INTIMATE PARTNER VIOLENCE (DOMESTIC VIOLENCE)

CHAPTER 61

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I. Introduction and general background

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans (Centers for Disease Control and Prevention [CDC], 2015b). In the United States, IPV is also commonly referred to as domestic violence, and can occur among heterosexual or same sex partners, either current or former, and does not require sexual intimacy, legal ties, or even cohabitation (CDC, 2015b). The term IPV also encompasses dating violence, defined as violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim (U.S. Department of Health & Human Services, 2009). IPV involves a "pattern of abusive behavior" with the intention to intimidate, control, and instill fear in the victim (U.S. Department of Justice [USDOJ], 2015). Victims, survivors who withstand the violence, can be male or female, educated or illiterate, able bodied or disabled, wealthy or poor, and any age (National Center for Victims of Crime, 2008a). They can be of any racial, ethnic, or cultural background, of any sexual orientation, and of any immigration/citizenship status; in fact, disclosure of IPV is often complicated for individuals who experience oppression or have fear of authority.

According to the 2009 California Penal Code Handbook (Section 1M.6, 137W, 242, 243, 273.5), acts of partner abuse include those that intentionally or recklessly cause, or attempt to cause, bodily injury or that place another person in reasonable apprehension of imminent serious bodily injury. IPV is considered by many as a prelude to murder (Ferguson, 2007; Strack & Gwinn, 2011). For this reason, clinicians play an important role in identifying indications of abuse as well as risk factors that indicate that the abuse will reoccur or heighten.

A. Definition and overview

The U.S. Department of Justice (2015) defines IPV in terms of the following five categories:

1. *Physical abuse* is defined as acts of hitting, slapping, shoving, grabbing, biting, etc. and also includes denying a partner medical care or forcing alcohol or drugs upon him or her.
2. *Sexual abuse* is coercing or attempting to coerce any sexual contact or behavior without consent, marital rape, forcing sex after physical violence, treating one in a sexually demeaning manner, and birth-control sabotage.
3. *Emotional abuse* involves undermining an individual's sense of self-worth, name calling, diminishing one's abilities, or damaging one's relationship with his/her children.
4. *Economic abuse* is defined as making or attempting to make an individual financially dependent by controlling or withholding one's access to money or forbidding attendance at school or employment.
5. *Psychological abuse* is different from emotional abuse as it involves causing fear by intimidation through threats to harm self, partner, children, or other individuals/pets/property involved in the victim's life. It also involves forcing isolation from one's community or threatening the victim's immigration status or custody of his/her children.

These categories of IPV are not mutually exclusive; they often present together as a complex ongoing pattern of abuse. Although all states have legislation that defines IPV, those definitions vary across states. IPV constitutes the willful intimidation, assault, battery, sexual assault, or other abusive behavior perpetrated by one family member, household member, or intimate partner against another (National Center for Victims of Crime, 2008a). In most state laws addressing IPV, the relationship necessary for a charge of domestic assault or abuse generally includes a spouse, former spouse, persons currently residing together or those that have within the previous year, or persons who share a common child. In addition, as of 2007, most states provide some level of statutory protection for victims of dating violence (National Center for Victims of Crime, 2008a).

B. Prevalence and incidence

In 2010 the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control, in collaboration with the National Institutes of Justice and the Department of Defense, developed a telephone survey, the National Intimate Partner and Sexual Violence Survey (NISVS). The NISVS began collecting ongoing population-based surveillance data, generating accurate and reliable incidence and prevalence estimates for intimate partner violence, sexual violence, dating violence, and stalking victimization (CDC, 2015a). The first report, released in 2014, stated that 20 people per minute are victims of physical violence by an intimate partner in the United States. The National Intimate Partner and Sexual Violence Survey data are summarized next.

1. Sexual Violence by Any Perpetrator
   One in 5 women or 18.3% of all women in the United States and 1 in 71 men or 1.4% of all men in the United States have been raped at some time in their lives. This includes full and attempted forced penetration and drug/alcohol facilitated violations.
2. Stalking Victimization by Any Perpetrator
   One in 6 women or 16.6% and 1 in 19 men or 5.2% report stalking victimization in the United States. Stalking victimization results in victims feeling fearful that they or someone close to them will be harmed or killed by the stalker; 66% of female victims of stalking were stalked by a current or former partner, and 41% of male victims were stalked by a partner.
3. Violence by an Intimate Partner
   One in 3 women (35.6%) and 1 in 4 men (28.5%) in the United States have experienced rape or violence and/or stalking by their intimate partner during their lifetime. Of those victims 1 in 4 women (24.3%) and 1 in 7 men (13.8%) have experienced severe violence, characterized by being hit by a fist or other object, beaten, or slammed against something hard. The survey also reports that half of all men and women have experienced psychological aggression. Of all victims of intimate partner violence, 69% of females and 53% of males experienced the first episode before the age of 25.
4. Violence by an Intimate Partner Experienced by Race/Ethnicity (**Table 61-1**)

C. Consequences

Although the severity of IPV can vary, the type of IPV that is repetitive and prolonged has been most closely associated with negative health sequelae (Humphreys &

TABLE 61-1 National Intimate Partner and Sexual Violence Survey: Victimization by Race/Ethnicity

Race/Ethnicity	U.S. Total	Black Non-Hispanic	White Non-Hispanic	Hispanic	American Indian or Alaska Native	Multiracial Non-Hispanic	Asian/ Pacific Islander
Event	% per total U.S. population						
Intimate Partner Violence (IPV), lifetime: WOMEN	31.5%	41.2%	30.5%	29.7%	51.7%	51.3%	15.3%
IPV, lifetime: MEN	27.5%	36.3%	26.6%	27.1%	43.0%	39.3%	11.5%
IPV Rape Victimization during lifetime: WOMEN	8.8%	8.8%	9.6%	6.2%	*	11.4%	*
IPV Rape Victimization during lifetime: MEN	0.5%	*	*	*	*	*	*
IPV Sexual Violence other than rape: WOMEN	15.8%	17.4%	17.1%	9.9%	*	26.8%	*
IPV Sexual Violence other than rape: MEN	9.5%	24.4%	22.2%	26.6%	24.5%	39.5%	15.8%
IPV Stalking Victimization, lifetime: WOMEN	**	9.5%	9.9%	6.8%	*	13.3%	*
IPV Stalking Victimization, lifetime: MEN	**	*	1.7%	*	*	*	*

* No data as not statistically reliable due to small case count.

** Data not available.

Data from Breiding, M. J., Smith, S. G., Basile, K. C., et al. (2014). Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. *MMWR, 63*(SS08), 1–18. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6308a1.htm#Table1

Campbell, 2010). This violence results in nearly 2 million injuries and nearly 1,300 deaths. Of the IPV injuries, more than 555,000 require attention by a healthcare provider, and more than 145,000 are serious enough to warrant hospitalization for 1 or more nights. In 2008, nearly 45% of female homicide victims were killed by intimate partners (Bureau of Justice Statistics, 2009b). Of note, IPV is the leading cause of premature death from homicide and injury among African American women between the ages of 15 and 24 years (Rennison & Welchans, 2002). As noted in the NISVS, 24.3% of women and 13.8% of men in the United States have been a victim of *severe* physical violence and nearly 15% of women and 4% of men have been injured as a result (Breiding et al., 2014). Research suggests that the risk of suffering from six or more chronic physical symptoms increases with the number of forms of violence experienced, even when the last episode was over 30 years ago (Nicolaidis, Curry, McFarland, & Gerrity, 2004). IPV costs in the United States are estimated at $12.6 billion on an annual basis, 0.1% of the gross domestic product (Waters et al., 2004). IPV also results in more than 18.5 million mental healthcare visits each year and 13.6 million days of lost productivity from paid work and household chores among IPV survivors and the value of IPV murder victims' expected lifetime earnings (National Center for Injury Prevention and Control, 2003).

In addition to the injuries inflicted during violent episodes, physical and psychological abuses are linked to a number of adverse health effects. These include arthritis; chronic neck or back pain; migraine or other types of headache; sexually transmitted infections (including HIV); chronic pelvic pain; peptic ulcers; irritable bowel syndrome; and frequent indigestion, diarrhea, or constipation (Coker, Smith, Bethea, King, & McKeown, 2000). Psychological consequences include posttraumatic stress disorder, depression, substance abuse, and suicidal behaviors (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). Six percent of all pregnant women are battered. Pregnancy complications, including low weight gain, anemia, infections, and first- and second-trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse (Parker, McFarlane, & Soeken, 1994).

Health behaviors are also significantly affected by IPV and research demonstrates that the more severe the violence the more impaired the health behaviors become, including engaging in high-risk sexual behavior, using harmful substances, and unhealthy diet-related behaviors, all resulting in overuse of the health services (Heise & Garcia-Moreno, 2002).

D. Risk factors

Factors that should heighten the clinician's index of suspicion regarding the possibility of IPV include medical records indicating repeated visits or previous injuries, a history of IPV or a history with inconsistent descriptions of injuries, and a past history of suicide attempts. Vague and nonspecific responses to questions with a history of anxiety, depression, sleeplessness, fatigue, or chronic somatic complaints may indicate intrafamilial crisis. Abuse is a frequent precipitant of suicide attempts, and those who attempt suicide are likely to have a history of IPV (Ellsberg et al., 2008).

E. Special populations

Special populations at increased risk of IPV include poor or homeless individuals; teenagers; pregnant or immigrant women; those with chronic illnesses (HIV) or disabilities; lesbian, gay, bisexual, and transgender individuals; and the elderly. Risks to note in these special populations and additional resources are highlighted in (**Table 61-2**). Clinicians should be aware of agencies or resources in the area that do focused work with these special populations. Clinicians should seek out additional information and culturally competent training to provide best practice care to these individuals.

TABLE 61-2 Special IPV Risk Populations

Risk	Data	Sources
Chronic illness (HIV)	The IPV risk for women with HIV may be as high as 67%, a rate three to four times greater than among HIV-negative women. HIV-positive women seem to experience IPV at rates comparable to HIV-negative women from the same underlying populations; however, their abuse seems to be more frequent and more severe.	Brief, Vielhauer, & Keane, 2006; Cobb, 2008; Gielen et al., 2007
Individuals with disabilities	Those with disabilities and deaf women have an increased risk of both typical and unique forms of violence. The greater the degree of cognitive impairment, the greater the risk for victimization and abuse.	Barrett, O'Day, Roche, & Carlson, 2009; Curry, Powers, Oschwald, & Saxton, 2004

TABLE 61-2 Special IPV Risk Populations *(Continued)*

Risk	Data	Sources
Immigrant women	More difficult for these women to seek or obtain help because of abusive partners using immigration status against her, threatening deportation. Language barriers, isolation, and a lack of familiarity with the United States social services system and legal rights. Fear that if she reports violence she will be treated with insensitivity, hostility, or discrimination by authorities. Low level of awareness about IPV among immigrants or refugees. Not seen as a problem in their community. May be recognized, but only as a family or private issue. Community members may condone IPV or do not consider various abusive or controlling acts to be IPV.	Kulwicki & Miller, 1999; Moracco, Hilton, Hodges, & Frasier, 2005; Murdaugh, Hunt, Sowell, & Santana, 2004; Runner, Yoshihama, & Novick, 2009; Shiu-Thornton, Senturia, & Sullivan, 2005; Yoshihama, 2008
Lesbian, gay, bisexual, or transgender individuals	Lifetime prevalence of IPV for women: Lesbian 43.8%, bisexual 61.1%, heterosexual 35.0%. Lifetime prevalence of IPV for men: Gay 26.0%, bisexual 37.3%, heterosexual 29.0%. Transgender: estimated 50% of transgender individuals report lifetime sexual violence Lesbian, gay, bisexual, or transgender individuals who are incarcerated are sexually assaulted at a rate 15 times higher than that of the general inmate population.	FORGE, 2012; Walters, Chen, & Breiding, 2013
Poor or homeless	IPV is the primary cause of family homelessness in 28% of cities surveyed across the United States, and 15% of homeless persons were victims of IPV. Between 25% and 50% of homeless families have lost their homes as a result of intimate partner abuse. Homelessness and poverty *significantly* increase a child's exposure to parental IPV. Women living in disadvantaged neighborhoods are more than twice as likely to be the victims of IPV as women in more affluent neighborhoods.	U.S. Conference of Mayors, 2008; Institute for Children and Poverty, 2010
Pregnant women	IPV in women of childbearing age may include reproductive coercion, sabotaged contraception, and forced pregnancy continuation or abortion, and may lead to gynecological disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (HIV). Other adverse outcomes correlating with IPV include poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight. The severity of violence may escalate during pregnancy or the postpartum period, and homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner. Abused women were twice as likely to begin prenatal care during the third trimester and more likely to abuse substances before and during pregnancy.	Bureau of Justice Statistics, 2009a; Cha & Masho, 2014; Chamberlain, &. Levenson, 2013; Cheng & Horon, 2010; Madkour, Xie, & Harville, 2014; Silverman et al., 2011; World Health Organization, 2013

(continues)

TABLE 61-2 Special IPV Risk Populations *(Continued)*

Risk	Data	Sources
Teenagers	The 2013 Youth Risk Behavior Surveillance reports a prevalence of physical dating violence between 13% (female) and 7.4% (male) among youth in grades 9 through 12. The prevalence of youth reporting sexual dating violence was 14.4% (female) and 6.2% (male). Among adult victims of rape, physical violence, and/or stalking by an intimate partner, 22% of females and 15% of males report their first experience of partner violence occurred between 11 and 17 years of age. When youth responses were evaluated based on reported race, Hispanic females (13.6/12.9%) followed by white females (12.9/14.6%) and black males (8.2/8.9%) followed by Hispanic males (7.0/6.7%) reported the highest incidence of both physical and sexual dating violence, respectively. Numerous risk factors have been correlated with adolescent dating violence, ranging from individual (substance use, depression, anxiety, age/gender, race/ethnicity, personal violence history, acceptance of violent behavior) to relationship level (aversive family communication, harsh parenting, hostile friendships, low parental monitoring). Protective factors include high empathy, high grade point average, high verbal IQ, positive relationship with mother, and attachment to school. Detrimental consequences may include increased alcohol, cigarette, and marijuana use; increased internalizing; and decreased number of close friends.	CDC, 2014b; Foshee, Reyes, Gottfredson, Chang, & Ennett, 2013; Keenan-Miller, Hammen, & Brennan, 2007; Miller et al., 2013; Silverman et al., 2011; Stöckl, March, Pallitto, & Garcia-Moreno, 2014; Vagi, Rothman, Latzman, Tharp Hall, & Breiding, 2013

F. Screening

The U.S. Preventive Services Task Force (USPSTF) now recommends IPV screening and has found benefits of detection and early intervention to reduce violence and improve health outcomes in women of childbearing age (Moyer, 2013). The USPSTF, however, has determined that current evidence is insufficient to assess the balance between the benefits and harms of screening for IPV in elderly or vulnerable adult populations (USPSTF, 2013). There are no current recommendations regarding screening men for IPV.

II. The focused IPV assessment and database (may include but is not limited to)

A. Subjective

Although many individuals may not bring up the subject of abuse on their own, many will discuss it in a private, confidential setting when asked simple, direct, nonjudgmental questions. See **Table 61-3** for approaches to phrasing questions. A variety of tools can be used to accurately measure victimization and offer the clinician specific scales in the areas of physical, sexual, psychological, and emotional victimization and stalking to guide their inquiries (Basile, Hertz, & Back, 2007; Thompson, Basile, Hertz, & Sitterle, 2006).

1. When IPV is identified:
   a. It is important to determine the identity of the person allegedly inflicting the injuries and document the circumstances surrounding the event, any past history of abuse, the nature of the injuries, and use of any threats or weapons. Whenever possible, use the patient's exact words and quotation marks.
   b. Additional history related to other health-risk behaviors (e.g., alcohol or drug use, tobacco) and chronic conditions, such as sleep problems, depression, and eating disorders, should be elicited. These conditions, along with currently being the victim of IPV, are predictors of the women's physical and psychological health (Svavarsdottir & Orlygsdottir, 2009).

B. Objective

Perform a complete head-to-toe examination or focused evaluation as indicated by history or report of injuries. Document the character and extent of all physical injuries, including areas of pain and tenderness, even if there is as yet no obvious bruising or injury. It is recommended to use photos or drawings whenever possible.

Additional components of the physical examination are listed in **Table 61-4**.

TABLE 61-3 Screening History Questions

USPSTF recommends use of a screening scale with women of reproductive age, elderly, and vulnerable. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS; English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST) (Rabin, Jennings, Campbell, & Bair-Merritt, 2009).
HITS
How often does your partner: (1) Physically hurt you? (2) Insult you or talk down to you? (3) Threaten you with harm? (4) Scream or curse at you?
WAST
(1) In general, how would you describe your relationship—a lot of tension, some tension, no tension? (2) Do you and your partner work out arguments with great difficulty, some difficulty, or no difficulty? (#3–#7 response options: often, sometimes, never) (3) Do arguments ever result in you feeling down or bad about yourself? (4) Do arguments ever result in hitting, kicking, or pushing? (5) Do you ever feel frightened by what your partner says or does? (6) Has your partner ever abused you physically? (7) Has your partner ever abused you emotionally? (8) Has your partner ever abused you sexually?
For women of reproductive age, select a scale for physical/sexual, psychological–emotional, stalking screening based on evidence of sensitivity and specificity for identifying IPV as well as utility within the clinical setting. The clinician must remain alert to clinical clues of IPV, abuse, and neglect of all populations, inclusive of elderly and vulnerable adults, males, and prepubescent females and assess further when indicated on clinical grounds.
Phrasing the Interview Questions
1. Begin with a framing statement such as "We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health" (Chamberlain & Levenson, 2013).
2. Advise patient of the limits of confidentiality, based on state mandates. For example, "Before we get started, I want you to know that everything here is confidential, meaning that I won't discuss what is said unless you tell me that… (insert the laws in your state about what is necessary to disclose)."
3. Sample questions:
Phrasing Questions: The Use of One of the Victimization Scales for Physical–Sexual, Psychological–Emotional, Stalking.
1. "Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?"
2. "Has your partner ever destroyed things that you cared about? Ever threatened or abused your children? Ever forced you to have sex when you didn't want to?"
3. "What happens when you and your partner disagree or fight? Do you ever feel afraid of your partner?"
4. "Has your partner ever prevented you from leaving the house, seeking friends, getting a job, or continuing your education?"
5. "If your partner uses alcohol or drugs, is s/he ever physically or verbally abusive to you when using?"
6. "Do you have guns or other weapons in your home? If so, has your partner ever threatened to use them?"

TABLE 61-4 Physical Examination

Components of the Physical Examination
Assess general appearance: Level of distress
Vital signs
Other physical examination data:
1. Look carefully for multiple abrasions and contusions to different anatomic sites and multiple injuries in various stages of healing.
2. Most accidents involve the extremities, whereas IPV injuries often involve the face, neck, chest, breasts, abdomen, genitalia, or anus.
Mental status examination: Evaluate mood, orientation, thought processes, and judgment.

III. Assessment

Evaluate the extent of any injuries and the need for immediate medical intervention. See **Table 61-5** for additional components of the assessment. Assess the need for mandatory reporting as cited in the respective state's penal codes (Durborow, Lizdas, O'Flaherty, & Marjavi, 2010). Legal requirement of health professionals to report suspected adult abuse to law enforcement is currently implemented in 16 states and remains a controversial issue. Victims report greater access to legal protection without the responsibility to report abuse themselves, a reduced sense of aloneness and guilt, teaching partners the seriousness of abuse, documentation of the incident and potentially positive interaction with police. However, concerns such as the risk of retaliation, fear of lost custody of their children, anxiety induced by required interactions with a social worker or other government authorities, being victimized by the health system, financial responsibility for the intimate partner violence report, as well as loss of autonomy and confidentiality are reportedly more significant than the benefits (World Health Organization, 2013). Although mandatory reporting is thought by some

TABLE 61-5 Assessment

Components of the Assessment
Determine the diagnosis (not mutually exclusive). 1. History of prior IPV. 2. Recent IPV without observable injury. 3. Current history of IPV with observable injury. a. Report as required by state regulations.
Determine the ICD (International Classification of Diseases) codes for IPV, which are divided into four categories (Rudman, 2000). 1. Adult maltreatment and abuse (995-81). 2. The primary diagnosis (underlying reason for admittance). 3. Modifier codes that provide details (E-codes). 4. History codes that provide information on previous incidents (V-codes). With ICD-10 implementation, code 995 will be replaced with T74 (confirmed) and T76 (suspected) and the coding will include: a. Suspected or Confirmed b. Encounter type (Initial encounter, Subsequent encounter, Sequela encounter) (Bryant, 2014)
Assess for suicidal or homicidal ideation.
Evaluate the safety of the patient and family members and children.
Identify any immediate risk and need for emergency housing, legal, or social service consultations.
Assess social support systems.
Determine ongoing risk of IPV.
Physical abuse ranking scale. More than five affirmatives indicate high danger (Wadman & Foral, 2007). 1. Throwing things, punching the wall—lower risk 2. Pushing, shoving, grabbing, throwing things 3. Slapping with an open hand 4. Kicking, biting 5. Hitting with closed fists 6. Attempted strangulation 7. Beating up, pinning to the wall or floor, repeated 8. Threatening with a weapon 9. Assault with a weapon—higher risk

authorities to help the victim and perpetrator to receive treatment, many health professionals are concerned that victims may be discouraged from disclosing information based on compromised provider–patient confidentiality and individual autonomy. Other concerns include the expense in time and resources and the risk of retaliation or escalation in partner violence in the event of unsuccessful prosecutions (American College of Emergency Physicians, 2014; Feder, Wathen, & MacMillan, 2013).

Whether or not forensic requirements of the criminal justice system require mandated reporting, appropriate management of the sexually assaulted patient is built upon therapeutic communication and requires the clinician to address the medical and emotional needs of the patient within the context of patient-centered care. Providers must be informed of the laws governing mandated reporting in their regions. A summary of the *Professions Mandated to Report* can be found at www.ncsl.org/research/human-services/child-abuse-and-neglect-reporting-statutes.aspx#1 (Child Welfare Information Gateway, 2014).

IV. Goals of clinical management

The goals in managing victims of IPV include consistent screening through thoughtful inquiry in a safe and confidential environment, identifying immediate injury and safety risks, appropriate reporting and referral, and the provision of information and support. Being aware of immigration concerns and cultural or ethnic differences is an important element in patient care. One of the earliest efforts to systematically address IPV in the clinical environment was the development of RADAR, which remains commonly used in practice. RADAR summarizes action steps that the clinician can use to increase comfort and ability recognize and treat victims of IPV (Harwell et al., 1998)

- **R**emember to routinely inquire about partner violence
- **A**sk directly about violence (see questions in Table 61-3), always in a private area
- **D**ocument findings of suspected or reported partner violence in the patient's chart
- **A**ssess patient safety (lethality or abuse scales)
- **R**espond, review patient options, and refer (Institute for Safe Families, 2002).

V. Plan

A. *Diagnostic testing*

Obtain radiographs, computed tomography, or magnetic resonance imaging based on the extent of injury.

B. *Management (includes treatment, consultation, referral, and follow-up care)*

Interventions designed to decrease health-risk behaviors, treat chronic health conditions or illnesses, and offer best practice first response to women who are victims of IPV can be offered to reduce the short- and long-term effects of violence on their physical and psychological health (Svavarsdottir & Orlygsdottir, 2009).

Patient management includes treatment, consultation, referral, and follow-up care. In the event there is a history of recent sexual assault (within 72 hours), it is important to refer the patient to the sexual assault response team or emergency department. In most instances law enforcement involvement is necessary to authorize a forensic examination and a report is filed both via telecommunications and in writing to the respective authorities. The clinician will follow the reporting guidelines as cited in the respective state's penal codes.

C. *Client/patient education*

Priority educational areas include the nature of IPV and the identification of emergency strategies. A personalized safety plan for patients can be found at www.domesticviolence.org/personalized-safety-plan/

VI. Self-management resources and tools

A. *Educational resources and support*

1. The clinician should be prepared to provide patient education brochures or frequently asked questions documents and to direct the patient to appropriate community agencies and support groups for victims of domestic violence (e.g., local shelters), statewide coalitions and helplines (e.g., Jane Doe in Massachusetts, APIADV in San Francisco, CA), and national resources, such as the National Domestic Violence Hotline (1-800-799-SAFE, 1-800-799-7233, or www.thehotline.org), National Dating Abuse Helpline and Love Is Respect (1-866-331-9474, text 77054, or www.loveisrespect.org), or the National Sexual Assault Hotline (1-800-656-HOPE or 1-800-656-4673).

B. *Resources for reducing stigma and increasing awareness of domestic violence*

1. Resources for reducing stigma and increasing awareness of domestic violence can be found at www.nomore.org. Social media and campaign efforts may be appropriate for use within the clinic setting and to promote open disclosure with anticipatory guidance.

C. *Other services and resources*

1. National Sexual Violence Resource Center (www.nsvrc.org)

2. National Center for Victims of Crime's Stalking Resource Center (www.victimsofcrime.org/our-programs/stalking-resource-center)
3. National Coalition of Anti-Violence Programs (www.avp.org/about-avp/coalitions-a-collaborations/82-national-coalition-of-anti-violence-programs)
4. National Online Resource Center on Violence Against Women (www.vawnet.org/)
5. Rape, Abuse, and Incest National Network (www.rainn.org), hotline at 1-800-656-HOPE

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