law concerns the protection of the public order. A violation of such laws is considered a "crime against the state" since the state is charged with protecting the public order. The state, therefore, is responsible for prosecuting these cases. A battered woman may press criminal charges against the batterer regardless of the status of their relationship (for example, even if she and her abuser have never lived together). These charges will be prosecuted by the State of North Carolina through the local district attorney's office. The following are possible criminal charges that can be brought against the batterer.

- Felonious assault with a deadly weapon with intent to kill and/or inflict serious injury—G.S. 14-32
- Assault by pointing a gun intentionally, whether in fun or not, and whether loaded or not—G.S. 14-34
- Discharging a firearm into occupied property—G.S. 14-34
- Assault on a female by hitting or by a show of violence—G.S. 14-33 Show of violence means defendant has an apparent ability to cause injury and puts the victim in reasonable fear of harm and causes victim to do something or refrain from doing something she would have done (e.g., leaving a place).
- Communicating a threat (to injure physically or to damage the property of another).—G.S. 14-277.1 The threat must be made in a manner that would lead a reasonable person to believe it will be carried out, and the threatened person must believe it

- Misdemeanor assault, battery or affray—G.S. 14-33
- Harassing phone calls, indecent language or harassment by repeating phone calls which threaten, terrify, or embarrass—G.S. 14-196
- Domestic criminal trespass. If a woman is living apart from her partner, or if the couple have a court-ordered separation or civil order directing one partner to stay away from the premises occupied by the other, or if a verbal or written agreement exists between the partners that they will live apart or in separate places of residence, then it is a domestic criminal trespass if he enters her premises after being forbidden to do so or if he remains after being ordered to leave.— G.S. 14-134.3
- Stalking—G.S. 14-277.3 A person commits the offense of "stalking" if the person willfully and on more than one occasion follows, is in the presence of or otherwise harasses another person without legal purpose and with the intent to

  (1) place the person in reasonable fear for her safety or for the safety of her immediate family or close personal associates or

  (2) cause her substantial emotional distress by placing ***her in fear of death, bodily injury or continued harassment,*** and that in fact causes substantial emotional distress

  (3) after reasonable warning or request to desist by or on behalf of the other person

  (4) the acts constitute a pattern of conduct over a period of time evidencing a continuity of purpose

a. Filing criminal charges

To start a criminal proceeding, the woman must report the crime to the police as soon as possible. If the police witness the assault, they probably will make an arrest on the spot. If she does not want to call the police, or if the police come and do not arrest the batterer, she can still have him arrested by going directly to the local magistrate to swear out a warrant for his arrest. Once she has explained her situation to the magistrate, the magistrate will decide whether to issue a warrant and what specific charge is appropriate in her situation.

The magistrate may request that she make an appointment with the district attorney to discuss her case before a warrant is issued. In

that case, the district attorney would recommend to the magistrate whether a warrant should be issued. When she meets with either the magistrate she should bring any information she has about the batterer's whereabouts, and the names and addresses of any witnesses to the incidents, so that the witnesses can be put on the subpoena list and can be notified when to come to court to testify for her. Also, she should leave an address where the court can serve her with a subpoena when her case is scheduled for trial.

b. Arresting the batterer

After the warrant has been issued, it is turned over to the police to be served. The person charged in the warrant may be arrested and taken to the courthouse or county jail for booking. In most criminal cases he has the right to have a reasonable bond set for appearance in court and subsequently may be released, soon after his arrest, once pretrial release conditions have been determined. For many domestic violence offenses only a judge may set bond during the first 48 hours after arrest. For unsecured bond, the batterer does not need to put up money or collateral guaranteeing that he will appear at the trial. He only needs to sign a form that he will pay a certain amount if he does not appear at the trial. However, once a defendant is taken into custody and charged, the judicial official (magistrate or judge, depending on the district) must determine if the release of the defendant will pose a threat to the safety and well-being of the victim or any other person. If the woman is afraid that he will try to hurt her after he is arrested, she should tell the judicial official. If the judicial official views the defendant as a threat, he may be held in custody for a reasonable period of time. If the defendant is released, certain conditions may be imposed such as requiring that the defendant post a secured appearance bond which means that he would have to put up money or property as collateral to guarantee that he will appear at the trial.

c. Going to trial

When her case is called for trial, the woman must be present and prepared to testify about exactly what the batterer has done and said to her and to provide evidence to substantiate her claims. The assistant district attorney prosecutes criminal cases and represents

her case in court. Ideally, the assistant district attorney talks with the woman before trying the case, but his or her time may be limited if there are many cases to be heard that day. In court, the assistant district attorney or judge will ask her questions about the batterer's abuse.

If the batterer is found guilty, the punishment for a criminal offense such as assault may be light. Although, as mentioned above, many of the criminal offenses may carry jail sentences, a man who is found guilty of beating a woman is often not jailed. His sentence may be suspended with conditions such as probation with substance abuse or batterers' treatment. Simply going through the trial may lead him to stop beating her or to escalate the beatings, or it may have no effect. However, a criminal conviction on his record may lead the judge to treat him more severely if he is arrested again.

3. Advantages and disadvantages of civil and criminal proceedings

In criminal proceedings, the state determines guilt resulting in a criminal record and punishment. In a civil disagreement, guilt is not established. Decisions are based on injury or disagreement. Pursuing charges in criminal court may lead to punishment of the offender for his behavior or to court-ordered treatment. Pressing criminal charges may also help the woman in the future if the batterer has convictions for past violent behavior on his record. However, the criminal process may be quite lengthy. Furthermore, the process is out of her control since these offenses are crimes against the state. She could be charged with frivolous prosecution and charged court costs if she does not follow through with the charges made against the batterer.

A protective order may offer more protection than a criminal conviction, may resolve more issues, and is usually not as time consuming as criminal procedures. The burden of proof to obtain a protective order is lower than to obtain a criminal conviction so the evidence required may be less. However, civil court can be very costly if the battered woman needs to hire an attorney, and the batterer will not gain a criminal record or serve time in jail. The woman may bring criminal charges and also seek a civil protective order. These advantages and disadvantages are summarized in the table below.

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Civil Proceedings

Advantages	Disadvantages
Resolve issues such as possession of property and child custody.	Costly if thewoman hires an attorney.
Less lengthy.	Batterer will not be imprisoned or have cirminal record.
Less evidence required.	

Criminal Proceedings

Advantages	Disadvantages
May punish the batterer.	Woman can be charged with frivolous prosecution if she drops the charges.
May order treatment for his behavior.	Evidence is more closely scruti nized.
May give the batterer a criminal record.	

4. Collecting Evidence for Criminal or Civil Proceedings

In a judicial proceeding, the judge's decision is often based only on the testimony of the woman and the batterer. The judge may rule in favor of whomever he or she views as more credible. However, material evidence of the abuse may sway the judge's decision in the woman's favor. Whatever legal action the woman pursues, evidence that substantiate her claims will play a key role. Therefore, the woman should make a record of any act or threat of violence by the batterer including: the date, time, and place of each incident; what was done and said; how and where she was injured; and the names of any persons who were present or who may have seen or heard the incident. The more specific and detailed the record, the more convincing the evidence will be to the judge. If she has an attorney, she should tell him or her about the batterer's acts and threats of violence. If she receives any visible injury, she should have pictures taken of the injuries. Most domestic violence programs should be able to photograph her injuries. Health department staff should be able to photograph her as well. Also, she should go to her healthcare provider for examination and treatment and ask the provider to document the nature and extent of her injury in her medical or dental record because she may later need this evidence. (Information about these procedures is included in the documentation section.) Other

types of physical evidence include torn or dirty clothes, pulled hair, broken household items, and copies of police reports and the batterer's criminal record. Written documentation, evidence, and the testimony of witnesses may be used in a court hearing as evidence of his character and integrity in suits for child custody or for temporary or permanent alimony.

B. Legal Considerations for Healthcare Providers

Since addressing domestic violence is a new role for many healthcare providers, many may be confused about their legal obligations. This section addresses some of the legal concerns a healthcare provider may have.

1. North Carolina's Reporting Requirements

The reporting requirements in North Carolina are somewhat ambiguous. If you are uncertain about whether to report a specific case of abuse, seek legal counsel.

a. Domestic Violence

There is no law requiring healthcare providers to report domestic violence. Healthcare providers may be held liable for breach of patient confidentiality if abuse is reported without the victim's permission. Unauthorized reporting also sends a message to the victim that the healthcare setting is not a safe place and may discourage her from seeking medical treatment in the future. Abusers often isolate their victims from their family and friends. The healthcare provider may be the only person whom she has access to and the only person she can communicate with in a safe environment. Most domestic violence advocates oppose mandatory reporting of battered women to law enforcement agencies without the women's consent. Reporting a battered woman to law enforcement may further stigmatize and endanger her. Also, efforts to empower a battered woman may be subverted by taking away her choice to pursue her own course of action. Breach of patient-professional confidentiality reinforces the victim's low self-esteem, her sense of powerlessness and cuts off an important avenue for support and potential escape.

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b. Child and Elder Abuse

North Carolina law assumes that children and the elderly are not autonomous, independent persons and are in need of special protection under the law that is not given to adult, non-elderly women. Under North Carolina law, all professionals are required to report incidents of suspected child or elder abuse or neglect. These mandatory reporting statutes override the confidentiality of the doctor-patient relationship.

If a woman discloses to a healthcare provider that children or elderly people have been abused, endangered, or neglected, the provider must report this abuse. If the perpetrator is a family member or caretaker, the provider must report the abuse to the Department of Social Services (DSS). Therefore, healthcare providers should explain to women the consequences of divulging this type of information. Likewise, if the client is a minor or elderly person and the provider suspects that she has been the victim of abuse, the provider must also report his or her suspicions to the DSS. Inform the women that if they divulge child or elder abuse you will have to report that abuse.

c. Criminal acts

North Carolina General Statute 90-21.20 requires physicians to report serious injuries resulting from criminal acts of violence, but there are some visible injuries requiring medical treatment that do not fall within the reporting requirements of this statute. The statute states that physicians are required to report:

Cases of wounds, injuries, or illnesses (that) include every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm, every case of illness apparently caused by poisoning, every case of a wound or injury caused, or apparently caused, by a knife or sharp or pointed instrument if it appears to the physician or surgeon treating the case that a criminal act was involved, and every case of a wound, injury, or illness in which there is grave bodily harm or grave illness if it appears to the

physician or surgeon treating the case that the wound, injury, or illness resulted from a criminal act of violence.

Battered women often suffer injuries such as contusions, abrasions, fractures and sprains. Pain without a readily apparent source is a common presenting symptom of abuse as well as stress, anxiety and depression. Most medical visits by victims of domestic violence are made for routine medical visits and non-life threatening injuries rather than overt trauma or the type of injuries that fall within the above statute.

a. Liability for unauthorized disclosure

Courts have upheld the right of the patient to recover damages from a healthcare provider for unauthorized disclosure on the grounds of invasion of privacy, breach of confidence and emotional distress. Healthcare providers need to know that a subpoena for medical records is not a court order protecting the provider from liability. Release of medical records to a party in a court proceeding without patient approval may lead to a law suit against the healthcare professional for breach of patient confidence or invasion of privacy. Gaining permission from the patient must be done with care. If the victim is still living with her abuser contacting her may put her in further danger. Healthcare providers should routinely take steps to obtain information on how to safely contact their patients. Once the patent has provided permission the records may be released. If the patient does not give permission, a court order must be obtained in order to release the records. Once a court order is received, the healthcare provider must comply and release the patient's records. The healthcare provider will then be protected from liability for breach of patient confidentiality.

2. Medical Negligence Liability

Some clinicians may be concerned about liability in helping battered women. However, as of May 1995, representatives of both the American Medical Association and the American Trial Lawyers Association were unaware of any lawsuits in which a healthcare provider has ever been sued for not responding appropriately to a case of domestic violence. However, healthcare professionals should be aware of the potential for negligence liability if they fail

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to identify domestic violence and thereafter if they fail to properly treat and refer the patient. In most medical negligence cases the patient must show the healthcare provider failed to exercise the degree of care that a reasonably prudent provider would have practiced in the same specialty in a similar community. If a provider fails to do this and causes a patient to suffer injuries that would otherwise not have occurred, the provider is liable for negligence. There must be a reasonable connection between the act or omission of the healthcare provider and the subsequent injuries of the patient. A plaintiff patient may demonstrate that a reasonable provider would have suspected and identified abuse and made appropriate referrals.

A healthcare provider will be expected to follow the common protocols for domestic violence. The American Medical Association has promulgated guidelines that recognize a duty by providers to identify and properly address domestic violence. The AMA Guidelines recommend organizations develop policies and procedures for the identification, documentation, treatment and referral process for victims of domestic violence.

a. Identification

Failure to diagnose domestic violence can lead to liability in the same way failure to diagnose other health conditions can. At this time there are no reported medical malpractice cases for failure to diagnose domestic violence. However, there courts have recognized liability for a physician's failure to diagnose child abuse. Early identification is crucial in stopping the severity and frequency of abuse. The AMA recommends providers routinely ask all women specifically about abuse. Domestic violence is a significant health problem for women. Healthcare providers see victims at all stages of the abuse. For many women the healthcare systme may be the only way they can learn about their options. Early and proper identification plays a crucial role in advancing a victim's safety.

b. Documentation

Proper documentation is critical for the success of the victim's legal actions against her abuser. Appropriate medical documentation helps to corroborate the victim's testimony. Often the medical record may be the only other evidence of the abuse. The AMA recommends the record include: chief complaint in woman's words,

description of abusive event, medical history, relevant social history, detailed description of the injuries, an opinion on whether the injuries were adequately explained, results of the laboratory and other diagnostic procedures, color photographs and imaging studies and the names of the police involved. Objective facts are more helpful than subjective opinions.

c. Treatment

The injury or complaint requires a complete physical examination and appropriate treatment. The victim's emotional status should also be assessed for suicidal tendencies, depression, anxiety and substance abuse.

d. Duty to inform

A patient has a right to be fully informed of all available treatment options. A healthcare provider has a duty to disclose all relevant information to ensure the patient makes an informed decision. Without information about legal and social services a victim of domestic violence can not make an informed choice to seek these services. If a provider fails to discuss healthcare options with a patient who has disclosed the abuse or whose injuries appear to be the result of abuse, the inaction may result in liability. The patient should be referred once the provider knows or should have known that he or she lacks the requisite skills to properly treat the condition. Referrals are often given to domestic violence shelters, domestic violence advocacy programs or counseling services with expertise in helping battered women.

3. Healthcare provider responsibility in legal proceedings

A healthcare provider can play an important role in legal proceedings by providing evidence on the woman's behalf. A healthcare provider may be subpoenaed to testify in court for either civil or criminal proceedings to present evidence about a woman's abuse. The provider will have to testify about the injuries he or she treated and about the contents of the client's record, including statements made by the client. A well-documented and legible (typed, if possible) medical record may help reduce the time the provider is

required to spend in judicial proceedings. The provider may be able to send the medical record in lieu of testifying, if the record is complete. The documentation section of this manual provides detailed information on thoroughly documenting abuse in a woman's medical record.

If the healthcare provider is called to testify in a court case, the following guidelines may be helpful.

- Insist on pre-trial preparation by the attorney presenting you as a witness, including practice of cross-examination questions.
- Provide the attorney calling you as a witness with a copy of your resume.
- Know the facts of the case well, and discuss troublesome areas or questions with the attorney before the court date.
- Feel free to propose questions for the attorney to ask you and any opposing expert.
- Listen to the question asked and answer only that question.
- Ask that a question be repeated or rephrased if you do not understand it.
- Do not volunteer information, especially on cross-examination
- Ask the judge if you can explain your answer if you feel that "yes" or "no" is not adequate.

Calmly correct an attorney who misstates prior testimony.

SUMMARY OF ADDITIONAL DOMESTIC VIOLENCE STATUTES

The following table updates material on Domestic Violence statutes beyond the Domestic Violence Protective Order information already presented. The table below is available from http://www.nccadv.org/2003_bill_summary.htm (accessed 08-04-04) and was entirely prepared by the North Carolina Coalition Against Domestic Violence.

Summary of 2003 Domestic Violence Bills*
Prepared by NCCADV

Bill # - S630
Name - Protective Order Clarification Act
Status - NCCADV Agenda Item
Effective Date - May 31, 2003
Purpose - Clarifies Chapter 50B to ensure that victims are able to renew protective orders multiple times for "good cause" and to ensure that consent orders are treated the same as orders entered pursuant to a hearing.

Bill # - S919
Name - Homicide Prevention Act
Status - NCCADV Agenda Item
Effective Date - Passed, Dec. 1, 2003
Purpose - Enhances victim safety by prohibiting the purchase and possession of firearms by persons subject to protective orders in high-risk cases and provides for the surrender of the firearms to the sheriff's office.

Bill # - H926
Name - Assault in the Presence of a Child
Status - Recommendation of Child Well-Being and DV Task Force NCCADV Supported
Effective Date - Passed, Dec. 1, 2003
Purpose - Creates an enhanced penalty for serious assaults that are committed within sight of a minor child who resides with one of the parties. Provides for mandatory supervised probation for 1st offense and mandatory minimum 30 days active time for subsequent offense.

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Bill # - S718
Name - Custody and Domestic Violence
Status - Recommendation of Child Well-Being and DV Task Force
NCCADV Supports
Effective Date - Eligible in short session 2004 N/A
Purpose - Enhances the safety of children by providing for a rebuttable presumption against awarding custody to a perpetrator of family violence in protective order cases and general custody cases.

Bill # - S439
Name - Omnibus ESC Changes
Status - Employment Security Commission Agency Bill
NCCADV Supported
Effective Date - Passed, June 23, 2003
Purpose - Improves NC's unemployment insurance laws, including clarifying that a victim of domestic violence is not required to have a protective order to qualify for benefits and may use other types of evidence.

* Text of bills are available at www.ncleg.net by entering H# or S# in the bill search box.

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SUMMARY OF NORTH CAROLINA SEX CRIME STATUTES

The statutes below have been summarized and arranged in general categories to provide an understanding of the extent and order to which North Carolina's criminal justice system addresses sexual violence. Those with questions about specific cases should review the laws and statutory provisions in their exact language (see **www.ncga.state.nc.us** or **www.findlaw.com**) and seek legal advice if necessary. Note that "G.S." stands for North Carolina General Statutes, a series of books often found in the reference section of a local library. It is important to keep in mind that while the criminal justice system and the laws it enforces are important tools to protect the public and identify criminal wrongs, victims themselves maintain the personal right to define what happened to them. That is, when victims experience a sexual violation, whether or not their experience is legally defined as a crime or proven to be a crime, it is a traumatic violation to them nonetheless and deserving of support and services.

For more information, including how to find the North Carolina rape crisis and sexual assault support services nearest you, please see www.nccasa.org or call the North Carolina Coalition Against Sexual Assault at (919) 431-0995 or toll-free at (888) 737-CASA.

Note on the NC Sex Offender & Public Protection Registry: Statutes marked by (SOR) below indicate those offenses requiring registration with the NC Sex Offender & Public Protection Registry [G.S. 14-208.5 through 14-208.32] after completion of a criminal sentence. Statewide public information listing registered sex offenders may be found online at http://sbi.jus.state.nc.us/sor/ .

FORCIBLE ACTS[1]

Vaginal Intercourse[2]

First Degree Rape [GS 14-27.2(2), Class B1 felony] (SOR)

Vaginal intercourse by force and without consent and (a) with use of a weapon, (b) inflicting serious injury, or (c) aided by others.

Second Degree Rape [GS 14-27.3(a), Class C felony] (SOR)

Vaginal intercourse (1) by force and without consent [note: no injury required], or (2) with a victim whom the perpetrator knows is mentally disabled, mentally incapacitated or physically helpless [note: no force or lack of consent required].

Other Sexual Contact

First Degree Sexual Offense [GS 14-27.4(a)(2), Class B1 felony] (SOR)

Sexual acts[3] (not vaginal intercourse) by force and without consent and (a) with use of a weapon, (b) inflicting serious injury, or (c) aided by others.

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[1] Defenses: Marriage is not a defense to forcible sexual acts (GS 14-27.8), nor is intoxication (see State v. Boone, 307 NC 198, 297 SE2d 585 (1982)).

[2] Vaginal intercourse is defined by case law as the slightest penetration of the female sex organ by the male sex organ. State v. Summers, 92 NC App. 453, 374 SE2d 631 (1988), cert. den., 324 NC 341, 378 SE2d 806 (1989).

[3] "Sexual act" is defined by GS 14-27.1(4) as "cunnilingus, fellatio, analingus, or anal intercourse," as well as "penetration, however slight, by any object into the genital or anal opening of another person's body."

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Second Degree Sexual Offense [GS 14-27.4(a)(1), Class C felony] (SOR)
Sexual acts (not vaginal intercourse) by force and without consent.

Second Degree Sexual Offense [GS 14-27.5, Class C felony] (SOR)
Sexual acts (not vaginal intercourse) with victim who the perpetrator knows is mentally disabled, mentally incapacitated or physically helpless [note: no force or lack of consent required].

Sexual Battery [GS 14-27.5(A)(a)(1), Class A1 misdemeanor] (i.e., "forced fondling")
Touching the sexual organ, anus, breast, groin, or buttocks of another directly or through clothing for the purpose of sexual gratification or sexual abuse or using these body parts to touch another (a) by force and without consent [note: no injury required], or (b) with a victim whom the perpetrator knows is mentally disabled, mentally incapacitated, or physically helpless [note: no force or lack of consent required].

STATUTORY RAPE & RELATED STATUTORY SEX CRIMES

A note on defenses to statutory rape and related sex crimes: Consent is no defense, nor is mistake of age a defense to the following statutory sex crimes in NC. However, marriage is generally a defense. The "age of consent" to have sexual intercourse in North Carolina is 16. The age of marriage in North Carolina is 18, although parental or judicial consent may be given for minors aged 14-17 to marry.

First Degree Rape [GS 14-27.2(1), Class B1 felony] (SOR)
Vaginal intercourse with victim under age 13 by defendant at least age 12 and 4 years older.

First Degree Sexual Offense [GS 14-27.4(a)(1), Class B1 felony] (SOR)
Sexual acts (not vaginal intercourse) with victim under age 13 by defendant at least age 12 and 4 years older.

Statutory Rape by 13, 14 or 15 year old [GS 14-27.7A, Class B1 or C felony]
Vaginal intercourse or sexual act with 13, 14 or 15 year old by defendant 5 years older (Class C felony) or by defendant at least 6 years older (Class B1 felony).

Indecent Liberties with a Child (adult perpetrator) [GS 14-202.1, Class F felony] (SOR)
Indecent and lewd acts with a child under age 16 by a defendant at least 5 years older.

Intercourse and Sexual Offense with Certain Victims [GS14-27.7(a), Class E felony] (SOR)
Vaginal intercourse or sexual act by caretaker with a minor residing in the home, or by an agent of an institution or person having custody of a victim of any age.

Indecent Liberties with a Child (juvenile perpetrator) [GS 14-202.2, Class 1 misdemeanor]
Indecent and lewd acts by a defendant under age 16 with a victim at least 3 years younger than the defendant.

Indecent Liberties with a Student [GS 14-202.4, Class I felony or A1 misdemeanor]
Indecent and lewd acts by a teacher, administrator, coach, school safety officer or other school personnel with a student at the same school, when the perpetrator is 4 or more years older than the victim (Class I felony) or less than 4 years older (Class A1 misdemeanor).

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Intercourse and Sexual Offense with Certain Victims (schools) [GS14-27.7(b)]
Vaginal intercourse or sexual act by a teacher, administrator, coach, school safety officer or other school personnel with a student at the same school, when the perpetrator is 4 or more years older than the victim (Class G felony) or less than 4 years older (Class A1 misdemeanor).

Crime Against Nature [GS 14-177, Class I felony]
Oral sex, anal sex, sex with objects by unmarried persons, and bestiality.[4]

Incest Between Near Relatives [GS 14-178, Class F felony] (SOR)
"Carnal" intercourse with grandparent, parent or sibling.

Incest Between Uncle and Niece or Nephew and Aunt [GS 14-179, Class 1 misdemeanor]
"Carnal" intercourse between uncle and niece or nephew and aunt.

Bigamy [GS 14-183, Class I felony]
Any person being married who marries another.

Fornication and Adultery [GS 14-184, Class 2 misdemeanor]
Unmarried persons who have engaged in "lewd and lascivious" association or cohabitation together, or by a married person with another not that person's spouse.[5]

Opposite Sexes in Same Hotel Room [GS 14-186, Class 2 misdemeanor]
Opposite sexes occupying the same bedroom at a hotel for immoral purposes; or falsely registering as husband and wife at a hotel.

Computer Solicitation of a Child [GS 14-202.3, Class I felony]
Computer solicitation of a child for sexual purposes by a perpetrator at least 16 with a victim under age 16 and at least 3 years younger than the perpetrator.

Employing or Permitting a Minor to Assist in an Obscenity Offense
[GS 14-190.6, Class I felony] (SOR)
Intentionally hiring, employing or permitting a minor under age 16 to assist in or commit an obscenity offense under Article 26.[6]

First Degree Sexual Exploitation of a Minor [GS 14-190.16, Class D felony] (SOR)
Knowingly uses, coerces or facilitates a minor to engage in sexual activity for a live performance or visual representation, or records or duplicates such representation for sale.

Second Degree Sexual Exploitation of a Minor [GS 14-190.17, Class F felony] (SOR)
Knowingly distribute, record or duplicate material showing a minor engaging in sexual activity [no sale required].

Third Degree Sexual Exploitation of a Minor [GS 14-190.17A, Class I felony] (SOR)
Knowingly possessing material showing a minor engaging in sexual activity.

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[4] The sexual acts comprising "crimes against nature" and the limitation to unmarried persons are defined by case law. See *State v. Poe*, 40 N.C. App. 385, 252 S.E.2d 843, cert. den. 298 N.C. 303, 259 S.E.2nd 304 (1979), appeal dismissed 445 U.S. 947, 100 S.Ct. 1593, 63 L. Ed. 2d 782 (1980).
[5] The acts must involve habitual intercourse, not a single act only. *State v. Robinson*, 9 NC App. 433, 176 SE2d 253 (1970).
[6] Article 26 refers to "Offenses Against Public Morality and Decency" (see G.S. 14-177 through 14-202.4). Obscenity is generally defined as sexual acts conducted in a patently offensive way (see G.S. 14-190.1).

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Prostitution (Adult) [GS 14-204 and GS 14-204.1, Class 1 misdemeanor][7]
To engage in, procure, or facilitate the offering or receiving of the body for sexual intercourse for hire or to loiter in a public place for the purpose of prostitution.

Promoting Prostitution of a Minor [GS 14-190.18, Class D felony] (SOR)
Knowingly force, facilitate or supervise a minor to engage in prostitution.

Participating in the Prostitution of a Minor [GS 14-190.19, Class F felony] (SOR)
An adult who solicits or pays for a minor to participate in prostitution.

NON-PHYSICAL SEXUAL CONTACT

Peeping [GS 14-202] (SOR at higher felony levels)
Secretly peeping into a room occupied by another person [Class 1 misdemeanor]; while in possession of a recording device [Class A1 misdemeanor]; while using or installing a recording device to obtain an image of the other person for the purpose of gratifying sexual desires [Class I felony]. Secretly recording images of another person's body underneath or through that person's clothing for the purpose of viewing their body or undergarments without their consent [Class I felony]. Knowing possession of an image of a person created in violation of this statute [Class I felony] or distribution of such images [Class H felony].

Sexual Harassment [GS 14-395.1, Class 2 misdemeanor][8]
Sexual harassment by a lessor or the agent of a lessor of residential real property against a lessee or prospective lessee (eg, sexual harassment while applying for an apartment rental). The vast majority of sexual harassment cases are brought in civil court.

Stalking [GS 14-277.3]
To be willfully on more than one occasion in the presence of the victim without legal purpose with the intent to place the victim in fear of his or her safety or the safety of the victim's family or associates, or to cause the victim substantial emotional distress (Class A1 misdemeanor, unless in violation of a court order (Class H felony), or multiple stalking convictions (Class F felony)).

Telephone Harassment [GS 14-196, Class 2 misdemeanor]
Using threatening, profane, vulgar or lewd language in a telephonic communication, or repeatedly making calls for the purpose of abusing or harassing the person called.

Cyber Stalking [GS 14-196.3, Class 2 misdemeanor]
Use of electronic communication to threaten harm to the victim or victim's family or to harass the victim.

Indecent Exposure [GS 14-190.9, Class 2 misdemeanor]
Exposing one's private parts in a public place in the presence of another of the opposite sex.

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[7] This section defines prostitution as an act of vaginal intercourse and nothing else. See *State v. Richardson* (1983) 307 N.C. 692, 300 S.E.2d 379.
[8] Sexual harassment is usually addressed by civil, not criminal law.

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PHYSICAL ASSAULT [9]

Simple Assault [GS 14-33, Class 2 misdemeanor]
Assaulting the person of another.

Simple Assault [GS 14-33(c), Class A1 misdemeanor]
(1) Assault causing serious injury or by use of a deadly weapon; (2) male assaulting a female aged 18 or older; (3) assault of a child under age 12.

Domestic Abuse of Disabled or Elder Adults [GS 14-32.3(a)]
Assault, failure to provide medical or hygienic care, or confinement or restraint of a disabled or elder adult under cruel or unsafe conditions causing mental or physical injury (Class H felony) or causing serious injury (Class F felony).

STRUCTURED SENTENCING IN NORTH CAROLINA (see GS 15A-1340.17)

FELONY LEVEL	SENTENCING RANGE (months in prison)
A	Life without parole – Death
B1	144 – Life without Parole
B2	94-210
C	44-210
D	38-183
E	15-74
F	10-49
G	8-36
H	4-25
I	3-12

MISDEMEANOR LEVEL	SENTENCING RANGE (days in jail)
A 1	1-150
1	1-120
2	1-60
3	1-20

Note: Class E felonies and lower grades of punishment permit intermediate and community punishment (i.e., less than full incarceration).

[9] Assault offenses are numerous, including multiple misdemeanor and felony charges, and habitual offender and injury and weapons related enhancements.

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THE DUTY TO REPORT SEXUAL VIOLENCE IN NORTH CAROLINA

Below is a general description of the legal reporting requirements related to sexual violence cases in North Carolina. For questions on specific cases, you should review the statutory provisions in their exact language and seek legal advice if necessary. Victim service agencies and licensed professionals may have developed broader reporting guidelines separate and apart from the statutory requirements.

As a victim or survivor or a concerned family member or friend, you may wish to ask service providers (e.g., law enforcement or counselors) if they intend to or are obligated to report your case to a government agency before you discuss the case with them. While you may have already reported or wish to report the case to law enforcement or Child Protective Services, once the report is made an investigation is usually required.

(1) ***Use of Weapons***. Medical personnel have a legal duty to report to the police in the jurisdiction where the patient is being treated, cases involving injuries caused by weapons (guns in every case, knives and sharp objects in suspected criminal cases), poisoning (in every case, and grave bodily harm or illness (due to suspected criminal violence). [NC Gen. Stat. 90-21.20]

(2) ***Disabled Adults***. Everyone has a legal duty to report suspected abuse, neglect or exploitation of disabled adults (age 18 and over) by their caretaker to the Dept. of Social Services. The disability can be mental or physical, as long as it prevents the adult from obtaining essential services. [NC Gen. Stat. 108A-102]

(3) ***School Property***. A principal has a legal duty to report certain suspected criminal acts occurring on school property to the police, including sexual assault (regardless of the age of the victim or perpetrator). [NC Gen. Stat. 115C-288(g)]

(4) ***Minors***.

(a) Everyone has a legal duty to report suspected child abuse and neglect (a child is an unmarried victim under age 18) by a "parent, guardian, custodian or caretaker" to the Dept. of Social Services Child Protective Services [NC Gen. Stat. 7B-301 and 115C-400]. This statute is limited to abuse by caretakers in its reference to NC G.S. 7B-101. There is no duty to report non-caretaker child abuse, and the willingness of CPS to investigate and provide services for cases of non-caretaker abuse varies throughout the state.

(b) In addition, medical professionals certified by a District Court judge have the special right to retain custody of a minor suspected of having been abused [NC Gen. Stat. 7B-308]. This duty overrides all privileges, including doctor-patient privilege, but not attorney-client privilege. [NC Gen. Stat. 7B-310].

The special emphasis on caretaker abuse is based on the recognition that victims are particularly vulnerable and in need of outside assistance in these cases. It is important for sexual violence victims and survivors and those who care about them to be aware of these reporting laws. In addition, service professionals should promote understanding of the reporting requirements and what the process that occurs once a report is made.

For more information on sexual violence issues, please see www.nccasa.org or contact the North Carolina Coalition Against Sexual Assault (NCCASA) at (919) 431-0995 or toll-free (888) 737-CASA.

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APPENDIX 2

MYTHS ABOUT VAW THAT AFFECT HEALTH CARE

There are many myths related to domestic and sexual violence that are commonplace in our society. Some of these myths are so widespread and often repeated that they are simply accepted as true without being challenged -- they simply become part of our cultural psyche. It is important to recognize the difference between myth and reality in order to challenge our own and others' assumptions about domestic and sexual violence, especially when those assumptions affect how health care is provided and whether a battered or sexually violated woman feels comfortable seeking assistance. Identifying and confronting mistaken beliefs that accompany these myths can help to ensure the best health care is provided and received by all.

Domestic violence myths that affect health care

Myth	Reality	Clinical Implications
Violence among family members is a criminal justice matter, not a health concern.	Domestic violence is not a private matter. It is a crime and a public health problem that must be identified and addressed.	Many conditions such as depression, chronic abdominal pains, low birth weight babies, and substance abuse are frequently treated without considering the cause as abuse. Identify the root cause of a woman's symptoms; avoid inappropriate or harmful treatment; and appropriately help her.
Some people deserve to be hit.	No one deserves to be abused. Period. The only person responsible for the abuse is the abuser. Physical violence, even among family members, is wrong and against the law.	It is important to document violent episodes in the patient's own words and withhold judgments about the relationship. Document actions using behavioral descriptions, not interpretations or what led up to the situation ("Partner kicked client" rather than "Client angry at partner, argued over money"). Regardless of who initiated an argument, violence is never the right or best solution.
The victim can stop the violence by changing her behavior.	Because violence is a behavioral choice of the abuser, the victim cannot control his behavior. Even so, many victims blame themselves for the abuse.	Tell a battered woman that the abuse is not her fault and that she does not deserve to be battered. Explain to her that the batterer is responsible for his own behavior.

Myth	Reality	Clinical Implications
Battering occurs only among women with lower socio-economic status and women of color.	Battering occurs in all social classes, cultures, races, ethnicities, and religions. However, battering may be less evident among the affluent who have better access to private physicians, counselors, or attorneys.	Screen all women for domestic violence regardless of socio-economic status, race, culture, and other socio-demographic characteristics.
Abused spouses can end the violence by divorcing their abuser.	According to a national survey, women who were divorced or separated were more than 11 times more likely to be violently victimized by an intimate than women who were married. In many cases, the separation process brings on an increased level of harassment and abuse. Many partner homicides occur when the woman leaves her partner.	Be aware that leaving the abuser can be the most dangerous period for a battered woman. Encourage the woman to evaluate the dangerousness of her situation. Help identify options suited for her immediate situation. Allow her to make her own decision about leaving since she knows the situation best.
Women are just as violent as men in their relationships.	At least 95% of serious partner assaults are committed against women. Male physical abuse against a woman is usually more severe and more frequent than that of a woman against a man. Also, women often resort to physical violence in self-defense rather than as a way to control or manipulate.	Avoid dismissing a situation that appears to be a two-way fight in cases when a woman admits to using physical force against her partner. Rather, get the details about the circumstances to make sure that the event is not part of a cycle of battering.
Batterers are abusive in other relationships.	Although many batterers are violent with other people as well, most batterers are not violent in other relationships.	Believe the woman when she discloses battering. Avoid making judgements of what is and is not possible in a relationship based on assessment of the partner while in public.

Myth	Reality	Clinical Implications
Domestic violence is usually a one-time event.	Domestic violence is a pattern of coercive behavior that occurs over time.	Provide information to women about the cycle of violence and the nature of battering. Informing women that battering consists of repetitive episodes of abuse that may increase in severity can perhaps help them identify at an earlier stage they are being battered.
Battered women stay in violent relationships. If it were that bad, she would just leave.	Most battered women leave their partner at least once. Many leave the batterer permanently. There are many reasons why women may not leave, but not leaving does not mean that the situation is okay or that the victim wants to be abused. Also, leaving can be dangerous. The most dangerous time for a woman being abused is when she tries to leave	Help a battered woman to identify her options and to determine if leaving is appropriate. Do not dictate what the woman should do. Rather, support her decisions.
Men who batter are often good fathers.	An estimated 87% of children in homes with domestic violence witness the abuse. Children are hurt cognitively, psychologically and in their social development by seeing their father batter their mother. As many as 60% of the children whose mothers are battered are also abused.	Pay attention to cues or symptoms that might indicate child abuse or neglect if you determine a female client is a battered woman. Report child abuse to Department of Social Services. Discuss with the client the effects on children of being exposed to violence or being abused. Support legislation that permits history of domestic violence to be considered in custody decisions.

Myth	Reality	Clinical Implications
Violence only occurs between heterosexual partners.	Battering occurs between partners of the opposite sex and between same sex partners. However, same sex partners are less likely to seek help because of homophobia. In addition, fewer services exist for battered gays and lesbians.	Be sensitive to the potential needs of lesbians and gay men. Use language that does not presume the gender of the client's partner.
Being pregnant protects a woman from battering.	Although studies have found different conclusions, in some cases pregnancy seems to increase the risk for battering. Twenty-five to forty-five percent of battered women are battered during pregnancy (Helton 1985; Gazmararian, et al., 1996).	Screen all pregnant women for abuse several times throughout the pregnancy. Domestic violence screening is an important component of prenatal care.
Alcohol and drug abuse cause battering.	Although an association between domestic violence and substance abuse has been found, alcohol or drugs are not sole determinants of whether a man becomes abusive when intoxicated. Abstinence from substance use, alone, will not remove the threat of violence. Women often use alcohol and other substances as a way of coping with their situation.	Do not attribute a batterer's behavior to his substance use. Be aware that if a woman has a substance abuse problem, battering may be an underlying cause. In addition, when referring to services, the provider should refer a battered woman both to a substance abuse treatment program as well as to a domestic violence program.

Sexual violence myths that affect health care

Myth	Reality	Clinical Implications
Men rape women because they are sexually aroused or have been sexually deprived	The motives for rape are complex but often include hostility against women, a desire to exert power and control, the desire to humiliate and degrade, and in some cases the desire to inflict pain. Rape is not about sexual gratification – it is a violent assault that is acted out sexually. The vast majority of men never rape, yet sexual arousal is a strong human urge. Claiming that men cannot control sexual urges is unfair to men and inaccurate. Seeing rape as a response to women sexually arousing and depriving men shifts the focus to victims' behaviors rather than holding rapists accountable for their actions.	When asking clients about sexual violence, remain calm, nonjudgmental, and understanding. Never ask the client what she did that led to the rape. Do tell the client that no one is ever responsible for being a victim; rather the sexually violent person is always responsible. Ask about what happened, but accept that many clients do not want to disclose the entire story. Always offer assistance and referrals, but clarify that she has the right to decide what she wants to do.
Only certain kinds of women get raped or sexually assaulted – it can't happen to me.	Sexual violence does not discriminate, but it does affect people of all ages, genders, sexual orientations, races, and economic classes. Rape is about power and control, not about how attractive the victim is or how the victim behaves.	Screen all clients for sexual violence, regardless of their personal characteristics. Educate all clients about sexual violence, not just the ones who disclose by displaying posters and providing verbal and written information including brochures the client can keep. Reaffirm that the person using sexual violence is always responsible for the assault or rape.

Myth	Reality	Clinical Implications
Acquaintance rape is not as serious as stranger rape.	Acquaintance rape is serious and is not about miscommunication, but rather about the rapist believing they have the right to control the actions of the victims to get what they want. Acquaintance rape can be just as violent as stranger rape, and the legal system does not distinguish between the two. Acquaintance rape causes similar trauma as stranger rape because victims lose control over their own mind, body, and spirit regardless of perpetrator.	When asking clients about sexual assault and rape, do not react differently simply based on whether the client knows the person who sexually violated them. Always ask about the effects of the sexual violence and offer appropriate assistance and referrals. Do not skip this step by assuming that the acquaintance rape will not cause serious trauma and other adverse effects.
Rapes are "spur-of –the-moment acts committed by strangers in dark alleys at night.	Most rapes are planned and occur in one's own home. Between 75-80% of rapes are committed by someone the victim knows, including a partner, friend, acquaintance, or family member. Most safety tips focus on stranger rape even though these are the minority of cases. Victims often carry even more self-blame, guilty feelings and shame when they are sexually violated by someone they know.	When asking clients about sexual assault and rape, take note of self-blame statements and provide reassurance and education. Reassure the client that dating or knowing another person does not take away from the right to control one's own body and make personal decisions about sex. Even if a rape occurs while dating, it is still rape, and the rapist is always responsible when using violence to control.
Most rapes are committed by black men raping white women	Men who rape come from all races, ethnicities, and social classes. Men who rape usually rape women from the same race, ethnicity, and social class as themselves – 80-90% of all violent crimes against women are committed by someone	

Myth	Reality	Clinical Implications
	of the same racial background (US DOJ, 1994). When rape does occur against someone of a different race, it is more often a white assailant raping a woman of color.	
A person cannot be raped by a partner or spouse.	Marital and date rapes are crimes. Everyone has the right to control one's own body and decline sex at any time, regardless of marriage. Marriage does not grant permanent sexual access to a spouse and a dating relationship does not grant sexual rights over a partner.	Ask all clients about sexual violence, regardless of marital or relationship status. Educate clients about their right to decline sex at their own discretion.
Men who rape are "sick" or "insane."	Men who rape are most often ordinary, everyday guys. Only a tiny percentage of men who rape can be considered clinically insane, yet these are the cases sensationalized by the media. This suggests that rapists fit a certain profile and are easy to spot, when in fact, they are indistinguishable from other men. The main difference between men who do and do not rape is their attitude towards women and the belief in their right of sexual access, hostility, and contempt towards women.	When educating clients about rape, discuss the fact that it is not easy to spot a potential rapist.

Myth	Reality	Clinical Implications
Women lie about being raped or use it to get even with their boyfriends.	Women do not lie about being raped; in fact, rape is the most underreported crime. About as many women make false reports about rape as in other felonies (only about 2%). In reality, most victims never tell anyone about the rape. Reporting is difficult, painful, and embarrassing and can cause a great deal of fear due to the scrutiny and suspicion victims often face when they tell their stories. As many as 98% of victims will never have their attacker caught, tried, or imprisoned.	Always believe a client who discloses being sexually victimized. Provide empathy and support and ask about the facts of what happened. Do not question the veracity of the victim's claim. Acknowledge the bravery required for disclosure and accept the client's decision about pursuing a legal case. Never try to talk a client into decisions about prosecution or collecting evidence, but rather provide information, options, and support regardless of the client's decision.

APPENDIX 3

DOMESTIC AND SEXUAL VIOLENCE RESOURCES

Provided below are several national and statewide organiza tions provide resources, assistance, information, and other services related to domestic and/or sexual violence. Inclusion of these organizations in this resource list does not imply endorsement by the North Carolina Department of Health and Human Services or any of its offices, including the Injury and Violence Prevention Branch.

FEDERAL ORGANIZATIONS

Centers for Disease Control and Prevention (CDC)
National Center for Injury Prevention and Control
Division of Violence Prevention
Mailstop K60
4770 Buford Highway NE
Atlanta, GA 30341-3724
Telephone: (770) 488-4362
Fax: (770) 488-4349
Email: DVPINFO@cdc.gov
Web: http://www.cdc.gov/ncipc/dvp/dvp.htm

The National Center for Injury Prevention and Control (NCIPC) guides national efforts to reduce the incidence, severity, and adverse outcomes of intentional and unintentional injuries in the United States. As the lead federal agency for injury prevention, NCIPC works closely with other federal agencies and national, state, and local organizations to reduce injury, disability, and premature death. The Division of Violence Prevention in CDC's Injury Center has the following priority areas for violence prevention: child maltreatment, intimate partner violence, sexual violence, suicide, and youth violence.

CDC provides leadership in developing intimate partner violence (IPV) prevention programs and evaluating their effectiveness. CDC's research on preventing IPV complements the work of other federal agencies to broaden the understanding of causes of violence and ways to prevent it. Using a public health approach to violence prevention, the CDC works to help define the problem, identify risk and protective factors, develop and test prevention strategies, and ensure widespread adoption. The website includes fact sheets, information on programs and activities, research projects, funding, and other related information.

National Women's Health Information Center (NWHIC)

National Women's Health Information Center (NWHIC)
Office on Women's Health
Department of Health and Human Services
200 Independence Avenue, SW
Room 730B Washington, DC 20201
Telephone: (202) 690-7650
Fax: (202) 205-2631
Web: http://www.4woman.gov/owh
http://www.4woman.gov/about

The National Women's Health Information Center (NWHIC) is the Office on Women's Health's clearinghouse for women's health information. The NWHIC provides a gateway to the vast array of Federal and other women's health information resources. This site provides links to a wide variety of women's health-related material developed by the Department of Health and Human Services, other Federal agencies, and private sector resources.

U.S. Department of Justice
Violence Against Women Office
810 7th Street, NW
Washington, DC 20531
Telephone (202) 307-6026
Fax (202) 307-3911
TTY (202) 307-2277
Web: http://www.ojp.usdoj.gov/vawo/

Since its inception in 1995, the Violence Against Women Office, now the Office on Violence Against Women (the Office) has handled the Department of Justice's legal and policy issues regarding violence against women, coordinated Departmental efforts, provided national and international leadership, received international visitors interested in learning about the federal government's role in addressing violence against women, and responded to requests for information regarding violence against women. The Office works closely with other components of OJP (Office of Justice Programs), the Office of Legal Policy, the Office of Legislative Affairs, the Office of Intergovernmental Affairs, the Immigration and Naturalization Office, the Executive Office for United States Attorneys, U.S. Attorneys' Offices, and state, tribal and local jurisdictions to imple-

ment the mandates of the Violence Against Women Act and subsequent legislation. Part of the site has information specifically about sexual violence: http://www.ojp.usdoj.gov/vawo/SexAssaultInfo.htm

Office for Victims of Crime (OVC)

U. S. Department of Justice, Office for Victims of Crime
Office for Victims of Crime Resource Center
National Criminal Justice Reference Service
P.O. Box 6000
Rockville, MD 20849-6000
Telephone: (800) 627–6872
TTY: (877) 712-9279
Web: http://www.ojp.usdoj.gov/ovc/

The Office for Victims of Crime (OVC) was established by the 1984 Victims of Crime Act (VOCA) to oversee diverse programs that benefit victims of crime. OVC provides substantial funding to state victim assistance and compensation programs——the lifeline services that help victims to heal. The agency supports trainings designed to educate criminal justice and allied professionals regarding the rights and needs of crime victims. OVC also sponsors an annual event in April to commemorate National Crime Victims Rights Week (NCVRW).

Communities Against Violence Network

Communities Against Violence Network
Web: http://www.cavnet2.org

CAVNET started as a diverse network of professionals and advocates working in the areas of domestic violence, stalking, sexual assault, and rape. Started by Marc Dubin (a former prosecutor and former Special Counsel to the Violence Against Women Office at the U.S. Department of Justice), CAVNET began as a listserv to allow this network of individuals to share resources, CAVNET rapidly grew into a non-profit, information sharing network that included many new and different areas, including violence between gay and lesbian partners, violence against persons with disabilities, and school violence among others. With the assistance of several national organizations and individuals, CAVNET continues to

develop and share resources. Communities Against Violence Network (CAVNET) provides an interactive online database of information; local, national, and international resources and agencies searchable by location, an international network of professionals, including a speakers bureau; and real-time voice conferencing with professionals and survivors, from all over the world, using the Internet. Some information requires membership to access.

The Family Violence Prevention Fund

The Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
Toll free: (888) Rx-ABUSE (792-2873)
Telephone: (415) 252-8900
Fax: (415) 252-8991
Web: http://www.endabuse.org

The Family Violence Prevention Fund is a national non-profit organization most noted for it's national public education campaign "There's No Excuse for Domestic Violence." The Fund also has a National Health Initiative on Domestic Violence (http://www.endabuse.org/health) that works to train health care providers throughout the nation to recognize signs of abuse and to intervene effectively to help battered women. This is achieved by providing resource and training materials, clinical tools, technical assistance, information and referrals, training and models for local, state, and national health policy-making for those interested in improving healthcare's response to domestic violence.

Hallmarks of this initiative include: the Ten-State Pilot Health Care Response to Domestic Violence program working to develop and implement state wide plans for a comprehensive health care system response to domestic violence; and the FVPF's Health Resource Center on Domestic Violence, which acts as the nation's clearinghouse for information on the health care response to domestic violence. Other projects include the Judicial Education Project, the Child Welfare Project, the National Workplace Resource Center on Domestic Violence, and the Battered Immigrant Women's Rights Project. Their Health Resource Center on Domestic Violence Provides resource and training material, technical assistance, information and referrals, and models for local, state and national health policymakers to support those interested in developing a comprehensive health care response.

Minnesota Center Against Violence and Abuse

Minnesota Center Against Violence and Abuse
School of Social Work
University of Minnesota
105 Peters Hall, 1404 Gortner Avenue
St. Paul, Minnesota 55108-6142
Telephone: (612) 624-0721
Fax: (612) 625-4288
Web: http://www.mincava.umn.edu

The Minnesota Center Against Violence and Abuse (MINCAVA) is an electronic clearinghouse located in the School of Social Work of the University of Minnesota with educational resources about all types of violence, including higher education syllabi, published research, funding sources, upcoming training events, individuals or organizations which serve as resources, and searchable databases with over 700 training manuals, videos and other education resources.

MINCAVA is also part of a cooperative project - the Violence Against Women Online Resources - between the Center and the United States Department of Justice, Office of Justice Programs, Violence Against Women Office. This website http://www.vaw.umn.edu/ provides law, criminal justice, and social service professionals with current information on interventions to stop violence against women.

National Center on Domestic and Sexual Violence

National Center on Domestic and Sexual Violence
7800 Shoal Creek Blvd., Suite 120-N
Austin, TX 78757
Telephone: (512) 407-9020
Fax: (512) 407-9022
Web: http://www.ncdsv.org

This program was founded in 1998 as the National Training Center on Domestic and Sexual Violence in order to develop and provide innovative training and consultation, to influence policy, and promotes collaboration and diversity in working to end domestic and sexual violence. NTCDV has a staff of nationally known trainers and sponsors national and regional conferences.

Renamed the National Center on Domestic and Sexual Violence in 2003, the organization helps a myriad of professionals who work with victims and perpetrators; law enforcement; criminal justice professionals such as prosecutors, judges and probation officers; health care professionals including emergency response teams, nurses and doctors; domestic violence and sexual assault advocates and service providers; and counselors and social workers. In addition to these professionals, NCDSV also works with local, state and federal agencies; state and national organizations; educators, researchers, faith community leaders, media, community leaders, elected officials, policymakers, and all branches of the military.

National Clearinghouse on Child Abuse and Neglect Information

National Clearinghouse on Child Abuse and Neglect Information
330 C Street SW
Washington, DC 20447
Telephone: (800) 394-3366
Web: http://www.calib.com/nccanch
Provides child abuse and neglect and child welfare resources.

National Coalition Against Domestic Violence

National Coalition Against Domestic Violence
For public policy or legislative issues:
1633 Q Street NW, Suite 210
Washington, DC 20009
Telephone: (202) 745-1211
Fax: (202) 745-0088
For membership and all other questions:
Post Office Box 18749
Denver, CO 80218-0749
Telephone: (303) 839-1852
Fax: (303) 831-9251
Email: sbaca@ncadv.org
Web: http://www.ncadv.org

The National Coalition Against Domestic Violence (NCADV) is a membership organization of domestic violence coalitions and service programs. The NCADV's work includes coalition building at the local, state, regional and national levels; support for the provision of community-based, non-violent alternatives - such as safe home and shelter programs - for battered women and their

children; public education and technical assistance; policy development and innovative legislation; focus on the leadership of NCADV's caucuses and task forces developed to represent the concerns of organizationally under represented groups; and efforts to eradicate social conditions which contribute to violence against women and children. The NCADV does not provide direct services to battered women and their children.

National Domestic Violence Hotline

National Domestic Violence Hotline
PO Box 161810
Austin, TX 78716
Telephone hotline: (800) 779-SAFE (7233)
TTY: (800) 787-3224
Administrative: (512) 453-8117
Fax: (512) 453-8541
Web: http://www.ndvh.org

The Hotline provides 24-hour, toll-free crisis intervention line, referrals to domestic violence and other emergency shelters and programs, and information about assistance networks and other resources to learn more about domestic violence. Informational materials on domestic violence and sexual assault, including national statistics are available. Use the administrative number to request materials.

The National Domestic Violence Hotline connects individuals to help in their area using a nationwide database that includes detailed information on domestic violence shelters, other emergency shelters, legal advocacy and assistance programs, and social service programs. Help is available in English or Spanish, 24 hours a day, seven days each week. Interpreters are available to translate an additional 139 languages.

***National Electronic Network on Violence Against Women* (VAWnet)**

National Electronic Network on Violence Against Women (VAWnet)
National Resource Center on Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112-2791
Telephone: (800) 537-2238,
TTY: (800) 553-2508
Web: http://www.vawnet.org

VAWnet provides online resources on sexual and domestic violence and is a project of the Pennsylvania Coalition Against Domestic Violence (PCADV) and the National Resource Center on Domestic Violence (NRCDV) and is supported by a grant from the National Center on Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC). VAWnet is guided by: a firm commitment to support the safety, justice and autonomy of all victims and survivors of domestic and sexual violence; a highly interactive and inclusive process to assure the perspective of marginalized individuals and communities; a deep awareness of the special concerns of advocates and activists working to end violence against women, and; a thorough understanding of the public interest served by domestic violence and sexual assault organizations working individually and collectively.

***National Network to End Domestic Violence* (NNEDV)**

National Network to End Domestic Violence (NNEDV)
660 Pennsylvania Avenue SE, Suite 303
Washington, DC 20003
Telephone: (202) 543-5566
Web: http://www.nnedv.org

The NNEDV is dedicated to creating a social, political and economic environment in which violence against women no longer exists through policy development, coalition-building, public education, and technical assistance to programs serving battered women and their children.

Through the National Network to End Domestic Violence Fund, the Network provides training, technical assistance and funds to domestic violence advocates.

National Resource Center on Domestic Violence

National Resource Center on Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112-2778
Telephone: (800) 537-2238
TTY: (800) 553-2508
Fax: (717) 545-9456
Web: http://www.nrcdv.org/

The National Resource Center on Domestic Violence (NRC) provides comprehensive information and resources, policy development and technical assistance designed to enhance community response to and prevention of domestic violence. There are 40 NRC publications, as well as NRC project descriptions and project publication lists available via VAWnet. These NRC projects include the Building Comprehensive Solutions to Domestic Violence Initiative, the Public Education Technical Assistance Project, and VAWnet.

National Sexual Violence Resource Center

National Sexual Violence Resource Center
Pennsylvania Coalition Against Rape
123 North Enola Drive
Enola, PA 17025
Telephone: (717) 909-0710
Toll Free: (877) 739-3895
TTY: (717) 909-0715
Fax: (717) 909-0714
Web: http://www.nsvrc.org

The National Sexual Violence Resource Center (NSVRC) opened in July 2000 as a national information and resource hub relating to all aspects of sexual violence. A project of the Pennsylvania Coalition Against Rape, the oldest and one of the largest state sexual assault coalitions, the NSVRC is funded through a grant from the Centers For Disease Control and Prevention's Division of Violence Prevention. Activities include building capacity for programs serving survivors of sexual assault, providing information and technical assistance, and working on policy development.

The National Sexual Violence Resource Center (NSVRC) is a comprehensive collection and distribution center for information, statistics, and resources related to sexual violence. It serves as a resource for state, territory, and tribal anti-sexual assault coalitions, rape crisis centers, allied organizations, community projects, policymakers, government entities, media, educators, health care providers and others working to address and eliminate sexual assault. The NSVRC does not provide direct services to sexual assault victims but rather supports those who do, such as coalitions, rape crisis centers, national, state and local agencies and allied programs. The NSVRC refers requests for direct victim's services to the appropriate state coalition and to a local program conveniently located to the caller.

Rape, Abuse & Incest National Network (RAINN)

Rape, Abuse & Incest National Network (RAINN)
Hotline: (800) 656-HOPE
Web: http://www.rainn.org

RAINN is the country's only national rape hotline. RAINN works as a call-routing system. When an individual calls RAINN a computer reads the area code and first three digits of their phone number and routes the call to the nearest member rape crisis center.

The Stalking Resource Center

The Stalking Resource Center
c/o National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington, DC 20036
Telephone: (202) 467-8700
Fax: (202) 467-8701
Web: http://www.ncvc.org

The Stalking Resource Center is a project of the National Center for Victims of Crime, funded through the Violence Against Women Office, U.S. Department of Justice. The Stalking Resource Center has established a clearinghouse of information and resources to inform and support local, multi disciplinary stalking response programs nationwide; developed a national peer-to-peer exchange program to provide targeted, on-site problem-solving assistance to VAWO Arrest grantee jurisdictions; and organized a nationwide network of local practitioners representing VAWO grantee jurisdictions to support their multi disciplinary approaches to stalking.

NATIONAL MEDICAL RESOURCES

American College of Obstetricians and Gynecologists (ACOG)

American College of Obstetricians and Gynecologists (ACOG)
Violence Against Women
409 12th Street SW
Washington, DC 20024-2188
Telephone: (202) 638-5577
Web: http://www.acog.org
Web: http://www.acog.org/from_home/departments/dept_web.cfm?recno=17 (direct to violence against women page)

ACOG is the nation's leading group of professional providing health care for women. ACOG is dedicated to the advancement of women's health through education, advocacy, practice, and research. The Violence Against Women homepage includes information, fact sheets, screening tools, protocols for clinical response, and many other resources targeting physicians and other health care providers.

American Medical Association

American Medical Association
515 N. State Street
Chicago, IL 60610
Telephone: (800) 621-8335
E-mail: violence@ama-assn.org
Web: http://www.ama-assn.org
http://www.ama-assn.org/ama/pub/category/3242.html (direct to violence prevention)

The American Medical Association provides information and guidelines on several violence issues, including domestic and sexual violence and youth violence. The website provides policy recommendations, ethical guidelines, tools, research descriptions and case studies, and many other resources that target physicians and other health care providers.

NATIONAL LAW ENFORCEMENT AND JUSTICE ORGANIZATIONS

American Bar Association

American Bar Association
Commission on Domestic Violence
740 15th Street NW, 9th Floor
Washington, DC 20005-1022
Telephone: 202.662.1737/1744
fax: 202.662.1594
Web http://www.abanet.org/domviol/home.html

The members of the Commission help resolve problems in family law, criminal law, victims' and individuals' rights, judicial administration, tort and civil rights litigation, and immigration law. Representatives of other professional organizations serve on the Commission to help develop a national domestic violence agenda as well as to enhance existing policies and solutions in the constantly changing fields of state and federal domestic violence law. Areas of focus include: policies, training materials, legal briefs, and sample legal forms relevant to domestic violence legal issues and proceedings.

Battered Women's Justice Project

Battered Women's Justice Project
phone: 800-903-0111
Extension 1 Criminal Justice
Extension 2 Civil Justice
Extension 3 Defense
fax: 218-722-0779
email: bwjp@aol.com
Web http://www.bwjp.org

The Battered Women's Justice Project consists of three sections, criminal justice, civil justice and the defense of battered women charged with crimes. Provides training, technical assistance, and other resources on civil and criminal justice issues related to domestic violence through a partnership of three nationally-recognized organziations:
Criminal Justice Center
Minnesota Program Development, Inc.
2104 4th Avenue, Suite B
Minneapolis, MN 55404
TTY (612) 824-8768
Addresses the criminal justice system's response to domestic violence, including the development of batterers' programs.
Civil Justice Center

National Center for Victims of Crime

National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington, DC 20036
Telephone: (202) 467-8700

Fax: (202) 467-8701
Web: http://www.ncvc.org

Although not violence against women exclusive, the National Center for Victims of Crime (NCVC) is a national non-profit organization that provides public policy advocacy; training and technical assistance to victim service organizations, counselors, attorneys, criminal justice agencies, and allied professionals; operates a toll-free hotline for crime victims; and a virtual library containing publications, current statistics with references, a list of recommended readings, and bibliographies.

NATIONAL RESOURCES FOR SPECIFIC POPULATIONS OR TOPICS

National Organization for Women (NOW) Legal Defense and Education Fund

National Organization for Women (NOW) Legal Defense and Education Fund
395 Hudson Street
New York, NY 10014
Telephone: (212) 925-6635
Web: http://www.nowldef.org

Pursues equality for women and girls in the workplace, schools, family, and courts through litigation, education, public information programs, technical assistance to Congress and state legislatures, media strategies, fact sheets, and coalition-building.

Asian and Pacific Islander Institute on Domestic Violence

Asian and Pacific Islander Institute on Domestic Violence
942 Market Street, 2nd Floor
San Francisco, CA 94102
Telephone: (425) 954-9964
Fax: (415) 954-9999
Web: http://www.apiahf.org/apidvinstitute/default.htm

The Asian and Pacific Islander Institute on Domestic Violence is a national network that works to raise awareness in Asian & Pacific Islander communities about domestic violence; expand leadership and expertise within Asian & Pacific Islander communities about prevention, intervention, advocacy and research; and promote culturally relevant programming, research, and advocacy by identifying promising practices.

Center for the Prevention of Domestic and Sexual Violence

Center for the Prevention of Domestic and Sexual Violence
2400 45th Street, Suite 10
Seattle, WA 98103
Telephone: (206) 634-1903
Fax: (206) 634-0115
Web: http://www.cpsdv.org

The Center for the Prevention of Domestic and Sexual Violence is an interreligious educational resource addressing issues of sexual and domestic violence. Their goal is to engage religious leaders in the task of ending abuse, and to prepare human services profession-

als to recognize and attend to the religious questions and issues that may arise in their work with women and children in crisis.

Center for Research on Women with Disabilities

Center for Research on Women with Disabilities
3440 Richmond Avenue, Suite B
Houston, Texas 77046
Telephone: (713) 960-0505
Toll Free: (800) 44-CROWD
Fax: 713-961-3555
Email: crowd@bcm.tmc.edu
Web: http://www.bcm.edu/crowd/index.htm

The Center for Research on Women with Disabilities (CROWD) is a research center that focuses on issues related to health, aging, civil rights, abuse, and independent living. CROWD's purpose is to promote, develop, and disseminate information to expand the life choices of women with disabilities so that they may fully participate in community life. More specifically, researchers develop and evaluate models for interventions to address specific problems effecting women with disabilities.

Corporate Alliance to End Partner Violence

Corporate Alliance to End Partner Violence
2416 E. Washington Street, Suite E Bloomington, IL 61704-4472
Telephone: (309) 664-0667
Fax: (309) 664-0747
Web: http://www.caepv.org

The Corporate Alliance to End Partner Violence (CAEPV) is a national non-profit alliance of corporations and businesses throughout the U.S. and Canada, united to educate and aid in the prevention of partner violence. CAEPV provides technical assistance and materials to help corporations and businesses address domestic violence in their workplaces.

The Institute on Domestic Violence in the African American Community

The Institute on Domestic Violence in the African American Community
University of Minnesota/School of Social Work
290 Peters Hall
1404 Gortner Ave.
St. Paul, MN 55108-6142
Telephone: (877) 643-8222
Fax: (612) 624-9201
Web: http://www.dvinstitute.org

The Institute on Domestic Violence in the African American Community seeks to create a community of African American scholars and practitioners working in the area of violence in the African American community, further scholarship in the area of African American violence, raise community consciousness of the impact of violence in the African American community, inform public policy, organize and facilitate local and national conferences and training forums, and to identify community needs and recommend best practices.

Women of Color Network (WOCN)

Women of Color Network
(614) 995-2439

The Women of Color Network is a national grassroots initiative created to meet the need for capacity-buidling among women of color domestic violence and sexual assault advocates and the communities of color they serve. The WOCN exists for the sole purpose of enhancing and drawing upon the single greatest untapped resource in addressing the unique, interlocking issues of race, class and gender in communities of color - women of color activitists.

Asian & Pacific Islander Institute on Domestic Violence

Asian & Pacific Islander Institute on Domestic Violence
(415) 954-9988 x 315
Web: www.apiahf.org/apidvinstitute

A project of the Asian and Pacific Islander American Health Forum, a national organization advocating for the health and well being of all Asians and Pacific Islanders in the U.S. The project seeks to eliminate domestic violence inthe Asian and Pacific Islander communities by 1) increasing awareness of the extent and dept of the problem; 2) making culturally-specific issues visible; 3) strengthening community models of prevention and intervention; 4) identify-

ing and expanding resources; and 5) informing and promoting research and policy.

National Center for Children Exposed to Violence (NCCEV)

National Center for Children Exposed to Violence (NCCEV)
Yale University Child Study Center
230 South Frontage Road
New Haven, CT 06520-7900
Telephone: (877) 49-NCCEV
Web: http://www.nccev.org/

A primary national resource center for anyone seeking information about the effects of violence on children and the initiatives designed to address this problem, including a dynamic body of literature, Internet resources and a bibliography database. A provider of training, technical assistance and consultation to a variety of collaborative community programs throughout the country that respond to children and families exposed to violence.

National Clearinghouse on Abuse in Later Life

National Clearinghouse on Abuse in Later Life
Wisconsin Coalition Against Domestic Violence
307 South Paterson Street, Suite 1
Madison, WI 53703
Telephone: (608) 255-0539
Fax: (608) 255-3560
Web: http://www.ncall.us/

NCALL's mission is to eliminate abuse in later life by challenging beliefs, policies, practices and systems that allow abuse to occur and continue and to improve safety, services and support to victims through advocacy and education. The goals of NCALL are to: 1) Improve safety, services and support of victims by assisting professionals through technical assistance, training and best practice recommendations; 2) Improve response to domestic abuse in later life by challenging existing beliefs and practices through training and consultation and the creation of new materials; and 3) Give voice to victims and support to advocates and other professionals who work with older victims. The Clearinghouse provides technical assistance, training, resources, and networking on abuse of older adults and adults with disabilities.

National Latino Alliance for the Elimination of Domestic Violence

National Latino Alliance for the Elimination of Domestic Violence
P.O. Box 322086 Ft. Washington Station
New York, NY 10032
Telephone: (646) 672-1404
Toll Free (800) 342-9908
Fax: (800) 216-2404
Email: information@DVAlianza.org
Web: http://www.DVAlianza.org

The National Latino Alliance for the Elimination of Domestic Violence (the Alianza) is a group of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understanding, sustain dialogue, and generate solutions to move toward the elimination of domestic violence affecting Latino communities, with an understanding of the sacredness of all relations and communities. Support from ACF/DHHS has allowed the Alianza to establish El Centro: National Latino Research Center on Domestic Violence and the Alianza Training and Technical Assistance (T/TA) Division.

National Network to End Violence Against Immigrant Women

National Network to End Violence Against Immigrant Women
Web: http://www.endabuse.org/programs

The National Network on Behalf of Battered Immigrant Women was co-founded in 1994 by the Family Violence Prevention Fund, AYUDA, NOW Legal Defense and Education Fund and the National Immigration Project of the National Lawyers Guild to nationally coordinate advocacy efforts aimed at removing the barriers battered immigrant and children face when they attempt to leave abusive relationships. Each organization provides leadership in their area of expertise.

National Organization for Women (NOW) Legal Defense and Education Fund

National Organization for Women (NOW) Legal Defense and Education Fund
Immigrant Women Program
1522 K Street NW, Suite 550
Washington, DC 20005
Telephone: (202) 326-0040
Web http://www.nowldef.org

The initial focus of Immigrant Women Program is the creation of a legal, institutional, and policy framework that allows battered immigrant women to end the destructive role that domestic violence plays in their lives and allows all immigrant women to achieve economic self-sufficiency. The ultimate agenda of the program is to address from a women's rights perspective the larger complex of social and legal challenges faced by women who emigrate to the United States.

Resource Center on Domestic Violence: Child Protection and Custody

Resource Center on Domestic Violence: Child Protection and Custody
Post Office Box 8970
Reno, NV 89507
Telephone: (800) 52-PEACE (527-3223)
Website: http://www.nationalcouncilfvd.org

Provides information, materials, consultation, and technical assistance related to child protection and custody within the context of domestic violence.

Sacred Circle, National Resource Center to End Violence Against Native Women

Sacred Circle, National Resource Center to End Violence Against Native Women
722 Saint Joseph Street
Rapid City, SD 57701
Telephone: (877) RED-ROAD (733-7623)
Fax: (605) 341-2472
Email: scircle@sacred-circle.com
Provides technical assistance, policy development, training institutes, and resource information regarding domestic violence and sexual assault to develop coordinated agency response in American Indian/Alaska Native tribal communities.

NORTH CAROLINA RESOURCES

NC Coalition Against Domestic Violence (NCCADV)
115 Market Street
Suite 400
Durham, NC 27701
Telephone: (919) 956-9124
Toll Free: (888) 232-9124
Fax: (919) 682-1449
Web: http://www.nccadv.org

North Carolina Coalition Against Sexual Assault (NCCASA)
183 Windchime Court, Suite 100
Raleigh, NC 27615
Telephone: (919) 431-0995
Toll Free: (888) 737-CASA
Fax: (919) 431-0996
E-Mail: info@nccasa.org
Web: http://www.nccasa.org/home.html

NC Council for Women and Domestic Violence Commission
1320 Mail Service Center
Raleigh, NC 27699-1320
Telephone: (919) 733-2455
Fax: (919) 733-2464
http://www.doa.state.nc.us/doa/cfw/cfw.htm

NC Victim Assistance Network
410 Morson Street
Raleigh, NC 27601-1558
Telephone: (919) 831-2857
Toll Free: (800) 348-5068
Fax: (919) 831-0824
Web: http://www.nc-van.org
—Provide support and information for crime victims across North Carolina.

North Carolina Department of Corrections
Public Information Office
4202 Mail Service Center
Raleigh, NC 27699-4202
Telephone: (919) 716-3700
E-mail: info@doc.state.nc.us
Web: http://www.doc.state.nc.us/
—Website provides opportunity to do offender searches, get statistics on crimes and convictions,

find information of various victims' services available, etc.

Statewide Automated Victim Assistance and Notification (SAVAN)
1201 Front Street
Raleigh, NC 27609
Telephone: (919) 733-4564
Toll Free: (877) NC-SAVAN (1-877-627-2826)
E-mail: victimservices@doc.state.nc.us
Web: http://www.doc.state.nc.us/victimservices/notification.htm#SAVAN
—Allows victims to sign up and get notified automatically when an offender is released from prison or has another change of status with the Department of Corrections. Available in English and Spanish.

NC Dept of Justice - NC Attorney General's Office
P.O. Box 629
Raleigh, NC 27602-0629
Phone: (919) 716-6400
Fax: (919) 716-6705
Web: http://www.ncdoj.com

The Attorney General's Office Includes:

NC Address Confidentiality Program
Telephone: (919) 716-6785
E-mail: acp@mail.jus.state.nc.us
Web: http://www.ncdoj.com/about/about_division_address_confidentiality_program.jsp
—Provides victims of domestic violence and stalking the ability to use the attorney General's office address instead of their own in all public and private documents in order to shield their residence address. The participants in the program receive their mail at a secure alternate address.

North Carolina Sex Offender Registry
Web: http://sbi.jus.state.nc.us/DOJHAHT/SOR/Default.htm
—Provides the public the ability to do searches for registered sex offender by county and name, and provides some statistics.

North Carolina General Assembly
Legislative Building
16 West Jones Street
Raleigh, NC 27603
Web: http://www.ncleg.net/
—Provides the public an ability to search for information on and read state statutes.

The NC Health Info project
Web: http://www.nchealthinfo.org/
—The NC Health Info project team has collected and cataloged web sites from around the state, using the Healthy Carolinians 2010 objectives as a guideline to ensure that the collection reflects the health needs of North Carolinians. NC Health Info provides access to health resources on the web, including web sites of local health services, providers and programs serving residents of North Carolina. Also, users of the site can get information about conditions, diseases and wellness. Provides the ability to search by topic and by county for local resources.

Project Esperanza
PO Box 26087
Raleigh, NC 27611
Telephone: (919) 856-2130
—Provides assistance for Domestic Violence victims with an emphasis on the Spanish speaking population ; offers resources and training.

El Pueblo, Inc.
4 N. Blount St., 2nd Floor
Raleigh, NC 27601
Telephone: (919) 835-1525
Web: www.elpueblo.org
—Non-profit, statewide advocacy and public policy organization dedicated to strengthening the Latino community. This mission is accomplished through leadership development, education, and promotion of cross-cultural understanding in partnerships at the l

RAPE VICTIMS ASSISTANCE PROGRAM (Last updated 05/25/04)
(From http://www.nccrimecontrol.org; Accessed on 08-10-04)

The Rape Victims Assistance Program reimburses a North Carolina medical provider up to $1,000 for gathering evidence for a rape kit. Hospital staff will submit a rape claim to the Rape Assistance Program to pay the hospital bill for the evidence collection.

What to do
In North Carolina, rape is a felony offense. Reporting the crime to law enforcement is the first step in apprehending and convicting an assailant. If the rape in not reported, the attacker is likely to hurt someone else. Telling a police officer about the rape does not mean the victim has to prosecute. A victim can tell law enforcement everything he or she remembers about the attacker and nothing about himself or herself, if the individual so chooses. If the victim wants to prosecute, the authorities will pursue the crime to the fullest extent of the law.

A victim should:

- Report the crime as soon as possible after it occurs.
- Remember as much as possible about the attacker and what took place.
- **Do not change clothes, bathe or douche.** Go straight to a hospital emergency room so evidence may be obtained. (You may wish to have your private physician meet you at the hospital's emergency room). Take a change of clothes to the hospital. The clothes you were wearing at the time of the attack will become part of the evidence collected.
- Call a family member, a friend, your clergyman, or a volunteer from a local rape crisis center for moral support. These people can offer support and assistance so that you do not have to face this situation alone.

Insurance
The Rape Victims Assistance Program will compensate victims for expenses not paid by a collateral source such as Medicaid, public or private insurance plans or other victim benefit sources. Payment requests are processed and paid depending on whether funds are available and if reports of the assault are verified in writing by the appropriate law enforcement agency.

Reasons for denial:

- If the assault is not reported to law enforcement within FIVE DAYS of the incident or without good cause, the claim will be denied.
- If medical treatment was not received within 90 days of the incident, the claim will be denied.
- If a bill is not submitted within six months of the date service rendered, the claim will be denied.
- If alleged victim makes a false report to law enforcement, the claim will be denied.
- If other insurance coverage pays the bill, the claim will be denied.

How medical providers can assist:

- Obtain all insurance information. Compensation is reduced or denied if the medical expense can be recouped by any collateral source such as Medicaid, public or private insurance plan or other victim benefit source.
- Obtain the name of the investigating law enforcement agency where the report was completed and submit with bill.
- Provide itemized statement.
- Ensure timely filing.

Questions

You may call the Rape Victim Assistance Program at 1-800-826-6200 (within NC) or (919) 733-7974.
You may look up the N.C. General Statute 14-27.2 (http://www.ncleg.net/) on First Degree Rape.
Or, write to:

Division of Victims Compensation Services
4703 Mail Service Center
Raleigh, North Carolina 27699-4703
fax (919) 715-4209