KY: Domestic Violence

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Contact hours: 3

Course price: $25

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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.

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Criteria for Successful Completions

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

Course Objectives

When you finish this course you will be able to:

- Define and explain intimate partner violence.
- Describe the scope of domestic violence in the United States and in Kentucky.
- List the four 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.
- Spell out the risks of intimate partner violence as well as the protective factors.
- Describe special considerations in rural domestic violence.
- Discuss the economic and societal costs of domestic violence.
- Explain the consequences of domestic violence.
- Outline screening and assessment of domestic violence in the healthcare setting.
- Tell how to document incidents of domestic violence.
- 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) describes physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner (CDC, 2016). 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, 2016; WHO, 2016).

There are four main types of IPV:

- Physical violence—the intentional use of physical force with the potential for causing death, disability, injury, or harm.

- Sexual violence (has five categories)
  - Rape or penetration of victim
  - Victim was made to penetrate someone else
  - Non-physically pressured unwanted penetration
  - Unwanted sexual contact
  - Non-contact unwanted sexual experiences
- Stalking—a pattern of repeated, unwanted attention and contact that causes fear or concern for one's own safety or the safety of someone else (eg, family member or friend).
- Psychological aggression—the use of verbal and nonverbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person (CDC, 2016, 2015, 2014b).

The CDC advocates use of a consistent definition of IPV, as above, to facilitate systematic data collection and meaningful comparisons and analysis of trends (CDC, 2016, 2015).

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 1994 to 2010, U.S. Department of Justice statistics showed that IPV declined by more than 60% for both males and females (Catalano, 2012), but a study of nonfatal domestic violence for 2003–2012 shows that females (76%) still experienced more domestic violence victimizations than did males (24%) (Morgan & Truman, 2014; CDC, 2014).

The rate of fatal incidents of intimate partner violence—sometimes referred to as **intimate homicide**—fluctuated during the period from 1980 to 2008 in the United States. The rate for both black and white males remained about 5% after 2002, while for females it rose from all-time lows in 1995 to 43% for black females and 45% for white females in 2008 (Cooper & Smith, 2011).

Violent crime statistics gathered in 2013 and 2014 reflect a continuing decrease in violent crime overall, including domestic violence and intimate partner violence, since 2005 (Truman & Langton, 2015). However, while the overall rate of homicide has declined, women continue to be 64% of the victims of intimate partner homicide, and, considering all murder victims, "women are six times more likely than men to be killed by a current or former partner" (Zweig, 2014).

Statistics gathered in the first Centers for Disease Control and Prevention (CDC) National Intimate Partner and Sexual Violence Survey (NISVS) in 2010 showed that 35.6% of women and 28.5% of men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime. In Kentucky it is 37.5% of women and 31% of men, while percentages in other states range from 26 to 48 for women and 17 to 40 for men (CDC, 2011). The NISVS is being administered annually and will be used to track trends in IPV as well as sexual violence and stalking (CDC, 2014).

Broad national survey data can be more telling than law enforcement statistics because of the reluctance of both women and men to report intimate partner violence. In the National Violence Against Women Survey (NVAWS) completed in 1996, 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 & Thoennes, 2000). However, a later review of studies found that reluctance to report can have many reasons, varies with the type of violence and the details of a given situation, and is not always correlated in the way people expect (Felson & Paré, 2005).

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, over 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 religious leaders, police, 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" (KCHFS, 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). As noted above, the most recent CDC statistics indicate that 37% of Kentucky women have suffered victimization by an intimate partner at some point in their lifetime (CDC, 2011). Because the definitions across data collections have not always been standardized, comparisons can be tricky; it will be important to follow the CDC NISVS data in future years.

Changes do take place. A 2013 editorial in the *Maysville Ledger-Independent* noted that Kentucky was one of just a few states that did not allow dating partners to obtain protection orders, and it had one of the highest percentages of high school students subjected to dating violence (Ledger-Independent, 2013). On January 1, 2016, House Bill 8 became effective, revising Kentucky's domestic violence statutes to extend "the ability to get a civil order of protection to victims of dating violence and abuse, sexual assault or stalking" (Kentucky Court of Justice, 2016; KRS 456.010-456.180).

On September 16, 2015, all fifteen of Kentucky's domestic violence programs participated in the 2015 National Census of Domestic Violence Services, a one-day survey held under the aegis of the National Network to End Domestic Violence. In just that one 24-hour period the state's programs provided services to 1,004 victims of domestic violence (adults and children). These services included support and advocacy, emergency shelter, transitional housing, prevention services, and educational services.

Unfortunately, on that same day, 129 requests (up from 89 in 2012) could not be met; 68% of the unmet requests were for housing. In the previous year across Kentucky, 40 individual services at local programs were reduced or eliminated and programs reported a decline in government and private funding as well as fewer donors. In addition, across the state 18 staff positions were eliminated, all of which had provided direct services, thus leaving fewer advocates to address requests for help. Losses of funding and staff in Kentucky are higher than the national average as reflected in the 2015 survey (NNEDV, 2015).

Overview of Kentucky Response

Kentucky's Adult Protection Act (KRS 209) requires the reporting of known or suspected incidences of adult abuse or neglect, and all required reports of domestic violence incidents by law 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 (KSP, 2014). [See later section of the course for specifics on Kentucky legislation.]

In fiscal year 2014 the DCBS investigated 20,481 allegations of domestic violence. This was a 7.5% decrease over 2013 (KSP, 2014). The number of allegations had begun to climb in 2008 and continued to climb through 2010, followed by small decreases in 2011 and 2012. However, the number of allegations investigated in 2012 was still greater than the 19,193 investigated in 2008, and the numbers increased again in 2013. Despite a decrease from 2013, the 2014 numbers still exceed those for 2008.

In fiscal year 2014 the Kentucky Coalition Against Domestic Violence **(KCADV)** received 23,620 domestic violence-related calls and 31,390 calls asking for information and/or referrals (KCADV, 2014a). Both figures represent declines over 2012 (3.8% and 44.7% respectively). While these declines reflect a continued downward trend and are important, domestic violence remains a critical problem in Kentucky.

Domestic Violence Centers

The first spousal 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 a statewide coalition—the Kentucky Domestic Violence Association, now called the Kentucky Coalition Against Domestic Violence (KCADV). "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" (KCADV, 2016).

Kentucky is divided into 15 multi-county Area Development Districts (ADDs) created by state law and run as local partnerships. The ADDs tap into local expertise and provide a means to organize planning, services, and statistical information across the state; thus "it made sense to use [them] as targeted areas for domestic violence services" (BADD, 2016). Kentucky reached the goal of providing services in every ADD in 1985 (KCADV, 2016).

These 15 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 379 people at one time (down from 465 in 2012 and 485 in 2008) (KCADV, 2014). In fiscal year (FY) 2014, 4,008 victims and their children were sheltered for 163,463 resident days, but almost 2,500 people were unable to be sheltered at some time during the year (KCADV, 2014, 2014a; KSP, 2014).

Services Provided by KY Domestic Violence Programs in Fiscal Year 2014 (July 1,2013 to June 30, 2014)		
New residential individuals served	3,258	1869 women 1350 children 28 men / 11 unknown
New non-residential individuals served	22,502	21,241 women 8 children 1221 men / 40 other
Residential bednights	163,463	

Source: KCADV, 2014a.

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 nonresidents are:

- Legal/court advocacy
- Case management
- Safety planning
- Support groups and individual counseling
- Children's groups and parenting classes
- Housing assistance
- Financial education, budgeting, and help in reaching economic independence
- Access to Individual Development Accounts, free tax preparation, and job search assistance
- Drug and alcohol services or referrals to substance abuse programs (KCADV, 2014)

In fiscal year 2014 Kentucky domestic violence programs provided medical advocacy for 2,143 adult residential clients and 909 nonresidents, and legal advocacy for 1,960 adult residential clients and 16,457 nonresidents. Group, family, and individual counseling sessions for all adult and youth clients totaled nearly 160,000 hours (KCADV, 2014a).

Domestic Violence Protective Orders

An important recourse for domestic violence victims is protective orders. **Emergency Protective Orders (EPOs)** and **Domestic Violence Orders (DVOs)** are court orders that can order an abuser to stay away from and/or not contact the person they have been abusing. Usually the petitioner first asks for an EPO and the petition is reviewed by a judge. EPOs cannot be effective for more than 14 days, so if the judge grants the order a hearing date is set within that time period and the respondent must be served with a copy of the order. At the hearing, the court will decide if a DVO should be issued. A DVO can be effective for up to three years (Legal Aid Network of Kentucky, 2009; KRS 403.740). As noted above, beginning in 2016 protective orders can be obtained by dating partners, not just those who are married, living together, or who have a child together.

According to statistics compiled by the Kentucky State Police (KSP) for its annual *Crime in Kentucky* report, 22,813 petitions were filed by persons seeking DVOsin calendar year 2014. This represents a small decline over 2013, but both figures were higher than the 21,207 filed in 2012. Emergency Temporary Orders and Emergency Protective Orders reported to the Law Information Network of Kentucky (LINK) showed a 4.5% decrease in 2014 over 2013 (KSP, 2014).

Batterer Intervention Programs

In Kentucky batterer intervention is established by statute (KRS 403.7505) and administrative regulation (920 KAR 2:020). A certification program for batterer intervention providers was established in 1996 and the first providers were certified two years later. There are now about 121 of these certified mental health professionals offering services in 54 counties. A list of providers is available from the DCBS website (KCHFS, 2013).

Types of Intimate Partner Violence

According to Kentucky law (KRS 403.720):

> **Domestic violence and abuse** means physical injury, serious physical injury, stalking, 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 grandparent, a parent, a child, a stepchild, or any other person living in the same household as the child if the child is the alleged victim.

> **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) identifies four types of intimate partner violence—**physical violence**, **sexual violence**, **stalking**, and **psychological aggression**. Information about the important revisions in definition can be found in the CDC's *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0*, which was published in 2015. The CDC strongly advocates for coherent and uniform definitions to improve the collection and analysis of data and help to identify trends and make comparisons (CDC, 2015).

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, aggressive hair pulling, slapping, punching, hitting 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, 2016)

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. The National Violence Against Women Survey (NVAWS) found that women who were physically assaulted by an intimate partner averaged 6.9 physical assaults by the same partner, while men who were assaulted averaged 4.4 assaults.

Women experience more chronic and injurious physical assaults at the hands of intimate partners than do men. The NVAWS 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. 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 (Tjaden & Thoennes, 2000).

Sexual Violence

Sexual violence is divided into five categories, any of which constitute sexual violence, whether attempted or completed. Additionally, all of these acts occur without the victim's consent, including cases in which the victim is unable to consent due to being too intoxicated (eg, incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs (CDC, 2016).

- **Rape or penetration of victim**. This includes completed or attempted, forced or alcohol/drug-facilitated unwanted vaginal, oral, or anal insertion. Forced penetration occurs through the perpetrator's use of physical force against the victim or threats to physically harm the victim.
- **Victim was made to penetrate someone else**. This includes completed or attempted, forced or alcohol/drug-facilitated incidents when the victim was made to sexually penetrate a perpetrator or someone else without the victim's consent.
- **Non-physically pressured unwanted penetration**. This includes incidents in which the victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated.
- **Unwanted sexual contact**. This includes intentional touching of the victim or making the victim touch the perpetrator, either directly or through the clothing, on the genitalia, anus, groin, breast, inner thigh, or buttocks without the victim's consent
- **Non-contact unwanted sexual experiences**. This includes unwanted sexual events that are not of a physical nature that occur without the victim's consent. Examples include unwanted exposure to sexual situations (eg, pornography); verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; and /or unwanted filming, taking or disseminating photographs of a sexual nature of another person (CDC, 2016).

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, the percentage of those who had 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)

Stalking and Cyberstalking

Stalking is a pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else (eg, family member or friend). Some examples include repeated, unwanted phone calls, emails, or texts; leaving cards, letters, flowers, or other items when the victim does not want them; watching or following from a distance; spying; approaching or showing up in places when the victim does not want to see them; sneaking into the victim's home or car; damaging the victim's personal property; harming or threatening the victim's pet; and making threats to physically harm the victim (CDC, 2016).

In the United States 7.5 million people are stalked in one year, with 85% of the victims being stalked by someone they know. Sixty-one percent of female victims and 44% of male victims are stalked by an intimate partner. Among women who have been murdered, 76% were stalked by their intimate partner and 67% had been abused by them. Stalking victims may become fearful and anxious, and their physical and mental health can suffer as a result (National Center for Victims of Crimes, 2012).

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, changes in the law in 2009 made **cyberstalking** a crime in Kentucky (KRS 508.130–150). Additional information for identifying and dealing with cyberstalking is available from the Kentucky Attorney General's office and at this link.

Psychological Aggression

Psychological aggression is the use of verbal and nonverbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person. Psychological aggression can include:

- Expressive aggression (eg, name-calling, humiliating)
- Coercive control (eg, limiting access to transportation, money, friends, and family; excessive monitoring of whereabouts)
- Threats of physical or sexual violence; control of reproductive or sexual health (eg, refusal to use birth control; coerced pregnancy termination)
- Exploitation of victim's vulnerability (eg, immigration status, disability)
- Exploitation of perpetrator's vulnerability

- Presenting false information to the victim with the intent of making them doubt their own memory or perception (eg, mind games) (CDC, 2016).

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 it difficult for the victim to break free of the cycle of violence.

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).

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).

The WHO Study of 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 overall level of sexual violence at 6%, while Ethiopia had the highest at 59%. The majority of reports were between 10% and 50% (WHO, 2005). A review study published by WHO in 2013 found substantially similar data. It shows the global average of prevalence of intimate partner violence of ever-partnered women to be 26.4%, ranging from a low of 8.9% in some areas of East Asia to a high of 77.7% in central Sub-Saharan Africa (WHO, 2013).

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 socio-demographic 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). 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

Every year in the United States approximately 324,000 women are abused during pregnancy. Worldwide the prevalence of IPV during pregnancy in one study ranged from a low of 1% in urban Japan to 28% in Peru Province (WHO, 2005). Other studies have found even higher percentages (WHO, 2011).

More research is critical to understand the details of IPV during pregnancy but what is known so far indicates many negative effects for both mother and unborn child. Effects can be seen in negative health behaviors such as tobacco, alcohol, and drug use or delayed prenatal care. Reproductive health may be affected by many things, including poor pregnancy weight gain, low birth weight, or obstetric complications. Physical and mental effects can include injury of all kinds—up to and including death, depression, poor attachment of mother to child, and others (ACOG, 2012; WHO, 2011).

Research has demonstrated that being pregnant does not protect women from IPV, but the evidence is conflicting as to whether violence increases or decreases during pregnancy. All of the usual triggers for IPV will be in play during pregnancy but the additional stresses that surround unplanned or unwanted pregnancies appear to be an additional risk factor for violence during pregnancy (WHO, 2011).

Pregnancy (at all stages) can present opportunities for healthcare professionals to inform and advise women regarding IPV and offer choices for assistance if a woman is being abused (ACOG, 2012). These professionals need to become knowledgeable on the recognition and documentation of abuse, applicable laws in their locale, and the variety of resources available for victims of IPV.

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, 2016a, 2014a; KCADV, 2014b).

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, 2013, n.d.)

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, 2013, n.d.).

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 its civil and criminal laws (Child Welfare Information Gateway, 2013, n.d.).

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, n.d.-2; KRS 600.020).

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 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; NIJ, 2011).

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 to provide services, especially as they relate 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; NIJ, 2011).

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 person eighteen (18) 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).

Elder abuse is still a problem that defies resolution. Most authorities believe the majority of incidents are not being reported. Signs of elder abuse may be missed by professionals who lack training in identifying these signs, and "the elderly may be reluctant to report abuse themselves because of fear of retaliation, lack of physical and/or cognitive ability to report, or because they don't want to get the abuser (90% of whom are family members) in trouble" (NCEA, n.d.).

Complicating prevalence estimates 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

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

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

A combination of individual, relational, community, and societal factors contribute to the risk of becoming an IPV victim or perpetrator. Understanding these multilevel factors can help identify various opportunities for prevention (CDC, 2015b).

Risk Factors for Intimate Partner Violence	
Individual Factors	▪ Low self-esteem ▪ Low income ▪ Low academic achievement ▪ Young age ▪ Aggressive or delinquent behavior as a youth ▪ Heavy alcohol and drug use ▪ Depression ▪ Anger and hostility ▪ Antisocial personality traits ▪ Borderline personality traits ▪ Prior history of being physically abusive ▪ Having few friends and being isolated from other people ▪ Unemployment ▪ Emotional dependence and insecurity ▪ Belief in strict gender roles (eg, male dominance and aggression in relationships) ▪ Desire for power and control in relationships ▪ Perpetrating psychological aggression ▪ Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration) ▪ History of experiencing poor parenting as a child ▪ History of experiencing physical discipline as a child
Relationship Factors	▪ Marital conflict-fights, tension, and other struggles ▪ Marital instability-divorces or separations ▪ Dominance and control of the relationship by one partner over the other ▪ Economic stress ▪ Unhealthy family relationships and interactions

Risk Factors for Intimate Partner Violence	
Community Factors	▪ Poverty and associated factors (eg, overcrowding) ▪ Low social capital-lack of institutions, relationships, and norms that shape a community's social interactions ▪ Weak community sanctions against IPV (eg, unwillingness of neighbors to intervene in situations where they witness violence)
Societal Factors	▪ Traditional gender norms (eg, women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions)

Source: CDC, 2015b

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).

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.

What is available 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 (RHIB, 2016; Logan & Walker, 2011; 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 to 1999 showed that overall "rates for family and intimate partner murders declined regardless of place, whereas rates of intimate partner murders increased only with rurality" (RHIB, 2016; 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 a 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, n.d.; Annan, 2008)

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.

A 2012 research project focused on a rural Appalachian setting found after a wide-ranging literature review and an independent survey that results were sometimes contradictory and many variables could be at work. Some conclusions that seemed intuitive were not necessarily borne out by results. Expected findings on rural/urban differences in barriers to screening patients for IPV did not materialize in the independent survey. Overwhelmingly, the barriers most cited by healthcare professionals were a belief that patients would be "noncompliant with recommendations" and a lack of confidence in "dealing with these types of problems" (Tedder, 2012).

As with IPV in general, more study is needed to fully understand the factors involved for victims, abusers, and health and social service professionals, and to establish effective solutions.

Cost to Society of Domestic Violence

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. Increased annual healthcare costs for victims of IPV can persist as much as 15 years after abuse ends. 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, 2015a, 2003).

Nearly 1 in 4 women (22.3%) and 1 in 7 men (14.0%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime. Nearly 14% of women and 3.5% of men have been injured as a result of IPV that included contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime. In 2010, 241 males and 1095 females were murdered by an intimate partner (CDC, 2015a). All of these unfortunate events mean costs to individuals and society for medical and psychological treatment, law enforcement, social services, lost days of work and school, and so on.

Apart from deaths and injuries, physical violence by an intimate partner is associated with a number of adverse health outcomes. Several health conditions associated with intimate partner violence may be a direct result of the physical violence (eg, bruises, knife wounds, broken bones, traumatic brain injury, back or pelvic pain, headaches). Other conditions are the result of the impact of intimate partner violence on the cardiovascular, gastrointestinal, endocrine, and immune systems through chronic stress or other mechanisms (CDC, 2015a). All of these carry hefty long-term price tags for individuals and society.

Consequences of Domestic Violence

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, 2015a, 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

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

Screening for Domestic Violence

Many healthcare and social services professionals are already involved with screening and assessment of clients for domestic violence, including intimate partner violence. Numerous professional associations have taken positions advocating screening of most, if not all, adults. As with all aspects of domestic violence, there are gaps in the research, sometimes resulting in contradictory findings and positions, and more research is needed.

In 2011 the Institute of Medicine (IOM) released a report on preventive services with recommendations that were quickly adopted by the U.S. Department of Health and Human Services. One of the recommendations was to provide screening and counseling to women regarding "interpersonal and domestic violence" (ASPE, 2013).

In January 2013 the U.S. Preventive Services Task Force (USPSTF) changed its recommendations regarding screening for IPV in women of childbearing age and screening for abuse and neglect in the elderly. The task force "recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services." The task force also "concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect" (USPSTF, 2013).

Prior to January 2013, the recommendation regarding IPV had been similar to the current one for abuse and neglect of the elderly. The research and reasoning that goes into recommendations, as well as suggestions for implementing recommendations, are discussed in detail on the USPFSTF website.

In discussing specific tools for screening, the task force notes that several instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are:

- Hurt, Insult, Threaten, Scream (HITS)—includes four questions, can be used in a primary care setting, and is available in both English and Spanish versions. It can be self- or clinician-administered.
- Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT)
- Slapped, Threatened, and Throw (STaT)—three-item self-report instrument that was tested in an emergency department setting
- Humiliation, Afraid, Rape, Kick (HARK)—a self-administered four-item instrument
- Modified Childhood Trauma Questionnaire, Short Form (CTQ-SF)
- Woman Abuse Screen Tool (WAST)

In regard to elderly and vulnerable adults, the task force found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting. However, the accompanying discussion reveals that this may be more about a lack of data, many variables, and the need for more research and practice (USPSTF, 2013).

The CDC has supported at least two studies that have evaluated assessment tools, and their reports can be consulted via the CDC website by anyone looking for more information about available screening tools for varying practice settings:

- *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1* (pub. 2007)

- *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools* (pub. 2006)

Healthcare professionals should make sure they understand and are trained to use any procedures, tools, and forms their institution already has in place for screening and assessment. In addition, it is important to be up to date on your state's requirements for reporting and documenting domestic violence information. Kentucky's reporting requirements are discussed in a later section.

Documenting Domestic Violence

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 to resolve landlord-tenant disputes (Isaac & Enos, 2001).

According to a number of studies, many medical records are not sufficiently 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 (eg, 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.
- in one-third of the patients' visits in which abuse or injury was noted, doctors' and nurses' handwriting was illegible in key portions of the records. 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 Legislation and Reporting Requirements

Legislation

Kentucky's Adult Protection Act (KRS 209), passed in 1976, **requires the 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. Changes in 2005 specifically addressed protection for victims of domestic violence with KRS 209A.

In 1996 legislation was enacted that mandated training about domestic violence for nurses and some other healthcare professionals (KBN, 2013).

An important recourse for domestic violence victims is **protective orders**, and KRS 403 deals with the purpose of, types, and procedures for obtaining protective orders. These are intended "to allow victims to obtain effective, short-term protection against further wrongful conduct in order that their lives may 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(1–3)). "A petition for an order of protection may be filed by: (a) a victim of domestic violence and abuse; or (b) an adult on behalf of a victim who is a minor otherwise qualifying for relief" (KRS 403.725(1)).

In many states, general stalking statutes have not kept up with new electronic technologies. However, in 2009 **cyberstalking** was made a crime in Kentucky by the addition of "computers, the Internet or other electronic network" to the definitions within the law prohibiting stalking (KRS 508.130–150).

Legislation in 2010 brought a noteworthy expansion of enforcement options against perpetrators of domestic violence when it included, among other things, the ability for "judges to order those who violate a domestic violence order to wear a global positioning system (GPS) tracking device. . . [and] extend[ed] the continuance of an un-served emergency protective order for 6 months, rather than the current 90 days" (WFIE, 2010).

Since then, legislation to extend to dating partners the right to obtain protective orders was proposed in each legislative session and was finally passed in the 2015 session. The changes to the law contained in House Bill 8 became effective on January 1, 2016, and now extend the ability to obtain protective orders against dating partners as well as to those who are married, living together, or have a child together (Kentucky Court of Justice, 2016; Autry, 2013).

Reporting Requirements

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 877 597 2331 for child abuse and 800 752 6200 for adult abuse. (See Resources at the end of the course for additional numbers and contact information.)

Child Abuse

"If you believe a child is being abused, neglected, or is dependent, you should call the Child Protection Hot Line at 877-KYSAFE1 (877 597 2331) or the Protection and Permanency office in your county" (KCHFS, 2015). Contact information for those offices may be obtained here.

Elder Abuse

Did you know. . .

> If you suspect elder abuse, you are legally required to report it (KCHFS, 2016).

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. (KCHFS, 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: chfs.ky.gov/agencies/dcbs/dpp/apb/Pages/elderabuse.aspx.

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, mental health professional, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse or neglect, 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 or neglect of an adult.

(4) Any person making such a report shall provide the following information, if known:
   (a) The name and address of the adult
   (b) The age of the adult
   (c) The nature and extent of the abuse or neglect, including any evidence of previous abuse or neglect;
   (d) The identity of the perpetrator, if known;
   (e) The identity of the complainant, if possible; and
   (f) Any other information that the person believes might be helpful in establishing the cause of abuse or neglect.

(5) Upon receipt of the report, the cabinet shall take the following action as soon as practical:
   (a) Notify the appropriate law enforcement agency, if indicated;
   (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."

Domestic Violence: 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 lifespan.
- 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 and References

Resources

Kentucky Adult and Child Abuse Reporting Hot Line
800 752 6200

Prevent Child Abuse Kentucky Parent Helpline
800 CHILDREN or 859 225 8879

Child Protection Hot Line
877-KYSAFE1 (877 597 2331)

VINE (Victim Information and Notification Everyday)
The National Victim Notification Network
800 511 1670
VINELink (online VINE)
www.vinelink.com/#/home

VINE Court Services
http://courts.ky.gov/Pages/VINE.aspx

Kentucky Coalition Against Domestic Violence (KCADV)
111 Darby Shire Circle
Frankfort, KY 40601
Phone: 502 209 5382
Fax: 502 226 5382
Email: info@kcadv.org (general information)
http://kcadv.org

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

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

Rural Health Information Hub (formerly Rural Assistance Center)
Rural Domestic Violence
https://www.ruralhealthinfo.org/topics/domestic-violence

Office on Women's Health (U.S. Department HHS)
Violence Against Women
www.womenshealth.gov/relationships-and-safety

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Post Test

Use the answer sheet following the test to record your answers.

1. Intimate partner violence (IPV):

    a. Refers to violence that occurs between current or former intimate partners.
    b. Refers only to relationships involving sexual intimacy.
    c. Never includes child abuse or elder abuse.
    d. Never includes violence against men.

2. The victims of intimate partner violence are evenly divided between men and women.:

    a. True
    b. False

3. The rate of intimate partner violence against women in Kentucky:

    a. Is lower than the national average.
    b. Has declined substantially in the past fifteen years.
    c. Affects KY women at a higher percentage than the national average.
    d. Is the same as that for men.

4. The agency mandated by Kentucky law to receive reports of adult abuse is the:

    a. Kentucky Coalition Against Domestic Violence.
    b. Kentucky State Police.
    c. Law Information Network of Kentucky.
    d. Department for Community Based Services.

5. Kentucky’s fifteen domestic violence programs currently provide:

    a. Adult residential shelter only.
    b. Nonresident services only.
    c. Services for children only.
    d. Resident and nonresident services to adults and children.

6. In Kentucky, protective orders are now available:

    a. To those who are married, living together, dating, or have a child together.

b. Only to those who are married and have children.

c. Only to dating partners.

d. Only to those who are married.

7. The CDC describes physical violence as:

a. Stalking and cyberstalking.

b. The intentional use of physical force with potential for causing death, disability, injury, or harm.

c. Abusive language that includes threats of violence.

d. The use of physical force to coerce another person to engage in a sex act.

8. Sexual and physical abuse is often accompanied by controlling behaviors. Controlling behaviors include:

a. Hitting and slapping.

b. Verbal abuse.

c. Preventing a partner from seeing friends.

d. Cyberstalking.

9. 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.

10. Prohibiting access to transportation, money, or friends and family are examples of:

a. Psychological aggression.

b. Stalking.

c. Physical violence.

d. Sexual violence.

11. An underlying component of all types of domestic violence is:

a. Isolating the victim from family and friends.

b. Coercive control and intimidation.

c. Withholding information.

d. Threat of physical violence.

12. The variable most likely to predict that a woman will be victimized by an intimate partner is a partner who is:

a. Of a different race.

b. From a different country.

c. Verbally abusive.

d. Of a different religion.

13. Children who are exposed to domestic violence are at risk for poor development. There is growing concern that a child's exposure to domestic violence:

a. May cause autism.

b. Contributes to physical illness.

c. May delay the child's development by five years or more.

d. Constitutes a type of psychological abuse.

14. 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.

15. According to available data, the highest rates of elder abuse:

a. Occur among elderly men.

b. Occur among women and those over age 80.

c. Are perpetrated by elderly men.

d. Are perpetrated by nursing home owners.

16. Termination of a relationship poses a greater risk of intimate partner violence:

a. For men.

b. For women.

c. For both men and women.

d. Only when the relationship lasted more than ten years.

17. Rural abuse victims may experience even greater effects of isolation than non-rural victims.:

a. True
b. False

18. Psychological consequences of intimate partner violence include all of the following except:

a. Antisocial behavior.
b. Decreased likelihood of becoming an abuser.
c. Emotional detachment.
d. Suicidal behavior in females.

19. A screening and assessment for IPV uses only one method and form.:

a. True
b. False

20. 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.

21. 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.

22. 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

Answer Sheet

KY: 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. _____

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

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

a. Define and explain intimate partner violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. List the four main categories of domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

g. Spell out the risks of intimate partner violence as well as the protective factors.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

h. Describe special considerations in rural domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

i. Discuss the economic and societal costs of domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

j. Explain the consequences of domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

k. Outline screening and assessment of domestic violence in the healthcare setting.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

l. Tell how to document incidents of domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

n. Discuss goals for prevention and education program research.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* This course contained no discriminatory or prejudicial language.

○ Yes ○ No

* The course was free of commercial bias and product promotion.

○ Yes ○ No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour

- ○ 40-49 minutes per contact hour
- ○ 30-39 minutes per contact hour
- ○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

- ○ Government or Department of Health website.
- ○ State board or professional association.
- ○ Searching the Internet.
- ○ A friend.
- ○ An advertisement.
- ○ I am a returning customer.
- ○ My employer.
- ○ Other
- ○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.

- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form

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

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

Your name and credentials/designations will appear on your certificate.

* License Number and State: _____

* Please email my certificate:

○ Yes ○ No

(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: $29

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____