ATrain EDUCATION

Kentucky: Domestic Violence

3 contact hours: $25

Author: Susan Walters Schmid, PhD

This course meets the domestic violence continuing education requirement for healthcare providers in the state of Kentucky.

This course will be reviewed every two years. It will be updated or discontinued on Dec 1, 2012.

Course Summary: The scope of domestic violence includes violence against women, children, and elders. This course describes best practices for screening, assessment, and documenting signs of violence when seen in the healthcare setting. Outlines Kentucky reporting requirements and discusses state programs to reduce incidence.

COI/Commercial Support: The planners and authors of this course have declared no conflict of interest and all information is provided fairly and without bias. We have received no commercial support for this activity and do not approve or endorse any commercial products displayed.

Off-Label Use: No off-label uses were discussed or recommended in this course.

Criteria for Successful Completion: 80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Accreditation Information

Nursing

ATrain Education, Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Physical Therapy

ATrain Education, Inc. is an approved reviewer and provider by the Physical Therapy Board of California and an approved provider by the New York State Board for Physical Therapy.

Occupational Therapy

ATrain Education, Inc. is an approved provider by the American Occupational Therapy Association. The following course information applies to occupational therapy professionals:

Target Audience: Occupational Therapists, OTAs
Instructional Level: Introductory
Content Focus:

- Category 1 - Domain of OT, Client Factors

Other Professions and Accreditations

See the ATrainCEU Accreditation page at http://www.ATrainCeu.com/accreditation.php.

Instructions

1. Read the course material and then complete the following forms:
   - A. Post Test
   - B. Evaluation Learning Activity
   - C. Registration Form
2. If you are not paying by credit card, prepare a check for the amount of the course made out to: *ATrain Education, Inc.*
3. Mail the completed forms and your payment to:

   ATrain Education, Inc
   5171 Ridgewood Rd
   Willits, CA 95490

When we receive your forms and payment, we will mail (or email, at your request) your completion certificate. If you have any questions, please call or email Info@ATrainCEU.com.

Course Objectives

When you finish this course, you will be able to:

- Describe the scope of domestic violence in the United States and Kentucky.
- List the five main categories of domestic violence.
- Explain the prevalence of violence against women and how it relates to domestic violence.
- Show the significance of the co-occurrence of child maltreatment and domestic violence.
- Identify the relationship of elder abuse to domestic violence.
- Outline the economic and societal costs of domestic violence.
- Teach best practices for screening, assessment, and documentation of domestic violence in the healthcare setting.
- Summarize Kentucky legislation relating to domestic violence, including reporting requirements for healthcare professionals.
- Discuss goals for prevention and education program research.

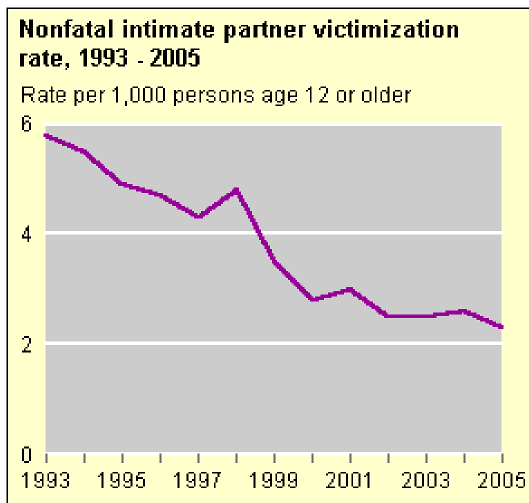
Intimate Partner Violence

Intimate partner violence (IPV) is defined as physical, sexual, or psychological harm by a current or former partner or spouse. It can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV is a serious, preventable public health problem that affects millions of people in the United States and throughout the world. In many societies this type of violence is considered "normal." It varies in frequency and severity and occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering (CDC, 2008; WHO, 2010).

The terms *domestic violence, family violence, wife beating, battering, spouse abuse,* and *dating violence* are often used interchangeably. However, in an effort to facilitate the collection of data and make comparisons among jurisdictions, an effort is being made to use a consistent definition and the CDC advocates the definition of IPV as noted above (CDC, 2008).

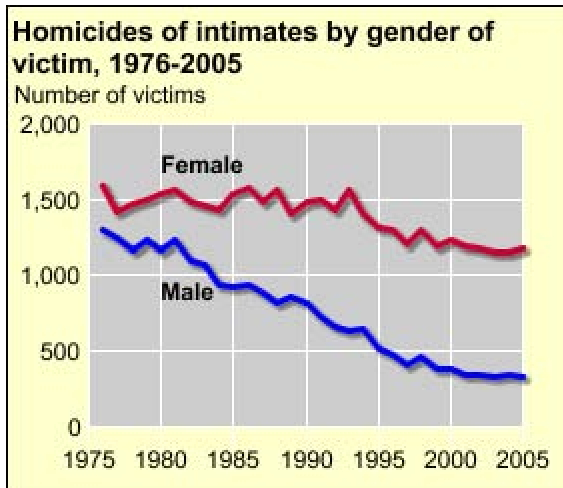
Just as intimate partner violence can be thought of as a continuum, domestic violence may also encompass child abuse when children are physically and psychologically harmed when IPV occurs, and elder abuse when the perpetrator is an intimate partner.

Although women can be violent to men, the vast majority of intimate partner violence is perpetrated by men against women. From 1976 to 2005, U.S. Department of Justice statistics showed that about 96% of women who experienced IPV were victimized by a man, while only about 3% reported that the offender was another woman (Catalano, 2007).



Source: U.S. Department of Justice.

Fatal incidents of intimate partner violence—sometimes referred to as "intimate homicide"—have declined in the United States since 1976. Between 1976 and 2005 the number of white females killed by intimates rose in the mid-1980s, then declined after 1993, reaching the lowest recorded numbers in 2002. The number of intimate homicides for all other race and gender groups declined over the same period; the number of black males killed by intimates dropped by 83%, white males by 61%, black females by 52%, and white females by 6% (Catalano, 2007).



Source: U.S. Department of Justice.

Describing trends based on law enforcement statistics can be problematic, however. In the United States less than one-fifth of the women raped by an intimate partner reported their most recent rape to the police. In a National Violence Against Women (NVAW) survey, most women and men who were physically assaulted failed to file a complaint, although women were more likely than men to report their victimization to the police (26.7% and 13.5%, respectively) (Tjaden and Thoennes, 2000).

This reluctance to report intimate partner violence to authorities is also a problem internationally. According to a World Health Organization (WHO) survey of more than 24,000 women in ten countries, more than half of the physically abused women surveyed reported that they had never sought help from a health service, shelter, legal service, or anyone in any position of authority such as police, religious leaders, or other government organizations (WHO, 2005).

Domestic Violence in Kentucky

In 2006, when Kentucky's governor appointed 36 members to the Council on Domestic Violence and Sexual Assault, the Cabinet for Health and Family Services noted in its press release that "a study of domestic violence in Kentucky reveals 1 of every 3 women has been victimized by an intimate partner" (CHFS, 2006). The study, completed in 2005 by the IPV Surveillance Project, had helped to demonstrate that Kentucky women were indeed experiencing domestic violence at a higher rate than the national average (Fritsch, 2005).

In November 2009 a special report in the Louisville *Courier-Journal* stated that in the previous three years 49 Kentuckians had been "killed by their husbands, boyfriends, or former mates" (Wolfson, 2009). Information compiled by the Kentucky Domestic Violence Association (KDVA) showed that these women ranged in age from 23 to 83 and about half of them had been the victim of murder-suicides (KDVA, 2008, 2009b). The personal and economic toll that domestic violence has taken and continues to take on Kentucky citizens is enormous and far-reaching, as the incoming president of the KDVA observed in early 2009:

> The economic impact of domestic violence has been overwhelming. In addition to the obvious costs to our healthcare system, our courts, jails, and prisons, it impacts the drop-out rate in our school, the number of children removed and placed into foster care, the health and welfare of our workforce, and absenteeism on the job. It impacts a family's ability to live in a home with a stable environment. And the growing use of drugs and alcohol as coping mechanisms for many of our families is becoming more of a factor each year.
>
> KDVA President, 2009a

Overview and Legislation

Kentucky's Adult Protection Act (KRS 209), passed in 1976, requires reporting of known or suspected incidences of adult abuse, neglect, or exploitation, and it was expanded in 1978 to include mandatory reporting and provision of voluntary protective services to spousal abuse victims (KSP, 2008). All required reports must be made to the Department for Community Based Services (DCBS), a department of the Kentucky Cabinet for Health and Family Services, Division of Protection and Permanency. In 1996 additional legislation (HB 309) was enacted that mandated training about domestic violence for nurses and some other healthcare professionals.

In fiscal year 2008 the DCBS investigated 19,193 allegations of domestic violence. This was a 7.4% increase over 2007 (KSP, 2008). The previous five years had shown a steady decrease in these numbers, but the 2008 figure was higher than that of both 2006 and 2007 (KSP, 2004–2008). Employment and economic stressors are known to play a role in domestic violence; recent widespread economic problems may have exacerbated domestic violence in some situations and be one factor in the increased number of incidents.

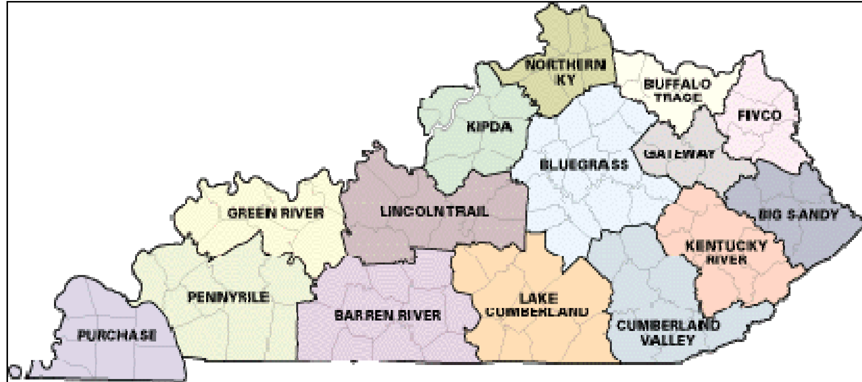
In fiscal year 2008 the Kentucky Domestic Violence Association received 35,636 domestic violence-related calls and 74,781 calls asking for information and/or referrals. The first figure has been increasing since 2005 (3–20% per year). And, while the 2008 information/referral calls dropped about 1.4% over 2007, in 2007 they had increased a dramatic 22% over the previous year (KSP, 2006–2008). Domestic violence continues to be a critical problem in Kentucky.

Domestic Violence Centers

The first spouse abuse shelter in Kentucky was opened by the Louisville YWCA in 1977, and by 1980 five more had opened. In 1981 staff members at those six shelter programs formed the Kentucky Domestic Violence Association (KDVA), which was intended to be a coalition of all the domestic violence programs in the state. "Its purpose was to provide mutual support, information, resource sharing and technical assistance; to coordinate services; and to collectively advocate for battered women and their children on statewide issues" (KDVA, 2010b).

The Kentucky Domestic Violence Association has fifteen member domestic violence programs, covering each of the state's fifteen Area Development Districts (ADDs). ADDs are public bodies created by state law and run by local partnerships. They provide a means to organize planning, services, and statistical information across the state (BGADD, 2010).

Kentucky's Area Development Districts



KDVA's original goal had been to provide services in every district, a goal that was reached in 1985. Because ADDs comprise multiple counties, most will have multiple domestic violence shelter and service locations to serve different areas within the district (KDVA, 2010a). In addition to these KDVA member facilities, there is a shelter program in the Pikeville area that is run by a local non-profit cooperative board and designed simply to serve Pike County.

These fifteen regional domestic violence programs began simply as safe shelters for domestic violence victims. This continues to be a critical part of the services provided, and these state-funded shelters have the capacity to shelter a total of 485 people at one time. This is a miniscule number compared to the needs of victims for shelter and, in 2008, 2,357 people were unable to be sheltered at some time during the year, and that number has been rising each year (KDVA, 2010b; KSP, 2006–2008).

Services Provided by Domestic Violence Programs in Kentucky in 2008–2009

New residential individuals served	3,986	• 2146 women • 1829 children • 10 men
New non-residential individuals served	23,238	• 20898 women • 694 children • 1646 men
Days of shelter	227,544	

Source: KDVA, 2009c.

These shelter programs now provide a variety of related support services, as over time staff members at these agencies have come to understand the complexity of the situation for victims of domestic violence and their growing needs. Among the variety of support services now provided to shelter residents and non-residents are:

- Legal/court advocacy
- Case management
- Safety planning
- Support groups
- Individual counseling
- Housing assistance
- Job search, resume writing, improving basic job skills
- Children's groups, parenting
- Drug and alcohol issues (KDVA, 2010b)

In fiscal year 2009 KDVA member programs provided medical advocacy for 4,275 residential clients and 2,612 nonresidents, and legal advocacy for 4,595 residents and 27,447 nonresidents. Group and individual counseling sessions for all clients totaled nearly 150,000 (KDVA, 2009c). These are just a few of the support services offered, and "the programs are also committed to preventing future domestic violence through public awareness and community education efforts. Domestic violence programs are working with schools, local professionals, and community groups to increase understanding of domestic violence issues" (KDVA, 2010b).

Domestic Violence Protective Orders

An important recourse for domestic violence victims is protective orders. A portion of KRS 403 deals with the purpose of, types, and procedures for obtaining protective orders. These are intended "to allow persons who are victims of domestic violence and abuse to obtain effective, short-term protection against further violence and abuse in order that their lives will be as secure and as uninterrupted as possible" and to make it easier for law enforcement officers to respond to domestic violence and abuse incidents and to give them authority to immediately apprehend violators (KRS 403.715). "Any family member or member of an unmarried couple who is a resident of this state or has fled to this state to escape domestic violence and abuse" may file a petition for a protective order (KRS 403.725(1)).

Usually the petitioner first asks for an Emergency Protective Order (EPO), which must be signed by a judge. Both parties must be notified of the order and the hearing date before it can take effect. EPOs are only good for 14 days but may be renewed if they expire before the respondent has been served. Unfortunately, until they have been served, no action can be taken by law enforcement officers. When the hearing is held the judge will determine if a Domestic Violence Order (DVO) is to be issued. DVOs can be issued for up to three years (Logan et al, 2009). A study released in 2009 demonstrated that protective orders in Kentucky have generally been effective at ending or reducing violence and reducing fear. However, they have not proven to be as effective for victims of stalking (Logan et al, 2009).

According to statistics compiled by the Kentucky State Police (KSP) for its annual *Crime in Kentucky* report, in fiscal year 2008 (ending June 30), 26,020 petitions were filed by persons seeking Domestic Violence Protective Orders. While there had been a small drop from 2006 and 2007, 2008 reflected a higher number than either 2006 or 2007. Emergency Temporary Orders and Emergency Protective Orders reported to the Law Information Network of Kentucky (LINK) showed a 3.1% increase in 2008 over 2007 (KSP, 2006–2008).

A noteworthy expansion of enforcement options against perpetrators of domestic violence is legislation just signed into law in April 2010. Known in Kentucky as "Amanda's Bill," this law (HB 1) includes a number of items related to the enforcement of protection orders and, among other things, "allows judges to order those who violate a domestic violence order to wear a global positioning system (GPS) tracking device…[and] extends the continuance of an un-served emergency protective order for 6 months, rather than the current 90 days" (WFIE, 2010).

Batterer Intervention Programs

Batterer intervention is established by statute in Kentucky (KRS 403.7505) and a certification program for batterer intervention providers was established in 1996. The first providers were certified two years later and there are now about 100 offering services in 45 counties. A list of providers is available from the DCBS (CHFS, 2010c).

Types of Intimate Partner Violence

According to Kentucky law (KRS 403.720), "domestic violence and abuse" means:

> … physical injury, serious physical injury, sexual abuse, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, or assault between family members or members of an unmarried couple.
>
> "Family member" means a spouse, including a former spouse, a parent, a child, a stepchild, or any other person related by consanguinity or affinity within the second degree.
>
> "Member of an unmarried couple" means each member of an unmarried couple which allegedly has a child in common, any children of that couple, or a member of an unmarried couple who are living together or have formerly lived together.

The Centers for Disease Control and Prevention (CDC) describes four types of intimate partner violence—**physical violence**, **sexual violence**, **threats of physical or sexual violence**, and **psychological/emotional violence**. Stalking and cyberstalking are increasingly being included as another type of intimate violence.

Physical Violence

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

- Scratching, pushing, or shoving
- Throwing, grabbing, or biting
- Choking, shaking, slapping, punching, or burning
- Use of a weapon
- Use of restraints or one's body, size, or strength against another person

Physical violence also includes coercing other people to commit any of the above acts (CDC, 2008).

Research has shown that physical violence is often accompanied by psychological abuse and in one-third to one-half of cases, by sexual abuse (Heise & Garcia-Moreno, 2002). The violence is usually not limited to one instance. A National Violence Against Women (NVAW) survey found that women who were physically assaulted by an intimate partner averaged 6.9 physical assaults by the same partner, while men averaged 4.4 assaults.

Women experience more chronic and injurious physical assaults at the hands of intimate partners than do men. The NVAW survey found that more than 40% of women who were physically assaulted by an intimate partner were injured during their most recent assault, compared with about 20% of the men (Tjaden & Thoennes, 2000).

Most injuries, such as scratches, bruises, and welts, were minor. More severe physical injuries may occur depending on severity and frequency of abuse. Physical violence can lead to death. In 2005 in the United States, 329 males and 1181 females were murdered by an intimate partner.

Between 2001 and 2005, for nonfatal intimate partner violence:

- 27% of female victims and 15% of male victims reported that the offender threatened to kill them.
- 23% of male victims were threatened with a weapon and 7% had an object thrown at them.
- About 1 in 10 female and male victims reported that the offender tried to hit, slap, or knock them down (US DOJ, 2007).

Female injuries sustained in nonfatal intimate partner violence, 2001–2005

	Average annual	
	Number	**Percent**
Total intimate partner victim	510,970	100%
Not injured	248,805	48.7%
Injured	262,170	51.3%
Serious injury (gunshot wound, knife wounds, internal injuries, broken bones, knocked unconscious)	25,710	5 %
Rape/sexual assault without additional injuries	13,350	2.6%
Minor injuries only	222,670	43.6%
Injuries unknown	435	*0.1%

*Based on 10 or fewer samples cases
Source: Catalano, 2007.

Male injuries sustained in nonfatal intimate partner violence, 2001–2005

	Average annual	
	Number	**Percent**
Total intimate partner victims	104,820	100%
Not injured	61,285	58.5%
Injured	43,540	41.5%
Serious injury	4,335	*4.1%
Minor injuries	38,050	36.3%
Rape/sexual assault without other injuries	580	*0.6%
Injuries unknown	570	*0.5%

*Based on 10 or fewer samples cases
Source: Catalano, 2007.

Children are sometimes injured during incidents of intimate partner violence between their parents; there is a large overlap between IPV and child maltreatment. One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al., 2001).

Sexual Violence

A **sexual act** is defined as contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object (Saltzman, 2001).

Abusive sexual contact is intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (Saltzman, 2001).

Sexual violence involves:

- Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed
- Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, for example, because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure
- Abusive sexual contact (CDC, 2008)

Sexual and physical abuse is often accompanied by controlling behaviors. In a World Health Organization survey of more than 24,000 women in ten countries, those who experienced one or more of the following controlling behaviors ranged from 20% in Japan to 90% in urban United Republic of Tanzania:

- Keeping her from seeing friends
- Restricting contact with her family of birth
- Insisting on knowing where she is at all times
- Ignoring or treating her indifferently
- Getting angry if she speaks with other men
- Often accusing her of being unfaithful
- Controlling her access to healthcare (WHO, 2005)

Threats of Physical or Sexual Violence

Threat of physical or sexual violence is defined as the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. This includes the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent. A person threatening physical or sexual violence may use words such as:

- "I'll kill you."
- "I'll beat you up if you don't have sex with me."

Or actions such as:

- Brandishing a weapon
- Firing a gun into the air
- Making hand gestures
- Reaching toward a person's breasts or genitalia (Saltzman, 2001)

Psychological and Emotional Violence

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. Psychological and emotional abuse involves trauma to the victim caused by acts, threats of acts, or coercive tactics, such as those listed below (CDC, 2008).

Psychological/emotional abuse can include:

- Deliberately humiliating, diminishing, or embarrassing the victim
- Controlling what they can and cannot do
- Withholding information
- Getting annoyed if they disagree with you
- Using the victim's money
- Taking advantage of or disregarding what the victim wants
- Isolating the victim from friends or family
- Prohibiting access to transportation, telephone, money, or basic resources
- Getting the victim to engage in illegal activities
- Using the victim's children to control their behavior
- Threatening loss of custody of children
- Smashing objects or destroying property
- Tarnishing the victim's reputation (Saltzman, 2001)

Coercive control and intimidation by the abusive partner is considered an underlying component of all of these types of violence. The abusive partner's ability to control relies on the abused person's belief that if she or he does not comply with the abusive partner's demands, the victim, the victim's children, or other persons or things the victim cares about will be harmed. Often, threats are alternated with acts of kindness from the perpetrator, making difficult for the victim to break free of the cycle of violence (CDC, 2009).

The ten-country World Health Organization survey and other research has consistently shown that emotional abuse can have a more profound and negative effect than physical violence. Between 20% and 75% of women across all the countries surveyed reported being the recipient of emotional abuse within the previous 12 months (WHO, 2005).

Stalking and Cyberstalking

In addition to the four types of intimate partner violence described above, stalking and cyberstalking have become increasingly common. **Stalking** generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property" (CDC, 2008).

According to the National Violence against Women survey, stalking by intimates is more prevalent than previously thought. Almost 5% of surveyed women and 0.6% of surveyed men reported being stalked by a current or former spouse, cohabiting partner, or date at some time in their lifetime; 0.5% of surveyed women and 0.2% of surveyed men reported being stalked by such a partner in the previous 12 months (Tjaden & Thoennes, 2000).

According to these estimates, more than 500,000 women and 185,000 men are stalked by an intimate partner annually in the United States. These estimates exceed previous estimates of stalking prevalence in the general population. The findings suggest that intimate partner stalking is a serious criminal justice problem, and each state should develop constitutionally sound and effective anti-stalking statutes and intervention strategies (Tjaden & Thoennes, 2000).

Today stalkers have at their fingertips a wide array of computers and equipment including the Internet, global positioning systems, cell phones, and tiny digital cameras. In many states, general stalking statues have not kept up with these new technologies. However, in 2009 the governor of Kentucky signed into law HB 315, which made **cyberstalking** a crime and defines it as "intentionally alarming, annoying, intimidating, or harassing a person with no legitimate purpose through electronic communication" (Noll, 2009). Additional information for identifying and dealing with cyberstalking is available from the Kentucky Attorney General's office and website at http://ag.ky.gov/cybersafety.

Violence Against Women

Violence against women has been the focus of international attention for more than twenty years. In 1993 the World Conference on Human Rights published the Declaration on the Elimination of Violence Against Women. It established that, according to international human rights law, "states have a duty to exercise due diligence to prevent, prosecute, and punish violence against women" (WHO, 2005).

Recognizing the need for research in the area of intimate partner violence, in 2005 the World Health Organization (WHO) completed a ten-country population-based survey of 24,000 women called the *WHO Multi-country Study on Women's Health and Domestic Violence against Women.* The WHO researchers asked participants a series of questions about physical and sexual violence, emotional abuse, and controlling behaviors.

Overall, the proportion of women who had ever suffered physical violence by a male partner ranged from 13% in Japan to 61% in provincial Peru. Japan had the lowest level of sexual violence at 6%, while Ethiopia had the highest figure of 59%. The majority of settings were between 10% and 50% (WHO, 2005).

It is well known that violence perpetrated against women by an intimate partner is often accompanied by emotionally abusive and controlling behavior. The National Violence Against Women survey found that women whose partners were jealous, controlling, or verbally abusive were significantly more likely to report being raped, physically assaulted, or stalked by their partners, even when other sociodemographic and relationship characteristics were controlled.

Having a verbally abusive partner was the variable most likely to predict that a woman would be victimized by an intimate partner. These findings support the theory that violence perpetrated against women by an intimate partner is often part of a systematic pattern of dominance and control (Tjaden & Thoennes, 2000).

Violence against women incorporates intimate partner violence, sexual violence, and other forms of violence against women such as physical violence committed by acquaintances or strangers (Saltzman, 2001). The victims are often emotionally involved and economically dependent upon the person victimizing them. In contrast, men are more likely to be victimized by someone outside their close circle of relationships (Heise & Garcia-Moreno, 2002).

Intimate Partner Violence during Pregnancy

Depending on the population, setting, or frequency of asking, between 0.9% and 20.1% of women in the United States reported they have experienced violence during pregnancy. Violence during pregnancy may be more common than some conditions for which pregnant women are routinely screened. As with screening for gestational diabetes, neural tube defects, preeclampsia, and behavioral risk factors such as smoking and alcohol use, screening for intimate partner violence should be incorporated into routine prenatal care (CDC, 2006).

Women who report violence around the time of pregnancy have reported higher prevalence of other demographic and psychosocial risk factors that also may have an effect on pregnancy. These include:

- Young maternal age/adolescence
- Unintended pregnancy
- Delayed prenatal care
- Smoking
- Alcohol and drug use
- Lack of social supports
- STD/HIV/AIDS (CDC, 2006)

Child Abuse

Intimate partner violence is often associated with the abuse of children. This is an important public health issue because witnessing violence in the home as a child is a strong risk factor for involvement in abusive relationships as an adult. In addition, experiencing abuse as a child has been associated with other risk factors such as depression, substance abuse, poor school performance, and high-risk sexual activity (CDC, 2009).

The Federal Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as, at minimum:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm (Child Welfare Information Gateway, 2010)

This definition of child abuse and neglect refers specifically to parents and other caregivers. A **child** under this definition generally means a person who is under the age of 18 or who is not an emancipated minor (Child Welfare Information Gateway, 2010).

CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment but does not provide specific definitions for other types of maltreatment such as physical abuse, neglect, or emotional abuse. While Federal legislation sets minimum standards, each state is responsible for providing its own definition of maltreatment within civil and criminal contexts (Child Welfare Information Gateway, 2010).

In Kentucky, **abused** *or* **neglected child** means a child whose health or welfare is harmed or threatened with harm when his or her parent, guardian, or other person exercising custodial control or supervision:

- Inflicts or allows to be inflicted upon the child physical or emotional injury by other than accidental means
- Creates or allows to be created a risk of physical or emotional injury to the child by other than accidental means

Physical injury means substantial physical pain or any impairment of physical condition.

Serious physical injury means physical injury that creates a substantial risk of death, or causes serious and prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily member or organ (Child Welfare Information Gateway, 2009).

Co-Occurring Domestic Violence and Child Maltreatment

Children exposed to domestic violence may be the victims of co-occurring maltreatment. In particular, domestic violence is a significant risk factor for verbal abuse, physical punishment, and physical abuse of children. Although high rates of co-occurring domestic violence and child maltreatment have been noted in the general population, this co-occurrence has most commonly been investigated in clinical samples of abused women and of physically abused children, with the majority of studies indicating rates of co-occurrence ranging from 30% to 60% (Kelleher, 2006).

There is evidence that children who are exposed to domestic violence and also experience maltreatment are at risk for poor development. There also is a growing concern that children's exposure to domestic violence constitutes a type of psychological or emotional abuse in and of itself (Kelleher, 2006).

Although domestic violence and child maltreatment commonly occur together, policy makers and planners of services lack a nationally representative study that examines the prevalence of this co-occurrence. Equally as important is the need for information on state and local policies and practices around services for families with co-occurring domestic violence and child maltreatment (Kelleher, 2006).

Domestic Violence and the Child Welfare System

Domestic violence is a significant problem for 30% to 40% of families in the child welfare system. Because co-occurring domestic violence and child maltreatment are so prevalent, many communities have implemented policies and practices to protect women and children from domestic violence, and provide services, especially as it relates to interactions with the child welfare system. Many of these initiatives have arisen out of local advocacy through domestic violence centers and services, while others come from national movements promulgated by the National Council of Juvenile and Family Court Judges, such as its Model Code or its more recent policy and practice recommendations, sometimes referred to as the "Greenbook" (Kelleher, 2006).

Elder Abuse

In 1980 the Kentucky Legislature passed legislation designed to protect adults who were "unable to manage their own affairs or to protect themselves from abuse, neglect, or exploitation" (KRS 209.090). For the purposes of this law the following definitions apply:

> **Adult** means a person18 years of age or older who, because of mental or physical dysfunctioning, is unable to manage his or her own resources, carry out the activity of daily living, or protect himself or herself from neglect, exploitation, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services
>
> **Abuse** means the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury
>
> **Neglect** means a situation in which an adult is unable to perform or obtain for himself or herself the goods or services that are necessary to maintain his or her health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult
>
> **Exploitation** means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources (KRS 209.020)

According to the best available estimates, between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection (NCEA, 2005). Complicating these estimates, however, is the difficulty in defining and quantifying elder abuse. Available data indicate that the highest rates of elder abuse are among women and those aged 80 and older. In 90% of cases, the perpetrator is a family member, most often a spouse or adult child (Nelson, 2004).

Risk and Protective Factors for IPV

A combination of individual, relational, community, and societal factors contribute to the risk of becoming a victim or perpetrator of intimate violence. Risk factors are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors are the same and some are associated with one another. For example, childhood physical or sexual victimization is a risk factor for both future perpetration and victimization. Understanding these multilevel factors can help identify various opportunities for prevention.

The termination of a relationship poses an increased risk for, or escalation of, intimate partner violence. This assumption is based on two types of evidence: divorced or separated women report more intimate partner violence than do married women. Also, interviews with men who have killed their wives indicate that either threats of separation by their partner or actual separation are most often the precipitating events that lead to the murder (Tjaden & Thoennes, 2000).

The National Violence against Women survey found that married women who lived apart from their husbands were nearly 4 times more likely to report that their husbands had raped, physically assaulted, and/or stalked them than were women who lived with their husbands (20% and 5.4%). Similarly, married men who lived apart from their wives were nearly 3 times more likely to report that their wives had victimized them than were men who lived with their wives (7.0% and 2.4%) (Tjaden & Thoennes, 2000).

These findings suggest that termination of a relationship poses an increased risk of intimate partner violence for both women and men. However, it should be noted that the survey data do not indicate whether the violence happened before, after, or at the time the couple separated. Thus, it is unclear whether the separation triggered the violence or the violence triggered the separation (Tjaden & Thoennes, 2000).

Adolescents are at increased risk for violence—from either their partner or from a family member. Women with HIV or AIDS are also at increased risk for violence (CDC, 2009).

Factors Associated with a Man's Risk for Abusing His Partner	
Individual factors	• Young age • Heavy drinking • Depression • Personality disorders • Low academic achievement • Low income • Witnessing or experiencing violence as a child
Relationship factors	• Marital conflict • Marital instability • Male dominance in the family • Economic stress • Unhealthy family relationships and interactions
Community factors	• Poverty • Low social capital • Weak community sanctions against IPV
Societal factors	• Traditional gender norms • Social norms supportive of violence

Source: Heise & Garcia-Moreno, 2002.

The World Health Organization population survey investigated which factors might protect a woman from intimate partner violence and which factors put her at greater risk. As in other studies, this survey looked at individual and partner factors as well as factors related to the woman's immediate social context (WHO, 2005).

The survey found that in all but two settings (Japan and Ethiopia), younger women (aged 15 to 19 years) were at higher risk for physical or sexual abuse within the last 12 months. In all but two settings (Bangladesh and Ethiopia), women who had been separated or divorced reported much more partner violence during their lifetime than currently married women. Higher education was associated with less violence in many settings (WHO, 2005).

Considerations in Rural Domestic Violence

Rural living may present additional problems for victims of domestic violence, as well as for healthcare providers practicing in rural settings. Unfortunately, research on the specific problems of domestic violence in rural areas is still only a small portion of the work done on domestic violence overall.

Available research suggests some important differences between domestic violence in rural and urban areas and highlights details that merit further research. While the rates of domestic violence in rural and urban areas appear to be similar, victim experiences may be very different. For rural victims of domestic violence, levels of education, employment opportunities, and income are all usually lower. More are homeless, and economic and social support options are generally fewer. Rural victims also appear to experience abuse earlier in their relationships than do urban women (Logan et al., 2003). While protective orders appear to be equally effective in rural and urban areas, rural victims encounter more problems obtaining the orders and getting them enforced, and they experience more personal distress and fear than do their urban counterparts (Logan et al., 2009).

In 2005 a study of twenty years of FBI statistics demonstrated that the more rural the area (based on size of population and distance from a major urban area) the more likely a murdered person was to have been murdered by a family member or intimate partner. Analysis of the data from 1980–1999 showed that "rates for family and intimate partner murders declined regardless of place, whereas rates of intimate partner murders increased only with rurality" (Gallup-Black, 2005).

As noted earlier, isolation—emotional, physical, and economic—can be a factor in why some victims stay in abusive relationships; the geographical circumstances of rural living can exacerbate this factor. There are numerous behaviors employed by abusers to create isolation for their victims, such as limiting a victim's access to family vehicles or preventing her from obtaining a driver's license, ridiculing her in front of others, or accusing her of flirting—thus making her even less likely to invite others to the home or go out herself; and even removing the telephone when leaving the house so that she has no means to communicate with others.

For rural victims these abuser behaviors may be compounded by the realities of rural living, including:

- Lack of phone service (landline or cell access)
- Limited or no public transportation
- Limited access to routine health care
- Long response times for police and medical emergency teams
- Weather and road conditions
- Weapons and dangerous tools more commonly available
- Seasonality of work that may leave the woman “trapped” with her abuser for long periods of time, and in winter alcohol use may increase
- Economic conditions of farm life—single income, value tied to land, need for all to work to stay solvent. If farm is only source of income a restraining order can’t be used to keep the abuser away
- Emotional conditions of farm life—strong ties to animals and land
- Intimidation of travel to a “big city” (WRAP-2, n.d.; Clifford, 2003)

Not only is access to routine health care often limited in rural areas, but rural citizens tend to have fewer insurance resources, providers may be unprepared to do routine IPV screening, and tight-knit communities may discourage people from reporting abuse. Locating shelters in rural areas is also more difficult because they are harder to hide.

Rural healthcare providers not only need to be able to identify domestic violence victims but also to be prepared to offer assistance that addresses the particular needs and problems of rural women. Patients experiencing abuse may have complaints or injuries that include arthritis, irritable bowel syndrome, stomach ulcers, chronic pain, migraines, and eating disorders, and one study found that approximately 64% of rural women with an STD are involved in an abusive physical and sexual relationship. Other closely associated complaints include insomnia, depression, post-traumatic stress disorder, panic disorder, and substance abuse (Clifford, 2003). In addition, safety plans and escape options for rural women may need to be adjusted to meet the specific realities of their situations.

Cost to Society

In 2003 dollars, costs associated with intimate partner violence exceeded $8.3 billion, which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives. Victims of severe intimate partner violence lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (CDC, 2003). This is generally considered an underestimate because the costs associated with the criminal justice system were not included.

The U.S. medical community treats millions of intimate partner rapes and physical assaults annually. Of the nearly 5 million intimate partner rapes and physical assaults perpetrated against women annually, approximately 2 million will result in an injury to the victim, and more than half a million will result in some type of medical treatment to the victim (Tjaden & Thoennes, 2000).

Of the estimated 2.9 million intimate partner physical assaults perpetrated against men annually, 581,391 will result in an injury to the victim, and 124,999 will result in some type of medical treatment to the victim. Many medically treated victims receive multiple forms of care—ambulance services, emergency room care, or physical therapy—and multiple treatments, such as several days in the hospital, for the same victimization (Tjaden & Thoennes, 2000).

Consequences

In general, victims of repeated violence experience more serious consequences than victims of one-time incidents. Women with a history of intimate partner violence are more likely to display behaviors that lead to further **health risks** such as substance abuse, alcoholism, and suicide attempts. Intimate partner violence is also associated with a variety of **negative health behaviors**; studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

Some victims may engage in high-risk sexual behaviors such as unprotected sex, decreased condom use, early sexual initiation, choosing unhealthy or multiple sexual partners, or trading sex for food, money, or other items. There is often an increased use of harmful substances and illicit drug use, alcohol abuse, and driving while intoxicated. Victims of intimate partner violence may also engage in unhealthy diet-related behaviors such as smoking, fasting, vomiting, overeating, and abuse of diet pills. They may also overuse health services.

Women who experience severe aggression by men such as not being allowed to go to work or school, or having their lives or their children's lives threatened, are more likely to have been unemployed in the past and be receiving public assistance (CDC, 2003). They may have restricted access to services, strained relationships with healthcare providers and employers, and be isolated from social networks.

Psychological Consequences of Intimate Partner Violence

- Depression
- Antisocial behavior
- Suicidal behavior in females
- Anxiety
- Low self-esteem
- Inability to trust men
- Fear of intimacy
- Symptoms of post-traumatic stress disorder
- Emotional detachment
- Sleep disturbances
- Flashbacks
- Replaying assault in mind

Screening and Assessment

The number of medical personnel treating injuries annually is in the millions. To better meet the needs of IPV victims, medical professionals should receive training in screening and assessment, learn to recognize the physical consequences of intimate partner violence, and initiate appropriate medical intervention strategies.

Clinicians have an opportunity to identify and intervene on behalf of abused women and men and to assist in breaking the intergenerational cycle that could affect their children. Whenever possible, at the point of detection, clinicians should communicate with the family's other healthcare providers, such as pediatricians. Clinicians should also be aware of and follow state reporting requirements related to domestic violence or child abuse and neglect (CDC, 2006).

Training in the use of efficient assessment methods can increase the percentage of providers that screen for intimate partner violence. When providers are asked why they do not screen for violence, they commonly indicate four major barriers:

- Time constraints
- Discomfort with the topic
- Fear of offending the patient or partner
- Perceived powerlessness to change the problem (CDC, 2006)

Health care organizations and individual providers can increase competency in and commitment to screening for violence. One such screening and intervention method can be summarized in the acronym RADAR, which was developed by the Massachusetts Medical Society (CDC, 2006).

Use Your RADAR:

- **R**outinely screen every patient
- **A**sk directly, kindly, non-judgmentally
- **D**ocument your findings
- **A**ssess the patient's safety
- **R**eview options and provide referrals (CDC, 2006)

The first step in the RADAR process is to routinely screen for violence. Assume that all patients are at risk for violence and ask every patient as part of his or her routine health assessment. Screening requires that the provider ask directly for information at multiple visits. In cases where violence is identified, document your findings in the patient's chart. Assess your patient's safety—is the patient or are his or her children in immediate danger? Finally, review the patient's options and provide him or her with referrals (CDC, 2006).

A woman's behavior during office visits can provide warning signs for possible intimate partner violence. Abused women may present with a flat affect or as frightened, depressed, or anxious. Severe cases may be characterized by symptoms of post-traumatic stress disorder (PTSD), such as dissociation, psychic numbing, or startle responses to touch. Abused women may appear overly compliant. Most patients have a number of questions, but an abused woman may have "learned" not to question authority. Conversely, an abused woman may exhibit excessive distrust of healthcare providers, possibly because of the fear and shame associated with the abuse and the possibility of its detection (CDC, 2006).

Possible Signs of IPV in Women

- Flat affect
- Fright, depression, anxiety
- Post-traumatic stress disorder (PTSD) symptoms (dissociation, psychic numbing, startle responses to touch)
- Over-compliance
- Excessive distrust

Source: (CDC, 2006).

Documentation

Medical records are often used as evidence in domestic violence cases. Clear, concise, and factual documentation can help establish that abuse has occurred. Medical professionals may not be aware that subtle differences in the way they document cases of domestic abuse can affect the usefulness of their records if there is a hearing. For example, "excited utterances" or "spontaneous exclamations" should be carefully documented because they have exceptional credibility due to their proximity to the event and because they are not likely to be premeditated. The victim or the victim's attorney can use a medical record to obtain a restraining order, qualify for special status or exemptions in public housing, welfare, health and life insurance, victim compensation, and immigration relief related to domestic violence and in resolving landlord-tenant disputes (Isaac & Enos, 2001).

According to a number of studies, many medical records are not sufficiently well-documented to provide adequate legal evidence of domestic violence. A study of 184 visits for medical care in which an injury or other evidence of abuse was noted revealed major shortcomings in the records:

- For the 93 instances of an injury, the records contained only 1 photograph. There was no mention in any records of photographs filed elsewhere (for example, with the police).
- A body map documenting the injury was included in only 3 of the 93 instances. Drawings of the injuries appeared in 8 of the 93 instances.
- Doctors' and nurses' handwriting was illegible in key portions of the records in one-third of the patients' visits in which abuse or injury was noted.
- Criteria for considering a patient's words an "excited utterance" were met in only 28 of the more than 800 statements evaluated (3.4%). Most frequently missing was a description of the patient's demeanor, and often the patient was not clearly identified as the source of the information. (Isaac & Enos, 2001)

Medical records could be more useful to domestic violence victims in legal proceedings if some minor changes were made in documentation. Clinicians can do the following:

- Take photographs of injuries known or suspected to have resulted from domestic violence.
- Write legibly. Computers can also help overcome the common problem of illegible handwriting.
- Set off the patient's own words in quotation marks or use such phrases as "patient states" or "patient reports" to indicate that the information recorded reflects the patient's words. To write "patient was kicked in abdomen" obscures the identity of the speaker.
- Avoid such phrases as "patient claims" or "patient alleges," which imply doubt about the patient's reliability. If the clinician's observations conflict with the patient's statements, the clinician should record the reason for the difference.
- Describe the person who hurt the patient by using quotation marks to set off the statement. The clinician would write, for example: The patient stated, "My boyfriend kicked and punched me."
- Avoid summarizing a patient's report of abuse in conclusive terms. If such language as "patient is a battered woman," "assault and battery," or "rape" lacks sufficient accompanying factual information, it is not admissible.
- Do not place the term "domestic violence" or abbreviations such as "DV" or "IPV" in the diagnosis section of the medical record. Such terms do not convey factual information and are not medical terminology. Whether domestic violence has occurred is determined by the court.
- Describe the patient's demeanor, indicating, for example, whether she is crying or shaking or seems angry, agitated, upset, calm, or happy. Even if the patient's demeanor belies the evidence of abuse, the clinician's observations of that demeanor should be recorded.
- Record the time of day the patient is examined and, if possible, indicate how much time has elapsed since the abuse occurred. For example, the clinician might write, "Patient states that early this morning his boyfriend hit him." (Isaac & Enos, 2001)

Kentucky Reporting Requirements

In 1978 the Adult Protection Act (KRS 209), which had been passed in 1976, was expanded to include mandatory reporting and provision of voluntary protective services to spousal abuse victims (KSP, 2008).

All suspected cases of domestic violence (including child, elder/adult, and spouse abuse) are to be reported to the Cabinet for Health and Family Services (CHFS). During normal working hours local Protective Services should be contacted but at all other times call (800) 752-6200.

Child Abuse

"If you believe a child is being abused, neglected or is dependent, you should call the Child Protection Hot Line at (800) 752-6200 or the Protection and Permanency office in your county" (CHFS, 2010a). A list of contact information for those offices is available by searching the website at https://apps.chfs.ky.gov/Office_Phone/index.aspx.

Elder Abuse

Did you know…

> If you suspect elder abuse, you are legally required to report it. (CHFS, 2010b).

The DCBS offers this guidance for anyone who is concerned about possible elder abuse:

> If you believe that an elderly person is in imminent danger, call (800) 752-6200 or your local law enforcement agency immediately. If the person is not in imminent danger but you are suspicious, watch the way the caregiver acts toward the elderly or disabled person. Look for a pattern of threatening, harassing, blaming or making demeaning remarks to the person — or isolating the person from family members and friends. Watch for an obvious lack of helpfulness or indifference, aggression or anger toward the person. Listen for conflicting stories about the elderly or disabled person's illnesses or injuries." Know the signs of neglect, physical abuse, sexual abuse, emotional/psychological abuse, and financial abuse. (CHFS, 2007)

A detailed list of many of the signs of self-neglect, caregiver neglect, physical abuse, emotional abuse, and financial abuse are provided on the CHFS Elder Abuse Awareness website at http://chfs.ky.gov/dcbs/dpp/eaa/SignsOfAbuse.htm.

Intimate Partner Abuse

Kentucky Revised Statue 209A.030 states the following:

> (2) Any person, including, but not limited to, physician, law enforcement officer, nurse, social worker, cabinet personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.
>
> (3) An oral or written report shall be made immediately to the cabinet upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: The name and address of the adult, or of any other person responsible for his care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation.

(4) Upon receipt of the report, the cabinet shall take the following action as soon as practical:

(a) Notify the appropriate law enforcement agency;
(b) Initiate an investigation of the complaint; and
(c) Make a written report of the initial findings together with a recommendation for further action, if indicated.

In January 1996 the Kentucky Attorney General rendered a written interpretation of the law at the request of a physician. This document known as Ky. OAG 96-6 may also be of help to nurses wishing clarification of the law. The full text may be found on the attorney general's website by searching "opinion 96-6."

Related Statutes

In addition to the mandatory reporting requirement laws, Kentucky nurses and other healthcare professionals should keep themselves informed of the current status of related statutes. Establish good communication with local law enforcement and judicial offices in order to stay abreast of any changes. The following programs relevant to domestic abuse situations

- Domestic violence protective orders
- Stalking law
- VINE (Victims Information and Notification Everyday) system

Prevention and Education

Most of the efforts directed against intimate personal violence center on reducing future additional risk, dealing with the consequences of the violence for the victim, and processing the perpetrators through the judicial system. As with its first agenda in 2002, the National Center for Injury Prevention and Control's new agenda for 2009–2018 reiterates the goal for prevention and education: stopping intimate personal violence from happening in the first place (primary prevention). Research efforts are urgently needed surrounding "early risk and protective factors related to perpetration." A better understanding of these factors should lead to more effective prevention programs. As before, prevention must address individual, relationship, community, and societal factors (NCIPC, 2009).

The National Center for Injury Prevention and Control has identified two tiers of research priorities for the next ten years aimed at preventing sexual violence and intimate partner violence. These ambitious goals reflect the strong need for detailed and broad-based data for the formulation and implementation of prevention strategies for sexual violence and intimate partner violence.

Tier 1 includes:

- Develop and evaluate surveillance methods for sexual violence and intimate partner violence victimization and perpetration.
- Examine the etiology of sexual violence and intimate partner violence perpetration to identify modifiable risk and protective factors and optimal times and strategies for prevention.
- Clarify the contexts within which violence occurs and the associations among types and subtypes of sexual violence and intimate partner violence, other types of violence, other risk behaviors, and other health outcomes to determine implications for prevention of perpetration.
- Examine the role of disparities in the occurrence and development of sexual violence and intimate partner violence and determine implications for prevention of perpetration.
- Evaluate the efficacy and effectiveness of programs, strategies, and policies across all levels of the social ecology to prevent and interrupt development of perpetration of sexual violence and intimate partner violence.
- Evaluate the efficacy and effectiveness of programs, strategies, and policies to prevent both sexual violence and intimate partner violence, multiple types of sexual violence and intimate partner violence, and other forms of violence.

Tier 2 includes:

- Assess the cost and health burden of sexual violence and intimate partner violence throughout the life span.
- Evaluate the economic efficiency of programs, strategies, and policies to prevent perpetration of sexual violence and intimate partner violence.
- Evaluate interventions for persons exposed to sexual violence and intimate partner violence to reduce risk for associated negative health consequences.
- Conduct dissemination and implementation research regarding programs, strategies, and policies used in the primary prevention of sexual violence and intimate partner violence.
- Examine when and how to adapt effective programs, strategies, and policies to prevent sexual violence and intimate partner violence for new settings and among diverse populations (NCIPC, 2009).

The World Health Organization, following its ten-country survey of violence against women made the following recommendations for prevention and education:

- Strengthen national commitment and action by promoting gender equality and women's human rights.
- Promote primary prevention including giving higher priority to child sexual abuse.
- Involve educators.
- Strengthen healthcare provider response.
- Provide support services for women living with violence.
- Sensitize the criminal justice system.
- Support research and collaboration and increase donor support. (WHO, 2005)

Resources

Kentucky Reporting Help Lines
Adult and Child Abuse Reporting Hotline
(800) 752-6200
Spouse Abuse Shelter Hotline
(800) 544-2022

VINE: The National Victim Notification Network / VINELink
Victim Information and Notification Everyday
(800) 511-1670

Kentucky Domestic Violence Association
P.O. Box 356
Frankfort, KY 40602
Phone: (502) 209-KDVA (5382)
Fax: (502) 226-KDVA (5382)
Email: info@kdva.org (general information)
http://www.kdva.org
http://www.kdva.org/kydvcenter.html (links to regional assistance programs)

National Domestic Violence Hotline
(Linea Nacional sobre la Violencia Domestica)
(800) 799-SAFE (800 799-7233)
TDD: (800) 787-3224
http://www.ndvh.org/

Centers for Disease Control and Prevention
Violence Prevention: Intimate Partner Violence
http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html

Rural Assistance Center
Domestic Violence
http://www.raconline.org/info_guides/public_health/domesticviolence.php

The National Women's Health Information Center
Violence Against Women
http://www.womenshealth.gov/violence/index.cfm

References

Bluegrass Area Development District (BGADD). 2010. *What Is an ADD?* Retrieved May 24, 2010 from http://www.bgadd.org/about.htm.

Catalano S. (2007). *Intimate Partner Violence in the United States*. U.S. Department of Justice: Bureau of Justice Statistics. Retrieved May 18, 2010 from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1000.

Centers for Disease Control and Prevention (CDC). (2009). *Understanding Intimate Partner Violence Fact Sheet*. Retrieved May 18, 2010 from http://www.cdc.gov/violenceprevention/pdf/IPV_factsheet-a.pdf.

Centers for Disease Control and Prevention (CDC). (2008). *Intimate Partner Violence: Definitions*. Retrieved May 18, 2010 from http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html.

Centers for Disease Control and Prevention (CDC). (2006). *Intimate Partner Violence during Pregnancy, A Guide for Clinicians*. Retrieved May 18, 2010 from http://www.cdc.gov/ReproductiveHealth/violence/IntimatePartnerViolence/.

Centers for Disease Control and Prevention (CDC). (2003). Costs of intimate partner violence against women in the United States. National Center for Injury Prevention and Control. Retrieved May 24, 2010 from http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm.

Child Welfare Information Network. (2010). *Definitions in Federal Law*. Retrieved May 24, 2010 from http://www.childwelfare.gov/can/defining/federal.cfm.

Child Welfare Information Gateway. (2009). *Definitions of Child Abuse and Neglect: Summary of State Laws*. Retrieved May 14, 2010 from http://www.childwelfare.gov/systemwide/laws_policies/statutes/defineall.pdf.

Clifford A. (2003). Intimate partner violence in rural women. *Kentucky Nurse* Oct-Dec 2003. Retrieved May 10, 2010, from findarticles.com/p/articles/mi_qa4084/is_200310/ai_n9315572.

Fritsch TA, Tarima SS, Caldwell GG, Beaven S. (2005). *Population-based surveillance of intimate partner violence against Kentucky women: A comparison of state and national definitions and findings*. Kentucky Injury Prevention and Research Center. Retrieved May 18, 2010 from http://www.kiprc.uky.edu/projects/ipv/Peer_Review--KY_Epi_Notes_and_Records_final.pdf.

Gallup-Black A. (2005). *Twenty Years of Rural and Urban Trends in Family and Intimate Partner Homicide: Does Place Matter?* Abstract. Retrieved May 18, 2010 from http://www.ncjrs.gov/app/publications/abstract.aspx?ID=209642.

Gil-González D, Vives-Cases C, Ruiz MT, et al. (2008). Childhood Experiences of Violence in Perpetrators as a Risk Factor of Intimate Partner Violence: A Systematic Review. *J Public Health* 2008;30(1):14–22. Oxford University Press. Retrieved September 17, 2008 from http://www.medscape.com/viewarticle/571357_1.

Heise L, Garcia-Moreno C. (2002). Violence by intimate partners. In E Krug, LL Dahlberg, JA Mercy, et al. (eds). World report on violence and health. Geneva (Switzerland): World Health Organization,. pp. 87–121. Retrieved May 24, 2010 from http://www.who.int/violence_injury_prevention/publications/violence/en/index.html and http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap4.pdf.

Isaac NE, Enos VP. (2001). *Documenting domestic violence: How healthcare providers can help victims*. Washington DC: National Institute of Justice. Retrieved May 18, 2010 from http://www.ncjrs.gov/pdffiles1/nij/188564.pdf.

Kelleher K, Gardner W, Coben J, et al. (2006). *Co-occurring Intimate Partner Violence and Child Maltreatment: Local Policies/Practices and Relationships to Child Placement, Family Services and Residence*. Document No. 213503. Retrieved May 24, 2010 from http://www.ncjrs.gov/pdffiles1/nij/grants/213503.pdf.

Kentucky Cabinet for Health and Family Services (CHFS). (2010a). Department for Community Based Services, Protection and Permanency, Child Safety Branch. Retrieved May 24, 2010 from http://chfs.ky.gov/dcbs/dpp/childsafety.htm.

Kentucky Cabinet for Health and Family Services (CHFS). (2010b). *Elder Abuse Awareness Overview*. Department for Community Based Services, Protection and Permanency. Retrieved May 24, 2010 from http://chfs.ky.gov/dcbs/dpp/eaa/.

Kentucky Cabinet for Health and Family Services (CHFS). (2010c). Department for Community Based Services, Violence Prevention Resources, Batterer Intervention. Retrieved May 24, 2010 from http://chfs.ky.gov/dcbs/dvpr/dv_default.htm.

Kentucky Cabinet for Health and Family Services (CHFS). (2007). Department for Community Based Services, Protection and Permanency, Elder Abuse Awareness, Signs of Abuse. Retrieved May 24, 2010 from http://chfs.ky.gov/dcbs/dpp/eaa/SignsOfAbuse.htm.

Kentucky Cabinet for Health and Family Services (CHFS). (2006). State Council on Domestic Violence and Sexual Assault appointed. Press release, August 17, 2006. Retrieved May 10, 2010 from http://chfs.ky.gov/news/Domestic+Violence+Council+appointed.htm.

Kentucky Domestic Violence Association (KDVA). (2010a). *History*. Retrieved May 11, 2010 from http://www.kdva.org/history.html.

Kentucky Domestic Violence Association (KDVA). (2010b). Member Domestic Violence Programs. Retrieved May 11, 2010 from www.kdva.org/kydvcenter.html.

Kentucky Domestic Violence Association (KDVA). (2009a). *KDVA UPDATE: Newsletter of the Kentucky Domestic Violence Association. Spring 2009*. Retrieved May 10, 2010 from http://www.kdva.org/documents/Spring2009.pdf.

Kentucky Domestic Violence Association (KDVA). (2009b). *KDVA UPDATE: Newsletter of the Kentucky Domestic Violence Association. Fall 2009*. Retrieved May 10, 2010 from http://www.kdva.org/documents/Fall2009.pdf.

Kentucky Domestic Violence Association (KDVA). (2009c). *Resources: Statistics*. Retrieved May 10, 2010 from http://www.kdva.org/documents/FY2009Stats.pdf

Kentucky Domestic Violence Association (KDVA). (2008). *KDVA UPDATE: Newsletter of the Kentucky Domestic Violence Association. Fall 2008*. Retrieved May 10, 2010 from http://www.kdva.org/documents/Fall2008.pdf.

Kentucky Domestic Violence Association (KDVA). (2006). *UPDATE: Newsletter of the Kentucky Domestic Violence Association. Fall 2006*. Retrieved May 11, 2010 from http://www.kdva.org/documents/Fall2006.pdf.

Kentucky Legislature. *Kentucky Revised Statutes*. Available from http://www.lrc.ky.gov/legislation.htm.

Kentucky State Police (KSP). (2004–2008). Crime and Traffic Data/Publications. *Crime in Kentucky*. Retrieved May 10, 2010 from http://www.kentuckystatepolice.org/data.htm#ciky.

Logan TK, et al. (2009). *The Kentucky Civil Protective Order Study: A Rural and Urban Multiple Perspective Study of Protective Order Violation Consequences, Responses, and Costs*. Retrieved May 24, 2010 from http://www.ncjrs.gov/pdffiles1/nij/grants/228350.pdf.

Logan TK, et al. (2003). *Qualitative Differences Among Rural and Urban Intimate Violence Victimization Experiences and Consequences: A Pilot Study*. Abstract. Retrieved May 20, 2010 from http://www.ncjrs.gov/app/publications/abstract.aspx?ID=200928.

National Center for Injury Prevention and Control. (2009). *CDC Injury Research Agenda 2009–2018*. Atlanta: Centers for Disease Control and Prevention, 2002. Retrieved May 24, 2010 from http://www.cdc.gov/injury/ResearchAgenda/CDC_Injury_Research_Agenda-a.pdf.

National Center on Elder Abuse (NCEA). (2005). *Elder Abuse, Prevalence and Incidence*. Retrieved May 24, 2010 from http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/FinalStatistics050331.pdf.

Nelson HD, Nygren P, McInerney Y, Klein J. (2004, March). *Screening Women and Elderly Adults for Family and Intimate Partner Violence: A Review of the Evidence for the U.S. Preventive Services Task Force*. Originally in *Ann Intern Med* 2004;140(5)387–96. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved May 24, 2010 from http://www.ahrq.gov/clinic/3rduspstf/famviolence/famviolrev.htm.

Noll J. (2009). Lawmakers Put Stop To "Cyberstalking." *Kentucky Post*. Retrieved May 18, 2010 from http://www.kypost.com/news/local/story/Lawmakers-Put-Stop-To-Cyberstalking/vW_XKWIa-0-m2mCI4JBLPg.cspx.

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. (2001). *Intimate Partner Violence Surveillance: Uniform definitions and recommended data elements, Version 1.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2001. Retrieved May 24, 2010 from http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/intimate.htm.

Tjaden P, Thoennes N. (2000). *Extent, Nature, and Consequences of Intimate Partner Violence. Findings from the National Violence Against Women Survey*. July 2000. NCJ 181867. Retrieved May 18, 2010 from http://www.ncjrs.gov/pdffiles1/nij/181867.pdf.

WFIE. (2010). *New domestic violence bill now law in Kentucky*. Retrieved May 14, 2010 from http://www.14wfie.com/Global/story.asp?S=12392016.

Wolfson, A. (2009). *Special report. Fighting domestic violence in Kentucky: Court orders offer protection to many – and advocates seek more*. Retrieved May 14, 2010 from http://www.courier-journal.com/article/20091115/NEWS01/911150316/Special-report-|-Fighting-domestic-violence-in-Kentucky.

Women's Rural Advocacy Programs (WRAP). (n.d.). *Why Women Stay: The Barriers to Leaving*. Retrieved May 24, 2010 from http://www.letswrap.com/dvinfo/whystay.htm.

Women's Rural Advocacy Programs (WRAP-2). (n.d.). *Problems of Rural Battered Women*. Retrieved May 10, 2010 from http://www.letswrap.com/dvinfo/rural.htm.

World Health Organization (WHO). (2010). *Gender, women and health: Gender-based violence*. Retrieved May 24, 2010 from http://www.who.int/gender/violence/en/.

World Health Organization (WHO). (2005). *Multi-Country Study on Women's Health and Domestic Violence against Women*. Retrieved May 24, 2010 from http://www.who.int/gender/violence/who_multicountry_study/en/index.html.

(Post test begins on next page)

Post Test

Use the Answer Sheet following the test to record your answers.

1. Intimate partner violence (IPV):
   a. Refers only to relationships that involve sexual intimacy.
   b. Never includes child abuse.
   c. Refers to violence that occurs between current or former partners or spouses.
   d. Never includes elder abuse.

2. The perpetrators of intimate partner violence are evenly divided between men and women.
   a. True
   b. False

3. The 2005 IPV Surveillance Project in Kentucky found that incidents of domestic violence:
   a. Had increased by 50% during the previous ten years.
   b. Had declined substantially and were no longer considered a significant problem.
   c. Did not include murder.
   d. Affected KY women at a higher rate than the national average.

4. The agency mandated by Kentucky law to receive reports of adult abuse is the:
   a. Department for Community Based Services.
   b. Kentucky State Police.
   c. Law Information Network of Kentucky.
   d. Kentucky Domestic Violence Association.

5. Kentucky's fifteen domestic violence programs currently provide only safe shelter.
   a. True
   b. False

6. In Kentucky protective orders have generally been found to be:
   a. Ineffective at reducing fear in victims.
   b. Ineffective at reducing violence.
   c. Less effective for stalking victims.
   d. Completely ineffective.

7. The Centers for Disease Control and Prevention describes physical violence as:
   a. Stalking and cyberstalking.
   b. The use of physical force to coerce another person to engage in a sex act.
   c. Abusive language that includes threats of violence.
   d. The intentional use of physical force with potential for causing death, disability, injury, or harm.

8. Choking, shaking, slapping, punching, or burning is an example of:
   a. Psychological violence.
   b. Stalking.
   c. Physical violence.
   d. Sexual violence.

9. Sexual and physical abuse is often accompanied by controlling behaviors. Controlling behaviors include:
   a. Preventing a partner from seeing friends.
   b. Verbal abuse.
   c. Hitting and slapping.
   d. Cyberstalking.

10. The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm is:
    a. Controlling behavior.
    b. Threat of physical or sexual violence.
    c. Psychological violence.
    d. Stalking.

11. An underlying component of all types of domestic violence is:
    a. Isolating the victim from family and friends.
    b. Withholding information.
    c. Coercive control and intimidation.
    d. Threat of physical violence.

12. Repeated harassing or threatening behavior such as following a person or making harassing phone calls is a description of:
    a. Sexual harassment.
    b. Coercive control and intimidation.
    c. Controlling behavior.
    d. Stalking.

13. The variable most likely to predict that a woman will be victimized by an intimate partner is a partner who is:
    a. Verbally abusive.
    b. From a different country.
    c. Of a different race.
    d. Of a different religion.

14. The Federal Child Abuse Prevention and Treatment Act (CAPTA) includes:
    a. Abuse or neglect by parents or other caregivers.
    b. Abusive behavior by a child's friend.
    c. Abusive behavior directed at a person under 20 years of age.
    d. Only physical abuse perpetrated on a child and does not include neglect.

15. Children who are exposed to domestic violence are at risk for poor development. Evidence shows that a child's exposure to domestic violence:
    a. May cause autism.
    b. Contributes to physical illness.
    c. Constitutes a type of psychological abuse.
    d. Has no effect on the child's development.

16. According to Kentucky law, obtaining or using another person's resources with the intent to deprive the person of those resources is:
    a. Exploitation.
    b. Abuse
    c. Coercion.
    d. Neglect.

17. According to available data, the highest rates of elder abuse:
    a. Occur among elderly men.
    b. Are perpetrated by elderly men.
    c. Are perpetrated by nursing home owners.
    d. Occur among women over age 80 and are perpetrated by a family member.

18. Intimate partner violence:
    a. Occurs as frequently in low income households as in high income households.
    b. Is more likely to occur if a woman lives with her husband than if separated from him.
    c. Occurs more often when a woman is separated from her husband.
    d. Is more likely to occur during middle age.

19. Rural abuse victims may experience even greater effects of isolation than non-rural victims.
    a. True
    b. False

20. Psychological consequences of intimate partner violence include all of the following except:
    a. Antisocial behavior.
    b. Emotional detachment.
    c. Suicidal behavior in females.
    d. Decreased likelihood of becoming an abuser.

21. A screening and intervention method for healthcare providers that may be used to detect, document and provide referrals to victims of domestic violence is called:
    a. PTSD.
    b. RADAR.
    c. CDC.
    d. DCBS.

22. When documenting a domestic violence occurrence, healthcare professionals should:
    a. Never take photographs.
    b. Write down their own observations, and never use quotation marks.
    c. Describe the patient's demeanor.
    d. Only report the time of day the patient is being examined, not the time the abuse occurred.

23. Any person who believes that a child is abused or neglected is required by Kentucky law to:
    a. Report suspected abuse to the police.
    b. Report the suspected abuse to the Kentucky Child Protection Hot Line.
    c. Call the National Abuse Hotline.
    d. Remove the abused child from their home.

24. In Kentucky, only nurses and other healthcare-related professions are required by law to report suspected cases of elder or child abuse.
    a. True
    b. False

25. In Kentucky, nurses and other healthcare-related professions are required by law to report suspected cases of spouse abuse.
    a. True
    b. False

(Answer sheet on next page)

Answer Sheet

Kentucky: Domestic Violence

Name (Please print your name): ____
Date: ________________

Passing score is 80%

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______
16. ______
17. ______
18. ______
19. ______
20. ______
21. ______
22. ______
23. ______
24. ______
25. ______

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks (*) are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

*1. Upon completion of the course, I was able to:

a. Describe the scope of domestic violence in the United States and Kentucky.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

b. List the five main categories of domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

c. Explain the prevalence of violence against women and how it relates to domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

d. Show the significance of the co-occurrence of child maltreatment and domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

e. Identify the relationship of elder abuse to domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

f. Outline the economic and societal costs of domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

g. Teach best practices for screening, assessment, and documentation of domestic violence in the healthcare setting.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

h. Summarize Kentucky legislation relating to domestic violence, including reporting requirements for healthcare professionals.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

i. Discuss goals for prevention and education program research.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*2. The course was written in a way that facilitated my learning.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*3. This course was free from commercial bias.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*4. The course met my continuing education needs.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*5. The material presented was supported by evidence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*6. The author avoided the use of anecdotal information as the main source of material.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*7. The course was free of product promotion.

❑ Yes ❑ No**

** If you answered no, please answer #8.

8. Was product promotion the sole purpose of the presentation?

❑ Yes ❑ No

* 9. It took me 60 minutes per contact hour to complete the course, test, and evaluation.

❑ Yes ❑ No**

** If your answer was no, how long did it take? ______________________________

10. My professional educational level is (check one):

Nursing

❑ Nurse Aide ❑ LVN/LPN ❑ RN (diploma) ❑ RN (AD)

❑ BSN ❑ MSN ❑ Nurse Practitioner / Advanced Practice Nurse

❑ PhD / DNSc

Therapy

❑ OT Aide ❑ COTA ❑ OT ❑ MOT ❑ OTD

❑ PT Aide ❑ PTA ❑ PT ❑ MPT ❑ MSPT ❑ DPT ❑ PhD

Other (please specify): ____

11. I heard about ATrain Education from:

❑ Search engine ❑ Advertisement

❑ Government or Board website ❑ Returning customer

❑ Friend ❑ Publication (Magazine, etc.)

❑ Other ___________________________

12. I found the ATrainCEU.com website easy to use:

❑ Yes ❑ No

13. Comments or suggestions (optional): ______________________________________

____

Registration Information

Please answer all of the following questions (*required).

* Name: ____

* Address: ____

* City: ________________________________State:______ Zip: __________

* Phone: ____

* Professional Designation: _________________________________

* License Number and State: _________________________________

Please email my certificate: ❑ Yes ❑ No
Email (required if you want your certificate sent by email): ____________________
(If you request an email certificate we will **not** send a copy of the certificate by US Mail.)

Payment Options
You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
3 contact hours: $25

Credit card information:
Name ____

Address (if different from above): ________________________________

City: ________________________________State:____ Zip: _________

Card type: ❑ Visa ❑ MC ❑ American Express ❑ Discover

Card number ________________________________ CVS # ______________

Expiration date ____

Test Completion and Mailing Instructions
1. Complete all forms:
   - ❑ Answer Sheet
   - ❑ Evaluation Learning Activity
   - ❑ Registration Form (this page)
2. If you are **paying by check,** prepare a check for $25 made out to ATrain Education, Inc.

3. Mail the completed forms and your payment to:
   ATrain Education, Inc
   5171 Ridgewood Rd
   Willits, CA 95490

When we receive your forms and payment, we will mail (or email, if you request it) your certificate of completion. If you have any questions or concerns, please call or contact us at Sharon@ATrainCEU.com. And thanks for taking the ATrain!