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Improving the Health Care Response to Domestic Violence:

A Trainer's Manual for Health Care Providers

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IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE: A Trainer's Manual for Health Care Providers

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Lisa James
Editor
Family Violence Prevention Fund
April, 1998

JAMES, L., *ACKNOWLEDGEMENTS*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

PREFACE

By Lisa James, M.A.

HOW THIS TRAINER'S MANUAL WAS DEVELOPED

Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers was produced by the Family Violence Prevention Fund with a grant from the Conrad N. Hilton Foundation. The manual is one of the products of the National Health Initiative, which seeks to strengthen the health care response to domestic violence by assisting health care providers to recognize domestic violence and, in collaboration with community advocates, intervene to support victims.

The Health Initiative began in 1994 with the development of a Resource Manual: *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*. Produced in collaboration with the Pennsylvania Coalition Against Domestic Violence, the *Resource Manual* is designed to help providers develop effective responses to domestic violence in any health care discipline or setting. In 1995, the FUND pilot tested a training program in twelve emergency departments from California and Pennsylvania. Materials from the *Resource Manual* were evaluated and applied during this intensive two-day training session and a new training and institutional reform model was developed. Since then, this model training program has been implemented in over 150 health care settings. As part of the National Health Initiative's Ten State Program, this model training program will be conducted in ten new states. In keeping with the goals of the National Health Initiative, the Ten State Program is working with coalitions of health care and domestic violence organizations to develop statewide plans to improve the health care response to domestic violence through training, policy reform and public education.

The *Trainer's Manual* is the most recent product of the National Health Initiative and is developed as a companion piece to the *Resource Manual*. The manual is designed to be used by health care educators in a wide variety of settings. It will be distributed nationally on request and to participants in the Ten State Program. The *Trainer's Manual* consists of five modules covering the dynamics of domestic violence, cultural competency in the health care setting, clinical strategies to respond to domestic violence (screening, assessment, documentation, intervention, and referral), practical applications and skills and legal and community resources.

The development of the *Trainer's Manual* was made possible by the work of many individuals. Modules One (Domestic Violence Victimization: a Primary Health Issue) and Three (Domestic Violence: Strategies for Screening, Assessment, Intervention and Documentation) were prepared by primary author Anne L. Ganley, Ph.D. and are based on the *Resource Manual*. Dr. Ganley also designed Module Four (Domestic Violence: Practical Application Session) applying her extensive experience conducting such sessions as a domestic violence educator and as faculty for the FUND. Part One of Module Five (Legal Issues and Community Resources) was authored by Ariella Hyman, J.D. of San

JAMES, L., *PREFACE*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

Francisco Neighborhood Legal Assistance Foundation, and incorporates training materials on the legal issues relevant to health care providers working with domestic violence victims. Part Two of that module, authored by Lisa James of the Family Violence Prevention Fund, instructs trainers on how to conduct a short presentation of local community resources available to victims and perpetrators of domestic violence.

The first drafts of these modules were then reviewed by a multi-disciplinary, multicultural team of reviewers including two physicians, a nurse, and a domestic violence advocate and survivor. Modules One and Three were pilot tested at the University of California San Francisco Medical Center. Authors integrated both the reviewer's comments and the pilot test results in producing a second draft of the *Trainer's Manual*.

During the same period, the FUND also developed departmental and clinical guidelines on cultural competency in the health care setting. (See Appendix A in the *Resource Manual*). A Cultural Competency Committee was convened to advise the FUND on how to better integrate cultural sensitivity into the *Trainer's Manual* and the Health Initiative as a whole. Dr. Ganley incorporated comments from the Committee into the *Trainer's Manual*. (See the *Resource Manual* for a list of Cultural Competency Committee Members)

After reviewing the work of the Cultural Competency Committee, it decided that in addition to integrating cultural competency case examples and concepts throughout the manual, many health care providers would benefit from specific training on how to provide culturally competent care to victims of domestic violence. John Fazio, R.N. M.S. (a member of the Cultural Competency Committee), and Anita Ruiz Contreras, R.N., M.S.N. who had conducted a cultural competency workshop together at the FUND's most recent training sessions for health care providers in San Francisco, developed Module Two. This module uses a practice model developed by the Emergency Nurses Association Diversity Task Force (1996-97), of which both authors were members. This session was then reviewed by cultural competency guideline author Dr. Sujata Warrier, Dr. Ganley and FUND staff. It was revised and included as Module Two of this *Trainer's Manual*.

Now, thanks to the continued support of the Hilton Foundation and the U.S. Department of Health and Human Services, we are able to offer this *Trainer's Manual* with the *Resource Manual* as a package. Our hope is that that interested health care providers can have the resource materials, training curricula and guidance to institutionalize a culturally appropriate health care response to domestic violence in their health care setting.

We invite you to send us your thoughts and feedback regarding this manual and commend your efforts to train health care providers on how to better respond to domestic violence. It is through the dedication and efforts like yours, that further injuries and other health problems resulting from domestic violence can be prevented.

JAMES, L., *PREFACE*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

INTRODUCTION

INTRODUCTION

By Anne L. Ganley, Ph.D.

A. TRAINER'S MANUAL: DOMESTIC VIOLENCE AND HEALTH CARE

This *Trainer's Manual* is designed to be a companion piece to *Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers* (Warshaw and Ganley, 1996, Family Violence Prevention Fund). Both manuals grew out of the recognition that domestic violence is a widespread problem that has multiple, significant health consequences to victims. Unfortunately, too often health care providers are less than effective in responding to domestic violence victims due to: 1) a lack of accurate information about domestic violence, or 2) a lack of awareness of the cultural contexts impacting both the patient and the provider, or 3) to both. Health care responses to domestic violence are shaped by health care providers' understanding of domestic violence. In addition, culture affects how both patients and providers view and experience domestic violence, and influences which approaches or resources for addressing the problem are available to them.

Developing effective, culturally appropriate health care responses to domestic violence requires integrating expertise about

- Health care;
- Domestic violence; and
- Diverse cultures and the impact of culture(s) on health issues and health care delivery.

This *Trainer's Manual* encourages the integration of these sometimes separate fields of expertise in the development of health care policies, procedures, practice, and trainings for responding to domestic violence victims.

The *Trainer's Manual* and the *Resource Manual* are two complementary approaches for addressing the educational needs of those health providers working with domestic violence victims and their children.

GANLEY, A., *INTRODUCTION*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

B. THE IMPACT OF DOMESTIC VIOLENCE ON HEALTH CARE

The number of domestic violence assaults in this country is staggering, whether measured by research studies, homicide statistics, criminal justice system responses, protection orders issued, requests for shelter services, visits to health care providers, or the stories of individual domestic violence victims. Approximately four million American women are physically abused each year.[1] And even these statistics may represent an underreporting of the problem since they capture only a portion of domestic violence assaults that take place daily.

Even though many health systems still do not routinely screen for domestic violence, an increasing number of domestic violence cases are reported by all health settings: primary care, emergency departments, and specialty clinics (such as clinics for orthopedics, ophthalmology, family planning, sexually transmitted diseases, obstetrics, dentistry, internal medicine, and mental health). One study conducted in an urban emergency department found that 24 percent of women seen for any reason had a history of domestic violence.[2] The U.S. Department of Justice reported that more than one in three women who seek care in emergency rooms for violence-related injuries are victims of domestic violence.[3]

Domestic violence has multiple health consequences for victims and their children. The most visible effects are the traumatic injuries and deaths due to victims being shot, stabbed, clubbed, punched, burned, choked, beaten, grabbed, pushed, shaken, kicked, or thrown.

There are other less obvious, but equally detrimental consequences to domestic violence victims who are controlled, terrorized, or trapped in abusive relationships by perpetrators' use of assaultive and coercive tactics. In addition to injuries, these abusive tactics may cause a wide variety of physical and psychological health problems (such as gastrointestinal problems, miscarriages, post-traumatic stress disorder, sleep disturbance, poor nutrition, sexually transmitted diseases, and unwanted pregnancies). Perpetrators' controlling tactics also may directly impact or aggravate victims' preexisting health problems (such as cardiac problems, asthma, or diabetes). Furthermore, there are victims who may suffer other health consequences when the perpetrators' control compromises the victim's ability to follow appropriate health protocols for themselves and/or their children.

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[1]The Commonwealth Fund, July, 1993. *First Comprehensive National Health Survey of American Women.* New York.

2Goldberg, W.G., & Tomlanovich, M.C., 1984. Domestic Violence Victims in the Emergency Department: New Findings. *Journal of the American Medical Association.*

[3]The U.S. Department of Justice, August, 1997.

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Treating the injuries or other obvious medical consequences of domestic violence without responding to the cause of the problem often results in inadequate care. Victims continue to be injured; they continue to require more and more medical interventions; their health deteriorates; and health care costs increase. To provide appropriate care to domestic violence victims, health care providers must be able to identify, assess, and intervene in culturally appropriate ways that directly address both the problem of domestic violence and its immediate health consequences.

Health care providers can play significant roles not only in improving the health of individual patients, but also in stopping domestic violence by participating in a coordinated community response. Domestic violence is a public health issue and stopping it requires the efforts of all community institutions working together:

1. to increase the safety of domestic violence victims.

2. to respect the autonomy of domestic violence victims, and

3. to hold domestic violence perpetrators, not victims, accountable for stopping the abuse.

C. The Need for Continuing Education Within Health Care Settings

Although there have been some changes, too frequently traditional education for health providers has not addressed the problem of domestic violence and its multiple effects on health. Consequently, health care providers often do not have the education they need to identify or respond effectively to domestic violence victims and their children. Individual practitioners and domestic violence experts have attempted to fill this gap by writing articles, providing presentations, and organizing their own trainings.[4]

Equally important to the need for accurate information about domestic violence is the need for continuing education to develop cultural competence in the delivery of health care. While there is an increased focus for health care workers on cultural competency,[5] there is little training specifically developed that integrates an understanding of both cultural competency and domestic violence. Additional integrated training programs and resources are needed to improve health care for all domestic violence

[4]The materials and references in the *Resource Manual* reflect this growing body of information.

[5]For references on Cultural Competency in the Health Setting: See *Resource Manual* Bibliography Appendix Q.

victims. This training is needed not only to improve the practice of individual clinicians, but also to improve the institutional response to this problem. To develop and implement effective policies and protocols specific to particular health care settings, staff need specialized education about domestic violence, cultural diversity, cultural competency, and culturally appropriate strategies for screening, assessment, intervention, and documentation. Given the demands on the health care system at this time and the need to reach the largest number of providers over time, training should be offered as part of continuing education programs within health care settings rather than solely through one-time conferences.

Trainings alone will not improve the health care response to domestic violence. In addition to trainings, providers need to have the system's support for this kind of care. Policies and procedures that guide all providers in the appropriate interventions for victims of domestic violence must be developed and implemented. The *Resource Manual* addresses these issues both in Chapter 4 on institutional change, and in Appendix B, an article that outlines how a hospital or clinic can bring about systems change through a series of team action planning and implementation sessions. Trainers using this manual may want to consider how to fit trainings into a broader approach to changing the system.

D. The Purpose of This Trainer's Manual

This *Trainer's Manual* outlines curricula covering domestic violence and cultural competency as well as teaching approaches for improving the clinical skills necessary to an effective response. The trainings reference the sections in the *Trainer's Manual* that can be used to develop policies and protocols for responding to domestic violence.

The manual is designed primarily for health care practitioners and domestic violence experts who want to offer specialized domestic violence trainings to health care providers. It also may be used as a guide for health educators or supervisors who are making decisions about the types of training to offer to their staff.

The five training modules are designed for health care practitioners who work in primary care, ob/gyn, family practice, and/or emergency medicine either in hospital and clinic settings, serving diverse patient populations. However, with minor adaptations, the training modules are also appropriate for a wide variety of specialty practitioners (such as surgeons, cardiologists, dentists, neurologists, mental health clinicians, and family planning clinicians) since health issues related to domestic violence appear in every health setting.

GANLEY, A., *INTRODUCTION*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

The training modules cover the following topics:

1. The dynamics of domestic violence and its impact on a victim's health

2. Cultural competency in responding to domestic violence victims

3. Specific clinical strategies for domestic violence screening, assessment, intervention, and documentation

4. Practical applications of screening, assessment, and intervention strategies

5. Legal issues and community resources for domestic violence victims as well as the legal and reporting issues for health care providers

E. Definitions of Terms Used in the Manual

The following are terms used throughout this manual that have a variety of meanings in other contexts. The definitions relating to domestic violence are explained in more detail in the *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*.[6] The culture/cultural competency definitions are the result of the work of the Family Violence Prevention Fund's Cultural Competency Advisory Committee, and are discussed in more detail in *From Sensitivity to Competency: Cultural Competency Guidelines for Health Care Providers*.[7] "Cultural competency" is terminology used regularly in the health care profession.

1. **Culture:**
   is defined broadly to extend beyond the categories of race and ethnicity, and to include other clinical population characteristics such as sexual orientation, class status, disability status, religious background, geographical location, veteran status, and immigration/citizenship status.

2. **Cultural competency:**
   refers to a set of attitudes, knowledge, and behaviors that reflect the health care provider's ability to respond to the needs of a diverse patient population.

[6]Warshaw and Ganley, 1996, pp. 15-45 XX.

[7]Warrier, PhD, Sujata and Brainin-Rodriguez, MD, JoEllen. Produced by the Family Violence Prevention Fund, 1998. See *Resource Manual* Appendix A for a list of Cultural Competency Committee Members.

3. **Domestic violence:**
is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

   As noted here, this definition of domestic violence does not include abuse, neglect, or sexual assault of children. However, oftentimes children are also victimized by a domestic violence perpetrator in the course of the abuse of an intimate partner. In some families seen in health care settings, there may be *both* domestic violence and child abuse, while in other families there may be only one, or neither, problem.

   This definition of domestic violence also does not encompass what is traditionally thought of as abuse of the elderly by an individual or institutional caregiver, unless that abusive caregiver is also the intimate partner of the elderly victim.

   The distinction between these issues is important because the interventions and legal issues differ.[8]

4. **Intimate partner:**
denotes current or former; dating, cohabiting, or marital; heterosexual, gay, or lesbian relationship.

5. **Domestic violence victim:**
refers to adult or adolescent patients who are being abused by their intimate partners.

   Other terms used in the community may be: battered woman, abuse victim, spouse abuse victim, domestic violence survivor, etc. Each term carries with it some difference in meaning and emphasis.

6. **Domestic violence perpetrator:**
is a person who is using assaultive and coercive tactics against an intimate partner.

[8]This *Trainer's Manual* is focused on issues related to intimate partner abuse, not the other types of violence: child, sibling, or elder abuse, or stranger violence. While often the health consequences of all forms of violence are similar, there are differences in dynamics and sometimes differences in response strategies. Training on those issues is beyond the scope of this manual. Trainers should read Chapter One of the *Resource Manual* to clarify differences among the types of family violence, if questions arise.

GANLEY, A., *INTRODUCTION*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

F. GENDER REFERENCES

In this manual, we have attempted to avoid using gender specific pronouns even though that the majority of heterosexual victims of domestic violence are female, while most perpetrators are male. The U.S. Department of Justice estimates that 95 percent of reported assaults on spouses or ex-spouses are committed by men against women. However, it is important to recognize that sometimes the perpetrator may be female and the victim may be male. Domestic violence also occurs in same-sex relationships where both the victim and perpetrator are the same gender.

Overview

Using the Trainer's Manual

OVERVIEW: USING THE *TRAINER'S MANUAL*

By Anne L. Ganley, Ph.D.

The *Trainer's Manual* provides information both about the subject to be taught and the process of teaching these issues. This chapter provides an overview of and a rationale for the design of the training modules. It also summarizes issues related to faculty selection, faculty preparation, and general training tips.

The information in this chapter can be used by trainers to adapt the modules to the specific educational needs of their audiences. The *Trainer's Manual* is not meant to be a script for specific trainings, but instead is a guide to allow trainers of varying backgrounds and skills to teach the issues key to improving the health care response to domestic violence victims.

A. UNDERLYING ASSUMPTIONS AND PRACTICAL CONSIDERATIONS FOR THIS *TRAINER'S MANUAL*

1. Barriers to Effective Responses

The barriers to health care providers in responding effectively to domestic violence victims are often related to practitioners' knowledge or skills, and/or to the health system's policies or procedures. The barriers include:

- Practitioners' knowledge and beliefs about domestic violence stemming from a lack of accurate information about domestic violence.

  While practitioners sometimes have a great deal of exposure to domestic violence through personal and professional experiences, they often have not had specific education about domestic violence or its health consequences.

- Practitioners' knowledge and skills in using specific identification, assessment, intervention, and documentation strategies with victims.

- Practitioners' lack of knowledge about diverse cultures and culturally appropriate health care strategies.

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

- The health care system's policies, procedures, and structures.[1]

  These include screening policies, mandatory reporting policies, and policies that block collaborations among health institutions, community resources, and victim advocacy resources such as: reimbursement coding directives, managed care policies, lack of administrative support for responding to domestic violence, etc.

2. The Purpose of the Trainings

These trainings are designed to provide the information needed for changes in the practice of both individual clinicians and health care systems.[2]

Ultimately, while changes in both individuals and systems may be required, changes in either area can occur before or at the same time. Changes in one area can inform and support change in the other.

3. Contextual Realities of Continuing Education

Continuing education within health care settings must be done in the context of the realities of the system, such as:

- Limits on the amount of time and resources for trainings
- Typical structures and formats for trainings

4. Trainings Are Based on Adult Learning Principles

a. Adults learn in different ways and are motivated to change their practices through different experiences or varied combinations of experiences, including:

   - visual experiences (such as slides, videos, and dramatizations),
   - personal stories,

[1]Rather than review this material here in detail, the trainer should refer to Chapter Four of the *Resource Manual*.

[2]While training modules do not spell out specific steps for making changes in policies and protocols, they do provide the conceptual foundation about domestic violence which must be understood in order to develop effective policies and protocols. Training participants who are interested in systems change issues should be referred to the *Resource Manual*, Chapter Four, and Appendix B of the *Resource Manual*.

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

- presentations of specific facts and information, or
- applications of concepts to clinical situations.

b. This manual attempts to respond to the diversity of learning styles by using or suggesting options for a variety of teaching methods throughout each of the modules.

c. Each module emphasizes allowing time for participants to interact with presenters and/or each other about the material covered during the training session. Research on adult learning indicates that adults *retain* more information for significantly longer periods of time when they are allowed to interact with the presented material. The importance of interaction time is true whether the material is presented through videos, lectures, slides, personal stories, or printed materials. Consequently, each module stresses leaving adequate time for interaction and the "Trainer's Tips" section suggest strategies for facilitating interactions about the material.

5. Domestic Violence Trainings and Participants' Personal Experiences

Domestic violence trainings for professionals may raise many personal issues in ways that some other health care trainings do not.

This manual is carefully designed to lessen the likelihood of those personal issues becoming a barrier to positive learning for participants. For example, attention has been given in the design of the modules to the optimum number and pacing of case examples, personal stories, or visual images of domestic violence. While such real-life examples are important to learning about domestic violence, they also can stimulate a lot of personal recall of domestic violence issues within the audience. Sometimes this recall can become overwhelming and block learning. Trainers are asked to consider this reality when planning their presentations.

6. Localizing the Material

This *Trainer's Manual* is designed to be used in a wide variety of health settings based in communities with varying laws, policies, practices, and resources.

Trainers will need to localize the material to the community and health care setting of their audiences. Suggestions for localizing the material are given throughout the *Trainer's Manual.*

B. THE STRUCTURE AND FORMAT OF THE FIVE TRAINING MODULES

1. Scheduling and Sequencing Modules.

a. The *Trainer's Manual* provides five 90-minute training modules for health care professionals on the topics of domestic violence and cultural competency. The five modules are designed to be either taught independently or in combination with each other. Each module has a different primary focus, but allows participants to raise questions that are more specifically covered in the other modules. When teaching one module, trainers need to be familiar with the material of all five in order to briefly cross-reference the others and to address any confusion a participant may have about any topic.

b. Although each module is designed to last 90 minutes, some can be split into two brief 45-minute sessions, or the 90-minute sessions can combined for a half-day, one-day, or one-and-a-half-day seminar.

2. The Structure of the Modules

Each module is organized into seven sections:

- Allotted teaching time
- Goals and objectives
- Specific training tips
- Presentation content outline
- Talking points: typical questions/issues raised by participants
- Participant handouts
- Suggested materials for transparencies or slides

In addition, Module Five also has a section on recommended faculty for both part one and two of the module.

3. The Format of the Modules

a. Content material appears either in **boldface** or regular font.

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

b. Process instructions to the trainers are clearly marked with an icon pointer and the term "trainer note" and are written in Tekton font.

c. Interactive Activities and Alternative Teaching Methods are boxed.

C. SELECTION OF TRAINERS

1. Collaborative Teams

The *Trainer's Manual* is designed to foster collaboration between domestic violence experts and health care professionals. A key issue is for the team to convey respect for the expertise of both fields, both as trainers, but also as collaborators in addressing the needs of domestic violence victims. Some health care settings have used a primary team of trainers (one from health care and one from the domestic violence field) with additions of specialized experts for certain sections (for example, victim legal advocates).

2. The manual should be used by trainers who individually or as part of a team have expertise in the following:

- Domestic violence
- Cultural competency
- Health care
- Training with health care providers

D. PREPARATION BY TRAINERS

1. Written Resources

Read and become familiar with this manual as well as *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*, and the *Cultural Competency Guidelines* in Appendix A of the *Resource Manual*.

The content outline and interactive teaching approaches described in each module assume that trainers are equally familiar with all three sources. At certain points, the trainer may want additional background material to handle the wide range of questions generated by these trainings. Bibliographies and key articles cited in the appendices of the *Resource Manual* can provide background to issues beyond the key points listed in the modules.

2. Selecting and Sequencing the Modules

The trainers will need to decide the sequence for teaching the modules based on the health care setting and audience needs. The total teaching time is 7.5 hours, *not* including time for breaks. A typical eight-hour training day with the appropriate breaks provides only six teaching hours, which would cover only four modules. However, the topics can be spread over time by teaching modules separately. To cover all topics, one-and-a-half days would be necessary. The authors suggest that modules be taught in the order listed (modules 1-5).

3. Arranging for Logistics

The trainer will need to arrange for the following logistics:

- Training space
- Faculty
- Equipment (such as audiovisual aids)
- Handout preparation and reproduction
- Advertising, notification, and registration for trainings
- Distributing and collecting evaluation forms for sessions. A sample evaluation is provided.

4. Arranging for Administrative Support for the Training Program

The trainer will need to work with administrative support to decide the following:

- Will training be mandatory, encouraged, or voluntary?
- Will supervisors/department heads participate?
- What is the commitment from the administration to provide ongoing training?

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

E. General Training Tips for the Five Modules

1. Developing Your Outline

a. The content outline is based on the materials in the *Resource Manual* and the *Cultural Competency Guidelines* in Appendix A of the *Resource Manual*. As a trainer who is knowledgeable about domestic violence issues and cultural issues, you will have your own knowledge and experiences to draw on for your presentations.

b. For four of the five modules, the presentation outline is primarily a content outline. The presentation outline is not a script to be read to participants. Faculty will need to use the content outline as a guide in the development of their personal teaching outline.

c. The module for the practical applications section has some sections which are scripted but require the trainer to have a great deal of information and experience when debriefing the case examples.

d. At specific points, the outline will indicate a teaching activity or optional methods for presenting certain concepts. The teaching instructions are marked with an icon pointer and optional methods are boxed. Trainers are also encouraged to develop additional approaches for presenting content.

2. Customizing the Presentations

Trainers must customize their presentations for:

- The specific health care setting and roles of participants
- The specific diversity of the providers and patients being served
- The specific community resources and legal context

a. The manual leaves the development and selection of case examples and handouts to the trainers. Some sample cases may be found in the appendices as well as in the *Resource Manual* and the *Cultural Competency Guidelines*. There are sample handouts at the end of each module. However, sessions will be more meaningful to the trainers and participants when the illustrations and handouts are customized by the trainers.

b. When preparing your customized outline, it is helpful to think of examples from the medical setting(s) of the audience. In addition, you may select case examples that illustrate:

- A variety of health care issues facing domestic violence victims;
- A diversity in both the culture(s) and interpersonal styles of domestic violence victims and the health care providers; and
- A variety of culturally appropriate, effective responses by health care practitioners.

Using cases that reflect this diversity prepares participants for the wide range of cases they will see in their work with patients.

c. Sometimes giving the most dramatic or complex cases can be discouraging to those wanting to learn about ways to change their practices. It may be helpful to consider the impact of all the case examples to be used in the 90-minute session and then select the number and type of illustrations optimal to the participants' needs.

d. Choose examples of varying complexity that focus on the specific point(s) you want to make. Remember that for each case example you give, the participants will think of several of their own cases. They can get lost if too many details or too many examples are presented. Also, take care that an example does not inadvertently perpetuate a myth about domestic violence or a specific cultural group.

e. Examples illustrating positive responses by health care providers are useful in reinforcing good practice and in encouraging improvement. Some participants are motivated to change more by positive than negative examples. While at times you may give an example of poor practice on the part of a provider, follow it up with positive examples. When using negative examples, it is also helpful to use one's own mistakes as illustration to convey that we all can improve and are in the process of improving practice.

3. Timing and Pacing the Presentation

Since the teaching time allotted for the modules is tight, carefully select your examples and state them briefly. Avoid the temptation to give too many examples or long, detailed stories. As noted above, participants have their own stories and examples in their minds. They may become overwhelmed by too many examples and then miss the point that you are trying to make by your case illustration.

4. Size of Participant Group

The timing of each presentation will be affected by the size of the group that is being trained. While the manual is designed to apply to many group sizes, the modules in the manual are most effective if taught in a group size of thirty participants or less.

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

5. The Importance of Interaction Time

a. The content outlines include those presentation points most relevant to health care providers, in a time frame that allows participants to interact with the presenter and other participants about the material.

b. If you do not have 90 minutes to teach the module, you can split a module into two 45-minute sections or you can cut 40 minutes of material. Avoid trying to speed through all the material by talking faster or by cutting interaction time with participants. Sometimes rushing to cover everything without time for interaction ends up reinforcing misinformation and poor practice.

c. Adding to the presentation points will cut down on the interaction time. It is important that discussion time not be lost since these trainings may challenge strongly held beliefs or misunderstandings about domestic violence, cultural issues, and/or clinical skills. Participants need time to process the material, ask for clarification, or state their misunderstandings so that the trainer or other participants can provide missing information. If you decide to add material to fit the needs of a particular audience, you can either add more time for teaching the session or identify points in the current outline that can be cut to allow for the additions.

6. Eliciting and Responding to Questions

a. Answer questions briefly and, where appropriate, refer participants to written materials for references and/or further clarification.

b. The content outlines indicate where to allow for 2-3 comments at the end of each major section. When taking questions at section breaks, avoid getting bogged down with one question or topic since you need to cover all sections of the modules.

c. Alert participants when their questions will be more adequately addressed in future trainings or when covered in detail in previous trainings.

7. Encouraging Participation

It is helpful to respond to as many different participants as possible and not to limit discussion to one participant's questions or comments. In a 1.5-hour training session, avoid calling on the same person more than once.

8. Use of Audiovisual Materials

a. Slides are frequently used in health care provider education and can be very helpful in communicating both the images of and the main points about

domestic violence. However, for the short modules described in this manual, slides should be used very selectively since the technology (e.g. having to turn lights off for viewing) can limit the interaction between presenter and audience and among participants.

b. For these training modules, a few slides or overhead transparencies can be used very effectively to highlight the main points about domestic violence, focus a discussion, illustrate the health impact of partner abuse, or clarify a procedure. All audiovisual aids need to be clearly presented and accessible to all participants. (For example, trainers should note if there are participants with hearing or visual impairments that would compromise their learning from audiovisuals and adjust the presentation accordingly.)

c. If using slides, it is helpful to plan out the specific techniques to be used to facilitate interaction with participants about the material on the slides (such as turning off the slides and raising the lights, providing handouts of the major points on the slides, or stopping periodically to take questions and comments throughout the presentation).

d. Please note on your outline wherever overheads/slides are to be used.

e. Inform participants when a handout of the overhead/slide is provided so they will know that they do not have to copy the material as you speak.

f. Sample materials for transparencies are provided at the end of each chapter and can be made into overheads or slides if desired.

9. Handouts

a. At the end of each module, sample handouts are provided for that section. You will need to choose how many and which handouts you will distribute. That choice will depend greatly on which modules you are teaching and the sequence of those modules. If you are sequencing the modules over several weeks or months, rather than in one to two days, you may need to provide handouts from previous or future sessions.

b. You do not have to present every point in the materials. Select only the main points you are making and suggest participants examine the handout's additional points after the session.

GANLEY, A. *OVERVIEW*, "Improving the Health Care Response to Domestic Violence: A *Trainer's Manual* for Health Care Providers," FAMILY VIOLENCE PREVENTION FUND (1998).

F. CONCLUSION

There is a great deal of diversity among trainers in how much detail and direction they want from a *Trainer's Manual*. Some prefer very detailed directions and others prefer only major points. This manual provides some of both. In some cases, it may provide more detail than you will use. In others, you may wish there were more detail. Your needs for specifics may vary according to composition of your training team and your own teaching experiences over time. The *Resource Manual* can provide more specific information. The *Trainer's Manual* is meant to be merely a guide that each trainer will ultimately make into her or his own.

MODULE ONE

Domestic Violence Victimization: A Primary Health Issue

MODULE ONE

Domestic Violence Victimization: A Primary Health Issue

by Anne L. Ganley, Ph.D.

TIME ALLOTTED: 90 MINUTES

GOALS AND OBJECTIVES

1. To establish that domestic violence is a primary health issue facing patients, their families, and health practitioners.

2. To correct the misinformation about domestic violence that typically blocks effective responses by health care professionals, and introduce the definitions and causes of domestic violence, as well as perpetrator and victim issues.

3. To illustrate the importance of developing and implementing culturally appropriate responses to domestic violence victims.

4. To provide brief, concrete examples of changes in practitionersÕ and health systemsÕ approaches that can be made to improve the response to domestic violence victims.

5. To motivate health care professionals to improve their response to domestic violence victims and their children.

TRAINING TIPS

1. Format of the chapter:

Presentation material and activities are in outline format and written in **boldface** or in regular font. Directions to the trainer are marked with an icon pointer and are written in Tekton font. Interactive activities and alternative teaching methods are boxed.

2. Specific preparatory readings

The content outline for Module One is primarily based on the materials in the Resource Manual, especially the Introduction and Chapter One and the *Cultural Competency Guidelines* in Appendix **A** of the *Resource Manual*.

3. The content outline for this module is for 90 minutes.

The material would need to be reworked for a shorter or longer session. If you do not have 90 minutes to teach this section, then you can easily split Module one into two 45-minute sections. For shorter presentations (such as a grand rounds session) you can cut 40 minutes of material and provide participants with a reference list of articles or a copy of an overview article (such as the Chapter One in the *Resource Manual*) that covers all the points in this presentation.

This is the one module where it is most tempting to condense the material by talking faster or by cutting participant interaction time. Yet it is during presentations about the dynamics of domestic violence when we are most likely to hear the misconceptions about domestic violence, victims, and perpetrators that lead to poor practice. Making time for questions from the participants during the presentation creates opportunities to correct those misconceptions.

4. Prepare case examples specific to the participants.

Examples should address:

- The health care setting(s) of the audience;
- A variety of health issues;
- A diversity in the culture(s) of both patient and provider;
- A variety of interpersonal styles of patients; and
- A variety of effective responses by health care practitioners.

5. Allow for 2-3 comments from participants at the end of major sections: Definitions of Domestic Violence, Causes of Domestic Violence, and Perpetrator and Victim Issues.

Answer questions briefly. Avoid getting stuck on one question or topic since you need to cover all of the material and conclude with a summary of concrete suggestions for improving clinical practice. Call on different participants throughout the training.

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

6. Prepare your overhead transparencies/slides.

Be familiar with audiovisual equipment or arrange for technical assistance. Note on your outline both when the audiovisuals will appear and when the equipment needs to be turned off. Sometimes in the flow of a presentation we lose awareness of the technology and forget that equipment can be very distracting to the audience. Also, note on your outline at what point you want to inform the audience that a handout of the overhead/slide is provided.

7. Use citations sparingly while presenting the material.

Since this presentation draws on the work of many people over many years, it is often difficult to decide which information needs citation and which does not. Referencing the general body of expertise that forms the foundation for the presentation is helpful. Avoid giving too many or long citations during the presentation. Participants will appreciate it if you provide guidance about additional, written, or Internet sources for current and future expertise. Citations and reference material can be provided in a handout and then referenced during the presentation.

8. Select appropriate handouts.

Suggested handouts appear at the end of the module. Some need to be localized by the trainers. You do not have to read or present every point in the handout materials. Select only the main points you want to cover and refer participants to the handout for the other points.

PRESENTATION OUTLINE:

Domestic Violence Victimization: A Primary Health Issue

I. INTRODUCTION
(5 minutes)

TRAINER NOTE: Refer participants to Handout #1-1 and/or transparency #1-1, which contain statitics for sections A-C. You may want to develop your own handout for these statistics to keep training current and localized.

A. Domestic violence is a widespread problem.

TRAINER NOTE: Provide any of the local, state, or national domestic violence statistics to illustrate the magnitude of the problem:

1. Number of crisis calls
2. Number of arrests and homicides
3. Number of requests for emergency shelter or victim services, victims turned away, etc.

TRAINER NOTE: See Handout # 1-1 and/or the *Resource Manual,* Introduction, for sample statistics

B. Domestic violence has a major health impact on victims and their children.

TRAINER NOTE: Use national statistics from the *Resource Manual*, Introduction and/or Handout #1-1, to illustrate both the breadth and frequency of health consequences.

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C. Domestic violence victims turn to their health care system for help for relief from the injuries and/or other health-damaging effects of their partnersÕ abusive conduct.

> TRAINER NOTE: Using either the *Resource Manual,* Introduction or local data, or Handout # 1-1, provide statitics indicating victims' presence in the health system specific to the participant's health care setting (such as primary care, dental, or emergency department).

1. For some victims, their first or only attempt to get help is from health care providers, rather than from the police, courts, or battered womenÕs services.

   a. Some victims may not be ready to identify themselves as needing legal or battered womenÕs services.

   b. Others do not use these specialized agencies because the police, legal system, or battered womenÕs services may not be accessible or appropriate resources, due to individual or cultural issues. Examples include:

      - Victims from certain ethnic communities who do not consider the police as a resource.
      - A hearing-impaired victim who is unable to access battered womenÕs crisis lines.
      - Victims whose batterers will not allow them to contact anyone other than health care providers.

2. For other victims, the community services of police, religious agencies, or victim services are the preferred initial points of contact. These agencies then may assist victims in accessing health care providers.

D. In order for health systems to respond more effectively and be part of a coordinated community response, health care providers need to have an understanding of both:

1. The dynamics of domestic violence, including

a. The nature of the problem and its impact on health,

b. The causes,

c. The perpetrators, and

d. The victims; and

2. **The cultural contexts of both domestic violence and health care.**

   The practitioner needs to be aware of how culture(s) can influence either the patientÕs or providerÕs understanding of domestic violence, their attitudes toward each other, and the health care providerÕs ability to treat the patient.

3. **Oftentimes it is our misunderstanding of one or more of these issues that decreases our effectiveness with our patients.**

   TRAINER NOTE: Insert an illustration of the previous point as experienced by the trainers such as:

   "I once responded to a patient who was a domestic violence victim by … {insert mistake} … because I did not know … {insert misunderstanding you once had about domestic violence or cultural issue}…."

ALTERNATIVE TEACHING METHODS

For either Option A or B or C, provide a one-page handout that demonstrates the health consequences of domestic violence with the supporting data. Create your own or adapt the case examples located in Appendix A and B of the *TrainerÕs Manual*.

OPTION A

Open the session by presenting 2-3 case examples. Use the same examples throughout the presentation, but layer in details as you proceed rather than providing all of them at the outset.

1. Start the session by briefly describing 2-3 different cases of domestic violence victims in the health system (1 minute each). Provide only the information that illustrates points in sections I. A-D. (For example: domestic violence is wide-spread, it has major health consequences, its victims appear in a variety of health settings, & it is important to understand domestic violence and its cultural context.

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

ALTERNATIVE TEACHING METHODS

OPTION A *continued*

2. Move directly from case examples into your presentation of the main points of sections I. A-C.

3. Conclude with section I. D on how misconceptions about either domestic violence or its cultural context can lead to poor practice. Discuss an error made in one of the case examples youÕve already mentioned.

In later sections of Module One, you can return to these same case examples and add facts that are relevant for teaching the additional concepts of the module, such as diversity among victims (e.g. race, class, sexual orientation, age, etc.) and the variety of interpersonal presentations in health settings (e.g. self-disclosing, withdrawing, rageful, depressed, etc.).

OPTION B

1. Open the session with 2-3 case examples (1 minute each). Use the same case examples throughout the module, but during this initial presentation describe all case details relevant to all of the concepts to be presented throughout Module One.

2. Then present points in sections I. A-D, only referring back to those details relevant to sections I. A-D. In the later sections of the presentation, you will refer to those case details relevant to the particular section.

OPTION C

Open with a 3-minute video clip or slide presentation that shows several domestic violence victims with a variety of health consequences. Then take two minutes to present points from sections I. A-D.

Such videos/slide presentations can be made using photographs, newspaper headlines, or clips from other videos (such as TV news clips or documentary segments).

See Appendix Q in the *Resource Manual* for listings of videos on domestic violence in the health setting.

ContinuedÉ

OPTION C *continued*

Remember to use the same criteria for developing the visual presentations that you would use for any case examples. (For example, they should reflect cultural diversity, etc.)

This type of 3-minute video/slide presentations is *not* a stand-alone training video. The clip should not show ÒexpertsÓ talking about the issues, but instead should provide a visual (and/or audio) view of domestic violence in the health care system. Such clips are meant to be used to bring alive the didactic presentation by the trainer.

II. BEHAVIORAL DEFINITION OF DOMESTIC VIOLENCE
(15 minutes)

TRAINER NOTE: Use Overhead Transparency #1-2 and refer participants to the first half of Handout #1-2.

Domestic violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion
- that adults or adolescents use against their intimate partners.[1]

A. Commentary on key elements of the definition

1. Behavioral vs. legal definition of domestic violence

a. In health care, a behavioral rather than a legal definition of domestic violence is used since it is more comprehensive and more relevant to clinical care.

[1]Warshaw, C. and Anne Ganley, *Domestic Violence: A Resource Manual for Health Care Providers*, 1996, Family Violence Prevention Fund.

b. Legal definitions may differ from this behavioral definition, and legal definitions vary between jurisdictions. Sometimes it is helpful to be aware of the legal definitions in your community since some patients who have had contact with the legal system are using that definition rather than this behavioral one.

☞ TRAINER NOTE: Trainers should know the community's legal definition of domestic violence and may provide a handout with that definition. Also, if you are planning to present module five at a later time, refer participants to that upcoming training on legal resources.

2. **Domestic violence occurs in either adult or adolescent; gay, lesbian, or heterosexual; dating, cohabiting, or married; current or past relationships.**

3. **Domestic violence is a pattern of:**

   - multiple tactics (physical, sexual, psychological, and economic), and/or
   - multiple episodes over time, and includes
   - a range of tactics: some injurious, some not; some criminal; some not.

   There may be a great deal of variety in the peretratorÕs pattern over time as well as variations between abusers.

4. **Domestic violence consists of a combination of physical attacks, terrorist acts, and controlling tactics that can result in fear as well as physical and psychological harm to victims and their children.**

5. **Domestic violence sets up a dynamic of power and control in the relationship.**

B. Abusive Behaviors List[2]

☞ TRAINER NOTE: Show participants Transparency #1-3 on abusive behaviors and/or refer them to the second half of Handout#1-2.

Describe briefly each category of the Abusive Behaviors List, focusing on behavioral examples of the perptrator's abusive acts, but do not give full case examples with information about victim, health setting, etc. In this section, the emphasis is on teaching the behavioral definition of domestic violence, rather than other related issues.

[2]Some trainers may prefer to use the Power and Control Wheel here. Please see Handout #1-3.

1. **Physical:**
   - spitting, poking, shaking, grabbing, shoving, pushing, throwing, hitting open handed, hitting closed handed, restraining, blocking escape, choking, hitting with objects, beating, kicking, using weapons, burning, controlling victimÕs access to health resources, etc.

2. **Sexual:**
   - persistently pressuring for sex, coercing sex through a variety of tactics, forcing sex in front of others, forcing sex with children or third parties, physically forcing or harming a victim sexually, etc.

3. **Psychological:**
   - violent acts against children or others to control intimate partner; threats of violence against victims, others, or self; intimidation through attacks against pets or property, yelling, stalking; controlling a victimÕs activities; isolating a victim; controlling a victim through immigration status; controlling a victimÕs access to resources (health care, medications, automobile, friends, schooling, jobs, childcare, etc.); emotional abuse; forcing a victim to do degrading things; controlling a victimÕs schedule, including health appointments, etc.

4. **Use of economics:**
   - withholding funds, spending family funds, making most financial decisions, not contributing financially to the family, controlling a victimÕs access to health insurance, etc.

5. **Use of children to control an adult victim:**
   - hostage taking of children; physical and sexual abuse of children; forcing children to engage in physical and psychological abuse of an adult victim; custody fights; using visitation with children to monitor an adult victim, etc.

C. Summary

Domestic violence consists of a variety of acts carried out in multiple episodes held together by the perpetratorÕs use of physical force or threats of harm to intimidate and control the victim.

You may hear about or see the injuries from one incident, while the domestic violence victim is dealing not only with that incident, but also with the history of past incidents and the fear of future ones.

Trainer Note: Facilitate a brief discussion using one of the following interactive activities:

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INTERACTIVE ACTIVITY

OPTION A

Ask participants to use the definition and then to list out 2-3 examples of physical domestic violence that they have heard about in their practice as health care professionals.

If they offer a nonphysical tactic, point out the appropriate category on the Abusive Behaviors List, then continue to solicit examples of physical abuse.

Keep the emphasis on physical abuse at this point in the presentation for several reasons:

- Physical tactics are the easiest ones for audience to identify as domestic violence.
- Some practitioners fail to identify the full range of what a perpetrator is doing physically.
- Some practitioners donÕt understand the connection between the use of or threats of physical force and the other tactics of control.

This exercise about physical abuse gives participants a place to begin to ground the concepts they heard in the discussion of definitions.

INTERACTIVE ACTIVITY

OPTION B

Ask the group if they have questions for clarification about the definitions you've discussed. Take one or two. Try to keep the group focused solely on issues related to definitions.

III. CAUSES OF DOMESTIC VIOLENCE
(15 minutes)

TRAINER NOTE: Refer participants to Handout 1-4 Causes of Domestic Violence and/or Transparency 1-4.

A. Domestic violence (the pattern of assaultive and coercive behaviors) is learned behavior.

1. **It is learned through observations of other people using these power and control tactics, and it is learned through using the tactics and having them reinforced.**

   a. It is not something people are born with and it is not a disease people catch.

   b. Violence and coercive tactics are used because they often work, at least temporarily or some of the time. Batterers use these tactics and too often are not held responsible for their behavior; consequently, they do it more.

2. **Domestic violence is learned in the family, in communities, and in society.**

INTERACTIVE ACTIVITY

Provide or solicit participants' examples of how domestic violence:

- is modeled (such as a child seeing spousal abuse at home, or a person seeing abuse of intimate partners as entertainment on MTV, in sitcoms, or in advertising).
- is reinforced by inappropriate responses from institutions, including law enforcement agencies, the media, religious or health care system (for example, victims being told to pray harder as the only solution for domestic violence, patients not being screened for domestic violence, asking a victim what she did to cause a perpetrator to abuse her).

It is often helpful to provide one non-health care and one health care example.

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B. Domestic violence is not caused by:

TRAINER NOTES: Use Overhead #1-4 and/or refer participants to Handout # 1-4, The Causes of Domestic Violence. When reviewing the causes, list each one and make a brief point about it.

To prepare for this section, use *Resource Manual*, Chapter One, Section II, to identify one point for each category #1-6. Health practitioners are particularly concerned about the relationship between domestic violence and: illness, alcohol/drugs, and the behavior of the victim.

As the trainer, you can choose the points you want to make refuting misunderstandings about the causes of domestic violence. There is more than one good point for each issue related to causes. With limited time, trainers should choose the points most relevant to participants. This section should be covered briefly. Trainers are merely introducing critical reflection on the more commonly held misconceptions about domestic violence.

1. **Genetics:**

   There is not a gene that causes people to be abusive to their intimate partners. Perpetrators are not born to abuse.

2. **Illness:**

   While certain illnesses (such as AlzheimerÕs and psychosis) may cause aggressive behavior in some patients, the complex pattern of assaultive and coercive behavior we have identified as domestic violence is learning-based, not illness-based. Illness-based violence is usually easy to distinguished from learning-based violence because it is accompanied by additional symptoms of the illness (e.g. changes in gait or speech). In illness-based violence, there is no consistent targeted victim of the abuse.

3. **Alcohol and/or drugs:**

   Research indicates that there is no causal relationship between alcohol and/or drug consumption and violent behavior and, in fact, there is a wide range of interpersonal responses to the influence of substances. Although for some individuals there may be an overlap between substance abuse and domestic violence issues, alcohol and/or drugs do not cause the abusive behavior. When the problems occur in tandem, it is important to identify each as an independent issue and develop a treatment plan that addresses them both issues.

4. **Stress and/or Anger:**

   Once again, using a simplistic model of stress or anger as a cause of domestic violence ignores the reality that many individuals who are stressed or angry do not abuse their intimate partners. The reality is that batterers also use assaultive and coercive tactics when they are not stressed or angry.

5. **Out of control behavior:**

   When we look at either the Abusive Behaviors List or the Power and Control Wheel, we can see that perpetrators carry out tactics (such as stalking) with a great deal of awareness and organization of thought. Batterers follow their own rules for when, where, how, and against whom to direct their abuse. This is not out of control behavior, even though batterers often talk about having Òlost itÓ or Ògoing over the edge.Ó

6. **Behavior of the victim or problems in the relationship:**

   Victims get battered both when they comply with or when they resist the demands of the batterer. Research indicates that the victimÕs behavior does not seem to have any impact on altering a battererÕs abuse.

☞ TRAINER NOTE: See Chapter One in *Resource Manual* for further details and background citations on each point.

INTERACTIVE ACTIVITY

Stop and take 2-3 questions from the participants about what does and does not cause domestic violence.

IV. UNDERSTANDING DOMESTIC VIOLENCE PERPETRATORS & VICTIMS

(10 minutes)

A. Individual experience with domestic violence

☞ Trainer Note: The following is a hand-raising exercise to sensitize participants to:

- The amount of individual experience they already have had with domestic violence;
- How that experience can increase their sensitivity and/or lead to stereotypes about victims or perpetrators; and
- How to use a behavioral definition of domestic violence in assessing domestic violence.

INTERACTIVE ACTIVITY

TRAINER'S INSTRUCTIONS TO PARTICIPANTS: Sample Script

I will ask you a series of questions, which I want you to answer just by a show of hands. During the exercise look around and note the responses of your colleagues.

1. First set of questions.
   Using the behavioral definition of domestic violence, answer the following questions:

➤ How many of you, in your role as a health care provider, have talked with a victim of domestic violence about the abuse?

➤ How many of you, as a health care provider, have talked with a domestic violence perpetrator about the abuse?

2. Second set of questions.
   Using the behavioral definition again, answer these questions:

➤ How many of you, in your nonwork interactions (such as with family, friends, acquaintances, and those who provide services to you Ñ car mechanic, insurance salesperson, hair stylist, etc.), have talked with a victim of domestic violence about the abuse?

➤ How many have talked in that nonwork world with a domestic violence perpetrator about the abuse?

3. Third set of questions.
   This time I do not want you to raise your hand É do not raise your hands É sit on your hands É and just answer these questions for yourself:[3]

➤ Using the behavioral definition of domestic violence, how many of you are victims/survivors of domestic violence?

➤ How many of you are perpetrators?

[3]The exercise is intentionally designed to avoid participant self-disclosure about personal experiences as victims or perpetrators. Given the limited time for this session, it would be very difficult to integrate appropriately the participantsÕ personal experiences as victims or perpetrators into this presentation. Sharing those experiences without sufficient time might detract from other learning experience. In other sessions, with more process time, such disclosure can enrich the learning experience of the entire group.

B. Influence of Prior Experience with Domestic Violence on Current Work with Patients

1. Most of us have a great deal of professional and personal experience with domestic violence.

2. That reality can be both our strength and our limitation.

3. Such experiences help us to put a real face on the statistics, to be sensitive to a real person behind the chart notes.

4. Sometimes prior experiences can be limiting when we are faced with domestic violence victims or perpetrators who are somewhat different than those we have met before. We may generalize from our individual experiences, expecting victims or perpetrators to conform to certain expectations. If the person before us doesnÕt meet our expectations, we may slip into thinking that he or she is not a ÒrealÓ victim or perpetrator, or this isnÕt ÒreallyÓ domestic violence.

5. Our prior experiences with this issue may reflect more about where we happened to have lived or worked than about domestic violence in general. It is important to not limit our understanding of domestic violence solely to what we individually have experienced, but to add to our own experience what we can learn from the experiences of others.

V. PERPETRATORS
(5 Minutes)

A. Perpetrators, like victims, come from all groups:

1. Perpetrators come from all ages, races, classes, religions, occupations, sexual orientations, and personality diagnoses.

2. Sometimes health care providers can be misled because the batterer doesnÕt look like a Òtypical batterer.Ó (For example, the batterer may be elderly, upper class, charming, or a professional.)

3. The one defining similarity among batterers is their use of tactics of control, not their demographics or personality traits.

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

B. Gender: Both men and women may perpetrate domestic violence.

1. In heterosexual relationships, perpetrators are usually male and victims are female.

> TRAINER NOTE: Use statistics in the *Resource Manual,* Chapter One, Sections IA and IIB. Give statistics for heterosexual relationships.

2. In same-sex relationships, both victims and perpetrators will be the same gender.

3. Regardless of who is doing it to whom, health care professionals need to take domestic violence seriously.

C. If a perpetrator accompanies a victim (or is in the health system as the patient), clinicians may hear the *minimizing, denying, or lying* about the domestic violence as well as the victim-blaming.

1. Examples of minimizing or denying:

   - ÒItÕs no big deal.Ó ... ÒMy partner bruises easily.Ó ... ÒShe hit a door/fell.Ó

2. Examples of blaming or justifying violence:

   - Sometimes the perpetrator acknowledges the incident, but either blames the victim (ÒShe was drunk.Ó ÒHe hit me first.Ó) or another cause (ÒI was drunk/under a lot of stress/having flashbacks.Ó) to avoid taking responsibility for the domestic violence.

3. Perpetrators are able to continue abusive conduct by avoiding responsibility for the abuse.

> TRAINER NOTE: Refer participants who want to learn more about this topic to the Resource Manual, Chapter III.

D. Sometimes perpetrators will use the health care provider to control the victim by a variety of coercive tactics.

☞ TRAINER NOTE: Provide examples from the health care system in which perpetrators' behaviors prevent the health care provider from having confidential access to the domestic violence victim, such as:

- accompanying the victim to appointments,
- canceling the victimÕs appointments,
- or being intimidating or cajoling, so that the provider will withdraw from the patient.

VI. VICTIMS

(20 minutes)

A. The primary victim: The intimate partner

1. Gender

a. In heterosexual relationships, the victim is most frequently female.

b. Research also indicates that female domestic violence victims sustain more serious injuries than male victims.

c. In same-sex violence: gay victims are male, and lesbian victims are female.

☞ TRAINER NOTE: Give statistics; either repeat the statistics you used in presenting the information on perpetrators or choose another statistic from the Resource Manual that illustrates one of these points.

2. Demographics

a. Domestic violence victims come from all groups, regardless of:

- race/ethnicity (It is important to note that domestic violence is a problem in all ethnic groups)

- class
- education/occupation
- age (It is important to remind participants about adolescents and elderly victims of domestic violence)
- physical ability
- sexual orientation
- personality traits

☞ TRAINER NOTE: Using the *Resource Manual*, Chapter One, Section IIIA and your own experiences, illustrate the above. Offer brief examples to show the variety of victims.

b. Victims are a very heterogeneous group.

It is important not to base our perceptions of victims solely on our own personal or professional experiences. Our experiences may be limited to victims with certain characteristics. We may not readily identify victims who come from other backgrounds or exhibit traits we have not previously encountered.

c. Being a domestic violence victim is due to the behavior of the perpetrator, *not* due to the victimÕs demographics.

3. Why battered women stay, leave, return, and leave[4]

☞ TRAINER NOTE: Refer participants to transparency #1-5 and/or Handout #1-5, Barriers to Leaving for Domestic Violence Victims.

a. Contrary to the myth, many battered women do leave abusive relationships.

b. However, it is important to remember leaving is a process that occurs over time.

c. To understand the leaving process (or the process of making other changes), one must understand the barriers that prevent a victim from leaving, which include:

[4]Research about victimsÕ leaving, returning to batterers, and leaving again has been done only on battered women in heterosexual relationships, not on male victims or victims of lesbian battering.

- **PerpetratorsÕ behavior. For example:**
  - escalating violence, stalking, threats against the children, hostage taking, threats of reporting to authorities (Immigration Naturalization Services, Child Protective Services, etc.)

- **Lack of safe options for victims and their children. For example:**
  - emergency shelter, housing, employment, effective legal restraints, concerns about immigration status, etc.

- **Victim overwhelmed by the immediate physical and psychological trauma. For example:**
  - victims who have been beaten, stalked, terrorized in crisis, etc.

- **Lack of continuous community and family support. For example:**
  - religious or cultural values that focus on maintaining family above all else;
  - threat of losing of close-knit community (for example, a Native American who must leave her tribe to flee her abuser);
  - victim-blaming by the perpetrator, counselors, courts, health care providers, family, friends, etc. that violence is the victimÕs fault and the victim should go back and fix it, or that the victim should Òjust leaveÓ to fix it;
  - the belief by the community that domestic violence is the least of the victimÕs problems in the face of others (such as parenting issues or unemployment);

- **The victimÕs ambivalent feelings. For example:**
  - wanting the violence to stop, but wanting to maintain the relationship.

Some helpers only focus on #5 as a barrier and do not consider the reality of how much factors #1-4 may prevent victims from leaving.

d. The health care provider sees a domestic violence victim at one stage in the process. How the provider responds can either support the victim or inadvertently support the abuser in further victimizing the victim.

4. VictimsÕ various presentation in health care settings.

a. In health care settings, victims may appear:
   - indirect, ill, depressed, passive, angry, afraid, reluctant to disclose, eager to tell everyone, waiting to tell someone, etc.

b. Much of what health care providers see or hear from domestic violence victims reflect the effects of living in abusive relationships and the victimsÕ survival strategies when they get little or no support. Too often the victims have already told their stories and sought help that was not provided. Having tried many other support-seeking strategies which failed to stop the abuser, they may comply with perpetrators in hopes that the violence will be less severe against them and/or children.

c. It is helpful to view the victimsÕ emotions and behaviors as normal reactions to the perpetratorsÕ abuse and as the victimsÕ attempts to protect themselves and their children.

5. **The goal of intervening with victims is not to make them separate from abusers, but to give them the information and support they need to make their own decisions.**

B. The forgotten victims: The children

1. **Domestic violence victims may be accompanied by children or the primary patient may be children from homes where there is domestic violence.**

As previously noted, children are harmed by the perpetratorÕs acts against the victim. Sometimes they are directly injured as they try to intervene or are used by the perpetrator against the victim.

☞ TRAINER NOTE: Give one example of how a perpetrator may use children against the victim. (See the children's section in the *Resource Manual*, Chapter One, Section IIIC).

2. **The perpetratorÕs use of children may have multiple physical, emotional, and behavioral effects on them.**

C. Other victims: Those trying to help or innocent bystanders

At times, a helper, family member, friend, or bystander may be injured or killed in domestic violence-related incident.

TRAINER NOTE: Give one local example of a helper, family, or friend victimized by domestic violence, or bystander who was injured or killed by a domestic violence related incident.

INTERACTIVE ACTIVITY

Ask participants if they have any questions. Take 1-2 questions for clarification on victim issues only.

VII. SUMMARY: IMPLICATIONS FOR THE HEALTH CARE PRACTICE

(10 minutes)

A. Domestic violence can be lethal and is a major health issue.

B. Guiding principles for the health care response to domestic violence victims:

TRAINER NOTE: Use Transparency #1-6 and refer participants to Handout #1-6.

1. Increase the safety of domestic violence victims and their children.
2. Respect the rights of domestic violence victims for self-determination.
3. Holds perpetrators, not victims, responsible for the violence and for stopping it.
4. Advocate on behalf of domestic violence victims and their children.
5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence victims.

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

C. Elements of an improved health care response to domestic violence victims:

TRAINER NOTE: Note that this material will be covered in Module Three. Refer to Transparency #1-7 and Handout #1-6.

1. Screen for domestic violence victims.
2. Assess the health impact of their victimization.
3. Conduct intervention by:
   a. Giving the victim validating messages: For example:
      - ÒI am concerned about your safety and well being.Ó
      - ÒYou do not deserve abuse.Ó
      - ÒYou are not alone.Ó
      - ÒThere are options and resources available.Ó
      - ÒDomestic violence is complicated, takes time to deal with, and I want to be helpful.Ó
   b. Providing information about domestic violence
   c. Assisting in safety planning
   d. Referring the victim to appropriate support and advocacy services

TRAINER NOTE: Create and refer to Handout #1-7 or wait and distribute this handout when presenting Module Five on community resources. See sample Handout #1-7 for instructions.

   e. Conducting a follow-up
4. Document the domestic violence.

VIII. CONCLUSION: OPEN TO ALL QUESTIONS
(15 minutes)

INTERACTIVE ACTIVITY

Ask for participants' questions and comments.

Remind participants that there are additional trainings and resources that go into more detail about strategies for an improved health care response and about community and legal resources.

TRAINER NOTE: Ask participants to complete the evaluation found in Handout #1-8.

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TALKING/DISCUSSION POINTS

A wide variety of issues come up when the participants have the opportunity to discuss the concepts presented. Below are some of the typical issues trainers may be faced with during discussions.

Being prepared to respond to such challenges makes the discussion periods more productive. There will not be time in the discussions to cover all the questions. Oftentimes simply being able to help participants think through one or two of their questions encourages them to re-examine their understanding of and practice in this area, which in turn promotes improved practice.

1. **In any discussion sections of the module, listen for confusion about the definition of domestic violence:**

   - **failing to see domestic violence as a pattern, rather than an isolated, individual event; how a pattern consists of various tactics and multiple incidents; how a perpetratorÕs conduct affects the victim over period of time. (For example, a patientÕs fear, rage, or numbness may be the result of long-term abuse rather than a specific incident).**

   - **failing to see a connection between the use of physical force against person or property and psychological tactics; how the physical assaults and threat of assaults establish control through fear; how subtle manipulations and even indulgences can be very coercive. (For example, health care providers may minimize a victimÕs reaction to an episode of verbal assault, and not consider that verbal abuse in light of physical attacks that have occurred in the past).**

2. **Listen for and then clarify any confusion about domestic violence being an issue of anger, out of control behavior, caused by alcohol or drug abuse, or caused by the victimÕs behavior.**

   Typically, health care providers will have some confusion about illness, alcohol or drugs, or the victimÕs behavior as the cause. Trainers should be very familiar with the Causes section of Chapter One, Section II of the *Resource Manual.*

3. **Assist participants in seeing how an ineffective health care response to victims further teaches perpetrators that what they are doing to victims is justified Ñ and how that response further isolates victims.**

   Batterers are always seeking others to collude with them and assist them in gaining further control over the victim.

   Also, ineffective responses teach victims that no outside help is available.

4. **In discussions about victims, listen for victim-blaming attitudes and clarify when possible how such views leave victims believing what perpetrators say about them and less able to act on their own behalf.**

   Explore misconceptions that victims can Òjust leaveÓ; remind participants of all the barriers.

5. **Listen for comments that Òvictims go from one battering relationship to another.Ó**

   Research indicates that this pattern is not true for the vast majority of battered women who leave abusive relationships. While it may be true for some, it does not mean that even those few want to be abused. Some victimsÕ experience teaches them that violence is prevalent and that the most they can hope for is a relationship in which the new partner is less violent than the last one. Also remind participants that perpetrators often hide their abusive behavior until their partners are deeply involved in the relationship.

6. **Listen for participantsÕ cultural misconceptions. Clarify when possible and encourage consultation to reflect on cultural issues and to improve practice.**

   Refer participants to the upcoming Cultural Competency module. If you plan to conduct it or the Cultural Competency Guidelines in Appendix A of the *Resource Manual.*

7. **Remind participants that change is a process that happens over time both for themselves and for their patients.**

8. **Stress doable steps that practitioners can take this day, this week, this month.**

   Also point out successes that groups of individual practitioners have had in changing a systemÕs policy or procedure through protocol development. An improved response to domestic violence victims is both on an individual level and/or a systemic one.

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

Module One

Handouts

PARTICIPANT HANDOUTS FOR MODULE ONE

HANDOUT #1-1	Domestic Violence as a Primary Health Issue
HANDOUT #1-2	Definition of Domestic Violence and Abusive Behaviors List
HANDOUT #1-3	Power and Control Wheel
HANDOUT #1-4	Causes of Domestic Violence
HANDOUT #1-5	Barriers to Leaving for Domestic Violence Victims
HANDOUT #1-6	Improved Health Care Response to Victims
SAMPLE HANDOUT #1-7	Community Resources for Domestic Violence Victims and Perpetrators. *(To be developed by each trainer; instructions attached.)*
HANDOUT #1-8	Evaluation of Module One

Handout #1 1

DOMESTIC VIOLENCE: A PRIMARY HEALTH ISSUE FACT SHEET

DOMESTIC VIOLENCE:

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, that adults or adolescents use against their intimate partners.

PREVALENCE:

Domestic violence is virtually impossible to measure with absolute precision due to numerous complications including the societal stigma that inhibits victims from disclosing their abuse and the varying definitions of abuse used from study to study. Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year[1] to 3.9 million women who are physically abused per year.[2]

On July 22, 1997, UNICEF released The Progress of Nations, 1997, which found that a quarter to half of women around the world have suffered violence from an intimate partner.[3]

One out of every four American women (26%) report that they have been physically abused by a husband or boyfriend at some point in their lives. 30% of Americans say they know a woman who has been physically abused by her husband or boyfriend in the past year.[4]

While women are less likely than men to be victims of violence crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner.[5]

INJURIES AND OTHER HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE:

The U.S. Department of Justice reported that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.[6]

Domestic violence is repetitive in nature: about 1 in 5 women victimized by their spouse or ex-spouse reported that they had been a victim of a series of at least 3 assaults in the last 6 months.[7]

The level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required hospital admission, and 13% required major medical treatment. 40% had previously required medical care for abuse.[8]

In 1996, approximately, 1,800 murders were attributed to intimates; nearly three out of four of these had a female victim.[9]

Continued...

Handout #1 1

Continued...

COSTS OF DOMESTIC VIOLENCE:

From 1987 to 1990, crime costs Americans $450 billion a year. Adult victims of domestic violence incurred 15% of the total cost of crime on victims ($67 billion).[10]

A study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to abused women, children and older people was $1,633 per person per year. This would amount to a national annual cost of $857.3 million.[11]

IDENTIFICATION OF DOMESTIC VIOLENCE:

92% of women who were physically abused by their partners did not discuss these incidents with their physicians; 57% did not discuss the incidents with anyone.[12]

In a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse or address the woman™s safety in 92% of the domestic violence cases.[13]

Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse to pregnant women.[14] Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women.[15]

PREGNANCY:

Each year, at least 6% of all pregnant women, about 240,000 pregnant women, in this country are battered by the men in their lives.[16]

Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women[17, 18], as are maternal rates of depression, suicide attempts, tobacco, alcohol, and illicit drug use.[19]

POLICY RECOMMENDATIONS:

A national public health objective for the year 2000 is for at least 90% of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spousal abuse.[20]

The Joint Commission for the Accreditation of Hospitals and Healthcare Organizations (JCAHO) requires that accredited emergency departments have policies and procedures, and a plan for educating staff on the treatment of battered adults.[21]

Continued...

ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL: IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE VICTIMS*, (1998) FAMILY VIOLENCE PREVENTION FUND.

Continued...

[1]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[2]The Commonwealth Fund, First Comprehensive National Health Survey of American Women, July, 1993.

[3]UNICEF, The Progress of Nations, 1997.

[4]Lieberman Research Inc., Tracking Survey conducted for the Advertising Council and the Family Violence Prevention Fund, July-October, 1996.

[5]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[6]U.S. Department of Justice, August 1997. Violence-related Injuries Treated in Hospital Emergency Departments. Michael R. Rand. Bureau of Justice Statistics.

[7]Zawitz, M. et.al. Highlights from 20 years of Surveying Crime Victims: The National Crime Victimization Survey, 1973-1992. Washington, D.C. U.S. Department of Justice, Bureau of Justice Statistics, October 1993.

[8]Berios, D.C. and Grady, D. Domestic Violence: Risk Factors and Outcome. The Western Journal of Medicine, Vol. 155(2), August 1991.

[9]Supplementary Homicide Reports, 1976-96.

[10]National Institute of Justice, 1996. Victims Costs and Consequences, A New Look. Washington, D.C.

[11]Meyer, H. The Billion Dollar Epidemic. American Medical News, January 6, 1992.

[12]The Commonwealth Fund, First Comprehensive National Health Survey of American Women Finds Them at Significant Risk, (News Release). New York: The Commonwealth Fund. July 14, 1993.

[13]Warshaw, C. ÒLimitation of the Medical Model in the Care of Battered Women.Ó Gender & Society, Vol. 3(4) December 1989.

[14]Soeken, K., McFarlane, J., Parker, B. (1998). The Abuse Assessment Screen. A Clinical Instrument to Measure Frequency, Severity and Perpetrator of Abuse Against Women. Beyond Diagnosis: Intervention Strategies for Battered Women and Their Children. Thousand Oaks, CA: Sage.

[15]McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. Journal of Obstetrical, Gynecological and Neonatal Nursing, January 1998.

[16]Centers for Disease Control and Prevention, The Atlanta Journal and Constitution, 1994.

[17]Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during Pregnancy: Effects on Maternal Complications and Infant Birthweight in Adult and Teen Women. Obstetrics & Gynecology, 841, 323-328.

[18]McFarlane, J. Parker B., & Soeken, K. (1996). Abuse during Pregnancy: Association with Maternal Health and Infant Birthweight. Nursing Research 45, 32-37.

[19]McFarlane, J., Parker, B., & Soeken, K. (1996). Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birthweight. Journal of Obstetrical Gynecological and Neonatal Nursing, 25, 313-320.

[20]Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention ObjectivesÑfull report with commentary. Washington, DC: U.S. Department of Health and Human Services, Public Health Services, 1991.

[21]Joint Commission on Accreditation of Healthcare Organizations. 1997 Hospital StandardsÑ Possible Victims of Domestic Abuse and Neglect.

Handout #1 2

Definition of Domestic Violence and Abusive Behaviors List

Domestic Violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

Abusive Behaviors List

1. Physical abuse:
   - spitting, poking, shaking, grabbing, shoving, pushing, throwing, hitting open handed, hitting closed handed, restraining, blocking escape, choking, hitting with objects, beating, kicking, using weapons, burning, controlling a victimÕs access to health resources, etc.

2. Sexual abuse:
   - persistently pressuring for sex, coercing sex through a variety of tactics, forcing sex in front of others, forcing sex with children or third parties, physically forcing or harming the victim sexually, etc.

3. Psychological attacks:
   - violent acts against children or others to control the intimate partner; threats of violence against victims, others, or self; intimidation through attacks against pets or property; yelling; stalking; controlling the victimÕs activities; isolating the victim; controlling the victim through immigration status; controlling the victimÕs access to resources (e.g. health care, medications, automobile, friends, schooling, jobs, child care, etc.); emotional abuse; forcing the victim to do degrading things; controlling the victimÕs schedules, including health appointments, etc.

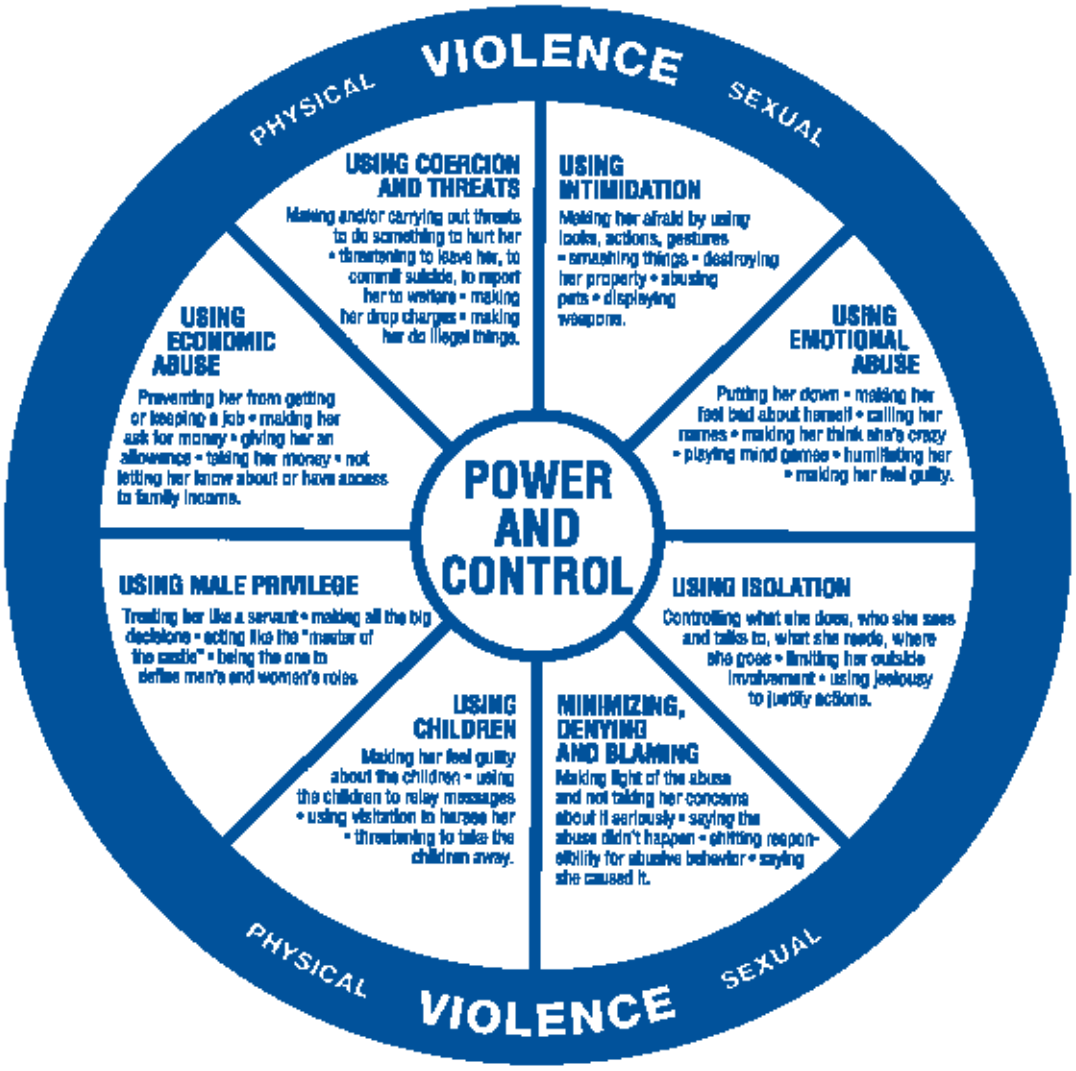
4. Use of economics:
   - withholding funds, spending family funds, making most financial decisions, not contributing financially to the family, controlling the victimÕs access to health insurance, etc.

5. Use of children to control an adult victim:
   - hostage taking of children; physical and sexual abuse of children; forcing children to engage in physical and psychological abuse of the adult victim; custody fights; using visitation with children to monitor the adult victim, etc.

Developed by Ganley, A. & Schechter, S. for *Domestic Violence: A National Curriculum for Child Protective Services,* Family Violence Prevention Fund, 1996.

Handout #1 3

POWER AND CONTROL WHEEL



Developed by the Domestic Abuse Prevention Project, 206 West Fourth Street, Duluth, MN 55806.

Handout #1 4

CAUSES OF DOMESTIC VIOLENCE

Learned behavior:

- learned through observation
- learned through experience and reinforcement
- learned in culture
- learned in family
- learned in communities: schools, peer groups, etc.

Not caused by:

- illness
- genetics
- alcohol/drugs
- anger/stress
- out of control behavior
- behavior of the victim or problems in the relationship

Developed by Ganley, A. & Schechter, S. for *Domestic Violence: A National Curriculum for Family Preservation Practitioners,* Family Violence Prevention Fund, 1995.

Handout #15

BARRIERS TO LEAVING FOR DOMESTIC VIOLENCE VICTIMS

1. PerpetratorÕs behaviors:
   - ➟ examples: escalating violence, stalking, threats against the children, hostage taking, threats of reporting the victim to authorities (INS, CPS, etc.).

2. Lack of safe options for domestic violence victims and their children:
   - ➟ examples: emergency shelter, housing, employment, effective legal restraints, concerns about immigration status, etc.

3. Victim overwhelmed by the immediate physical and psychological trauma:
   - ➟ examples: victims who have been beaten, stalked, terrorized or who are in crisis, etc.

4. Lack of continuous community and family support:
   - ➟ example: religious or cultural values that focus on maintaining the family above all else.
   - ➟ example: loss of close-knit community (such as a Native American who must leave her tribe to flee her abuser).
   - ➟ example: blaming of the victim by the perpetrator, counselors, courts, health care providers, family, friends, etc. that violence is the victimÕs fault and the victim should go back and fix it, or Òjust leaveÓ to fix it.
   - ➟ example: the belief by the community that domestic violence is the least of the victimÕs problems in face of others (parenting issues, unemployment, etc.).

5. The victimÕs ambivalent feelings:
   - ➟ example: victims who want the violence to stop, but want to maintain their relationships.

Handout #1 6

Improved Health Care Response to Victims

Guiding Principles for an Improved Health Care Response to Domestic Violence Victims:

1. Increase the safety of the domestic violence victims and their children.
2. Respect the rights of domestic violence victims for self-determination.
3. Holds perpetrators, not victims, responsible for the violence and for stopping it.
4. Advocate on behalf of domestic violence victims and their children.
5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence victims.

Elements of an Improved Health Care Response to Domestic Violence

1. Screen for domestic violence victims.
2. Assess the health impact of their victimization.
3. Conduct intervention by:
    a. Giving the victim validating messages;
    b. Providing information about domestic violence;
    c. Assisting in safety planning;
    d. Referring the victim to appropriate support and advocacy services; and
    e. Conducting a follow-up session.
4. Document the domestic violence.

Sample Handout #1 7

Sample

COMMUNITY RESOURCES FOR DOMESTIC VIOLENCE VICTIMS AND PERPETRATORS

(To be provided by trainer)

Prepare a list of information about community resources available to domestic violence victims and perpetrators in the area. For each agency or service on your list, include the agency name, phone number, address, hours of operation, summary of services offered (including a description of services for clients with disabilities, multilingual and/or multicultural services, programs for same-sex domestic violence, etc.).

THE LIST SHOULD INCLUDE THE FOLLOWING:

- Telephone crisis services: National Domestic Violence Hotline (1-800-799-7233, or 1-800-799-3224 for the hearing impaired) and other local numbers
- Temporary shelters and transitional housing
- Shelter-based support groups
- Nonresidential or residential outreach services for battered women (such as advocacy, case management, child care, and transportation services)
- Legal advocates and victim services
- Individual counseling
- Perpetrator intervention programs
- Services for specific cultural or demographic groups (such as ethnic groups, gay and lesbians, immigrants, monolingual non-English speaking groups, teens, etc.)

ContinuedÉ

Sample Handout #1 7

ContinuedÉ

ON THIS OR A SEPARATE HANDOUT ALSO INCLUDE THE FOLLOWING information about domestic violence agencies and other local agencies that offer programs for services not specifically related to domestic violence.

- Housing assistance
- Advocacy/case management
- Job-training and seeking services
- Child care and other childrenÕs services
- Sexual assault services
- Transportation services
- Gay, lesbian, and bisexual support groups
- Substance abuse programs
- Immigration services
- Nutritional programs

GANLEY, A. ÒDOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE.Ó *TRAINERÕS MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND

Handout #1 8

EVALUATION OF MODULE ONE:

DOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE

Your comments and suggestions will help us provide you with better trainings in the future

1) Will this information be useful to you in your current area of responsibility?

❑ Yes ❑ No

What was the most useful?

_____

_____

_____

_____

What was the least useful?

_____

_____

_____

_____

2) The information presented was:

❑ Too Complex ❑ Appropriate ❑ Too Simple

3) The presenter was:

❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Comments:

_____

_____

_____

_____

_____

Module One

Transparencies / Slides

Domestic Violence Victimization: A Primary Health Issue

TRANSPARENCIES / SLIDES FOR MODULE ONE

This section includes materials that can be made into either transparencies or slides. The pages to follow have been formatted for transparencies, but can be modified for slides. Please note that the numbering on the participant handouts do not correspond directly to the numbering of the transparencies since certain handouts are covered by more than one transparency.

TRANSPARENCY #1–1

DOMESTIC VIOLENCE AS A PRIMARY HEALTH ISSUE

One out of every four (26%) American women report that they have been physically abused by a husband or boyfriend at some point in their lives.

37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.

Complications of pregnancy, including:

- low weight gain
- anemia
- infections
- first & second trimester bleeding
- maternal rates of depression
- suicide attempts
- tobacco, alcohol & illicit drug use.

"DOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

TRANSPARENCY #1–2

DEFINITION OF DOMESTIC VIOLENCE

Domestic violence is:

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

GANLEY, A. "DOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

TRANSPARENCY #1–3

DOMESTIC VIOLENCE: ABUSIVE BEHAVIORS

1. Physical Abuse
2. Sexual Abuse
3. Psychological Abuse
4. Use of Economics
5. Use of Children to Control an Adult Victim

TRANSPARENCY #1–4

CAUSES OF DOMESTIC VIOLENCE

Learned behavior:

- learned through observation
- learned through experience and reinforcement
- learned in culture
- learned in family
- learned in communities: schools, peer groups, etc.

Not caused by:

- illness
- genetics
- alcohol/drugs
- anger/stress
- out of control behavior
- behavior of the victim or problems in the relationship

BARRIERS TO LEAVING FOR DOMESTIC VIOLENCE VICTIMS

1. Perpetrator's behaviors

2. Lack of safe options for domestic violence victims and their children

3. Victim overwhelmed by the immediate physical and psychological trauma

4. Lack of continuous community and family support

5. The victim's ambivalent feelings

TRANSPARENCY #1–6

GUIDING PRINCIPLES FOR AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Increase the safety of domestic violence victims and their children.

2. Respect the integrity and authority of victims for making their own life choices.

3. Hold perpetrators, not victims, responsible for both the abuse and for stopping it.

4. Advocate on behalf of domestic violence victims and their children.

5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence.

ELEMENTS OF AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Routine Screening for Domestic Violence Victimization

2. Assessment of the Domestic Violence

3. Intervention with Patients Who Are Domestic Violence Victims

4. Documentation of the Domestic Violence in Health Records

MODULE TWO

Domestic Violence: Cultural Competency in the Health Care Setting

MODULE TWO:

Domestic Violence: Cultural Competency in the Health Care Setting

by John Fazio, R.N., M.S. and
Anita Ruiz-Contreras, R.N., M.S.N.

TIME ALLOTTED: 90 MINUTES

GOALS AND OBJECTIVES

1. To define the terms "culture" and "cultural competency" as they apply to domestic violence.

2. To increase health care professionals' awareness of culture and how to interact within different cultural perspectives when responding to domestic violence victims.

3. To provide a practice model that promotes a response to domestic violence that is free of discrimination and committed to cultural competency.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

TRAINING TIPS

1. Format of the chapter:

Presentation material and activities are in outline format and written in **boldface** or in regular font. Directions to the trainer are marked with an icon pointer and are written in Tekton font. Interactive activities are boxed.

2. Specific preparatory readings:

The material in Module Two is based primarily on work developed by the authors and the Emergency Nurses Association's 1996-97 Diversity Task Force. It also corresponds with *From Sensitivity to Competency: Clinical and Departmental Guidelines to Achieving Cultural Competency* (see Appendix A of the *Resource Manual*).

3. The module is designed to last 90 minutes.

This content outline should be taught in a training time frame that allows participants to interact about the material with the trainer and with other participants. It is a very tight time frame and if possible, trainers should allot an additional 10-15 minutes) to allow for more discussion and interactive activities.

If you do not have 90 minutes to teach this section, the presentation can be shortened. However, be sure to include at least one of the interactive (ice-breaking) exercises prior to presenting the practice model. If you are presenting to a large group, you may consider not conducting the interactive activity for section II-D to allow for more time for questions and discussion during the other interactive activities. (See notes within the presentation outline).

4. Review the participant's previous cultural sensitivity training.

Be aware that many participants may have attended some form of cultural sensitivity workshop prior to this training. It is important to clarify the goal of this cultural competency training and differentiate it from prior training.

The following describes the distinctions between the two types of training:

Cultural Sensitivity Training

Cultural sensitivity training sessions often review cultural beliefs and behaviors, and ask participants to be aware of and sensitive to their own beliefs and behaviors. Training sessions may range from a class on a specific cultural group to case study reviews.

Cultural Competency Training

In cultural competency training, participants are encouraged to go beyond sensitivity, to *appropriately respond* to the needs of different cultural groups. In order to be culturally competent, the health care provider must combine specific knowledge with specific information provided by the patient, incorporate an awareness of one's own biases, and approach the definition of culture with a critical eye and open mind.

5. After reviewing the presentation outline, prepare case examples for the participants that illustrate the module's main points.

Case examples should address:

- The health care setting(s) of the audience;
- A variety of health issues;
- Diversity in the cultures of both patient and provider;
- A variety of interpersonal styles of patients; and
- A variety of effective responses by health care providers.

6. Presentation of the material:

a. Cultural competency training sessions may raise personal issues for the participants, and reactions to the content may vary. It is important to engage the audience and make the environment safe for open discussion. Remember to:

- Make eye contact and pay attention to participants' body language.
- Listen attentively to comments and questions and then address them briefly.
- Speak loudly enough so that you are heard in the back of the room.
- If needed, use a microphone that will allow for your free movement.

b. Humor works well as an ice-breaker, but use it judiciously and with careful consideration of its content. Avoid making jokes about individual groups, and do not use profanity or sexual innuendo.

7. Prepare transparencies/slides in advance.

Consider the size of the audience and room size when choosing audiovisual materials. Flip charts work well with small groups (less than 20 to 25 people), but are not as effective with larger groups.

Be familiar with audiovisual equipment or arrange for technical assistance. Note on your outline both when the audiovisuals will appear and when equipment needs to be turned off. Sometimes in the flow of a presentation, presenters may forget to turn off an overhead projection, which can be distracting to the participants. Also, note on your outline to inform the audience if a handout of the overhead transparency/slide is provided.

Suggested transparencies/slides are included at the end of the module.

8. Select appropriate handouts.

Suggested handouts appear at the end of the module. You do not have to present every point listed in the handout materials. Select only the main points you want to cover and refer participants to the handouts for additional information.

If training participants do not each have a copy of the *Resource Manual*, it is recommended that the trainer photocopy Appendix A *From Sensitivity to Competency: Clinical and Departmental Guidelines to Achieving Cultural Competency* as a handout for this module.

PRESENTATION OUTLINE:

Domestic Violence: Cultural Competency in the Health Care Setting

I. INTRODUCTION, GOALS, AND GROUND RULES
(10 minutes)

A. Introduction

☞ TRAINER NOTES: The introduction sets the tone of the learning environment as a safe space that is open to honest discussion. In a safe environment, participants feel empowered to share their feelings without reprisal from other members of the group.

INTERACTIVE ACTIVITY

Introduce yourself and become acquainted with the participants. Briefly tell them something of interest about yourself, even if someone else has introduced you. You may want to state why this topic is important to health professionals. Ask some questions about the composition of the group: Are participants physicians, nurses, administrative or social service staff, advocates, etc.?

B. Goals of the Session

☞ TRAINER NOTE: Provide Handout #2-1 outlining the goals of the session and/or project transparency #2-1.

The goals of this session are:

- To define the terms "culture" and "cultural competency" as they apply to domestic violence.
- To increase health care professionals' awareness of culture and how to interact within different cultural perspectives when responding to domestic violence victims.
- To provide a practice model that promotes a response to domestic violence that is free of discrimination and committed to cultural competency.

C. Ground Rules for the Discussion

☞ TRAINER NOTES: It is essential that the session leader, or a designee, facilitate the ground rules discussion and monitor for compliance with the established ground rules.

INTERACTIVE ACTIVITY

Distribute Handout 2-2, Suggested Ground Rules for Cultural Competency Presentation, to participants. Open discussion of ground rules by emphasizing that rules will help make the learning environment safe for honest discussion.

Briefly state each ground rule aloud. Ask whether participants have any additions or deletions. Keep the ground rules posted during the session.

1. Challenge yourself regarding your assumptions and beliefs.
2. Take responsibility for listening to new ideas and different perspectives.
3. It is not okay to blame, judge, or criticize.
4. Speak for yourself out of your own personal experiences.
5. You will not be expected to discuss issues beyond your own comfort level.
6. Honor personal information shared in the session by keeping it confidential.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

D. Review of Participants' Previous Training

INTERACTIVE ACTIVITY

Ask participants to identify, by show of hands, any previous training they have received regarding domestic violence. This will help trainers in knowing how to connect this training to previous ones.

Then ask participants to raise their hands if they have received any previous training regarding cultural sensitivity and cultural competency. (See Trainer's Tips, above, for clarification of terms.)

1. The primary goal of this session is to provide a practice model that promotes a response to domestic violence that is free of discrimination and committed to cultural competency.

2. This session *will not* provide comprehensive information or tips for responding to specific cultural groups.

☞ TRAINER NOTE: Experience from previous training may impact participants' openness to the session. Also, the session may differ from previous training in that it provides a practice model rather than information about specific cultural groups.

II. CULTURAL COMPETENCY TRAINING
(25 minutes)

A. We are similar, yet different in a variety of ways.

☞ TRAINER NOTES: Interactive Activity for Section II. A Begin with either of the interactive activities that follow:

When choosing which interactive activity to use, consider the overall training time and the audience. For a large group, the hand-raising exercise, Option A, is more appropriate than Option B, which involves discussion. Plan on limiting either option to 10 minutes; if the exercise lasts any longer, participants may lose the focus of the overall presentation.

Option A can help participants recognize general differences before you launch a discussion of sensitive distinctions such as race or class.

Option B also highlights differences, but also demonstrates our similarities as well, and shows how both influence our perceptions of ourselves and others. The perceptions are not good or bad, but different.

INTERACTIVE ACTIVITY

OPTION A

The following hand-raising exercise is intended to highlight differences, yet similarities will also be evident. Instruct participants that you will be asking a series of questions to which you want them to respond with a show of hands. Instruct them to look around and note the response of their colleagues. Ask any or all of the following:

- ➤ How many of you live inside (area where session is being held)?
- ➤ How many of you live outside (area where session is being held)?
- ➤ How many of you are an only child?
- ➤ How many of you have one brother or sister?
- ➤ How many of you have more than one brother or sister?
- ➤ How many of you have had any grandparent come from another country into the United States?
- ➤ How many of you have had all grandparents come from another country into the United States?
- ➤ How many of you have had all grandparents come from the United States?
- ➤ How many of you are not sure?
- ➤ How many of you speak another language, in addition to English?
- ➤ How many of you speak more than one language, in addition to English?
- ➤ How many of you have minimal to no clinical experience working with domestic violence victims?
- ➤ How many of you have moderate clinical experience working with domestic violence victims?
- ➤ How many of you have vast clinical experience working with domestic violence victims?

Conclude by reviewing the following points and stating the goal of the exercise:

1. We all have similarities and differences that influence our experiences and our perspectives. Some similarities and differences may be visible, while others are invisible.
2. This exercise is meant to help you recognize general differences, the complexities of each individual, and the assumptions we make about one another.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

INTERACTIVE ACTIVITY

OPTION B

The following group exercise is intended to help participants begin recognizing differences, yet similarities will also be evident. Tell participants that you will facilitate an exercise using an analogy to shoes.

1. Begin by naming five types of shoes. Instruct participants to pick the type of shoe that best represents them (e.g., "If you were a pair of shoes, not a person, what kind of shoe would you be?") They should not name the type of shoes they are wearing, but the shoes with which they self-identify. Do not offer descriptions of the shoes; just name them.
   - ➤ Dress Shoes
   - ➤ Hiking Boots
   - ➤ Loafers
   - ➤ Running Shoes
   - ➤ Sandals
2. Give participants 30 seconds to choose the shoe with which they identify.
3. Next, ask participants to raise their hands as you call out the shoe they picked. Instruct them to look around and note the response of their colleagues.
4. Ask a few participants to share their thoughts about "being that shoe". There may be positive and negative comments made regarding each of the shoes. Debrief the exercise by noting that:

We all have similarities and differences, based on how we identify and perceive ourselves and others.

Health care providers may have interacted with a patient who they perceived to be culturally different than the patient actually was. Give an example or elicit an example from the group.

Health care providers' response to patients is affected by any perceived similarities or differences.

The exercise may be conducted by using other analogies, like cars, instead of shoes.

B. Definition of Culture

1. Culture is an area where we have commonalties and differences with others.

☞ TRAINER NOTE: Distribute Handout #2-3 on the definition of culture and/or project Handout #2-2 as a transparency.

2. Definition of culture:

For the purpose of this workshop, we define culture as:

Shared experiences or commonalties that groups of individuals have developed in relation to changing social and political contexts.

3. Culture may be based on:

- Race
- Ethnicity
- Sexual orientation
- Religion
- Age
- Class
- Immigration status
- Disability status
- Other axes of identification

C. Culture is fluid and heterogeneous, determined by time and geography.

1. Culture is always in flux.
Therefore, health care providers must not assume that because a patient comes from a particular cultural group, they necessarily share the values commonly attributed to that group.

2. There is as much diversity *within cultures* **as there is between cultures.**
We must acknowledge differences as well as commonalties within cultures.

➟ For example: How a patient defines healing may vary within a cultural group depending on differences in spiritual beliefs, class, etc.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

D. Both the health care provider's and domestic violence victim's cultures (as defined above) impact the victim's care.

1. The interaction between the individuals during the health care visit is affected by the knowledge, attitudes, and behaviors of both the health care provider and domestic violence victim. For example:

- An African-American woman may be reluctant to reveal domestic violence to a Caucasian male nurse due to perceived differences in cultural values or stereotypes.

- Health care providers may neglect to screen upper-middle-class Caucasian women for domestic violence, assuming that they could not be experiencing domestic violence.

2. Interactive Activity for Section II. D

☞ TRAINER NOTE: This exercise can be optional if the trainer would like to spend more time on the explanation of the practice model.

INTERACTIVE ACTIVITY

The following exercise illustrates how the use and definitions of words may differ between health care providers and patients, thus coloring each of their perspectives during the health care visit.

Although the terms ethnicity, nationality, and race are often used interchangeably, they actually have distinct uses and meanings.

1. Ask participants for a definition of ethnicity. Write the responses on a marker board or flip chart. Then review the definition of ethnicity with the group:

   Ethnicity refers to an individual's racial, national, tribal, religious, or linguistic heritage. For example, people who self-identify as Mexican, Inuit, or Muslim are all tracing themselves to a particular ethnic group.

2. Next, ask participants to define nationality. Again, write the responses on a marker board or flip chart. Then review the definition of nationality, and outline how ethnicity differs from it:

Continued...

INTERACTIVE ACTIVITY

... Continued

Nationality refers to one's country of origin or citizenship. For example, people who self-identify as American or Chinese refer to their native or adopted country. (Note: Some individuals born in the United States with Chinese ancestors may self-identify as Chinese American.)

3. Next, elicit the definition of race and write the responses on the board or chart. Review the definition of race, noting how it differs from the previous terms:

Race generally refers to genetically transmitted physical characteristics (for example, Black and White).

The exercise will elicit a variety of responses from the participants. Some participants may have strong views about these terms and their meanings. In discussing these terms, note how they are constantly being refined as the world changes. (For example, the U.S. Census Bureau has recently adopted more terms for race, partly due to increasing awareness of biracial and multiracial individuals.)

4. Summary:

This exercise illustrates how differently we define and use terms and often how strongly we feel about our own definitions. This is also true for definitions of "domestic violence," "family," "partner," etc. Some of our definitions of those terms are influenced by culture.

When working with domestic violence victims, the health care providers must listen for and recognize the nuances in meaning of terms such as "domestic violence", "family", "partner", etc. (For example, a patient might define "battered women" as "women who are not able to fight back," and thus exclude their experiences of being battered and fighting back.) Often it is helpful to ask patients what they mean when using certain terms. Then the health care provider will be able to use words that are appropriate to the patient.

A person's perspectives may be invisible, yet they directly affect the interactions between the health care provider and patient.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

E. Cultural competency

☛ TRAINER NOTE: Refer participants to Handout # 2-4 and/or project transparency #2-3.

1. Cultural Competency refers to the process by which health care providers:
   - Combine general knowledge with specific information provided by the patient,
   - Incorporate an awareness of their own biases, and
   - Approach the definition of culture with a self-reflective and open mind.
2. Recognizing that individuals have different perspectives based on their diversity is the first step in a lifelong process of becoming culturally competent.

F. When working with domestic violence victims, a successful culturally competent intervention incorporates:

☛ TRAINER NOTE: Project Transparency #2-4

- An understanding of the definition of cultural competency;
- An awareness of one's own biases, prejudices, and knowledge concerning patients and their culture; and
- A recognition of professional power (such as the power differential between provider and patient) in order to avoid imposing one's own values on the patient.

☛ TRAINER NOTE: (Refer participants to *From Sensitivity to Competency: Clinical and Departmental Guidelines to Achieving Cultural Competency,* in Appendix A of the Resource Manual for further commentary.)

III. CULTURAL COMPETENCY PRACTICE MODEL
(20 minutes)

CULTURAL COMPETENCY PRACTICE MODEL

A	Assumptions	The act of taking for granted or supposing that a thought or idea is true
B	Beliefs	Shared ideas about how a group operates
C	Communication	The two-way sharing of information that results in an understanding between the receiver and the sender
D	Diversity	The way in which people actually differ (regardless of other people's assumptions or beliefs) and the effect that those differences have on their response to health care
E	Education/Ethics	Gaining knowledge about a diverse group and recognizing that ethical issues may be viewed differently by different groups

Adapted from the practice model developed by the Diversity Task Force (1996-97) of the Emergency Nurses Association: Park Ridge, IL.

A. This practice model can be used to assist health care providers as they incorporate diversity in their work with domestic violence victims.

This model was developed by the Emergency Nurses Association (Diversity Task Force 1996-97)

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

1. This is a model for health care providers to use in reflecting on their own attitudes and behaviors. It is designed to help them integrate cultural issues into their practice and improve clinical care with patients.

2. It can be used to improve all aspects of the response to domestic violence: screening, assessment, intervention, and documentation.

3. It can be used at any point prior to or during interactions with patients or co-workers as well as in case consultations.

☞ TRAINER NOTE: Provide the Handout #2-5 and/or project transparency #2-5. Review the elements of the practice model. If the group discussion strays off-course into the specifics of cultural differences, refocus the conversation back to the model and its goals.

B. Elements of the Practice Model

1. A is for Assumptions

a. An assumption takes for granted or supposes that a thought or idea is true.

b. This supposition is based on little or no experience or data. Often it includes biases or stereotypes.

c. Assumptions about domestic violence:

INTERACTIVE ACTIVITY

Ask participants: Prior to the presentation 'Domestic Violence: A Primary Health Issue' what were your assumptions about domestic violence, including:

- the nature of the problem and its impact on health,
- its causes,
- the perpetrators, or
- the victims

that proved to be inaccurate?

Continued...

INTERACTIVE ACTIVITY

Continued…

For example:

➟ An inaccurate assumption may be that victims can really just leave if they wanted to badly enough.

Encourage participants to be honest in their responses.

d. Assumptions about culture:

INTERACTIVE ACTIVITY

Ask participants:

"Name one assumption about culture that you had and later found out was inaccurate."

(Elicit 2-3 examples.)

Participants should remember that:

- The health care provider must not assume that because patients come from a particular cultural group, they necessarily share the values commonly attributed to that group.
- There is as much diversity within cultures as there is between cultures.
- We must acknowledge commonalties as well as differences between cultures.

e. Assumptions of both the health care provider and domestic violence victim affect the health care response.

Sometimes assumptions can be detrimental to the domestic violence victim, negatively affecting the health care visit. For example:

➟ If a health care provider assumes that a patient of a particular class or gender cannot be battered, the assumption may prevent screening by the provider or inhibit disclosure by the patient, and lessen the provider's ability to offer assistance or referrals.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

f. The first step in using the cultural competency practice model is to reflect on whether you are making any assumptions that will prevent good clinical care.

2. B is for Beliefs

a. Beliefs are shared ideas about how a group operates.

b. Beliefs are tenets that are held in common by a group of people and are usually based on an examination of evidence (experience and/or data).

c. Beliefs may be true or untrue.

- Some beliefs have been proven to be true.

  ➟ For example: Smoking is detrimental to health.

- Other beliefs have been found to be untrue due to new evidence.

  ➟ For example: The Earth is flat, or AIDS can be easily transmitted through kissing.

- Some beliefs may fit a group of people in general, but not each individual within that group.

  ➟ For example: A cultural group may avoid self-disclosure, but an individual from that group may be very willing to self-disclose.

☞ TRAINER NOTES: Relate one of the assumptions you've previously discussed to a belief that most of the participants hold, or have recently learned, regarding domestic violence. Show how this potentially damaging assumption is inconsistent with the belief. For example:

➟ False assumption: "Gays and lesbians are not battered." vs. Belief: "Anyone can be a victim of domestic violence."

d. Both the health care provider's and domestic violence victim's beliefs impact the health care response to domestic violence. These beliefs might help or harm the victim. For example:

➟ Helpful belief: A health care provider believes that domestic violence crosses all cultures, and consequently provides universal screening of all patients.

➟ Harmful belief: Believing that victims do not know how to care for themselves, a health care provider calls law enforcement in all cases of domestic violence without the consent of the victim.

e. Discussion of participant's beliefs.

INTERACTIVE ACTIVITY

Take 2-3 minutes to facilitate a "beliefs" exercise by directing the following question to the audience:

"Name one belief you have as an adult that is different from those of your mother, father, grandparent, aunt, etc."

Have one participant briefly give an example.

Then ask the group to think of a belief they may have, or once had, regarding culture and domestic violence (such as the belief that most Native Americans are alcoholics and that is what causes their domestic violence). Discuss how the belief may help or prevent a health care provider in identifying and assisting a domestic violence victim.

3. C is for Communication

a. Communication is the two-way sharing of information that results in an understanding between the receiver and sender.

b. Both the sender's and receiver's assumptions and beliefs about culture and/or domestic violence may create a barrier to communication.

c. Health care providers may communicate their biases, prejudices, and knowledge concerning patients and their cultures in verbal and non-verbal behaviors and gestures.

d. To avoid communication barriers, health care providers generally should:

- Talk about domestic violence privately.
- Normalize the subject of domestic violence.
  - ➟ For example, you might say, "I have seen a number of patients who have experienced this."
- Use eye contact appropriate to the culture of the patient. Eye contact may vary depending on cultural beliefs.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

- Use terms appropriate to the patient. The patient's definition of "family," "domestic violence," "partner," etc. may differ from the provider's understanding of these terms.

e. For the most helpful and appropriate health care response, health care providers should:

- Be nonjudgmental and calm.
- Be patient and listen attentively to patients. Let them narrate their experience.
- Be respectful of cultural values and seek clarification when necessary. Gather information about the culture from the patient.
- Validate patients' strengths and those of their cultures (such as family loyalty and spirituality).
- Be willing to respectfully negotiate differing values when a patient's health appears to be in danger. (For example, a health care provider should challenge a patient's belief, due to a cultural premise, that a beating was deserved.)

f. Assistance may be needed to improve communication between the health care provider and the patient.

- If you are unsure which terms are appropriate, ask the patient which they prefer and use that terminology.
- Use a professional translator when language barriers exist. To ensure patients' safety and enable them to speak freely, do not allow partners or family members who have accompanied them to the health care setting to act as translators.

☞ TRAINER NOTE: See the Cultural Competency Guidelines, Appendix A of the *Resource Manual*, and Module Three on clinical strategies. For more information on strategies to improve communication and the use of translators.

- Use simple language and a broad definition of domestic violence, especially if you suspect a comprehension deficit due to educational level or misunderstanding of terms.

4. D is for Diversity

a. In this practice model, diversity refers to the way in which people actually differ (regardless of other people's assumptions or beliefs) and the effect those differences have on their response to health care.

b. When using this practice model, an examination of "diversity" refers to an examination of any additional cultural issues (including power differentials) that are not raised when considering assumptions and beliefs. These issues also impact the patient/provider interaction. For example:

- A provider may have examined their assumptions or beliefs about a patient's ethnicity but did not consider the patient's sexual orientation.

c. A significant point of diversity in the health care provider/patient interaction is the inherent power differential. In the clinical setting, the health care provider inherently has more power than the patient, and as a result, has more ability to impose their views on the patient. Therefore, health care providers are responsible for being aware of their biases, and approaching patients with a self-reflective eye and open mind.

5. E is for Education/Ethics

a. Education is the gaining of knowledge about a diverse group.

INTERACTIVE ACTIVITY

Offer one or two examples of diversity issues that negatively impact the response to domestic violence, but end the discussion with a positive example. For example:

- A negative response to an issue of diversity:

  A Dominican immigrant patient comes into the health care setting with multiple injuries. The health care provider (correctly) assumes that she is a victim of domestic violence and recommends calling police. The patient denies the abuse because she is undocumented and fears that if she acknowledges the violence, the health care provider will turn her into the Immigration and Naturalization Service. The health care provider, becomes frustrated with her denial and her unwillingness to call the police and, refuses to assist the patient.

Continued...

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

INTERACTIVE ACTIVITY

Continued...

➟ A positive response to an issue of diversity:

A Chinese-American woman is denying domestic violence, despite presenting with injuries consistent with intentional assault. The health care provider sends messages of concern and support, remains non-judgmental and open to discussion throughout the visit, discusses confidentiality issues with her and provides culturally appropriate information about domestic violence for her use should she decide she needs it.

Ask the group to discuss an experience of a diversity issue as outlined here and how it impacted the delivery of health care.

b. Ethics is recognizing that ethical issues may be viewed differently by different groups. For example:

   ➟ The use of law enforcement is experienced differently by different cultures; this difference presents specific ethical dilemmas to patients or providers depending on their cultures.

c. Since it is impossible to know and understand every nuance of every culture and how each culture views ethical issues, health care providers must always remain open to learning from their patients and other health care providers.

d. Cultural competence is a process, a life-long endeavor. Educate yourself and be sensitive to the ethics of the culture by:

   - Listening attentively to your patients;
   - Working or volunteering in the community representing your patients' culture(s);
   - Establishing ties with advocates within the community representing your patients' culture(s); and
   - Conducting or attending in-service trainings led by culture-specific domestic violence services within the community.

IV. USING THE CULTURAL COMPETENCY PRACTICE MODEL

(30 minutes)

A. Effective Responses to Domestic Violence Victims

☞ TRAINER NOTE: Review the following material and give participants Handout #2-6, which covers the major points of Module One. Due to limited time, do not review the material on the handout.

In order for health systems to respond more effectively and to be part of a coordinated community response, health care providers need to have an understanding of:

1. **The dynamics of domestic violence, including:**
   - The nature of the problem and its impact on health;
   - Its causes;
   - The perpetrators; and
   - The victims;
2. **As well as the cultural contexts of both domestic violence and the health care provision.**

B. Applying the Cultural Competency Practice Model

☞ TRAINER NOTE: For this exercise, trainers must develop handouts for case scenarios which allow participants to examine their response to patients and formulate culturally competent approaches. Trainers should offer cases that represent the diverse patient population of their health care setting. See Sample Handout #2-7 for instructions. In addition, sample case scenarios are provided in Appendix A.

Introduce the following exercise by saying that it gives participants the opportunity to use the Cultural Competency Practice Model described in Section III and lessons learned earlier in Module One.

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

INTERACTIVE ACTIVITY

Demonstrate the practice model:

Develop or select from Appendix A one case scenario to use in order to demonstrate the Practice Model. Read the case aloud to the entire group and "talk out" each step of the practice model (Discuss your assumptions about this patient, and your beliefs and the impact they are having on the patient provider interaction etc.) Raise one or two of the discussion questions and present your responses to each of them.

Have participants practice using the model:

Depending on the size of your group and the amount of time available chose one of the following exercises.

OPTION 1

Read a second case scenario aloud and solicit responses from the audience about each section of the practice model (e.g. what are their assumptions and beliefs about this patient, what are the communication issues relevant to this scenario). Pose each of the discussion questions and solicit responses from the audience.

OPTION 2

Divide the participants into small groups and distribute a copy of a case scenario to each group. Ask that each group select a facilitator. Read the case aloud and ask the facilitator to begin a discussion about each element of the practice model (ABCDE) and the follow-up discussion questions. Walk around the room and facilitate discussion where needed. After 15 minutes reconvene the entire group for concluding remarks about this module.

V. CONCLUSION
(5 minutes)

A. Review of the key points regarding the definitions of the terms "culture" and "cultural competency" as they apply to domestic violence

1. **Culture:**
   consists of shared experiences or commonalties that groups of individuals have developed in relation to changing social and political contexts based on: race ethnicity, sexual orientation, religion, age, class, immigration status, disability status or other axes of identification. Culture is fluid and heterogeneous and determined by time and geography.

2. **Cultural competency refers to the process by which health care providers**

   - combine general knowledge with specific information provided by the patient;
   - incorporate an awareness of their own biases;
   - and approach the definition of culture with a critical eye and an open mind.

B. The Cultural Competency Practice Model is a tool which promotes a discrimination-free response to domestic violence.

It provides a framework for health care providers to engage in a self reflective process which helps them integrate an awareness of cultural issues into their interaction with patients.

C. Becoming culturally competent is a life-long process.

When working with domestic violence victims a successful culturally competent intervention begins with:

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

- An awareness of one's own biases, prejudices, and knowledge;
- a recognition of professional power in order to avoid imposing one's own values on the patient;
- knowledge concerning patients and their culture; and
- an openness to listening to and respecting new ideas and different perspectives.

INTERACTIVE ACTIVITY

Take general questions and comments.

☞ TRAINER NOTE: Ask Participants to complete Handout 2-8, the evaluation form.

TALKING/DISCUSSION POINTS

A wide range of participant responses may arise during the discussion of domestic violence and culture based on participants' perceptions, biases, and prejudices. Below are some general points:

1. **The ground rules are important, because they name acceptable behaviors that foster a safe environment that is open to honest discussion.**
   Do not skip the ground rules discussion. Listen for violations of the rules. The trainer must be prepared to bring a participant or the group back to the rules.

2. **Listen for any attempts to apply "rules" or formulaic approaches to understanding specific cultural groups.**
   Reinforce to participants that culture is fluid and heterogeneous, determined by time and geography. Remind participants that there is as much diversity within cultures as between cultures.

3. **Help participants recognize the professional power they have in interacting with patients.**
   Listen for participant's comments that suggest they do not grasp the power differential with patients, in particular with domestic violence victims who may be afraid of disclosure.

4. **Encourage participants to educate themselves about the culture(s) of their patient population.**
   Participants may ask the trainer to provide concrete suggestions about how best to respond to specific cultural groups. Remind participants that the training is meant to provide general guidelines only. Suggest that providers gather specific information by:

   - Learning about the culture from the patient;
   - Seeking clarification if a cultural issue is unclear; and
   - Establishing ties within communities representing the culture(s) of the patient population.

5. **Reinforce that culturally competent care will better ensure patient safety and self-determination.**

FAZIO, J. & RUIZ-CONTRERAS, A., "DOMESTIC VIOLENCE: CULTURAL COMPETENCY IN THE HEALTH CARE SETTING," *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

Module Two

Handouts

PARTICIPANT HANDOUTS FOR MODULE TWO

HANDOUT #2-1	Goals of Cultural Competency Module
HANDOUT #2-2	Suggested Ground Rules for Cultural Competency Module
HANDOUT #2-3	The Definition of Culture
HANDOUT #2-4	The Definition of Cultural Comptency
HANDOUT #2-5	Cultural Competency Practice Model
HANDOUT #2-6	Causes and Impact of Domestic Violence
SAMPLE HANDOUT #2-7	Case Scenarios for Application of the Practice Model *(to be developed by trainer; instructions attached)*
HANDOUT #2-8	Evaluation Form for Module Two

Handout #2–1

GOALS OF THE CULTURAL COMPETENCY SESSION

- To define the terms "culture" and "cultural competency" as they apply to domestic violence.

- To increase health care providers' awareness of culture and how to interact within different cultural perspectives when responding to domestic violence victims.

- To provide a practice model that promotes a response to domestic violence that is free of discrimination and committed to cultural competency.

Handout #2–2

SUGGESTED GROUND RULES

- Challenge yourself regarding your assumptions and beliefs.
- Take responsibility for listening to new ideas and different perspectives.
- It is not okay to blame, judge, or criticize.
- Speak for yourself out of your own personal experiences.
- You will not be expected to discuss issues beyond your own comfort level.
- Honor personal information shared in the session by keeping it confidential.

Handout #2–3

THE DEFINITION OF CULTURE

Culture refers to shared experiences or commonalties that groups of individuals have developed in relation to changing social and political contexts, based on:

- race
- ethnicity
- sexual orientation
- religion
- age
- class
- immigration status
- disability status
- other axes of identification

Handout #2–4

DEFINITION OF CULTURAL COMPETENCY

1. CULTURAL COMPETANCY REFERS TO THE PROCESS BY WHICH HEALTH CARE PROVIDERS

   - ➤ Combine general knowledge with specific information provided by the patient,
   - ➤ Incorporate an awareness of their own biases, and
   - ➤ Approach the definition of culture with a self reflective and open mind.

   Recognizing that individuals have different perspectives based on their diversity is the first step in a lifelong process of becoming culturally competent.

2. WHEN WORKING WITH DOMESTIC VIOLENCE VICTIMS, A SUCCESSFUL CULTURALLY COMPETENT INTERVENTION INCORPORATES:

   - ➤ An understanding of the definition of cultural competency;
   - ➤ An awareness of one's own biases, prejudices, and knowledge concerning patients and their culture; and
   - ➤ A recognition of professional power (such as the power differential between provider and patient) in order to avoid imposing one's own values on the patient.

Handout #2–5

CULTURAL COMPETENCY PRACTICE MODEL

A	Assumptions	The act of taking for granted or supposing that a thought or idea is true
B	Beliefs	Shared ideas about how a group operates
C	Communication	The two-way sharing of information that results in an understanding between the receiver and the sender
D	Diversity	The way in which people actually differ (regardless of other people's assumptions or beliefs) and the effect that those differences have on their response to health care
E	Education/Ethics	Gaining knowledge about a diverse group and recognizing that ethical issues may be viewed differently by different groups

Adapted from the practice model developed by the Diversity Task Force (1996-97) of the Emergency Nurses Association: Park Ridge, IL.

Handout #2–6

CAUSES OF DOMESTIC VIOLENCE

LEARNED BEHAVIOR:

- learned through observation
- learned through experience and reinforcement
- learned in culture
- learned in family
- learned in communities: schools, peer groups, etc.

NOT CAUSED BY:

- illness
- genetics
- alcohol/drugs
- anger/stress
- out of control behavior
- behavior of the victim or problems in the relationship

Developed by Ganley, A. and Schechter, S. for *Domestic Violence: A National Curriculum for Family Preservation Practitioners*. Family Violence Prevention Fund, 1995.

Sample Handout #2–7

Sample

INSTRUCTIONS ON HOW TO DEVELOP CASE SCENARIOS FOR APPLICATION OF THE PRACTICE MODEL

(To be developed by trainer)

Trainers should develop case scenarios that represent the diverse patient population of their health care setting. In addition, samples are provided in Appendix A. When developing case scenarios, use the following steps:

1. Review cultural axes of identification
   - ✓ race
   - ✓ ethnicity
   - ✓ sexual orientation
   - ✓ religion
   - ✓ age
   - ✓ class
   - ✓ immigration status
   - ✓ disability status
   - ✓ other axes of identification
2. Select specific cultural groups that are common to the health care setting (such as Lesbian, Latin/Hispanic female, Orthodox Jewish female, African-American teen, etc.).
3. Write the case example as a short summary of the patient's clinical presentation or interaction with a health care provider. (See sample in Appendix A)
4. For each step of the Practice Model (ABCDE), ask participants to reflect on relevant issues, such as
   - ➤ What assumptions about this patient's culture do you have?
   - ➤ What beliefs do you have regarding this patient presentation? etc. (to develop these questions see sample in Appendix A for a model)
   - ➤ What are the communication issues relevant to the patient/provider interaction?
   - ➤ What additional aspects of diversity may be present which have not been examined by your reflection of assumptions and beliefs?
   - ➤ What educational recommendations do you have for the health care provider?
   - ➤ What are the ethical issues, if any, presented in this case scenario?

Handout #2–8

EVALUATION MODULE TWO:

DOMESTIC VIOLENCE:
CULTURAL COMPETENCY IN THE HEALTH CARE SETTING

Your comments and suggestions will help us provide you with better trainings in the future

1) Will this information be useful to you in your current area of responsibility?
❑ Yes ❑ No

What was the most useful?

_____
_____
_____
_____

What was the least useful?

_____
_____
_____
_____

2) The information presented was:
❑ Too Complex ❑ Appropriate ❑ Too Simple

3) The presenter was:
❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Comments:

_____
_____
_____
_____

Module Two

Transparencies/Slides

Transparencies/Slides for Module Two

TRANSPARENCY #2–1

GOALS OF THE CULTURAL COMPETENCY MODULE

- To define the terms "culture" and "cultural competency" as they apply to domestic violence.
- To increase health care providers' awareness of culture and how to interact within different cultural perspectives when responding to domestic violence victims.
- To provide a practice model that promotes a response to domestic violence that is free of discrimination and committed to cultural competency.

TRANSPARENCY #2–2

THE DEFINITION OF CULTURE

Culture refers to shared experiences or commonalties that groups of individuals have developed in relation to changing social and political contexts, based on:

- race
- ethnicity
- sexual orientation
- religion
- age
- class
- immigration status
- disability status or
- other axes of identification

TRANSPARENCY #2–3

DEFINITION OF CULTURAL COMPETENCY

Cultural Competency refers to the process by which health care providers:

- ➤ Combine general knowledge with specific information provided by the patient,
- ➤ Incorporate an awareness of their own biases, and
- ➤ Approach the definition of culture with a critical eye and open mind.

Recognizing that individuals have different perspectives based on their diversity is the first step in a lifelong process of becoming culturally competent.

TRANSPARENCY #2–4

ELEMENTS OF A CULTURALLY COMPETENT INTERVENTION

Culturally competent interventions incorporate:

- An understanding of the definition of cultural competency;
- An awareness of one's own biases, prejudices, and knowledge concerning patients and their culture; and
- A recognition of professional power (such as the power differential between provider and patient) in order to avoid imposing one's own values on the patient.

TRANSPARENCY #2–5

CULTURAL COMPETENCY PRACTICE MODEL

A. Assumptions

B. Beliefs

C. Communication

D. Diversity

E. Education/Ethics

Adapted from the practice model developed by the Diversity Task Force (1996-97) of the Emergency Nurses Association: Park Ridge, IL.

MODULE THREE

Domestic Violence: Strategies for Screening, Assessment, Intervention, and Health Records Documentation

MODULE THREE

Domestic Violence: Strategies for Screening, Assessment, Intervention, and Health Records Documentation

by Anne L. Ganley, Ph.D.

TIME ALLOTTED: 90 MINUTES

GOALS AND OBJECTIVES

1. To review with health care professionals that domestic violence is a significant health issue requiring response from the health care system.

2. To educate practitioners about simple, concrete, culturally appropriate ways to improve their response to domestic violence victims through routine screening, assessment, intervention, and documentation.

TRAINING TIPS

1. Format of the chapter:

Presentation material and activities are in outline format and written in **boldface** and in regular font. Directions to the trainer are are marked with an icon pointer and written in Tekton font. Interactive activities are boxed.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

2. **This content outline is based on the materials in Chapter Two of the *Resource Manual*, and the materials developed by the Cultural Competency Committee (see the Resource Manual, Appendix A).**

   As a trainer who is experienced and knowledgeable about domestic violence issues, clinical strategies, and cultural issues, you will also have your own experiences and examples to draw on for your presentations.

3. **Since this module deals directly with clinical practice, trainers should be familiar with the clinical policies that guide the practices of the participants.**

4. **There is more material than can be adequately covered in the allotted time.**

   Therefore, trainers will need to reference, but not review, the detailed handouts on the clinical strategies. The content outline includes those presentation points most relevant to culturally appropriate clinical strategies. The presentation should be paced to allow adequate time for participants to interact with the trainer and other participants about the material.

5. **If you do not have 90 minutes to do this module, it can be split into two 45-minute sections.**

   Another option is to focus on one topic (for example, screening) and provide detailed handouts for the others (assessment, interventions, and documentation). Sometimes rushing to cover all segments without allowing time for participant interaction ends up in reinforcing misinformation and poor practice.

6. **When preparing your outline for the presentation, choose case examples appropriate to the participants that illustrate:**

   - the variety of health care issues facing domestic violence victims,
   - the diversity in both the cultures and interpersonal styles of domestic violence victims, and
   - a variety of effective responses by health care professionals.

   Use examples that reflect the diversity that participants experience in their settings. At some point in the presentation, it may be helpful to offer one example that they would not typically experience in their settings. Using a combination of typical and atypical examples engages participants in reflecting about their practices.

7. **Overheads:**

   Please note on your outline wherever overheads or slides are used. Also inform participants if an overhead or slide is provided as a handout.

8. **Allow for 2-3 comments at the end of each major section.**

   Answer questions briefly and refer participants to written materials in the *Resource Manual* or handouts for further clarification. During these brief question periods, avoid getting bogged down on one topic, since you need to cover all sections and still allow time at the end to offer concrete suggestions for changing individual practice.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

9. Mini-demonstrations:

Since this module is specifically focused on changes in clinical practice, participants respond well to "mini-demonstrations" of the practice strategies for the segments: on screening, assessment, and intervention skills.

For each clinical skills segment, follow your presentation of the content with a mini-demonstration. *Encourage participants to see that there are a variety of "right" approaches, not just one.*

INTERACTIVE ACTIVITIES

SUGGESTIONS FOR MINI-DEMONSTRATIONS OF CLINICAL SKILLS

OPTION A

Have the participants as a group take role of the practitioner for two cases presented in the introduction. Ask them to list what they would say or do to screen (assess, or intervene) with the domestic violence victims in those specific cases. List concrete examples given by the participants on the board or repeat verbally their suggestions.

OPTION B

For each clinical skill (screening, assessment, and intervention), take on the role of a patient who is a victim of domestic violence. Invite participants to be the health care provider and call out their responses to you, the patient. Respond to the participants' comments or questions as if you were the patient. Repeat the demonstration with 2-3 participants to elicit a variety of appropriate responses from the clinicians.

OPTION C

Have 2-3 participants take the role of the patient with you taking on the role of the provider. Model appropriate strategies for screening (assessing, or intervening) with domestic violence victims.

PRESENTATION OUTLINE

Domestic Violence: Strategies for Screening, Assessment, Intervention, and Health Record Documentation

I. INTRODUCTION
(10 minutes)

☞ TRAINER NOTES: The following is designed to be a brief introduction to provide the conceptual framework for the heart of this module: clinical strategies. This introduction is a much condensed 10-minute summary of Module One. The biggest challenge is to keep this introduction brief since each point can lead to a lengthy discussion. While you must be prepared with the details behind each point, list only the major ones. Some participants want to discuss these issues and will never get to the presentation on the practical clinical strategies. Yet it is the review of those practical clinical skills that is so crucial to making changes in individuals' clinical approaches with patients. Refer participants wanting more lengthy discussion to readings in the *Resource Manual.*

A. Domestic violence has serious health consequences, and health care providers should improve their response to its victims.

☞ TRAINER NOTES: Refer participants to Handout # 3-1. Offer two case examples to illustrate the health impact of domestic violence and the importance of an improved health care response. The case examples (1 minute each) should reflect the health settings of the participants, the cultural diversity of their patients, and the need for improving health practitioners' response.

Remember, this module is focused more on clinical practice than on teaching the dynamics of domestic violence. Consequently, case examples should include information about the health care setting and the practitioner's response as well as the health outcome of that response. Examples can also be pulled from the case scenarios in Appendix A and B.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

B. Health care providers see domestic violence victims with a variety of health issues resulting from abuse, including:

1. Injuries resulting from domestic violence

2. Illnesses or health problems directly resulting from the perpetrator's abusive conduct such as:

   ➟ muscle spasms, recurring headaches, STDs, etc.

3. Health problems that are seemingly unrelated to domestic violence, but are due to (or aggravated by) the perpetrator's controlling behaviors such as:

   ➟ victims having difficulty managing chronic illnesses such as diabetes, asthma, lupus, seizures, or substance abuse, due to the perpetrator's withholding medication, denying the victim regular access to health care, interfering with health protocol, etc.

C. Domestic violence is defined as a pattern of behavior.

☞ TRAINER NOTES: Use Transparency #3-1 (or butcher paper with the definition of domestic violence given in Module One; butcher paper will allow the definition to remain visible throughout the presentation) and refer participants to handout #3-2. Make reference to the definition, but do not get into a lengthy discussion of it.

1. Domestic violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion
- that adults or adolescents use against their intimate partners.

2. Clinical skills discussed in this module address intimate partner abuse, not child abuse or abuse of elderly.

D. Guiding principles[1] for improving the health care response to domestic violence.

☞ TRAINER NOTE: Use Transparency #3-2 (or butcher paper of the Guiding Principles; butcher paper will allow the list to remain visible throughout presentation) and refer participants to Handout #3-3. Trainers should be comfortable with referencing these principles throughout all trainings and encourage participants to use them whenever they feel stuck in sorting out how to respond to an individual patient or in developing an institutional response.

1. Increase the safety of domestic violence victims and their children.
2. Respect the integrity and authority of victims for making their own life choices.
3. Hold perpetrators, not victims, responsible for both the abuse and for stopping it.
4. Advocate on behalf of domestic violence victims and their children.
5. Be willing to make changes in both individual practice and the health care system in order to improve the health care response to domestic violence victims.

E. To respond more effectively to domestic violence victims and their children, we are making changes in how we:

1. Screen for domestic violence victimization,
2. Assess the domestic violence,
3. Intervene with domestic violence victims, and
4. Document domestic violence as a health issue.

II. IMPROVING THE HEALTH SYSTEM'S RESPONSE
(15 minutes)

Changes in the health care response to domestic violence victims need to overcome the system's barriers and must be based on an understanding of the forces influencing victims in their struggle to survive.

[1]These are the guiding principles for the FUND's Health Care Initiative and also appear in the *Resource Manual,* Chapter Two, Section I.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

A. Provider barriers to providing an effective health care response to domestic violence are or have been:

1. **Practitioners' misinformation and misconceptions about domestic violence and/or about cultural issues that sometimes lead practitioners to have unrealistic goals for their patients, or for themselves as helpers.[2]**

2. **Practitioners' lack of clinical skills in knowing how to respond effectively through specific, doable steps with culturally diverse patients.[3]**

3. **Structural issues of the health care setting.[4] For example:**
   - ➟ such as limited time or lack of administrative support for screening and/or responding to the patients, staff training, documentation forms, etc.

4. **Practitioners' confusion about standards of care requirements, confidentiality, and reporting requirements.**[5]

5. **Practitioners' lack of information about legal issues and community resources for domestic violence victims.**[6]

Changes in practice must overcome these provider barriers. Sometimes, change will occur one individual practitioner at a time. At other times, change will happen through the collective efforts of practitioners who develop and implement a protocol that responds realistically to barriers in a more comprehensive way.

☞ TRAINER NOTE: Refer participants to sample protocols and forms in the *Resource Manual* Appendix C and to any efforts that are already underway in their health care settings.

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[2]This information is covered in Modules One and Two.

[3]These approaches are presented in Modules Two and Three.

[4]These issues are usually raised in any training and are covered in Chapter Four of the *Resource Manual*, and in Appendix B of the *Resource Manual*.

[5]This material is discussed in Module Five.

[6]This material is discussed in Module Five.

B. Patient barriers to seeking effective assistance may include any of the multiple issues that influence domestic violence victims, such as:

1. Fear of the perpetrators' too often escalating violent and controlling tactics

2. Possibility of losing custody of children

3. Lack of realistic options for:

   ➟ financial resources, housing, employment, safety, health care, etc.

4. History of having received inappropriate and victim-blaming responses from other helpers. For example from:

   ➟ law enforcement, health care providers, counselors, clergy, family, friends, etc.

5. Fear of possible reports to third parties. For example:

   ➟ insurance companies, mandatory health care provider reporting requirements, etc.

6. Fear of drawing attention to immigration status

7. Language issues

8. Cultural or religious issues. For example:

   ➟ cultural rejection of certain medical procedures, fear of revealing sexual identity, identifying an experience as marital rape, etc.

C. Transition to the remainder of the presentation:

The next sections about screening, assessment, intervention, and documentation are divided here solely for teaching purposes and with the understanding that in clinical practice these functions are often interwoven.

☞ TRAINER NOTES: Project Transparency #3-3 for an overview of the four major topics: Screening, Assessment, Intervention, and Documentation and refer participants to Handout # 3-3)

For each section, trainers should include specific examples from their own experiences.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

III. ROUTINE SCREENING
(15 minutes)

A. Goal of routine screening: To identify patients who are victims of domestic violence in order to respond to them effectively.

B. Why screen routinely?

1. Domestic violence victimization is such a common and significant health issue, it is helpful to know which patients are domestic violence victims and which are not.

2. Since domestic violence is a particularly common health problem for women, it is more efficient to use routine screening procedures for all female patients than to screen only when there are specific indicators.

   Screening first for indicators takes time that can be more efficiently used in routinely asking all female patients 2-3 screening questions about domestic violence.

3. Routine screening will uncover both those domestic violence victims who have indicators and those who have health problems that initially appear unrelated to domestic violence.

4. Routine screening serves to educate patients. It communicates that domestic violence is a significant health issue and that health care providers are a resource for dealing with this problem whenever a patient may need assistance.

5. For male patients, screening techniques can be used either only with those male patients who have particular indicators or with all male patients.

   If the participants' facilities have or want to develop a policy of screening all patients, then clinicians must be prepared to distinguish between victims and perpetrators. Because perpetrators commonly say they are the "real victim," this is an ongoing educational challenge. Because of the lower percentage of male victims, a facility may decide to screen all female patients and only those males who have particular indicators.

C. Who screens?

1. Every health care provider should be able to screen for domestic violence, either when gathering a patient's primary care health history or responding to a specific health concern.

2. For health care settings developing domestic violence protocols, the protocol should indicate who is responsible for screening and at what point it should be done.

3. It is recommended that for multidisciplinary teams, each member be trained to carry out all interview procedures in order to provide coverage if the protocol-designated "screener" is unavailable or if the patient feels more comfortable disclosing to someone else.

D. How to screen for domestic violence through interviews:

☞ TRAINER NOTES: : When covering this section, provide brief, concrete examples reflective of the participants and their patients. Use screening information from the Cultural Competency Guidelines in the Resource Manual, Appendix A as a reference.

Provide Transparency #3-4 and refer participants to Handout #3-4 on screening tips and sample questions/comments.

1. General tips

a. Screen for domestic violence only when you have privacy with the patients.

Be sure you are away from other family or friends who may be accompanying the patient to the health care setting.

b. As with other sensitive issues, screen for domestic violence only after you have established an initial connection with the patient.

c. Issues related to the use of interpreters should be considered in light of the need for patient confidentiality in disclosing domestic violence or other sensitive issues.

Using accompanying family or friends to translate may not provide the patient with the confidentiality necessary for self-disclosure on sensitive topics. Use professional interpreters or other health care providers.

☞ TRAINER NOTE: Trainers should be familiar with translation issues as discussed in the *Resource Manual* and the *Cultural Competency* Guidelines and insert additional information when relevant to the participants.

d. Discuss any limits on confidentiality.[7]

If there are local reporting requirements for health care providers, explain what those are and the implications of reporting.

☞ TRAINER NOTE: Refer participants to Module Five, the training on legal and community resources. It will cover mandatory requirements for health care providers reporting domestic violence.

e. Present screening as routine as something you ask all patients because of the prevalence of the problem for all patients.

Some patients may think you are only asking certain people because of stereotypes about race or class.

f. Be calm, matter-of-fact, and non judgmental of the patient in talking about this issue.

The style of a provider's interview approach often increases or decreases a patient's willingness to disclose. Invite disclosure rather than demand information; ask without blaming.

g. Gather behavioral descriptions of what transpired rather than why it happened or its meaning. For example:

➟ Ask if the patient has been slapped, pushed, grabbed, threatened, followed, rather than abused or battered.

Initially avoid using terms like beaten, abused, battered or domestic violence. They have different meanings to different people, and patients may unintentionally give misleading answers because the questions are not clear to them. For example:

➟ A woman reported that she was not abused because she was able to physically fight back. She thought abused women were unable or unwilling to fight back.

When first screening, the provider is attempting to determine whether or not someone is using, or has used, physical force against person or property (or used the threat of such harm) with this patient.

h. Use open-ended questions initially, then follow-up questions for clarification; provide behavioral examples in your follow-up. For example:

[7] This issue of patient education about limits on confidentiality may be covered prior to screening questions. Some facilities inform patients about any limitations on patient confidentiality prior to any information gathering. Depending on the policy/protocol, this issue of reporting may be handled only after a patient has been identified as a domestic violence victim.

- To begin, you may ask, "How does he fight with you?" or "Has he ever hurt you?"

- Follow up with questions like "Has he ever pushed, shoved, kicked, or grabbed you?"

Sometimes it is easier for victims to acknowledge what they think are the lower levels of physically abusive behavior. Victims occasionally minimize what has been done to them as a way to cope with abuse. When patients acknowledge that some type of physical force or threats of harm have been used against them, then the provider can ask more directly about other forms of abuse. This will be covered in the assessment section.

i. Sometimes patients will respond to questions about what happened with answers about why something happened. For example:

- "We were fighting," "I've been depressed a lot," or "He's under a lot of stress/is drinking."

Listen respectfully and then go back to asking for a description of what took place when that problem came up.

j. Respectfully use the language or vocabulary style of the patients to gather information and convey an understanding of their world. For example:

- When your "boyfriend" ("husband," "lover," "partner," "honey," "sweetie," etc.)

- "fights" you ("gets into it with you," "is in your face," "frightens you," "is pissed off with you," "is on your case," etc.),

- does he ever push, shove, grab, or strike you?

k. Listening is one of the most important clinical skills in screening for domestic violence (as well as in assessment and intervention).

It is often a key element in using culturally appropriate approaches.

Listening allows the patient to define the problem from their perspective, which then helps the provider in developing an intervention strategy.

Oftentimes domestic violence victims are described as avoiding disclosure of domestic violence. However, many victims *do* talk about the domestic violence and get discouraged by how often they are not heard. For example:

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

➟ One patient had repeatedly told her health care provider that the fights with her husband were "making her sicker and sicker" with her diabetes. She also reported that one time he had pushed her against a wall and she had an asthma attack. This led her to increase her use of medication, even though she was on a protocol to decrease her dependence on the inhalers. At each of 10 visits during a two-month period, she talked about the fights and was medically treated for the injuries, diabetes, or asthma. The provider never responded to the domestic violence issues.

Screening, assessment, and intervention will dramatically improve as we improve our listening accuracy.

2. Sample openings for domestic violence screening

Oftentimes providers or patients find direct questioning about domestic violence without preparation or transition to be abrupt. Sometimes framing an inquiry about sensitive issues will encourage more self-disclosure.

☞ TRAINER NOTE: Give 2-3 other examples from your own experience or from Chapter Two of the Resource Manual, adjusting your vocabulary to reflect different patient groups. Or choose from the following:

➟ "I am going to ask you some quick, routine questions that I ask all patients in order to understand their health. I may be jumping from topic to topic so I can get the big picture and then we can go back and talk about what is important to you."

➟ "I am concerned that your medical problem may be the result of someone hurting you. Is that happening?"

➟ Connect the inquiry to something the patient has already said. Example: "You mentioned your partner's substance abuse, temper, stresses, etc. When that happens, has your partner ever physically hurt you or physically fought with you or threatened you?"

➟ "Many patients have health problems because of fights with their husbands. Do you know anyone who has had that problem? Has that problem ever happened to you? Is it happening to you now?"

3. Sample screening questions to follow up an opening

☞ TRAINER NOTE: Give participants 2-3 sample screening questions that may follow the opening questions. For example:

- "Sometimes the people we care about hurt us. Has that happened to you?"
- "Has your partner used physical force against you . . . or property . . . or someone else when fighting with you?"
- "Has your partner (family member, etc.) physically hurt or threatened you?"
- "Have you been pushed, shoved, grabbed, or slapped by your partner? Has your partner attacked property or pets or others when fighting with you?"
- "Have you been physically hurt by your partner?"
- "Are you afraid of your partner? If so, what is your partner doing that makes you afraid?"
- "Has your partner humiliated you or controlled you in a harmful way?"

E. What if your patient denies domestic violence?

1. Accept the response.

Not all patients are domestic violence victims. If a patient seems uneasy about the inquiry, reassure them that these are routine questions asked of everyone due to the prevalence of the problem. Many patients appreciate routine questions about their overall health.

2. If you are still concerned that domestic violence may be occurring, briefly let patients know that you are a resource if that problem should ever be an issue for them.

Let patients know where they can get more confidential information about domestic violence. Then move on to other topics. Routine inquiry often opens doors that domestic violence victims will use later.

INTERACTIVE ACTIVITY

- Take 2-3 questions about the topic of screening for clarification.
- Elicit 2-3 ways participants accomplish the screening function.
- Using one case scenario that you have developed, do a mini-demonstration described at the beginning of the module in the training tips.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

IV. ASSESSMENT OF THE DOMESTIC VIOLENCE
(15 minutes)

Once patients acknowledge domestic violence, there are several issues that require assessment.

A. Time spent on assessment of the domestic violence

1. The amount of time the practitioner spends on assessment varies greatly depending on the health care setting and the patient. In a setting with extremely limited contact with the patient, the provider will inquire only very briefly on each of the assessment points.

2. Remember, assessment is just information gathering through active listening. It is intertwined with screening and interventions for health problems. It is helpful to let the patient tell the story in their own way.

3. Assessment can occur over a series of visits.

4. When the provider feels that the time factor compromises the assessment, then the provider can acknowledge this fact to the patient, convey concern about the domestic violence, and move onto intervention strategies (covered in next section).

☞ TRAINER NOTE: Project transparency #3-5 and refer participants to Handout #3-5 on Assessment Points and review the following:

B. Issues that require assessment

1. Immediate safety needs of the victim

Assess whether the domestic violence victim is in immediate danger. For example:

- The provider may ask: "Where is the perpetrator now?"
- "Where will the perpetrator be when the patient is finished with the medical care?"
- "Does the patient want or need security to be notified immediately?"

2. Pattern and history of the abuse

Assess the perpetrator's physical, sexual, or psychological tactics as well as the economic coercion of the patient. For example, the provider might ask:

- "How long has the violence been going on?"
- "Has your partner forced or harmed you sexually?"
- "Have others been harmed by your partner?"
- "Does your partner control your activities, money, or the children?"

3. Connection between domestic violence and the patient's health issues

Assess the impact of the abuse on the victim's physical, psychological, and spiritual well-being. Try to ascertain the degree of the perpetrator's control over the victim with questions such as:

- "Have there been other incidents resulting in injuries or medical problems?"
- "How is the abusive behavior affecting your current health?"

4. Victim's current access to advocacy and support resources.

Assess what community resources are available or accessible to this patient. Providers may ask:

- "What advocacy and support resources (if any), in addition to the health care provider, are available to you now?"
- "Have you tried to use community resources in the past? If so, what happened?"

5. The patient's safety: Is there future risk of death or significant injury/harm (lethality) due to the domestic violence?

Ask about the perpetrator's tactics: use of weapons, escalation in frequency or severity of the violence, hostage taking or stalking, homicide or suicide threats, and use of alcohol or drugs, as well the health consequences of past abuse. If there are children, inquire about the children's physical safety.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

INTERACTIVE ACTIVITY

- ➤ Take 2-3 questions or elicit examples of assessments from the participants' own practices.
- ➤ Do a mini-demonstration of one assessment as described in the Training Tips section of this module.

V. INTERVENTION/RESPONSES
(20 minutes)

☞ TRAINER NOTE: Use Transparency #3-6 and refer participants to Handouts #3-6.

A. Goals for effectively responding to domestic violence victims:

1. Increase victim safety, and

2. Support victims in protecting themselves and their children.
   To accomplish this, health care providers must:
   - validate victims' experiences,
   - provide support,
   - provide information about resources/options.

The goal is *not* to get the patient to leave their abusers or "fix" the situation or the relationship for the patient, but to provide support and information.

B. Listen to the patient and provide validating messages.

Sample validating messages:

➟ "You don't deserve this. There is no excuse for domestic violence. You deserve better."

➟ "I am concerned. This is harmful to you (and it can be harmful to your children)."

➟ "This is complicated. Sometimes it takes time to figure this out."

➟ "You are not alone in figuring this out.[8] There may be some options. I will support your choices."

➟ "I care. I am glad you told me. I want to know about domestic violence so we can work together to keep you safe and healthy."

C. Listen and respond to safety issues.[9]

1. Encourage victims to make safety plans for when:

- a batterer is present in the medical setting,
- a victim fears leaving the medical setting, or
- a victim is returning to the batterer.

2. Develop an initial safety plan with patient.

☞ TRAINER NOTE: Refer participants to Handout #3-7 on Safety Planning, but do not cover it in detail. Suggest that participants read through the material at a later point and schedule a separate training session to discuss the safety planning process. If the health setting has a brochure for patients that includes safety planning, include a sample as a handout.

D. Provide the following information about domestic violence to the patient:

1. Domestic violence is a health issue affecting patients (and their children). Violence can escalate; damage from the abuse escalates over time.

[8]The options open to each patient may vary greatly. Options are greatly influenced by the resources available. Sometimes few of the traditional options such as battered women's services or community agencies are open to some victims. However, over time and with support, victims often can find creative alternatives to accepting that they deserve the abuse.

[9]It is very difficult to teach how to make safety plans in an overview session like this. Provide Handout #3-7 on safety planning in health care settings, or focus only on this intervention in the training session. Trainers should try different approaches depending on their audience and setting. If trainers are working in an area where there are limited or no domestic violence agencies, more time should be spent on safety planning.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

2. Stopping domestic violence is the responsibility of the perpetrator, not the victim.

3. Victims, with assistance and support from others, can increase their own safety (and children's).

4. List whichever support is available: health system support, legal options, community advocacy services, etc.

E. Make referrals to local resources.

☞ TRAINER NOTES: Trainers need to make a handout for participants detailing local resources for domestic violence victims. See Sample Handout #3-8 for instructions or refer to an already developed list of local resources which can be distributed directly to patients.

Refer participants to Module Five for more information on community resources and legal issues.

Providers should give the following information to the patient:

1. Describe advocacy and support systems within the health care setting.

2. List advocacy and support services within the community (if any).

F. Follow-up steps for health care practitioners:

1. Schedule future appointments:

Ensure that the patient will have a connection to a primary care provider. At subsequent visits, ask what happened after the last visit.

2. Review medical records:

Ask about past episodes of domestic violence noted in medical records in order to communicate a concern for the patient and a willingness to address this health issue openly.

3. Summary comment:

Domestic violence, like other health issues (smoking, poor nutrition, high blood pressure, etc.), often requires multiple interventions over time before it is resolved.

INTERACTIVE ACTIVITY

- ➤ Take 2-3 questions or elicit examples of interventions from the participants' own practices.
- ➤ Do a mini-demonstration of one intervention as described in the Training Tips section of this module.

VI. DOCUMENTATION

(10 minutes)

A. Why health care providers should document domestic violence:

1. **For good clinical care:**

   documentation provides records of the effects of a pattern over time; increases communication among multiple providers; provides documentation of earlier episodes that can assist the patient in recognizing escalation, etc.

2. **For the practitioner's legal issues:**

   such as standards of care, mandatory reporting requirements, etc.

3. **For the patient's legal issues:**

   documentation is useful as evidence to get a no contest order in criminal proceedings, to file for child custody; or for other future use.

B. Strategies for documentation:

☞ TRAINER NOTE: Refer participants to Handout #3-9 on Documentation Tips. See *Resource Manual* Appendix F for sample documentation forms.

1. **Use body maps and/or pictures to identify injuries:**

   When using photos, get consent and review photography procedures.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

2. Types of notes to put in chart:

a. Describe specifics about abusive incidents: who inflicted the domestic violence, the perpetrator's abusive conduct, health impact on victim (injuries and other medical issues), if the perpetrator uses alcohol/drugs and/or weapons.

b. Use the patient's own words in quotes and factually descriptive language; avoid extraneous medical facts.

c. Document options discussed, referrals made, discharge information, and all follow-up arrangements.

d. If there is mandatory reporting, document how it will be done.

INTERACTIVE ACTIVITY

➤ Take 1-2 questions on documentation issues.

VII. CONCLUSION
(5 minutes)

A. The health care provider's goal is to:

1. Increase victim safety, and

2. Support victims in protecting themselves and their children.

To accomplish this, providers should validate victims' experiences, provide support, and provide information about resources/options.

The goal is *not* to get patients to leave their abusers or "fix" the situation or the relationship for them.

B. These clinical practices are doable even when time is limited.

At first, they can sound overwhelming, but many take only a few minutes and have a major positive impact on victims in decreasing their isolation and the control perpetrators have over their lives.

C. It is important to communicate to the patient that there is no excuse for domestic violence, that the patient is not alone, and that you care.

INTERACTIVE ACTIVITY

➤ Take general questions/comments.

☞ TRAINER NOTE: Pass out Handout #3-10, the evaluation form.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

TALKING/DISCUSSION POINTS

1. One of the challenges of this module is to keep the focus on clinical practice.

Participants may get sidetracked discussing the basics of domestic violence or special legal or community issues. Trainers will need to find ways to respond to the issues briefly, note that they are beyond the scope of the training at hand, refer to written resources to be read later, or refer to future training sessions. It is often helpful at the beginning to find out which participants have attended previous sessions. Ask participants to raise their hands if they have attended previous sessions.

2. Listen for victim-blaming statements or questions sometimes couched in terms of the less than perfect "victim" (such as a victim who is a substance abuser).

Attempt to clarify that whatever the circumstances, the domestic violence victim does not deserve to be abused and these problems are not helped by the perpetrator's abuse

3. Listen for cultural misconceptions and clarify when they arise. For example:

- "For some cultures, domestic violence is acceptable and therefore not a health risk."
- "Some women of color are so strong that interventions are unnecessary."

4. Point out to practitioners that if patients refuse a health care provider's suggestions to deal with the domestic violence, temporarily they may know better how to proceed than the provider does.

Victims often know better than the provider what actions the perpetrator, community, and themselves are capable of taking.

5. Listen for participants' frustrations with domestic violence cases and attempt to identify the source.

Sometimes it is frustration with violence itself, the complexity of the issues, feelings of inadequacy, or the health care system.

Express understanding of these feelings. Encourage participants to become aware of those times when their frustration with other issues may get dumped on the domestic violence victims simply because they are there.

6. Encourage realistic goals for victims and practitioners.

There are practical time and resource limitations in how much either can accomplish. For practitioners, responding effectively and in culturally appropriate ways

to domestic violence takes time, especially when first using new approaches. However, it gets easier and more efficient over time. Eventually, such approaches save the time we would spend with patients on return visits because they received inadequate care the first time.

Practitioners may feel frustrated about the lack of accessible resources for patients. Remind participants that providing validating messages to the patient results in the health care system becoming a resource for that patient.

7. Encourage collaboration and sharing of successes among practitioners within the health care setting.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

MODULE THREE

Handouts

PARTICIPANT HANDOUTS FOR MODULE THREE

Handout #3–1

DOMESTIC VIOLENCE: A PRIMARY HEALTH ISSUE FACT SHEET

DOMESTIC VIOLENCE:

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, that adults or adolescents use against their intimate partners.

PREVALENCE:

Domestic violence is virtually impossible to measure with absolute precision due to numerous complications including the societal stigma that inhibits victims from disclosing their abuse and the varying definitions of abuse used from study to study. Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year[1] to 3.9 million women who are physically abused per year.[2]

On July 22, 1997, UNICEF released The Progress of Nations, 1997, which found that a quarter to half of women around the world have suffered violence from an intimate partner.[3]

One out of every four American women (26%) report that they have been physically abused by a husband or boyfriend at some point in their lives. 30% of Americans say they know a woman who has been physically abused by her husband or boyfriend in the past year.[4]

While women are less likely than men to be victims of violence crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner.[5]

INJURIES AND OTHER HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE:

The U.S. Department of Justice reported that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.[6]

Domestic violence is repetitive in nature: about 1 in 5 women victimized by their spouse or ex-spouse reported that they had been a victim of a series of at least 3 assaults in the last 6 months.[7]

The level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required hospital admission, and 13% required major medical treatment. 40% had previously required medical care for abuse.[8]

In 1996, approximately, 1,800 murders were attributed to intimates; nearly three out of four of these had a female victim.[9]

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COSTS OF DOMESTIC VIOLENCE:

From 1987 to 1990, crime costs Americans $450 billion a year. Adult victims of domestic violence incurred 15% of the total cost of crime on victims ($67 billion).[10]

A study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to abused women, children and older people was $1,633 per person per year. This would amount to a national annual cost of $857.3 million.[11]

IDENTIFICATION OF DOMESTIC VIOLENCE:

92% of women who were physically abused by their partners did not discuss these incidents with their physicians; 57% did not discuss the incidents with anyone.[12]

In a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse or address the womanís safety in 92% of the domestic violence cases.[13]

Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse to pregnant women.[14] Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women.[15]

PREGNANCY:

Each year, at least 6% of all pregnant women, about 240,000 pregnant women, in this country are battered by the men in their lives.[16]

Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women[17, 18], as are maternal rates of depression, suicide attempts, tobacco, alcohol, and illicit drug use.[19]

POLICY RECOMMENDATIONS:

A national public health objective for the year 2000 is for at least 90% of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spousal abuse.[20]

The Joint Commission for the Accreditation of Hospitals and Healthcare Organizations (JCAHO) requires that accredited emergency departments have policies and procedures, and a plan for educating staff on the treatment of battered adults.[21]

Continued...

"DOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE." *TRAINER'S MANUAL: IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE VICTIMS* , (1998) FAMILY VIOLENCE PREVENTION FUND.

Continued...

[1]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[2]The Commonwealth Fund, First Comprehensive National Health Survey of American Women, July, 1993.

[3]UNICEF, The Progress of Nations, 1997.

[4]Lieberman Research Inc., Tracking Survey conducted for the Advertising Council and the Family Violence Prevention Fund, July-October, 1996.

[5]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[6]U.S. Department of Justice, August 1997. Violence-related Injuries Treated in Hospital Emergency Departments. Michael R. Rand. Bureau of Justice Statistics.

[7]Zawitz, M. et.al. Highlights from 20 years of Surveying Crime Victims: The National Crime Victimization Survey, 1973-1992. Washington, D.C. U.S. Department of Justice, Bureau of Justice Statistics, October 1993.

[8]Berios, D.C. and Grady, D. Domestic Violence: Risk Factors and Outcome. The Western Journal of Medicine, Vol. 155(2), August 1991.

[9]Supplementary Homicide Reports, 1976-96.

[10]National Institute of Justice, 1996. Victims Costs and Consequences, A New Look. Washington, D.C.

[11]Meyer, H. The Billion Dollar Epidemic. American Medical News, January 6, 1992.

[12]The Commonwealth Fund, First Comprehensive National Health Survey of American Women Finds Them at Significant Risk, (News Release). New York: The Commonwealth Fund. July 14, 1993.

[13]Warshaw, C. "Limitation of the Medical Model in the Care of Battered Women." Gender & Society, Vol. 3(4) December 1989.

[14]Soeken, K., McFarlane, J., Parker, B. (1998). The Abuse Assessment Screen. A Clinical Instrument to Measure Frequency, Severity and Perpetrator of Abuse Against Women. Beyond Diagnosis: Intervention Strategies for Battered Women and Their Children. Thousand Oaks, CA: Sage.

[15]McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. Journal of Obstetrical, Gynecological and Neonatal Nursing, January 1998.

[16]Centers for Disease Control and Prevention, The Atlanta Journal and Constitution, 1994.

[17]Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during Pregnancy: Effects on Maternal Complications and Infant Birthweight in Adult and Teen Women. Obstetrics & Gynecology, 841, 323-328.

[18]McFarlane, J. Parker B., & Soeken, K. (1996). Abuse during Pregnancy: Association with Maternal Health and Infant Birthweight. Nursing Research 45, 32-37.

[19]McFarlane, J., Parker, B., & Soeken, K. (1996). Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birthweight. Journal of Obstetrical Gynecological and Neonatal Nursing, 25, 313-320.

[20]Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives—full report with commentary. Washington, DC: U.S. Department of Health and Human Services, Public Health Services, 1991.

[21]Joint Commission on Accreditation of Healthcare Organizations. 1997 Hospital Standards—Possible Victims of Domestic Abuse and Neglect.

Handout #3–2

Definition of Domestic Violence and Abusive Behaviors List

Domestic Violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

Abusive Behaviors List

1. Physical abuse:
   ➟ spitting, poking, shaking, grabbing, shoving, pushing, throwing, hitting open handed, hitting closed handed, restraining, blocking escape, choking, hitting with objects, beating, kicking, using weapons, burning, controlling a victim's access to health resources, etc.

2. Sexual abuse:
   ➟ persistently pressuring for sex, coercing sex through a variety of tactics, forcing sex in front of others, forcing sex with children or third parties, physically forcing or harming the victim sexually, etc.

3. Psychological attacks:
   ➟ violent acts against children or others to control the intimate partner; threats of violence against victims, others, or self; intimidation through attacks against pets or property; yelling; stalking; controlling the victim's activities; isolating the victim; controlling the victim through immigration status; controlling the victim's access to resources (e.g. health care, medications, automobile, friends, schooling, jobs, child care, etc.); emotional abuse; forcing the victim to do degrading things; controlling the victim's schedules, including health appointments, etc.

4. Use of economics:
   ➟ withholding funds, spending family funds, making most financial decisions, not contributing financially to the family, controlling the victim's access to health insurance, etc.

5. Use of children to control an adult victim:
   ➟ hostage taking of children; physical and sexual abuse of children; forcing children to engage in physical and psychological abuse of the adult victim; custody fights; using visitation with children to monitor the adult victim, etc.

Developed by Ganley, A. & Schechter, S., for *Domestic Violence: A National Curriculum for Childern's Protective Services*. Family Violence Prevention Fund 1996.

Handout #3–3

Guiding Principles for Improving the Health Care Response to Domestic Violence

1. Increase the safety of domestic violence victims and their children.

2. Respect the integrity and authority of victims for making their own life choices.

3. Hold perpetrators, not victims, responsible for the both the abuse and for stopping it.

4. Advocate on behalf of domestic violence victims and their children.

5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence victims.

Elements of an Improved Health Care Response to Domestic Violence

1. Routine Screening for Domestic Violence Victimization

2. Assessment of the Domestic Violence

3. Intervention with Patients Who Are Victims of Domestic Violence

4. Documentation of the Domestic Violence as a Health Issue in Health Records

Handout #3–4

DOMESTIC VIOLENCE SCREENING TIPS

General Tips:

1. Privacy:
   Screen for domestic violence only when you have privacy with the patient, away from other family or friends.

2. Timing:
   As with other sensitive issues, screen for domestic violence only after you have established an initial connection with the patient.

3. Use of interpreters:
   If you are unable to converse fluently in the patient's primary language, use professional interpreters or another health professional as a translator. The patient's family or friends should not be used as interpreters on issues about domestic violence.

4. Discuss confidentiality and any limits to confidentiality.
   If there are reporting requirements for the health care provider, explain what those are and the implications of reporting.

5. Present screening of domestic violence as routine.
   This is something you ask all patients because of the prevalence of the problem for all people.

6. Be calm, matter-of-fact, and non judgmental of the patient.
   The style of our interview approach often increases or decreases a patient's willingness to disclose.

7. Gather behavioral descriptions of what happened rather than why it happened or its meaning.
   For example, ask if the patient was slapped, pushed, grabbed, threatened, or followed, rather than abused or battered.

8. Use more open-ended questions initially.
   Use behavioral examples in the follow-up inquiry.

9. Respectfully use the patients' language and vocabulary
   to gather information and to convey an understanding of their world.

10. Listening is one of the most important clinical skills for domestic violence. It is often a key element in using a culturally appropriate approach. Listening allows the patient to define the problem, which then assists the provider in developing the intervention.

Continued...

Handout #3–4

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Sample openings for domestic violence screening:

- "I am going to ask you some quick, routine questions that I ask all patients in order to understand their health. I may be jumping from topic to topic so I can get the big picture and then we can go back and talk about what is important to you."
- "I am concerned that your medical problem may be the result of someone hurting you. Is that happening?"
- Connect the inquiry to something patient has already said. "You mentioned your partner's substance abuse/temper/stresses. When that happens, has your partner ever physically hurt you, or physically fought with you, or threatened you?"
- "Many patients have health problems due to fights with their husbands. Do you know anyone who has had that problem? Has that problem ever happened to you? Is it happening to you now?

Sample screening questions to follow the opening:

- "Has your partner use physical force against you ... or property ... or against someone else when fighting with you?"
- "Has your partner (family member, etc.) physically hurt or threatened you?"
- "Have you been pushed, shoved, grabbed, or slapped by your partner? Has your partner attacked property, pets, or others when fighting with you?"
- "Are you afraid of your partner? If so, what is your partner doing that makes you afraid?"
- "Has your partner humiliated you? Has your partner controlled you in a harmful way?"

What if your patient denies domestic violence?

1. Accept the response.

   Not all patients are domestic violence victims. If a patient seems uneasy about the inquiry, reassure them that these were routine questions asked of everyone due to the prevalence of the problem. Many patients are appreciative of routine questions about their overall health.

2. If you are still concerned that domestic violence may be occurring,

   briefly let patients know that you are a resource if that problem should ever be an issue for the patient. Let them know where they can get more confidential information about domestic violence, and then move on to other topics. Routine inquiry often will open doors that domestic violence victims will use later.

GANLEY, A. "DOMESTIC VIOLENCE: STRATEGIES FOR SCREENING, ASSESSMENT, INTERVENTION, AND DOCUMENTATION." *TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS*, FAMILY VIOLENCE PREVENTION FUND (1998).

Handout #3–5

DOMESTIC VIOLENCE ASSESSMENT TIPS

1. Assess the immediate safety needs of the victim.

   Is the domestic violence victim in immediate danger? Where is the perpetrator now? Where will the perpetrator be when the patient is finished with the medical care? Does the patient want or need security to be notified immediately?

2. Assess the pattern and history of the abuse.

   Assess the perpetrator's physical, sexual, or psychological tactics, as well as the economic coercion of the patient.

   "How long has the violence been going on? Has your partner forced or harmed you sexually? Have others been harmed by your partner? Does your partner control your activities, money, or the children?"

3. Assess the connection between domestic violence and the patient's health issues.

   Assess the impact of the abuse on the victim's physical, psychological, and spiritual well-being: What is the degree of perpetrator's control over the victim.

   "Have there been other incidents resulting in injuries or medical problems? How is abusive behavior affecting your current health?"

4. Assess the victim's current access to advocacy and support resources.

   Are there community resources available to this patient? Has the patient tried to use them in past? If so, what happened? What resources (if any), in addition to the health care provider, are available now?

5. Assess patient's safety: Is there future risk of death or significant injury/harm (lethality) due to the domestic violence?

   Ask about the perpetrator's tactics: use of weapons, escalation in frequency or severity of the violence, hostage taking or stalking, homicide or suicide threats, use of alcohol or drugs as well as about the health consequences of past abuse. If there are children, inquire about the children's physical safety.

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Handout #3–6

DOMESTIC VIOLENCE INTERVENTION TIPS

Goals for effectively responding to domestic violence victims:

- ➤ increase victim safety and
- ➤ support victims in protecting themselves and their children by validating their experiences, providing support, and providing information about resources/options.
- ➤ The goal is not to get them to leave their abusers or the "fix" the situation or the relationship for the patient, but to provide support and information.

1. Listen to the patient and provide validating messages:

   - ➟ "You don't deserve this. There is no excuse for domestic violence. You deserve better."
   - ➟ "I am concerned. This is harmful to you (and it can be harmful to your children)."
   - ➟ "This is complicated. Sometimes it takes time to figure this out."
   - ➟ "You are not alone in figuring this out. There may be some options. I will support your choices."
   - ➟ "I care. I am glad you told me. I want to know about domestic violence so we can work together to keep you safe and healthy."

2. Listen and respond to safety issues:

   a. Encourage victims to make their own safety plan for when a batterer is present in the medical setting, a victim fears leaving the medical setting, or a victim is returning to the batterer.

   b. See separate handout on safety planning.

Continued...

Continued...

3. Provide information about domestic violence to the patient:

   a. Domestic violence is health issue for patient (and children). Violence can escalate; damage from the abuse escalates over time.

   b. Stopping domestic violence is the responsibility of the perpetrator, not victim.

   c. Victims, with assistance and support from others, can increase their own safety (and their children's).

   d. List whichever supports are available: within the health system; legal options; community advocacy services, etc.

4. Make referrals to local resources:

   a. Advocacy and support systems within the health care setting

   b. Advocacy and support services within the community (if any).

5. Follow-up steps for health care practitioners:

   a. Schedule future appointments. Ensure the patient will have a connection to a primary care provider. Ask what happened after the last visit.

   b. Review medical records and asking about past episodes of domestic violence in order to communicate a concern for patient and a willingness to address this health issue openly.

   c. Domestic violence, like other health issues (smoking, poor nutrition, high blood pressure, etc.), often requires multiple interventions over time before it is resolved.

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Handout #3–7

SAFETY PLANNING WITH DOMESTIC VIOLENCE VICTIMS

Safety Measures While You're In An Abusive Relationship

If you are living with the person who is battering you, here are some things you can do to ensure your and your children' s safety.

1. Have important phone numbers memorized —friends and relatives whom you can call in an emergency. If your children are old enough, teach them important phone numbers, including when and how to dial 911.

2. Keep this information about domestic violence in a safe place —where your batterer won't find it, but where you can get it when you need to review it.

3. Keep change for pay phones with you at all times.

4. If you can, open your own bank account.

5. Stay in touch with friends. Get to know your neighbors. Resist any temptation to cut yourself off from people—even if you feel like you just want to be left alone.

6. Rehearse your escape plan until you know it by heart.

7. Leave a set of car keys, extra money, a change of clothes and copies of the following documents, with a trusted friend or relative: your and your children's birth certificates, your children's school and medical records, bank books, welfare identification, passport or green cards, immigration papers, your social security card, lease agreements or mortgage payment books, insurance papers, important addresses and telephone numbers, any other important documents.

Continued...

Reproduced from a booklet developed by the Los Angeles County Community and Senior Services Domestic Violence Unit, 1996.

Continued...

Safety After You Have Left The Relationship

Once you no longer live with the batterer, here are some things you can do to enhance your and your children's safety.

1. Change the locks
   —if you're still in your home and the batterer is the one who has left.

2. Install as many security features as possible in your home.
   These might include metal doors and gates, security alarm systems, smoke detectors and outside lights.

3. Inform neighbors that your former partner is not welcome on the premises.
   Ask them to call the police if they see that person loitering about your property or watching your home.

4. Make sure the people who care for your children are very clear about who does and who does not have permission to pick up your children.

5. Obtain a restraining order.
   Keep it near you at all times, and make sure friends and neighbors have copies to show the police.

6. Let your co-workers know about the situation
   —if your former partner is likely to come to your work place to bother you. Ask them to warn you if they observe that person around.

7. Avoid the stores, banks, and businesses you used when you were living with the batterer.

8. Get support counseling. Attend workshops. Join support groups.
   Do whatever it takes to form a supportive network that will be there when you need it.

Reproduced from a booklet developed by the Los Angeles County Community and Senior Services Domestic Violence Unit, 1996.

Sample Handout #3–8

Sample

COMMUNITY RESOURCES FOR DOMESTIC VIOLENCE VICTIMS AND PERPETRATORS

(To be provided by trainer)

Prepare a list of information about community resources available to domestic violence victims and perpetrators in the area. For each agency or service on your list, include the agency name, phone number, address, hours of operation, summary of services offered (including a description of services for clients with disabilities, multilingual and/or multicultural services, programs for same-sex domestic violence, etc.).

THE LIST SHOULD INCLUDE THE FOLLOWING:

- Telephone crisis services: National Domestic Violence Hotline (1-800-799-7233, 1-800-799-3224 for the hearing impaired) and other local numbers
- Temporary shelters and transitional housing
- Shelter-based support groups
- Nonresidential or residential outreach services for battered women (such as advocacy, case management, child care, and transportation services)
- Legal advocates and victim services
- Individual counseling
- Perpetrator intervention programs
- Services for specific cultural or demographic groups (such as ethnic groups, gay and lesbians, immigrants, monolingual non-English speaking groups, teens, etc.)

Continued...

Sample Handout #3–8

Continued...

ON THIS OR A SEPARATE HANDOUT INCLUDE THE FOLLOWING information about domestic violence agencies and other local agencies that offer programs for services not specifically related to domestic violence:

a. Housing assistance

b. Advocacy/case management

c. Job-training and seeking services

d. Child care and other children's services

e. Sexual assault services

f. Transportation services

g. Gay, lesbian, and bisexual support groups

h. Substance abuse programs

i. Immigration services

j. Nutritional programs

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Handout #3–9

Essential Elements of Documentation of Domestic Violence in Health Records

History

Chief Complaint/History of Present Illness: Elicit and record precise details of the abuse and their relationship to the presenting problem. Include relevant trauma history and relationship of abuse to any concurrent medical symptoms.

Past Medical History/Review of Systems: Ask about and record any medical, trauma, obstetrical or gynecological, psychiatric, or substance abuse histories that are related to domestic violence. Document conditions which will affect the patient's safety or ability to deal with the abuse.

Sexual History: Document any sexual assault, lack of barrier protection, STD's, unplanned pregnancy, abortions, miscarriages and ability to use birth control.

Medication History: Document any relationship between the abuse and the use of psychoactive, analgesic or other medication.

Relevant Social History: Document the relationship to abuser, living arrangement, abuser's access to victim.

In recording the abuse, whenever possible, use patient's own words, "Jimmy, my husband, hit me in the eye."

Physical Examination

Record precise details of findings related to abuse, including a neurologic and mental status exam. Use body map and photographs to supplement written description. Use standard evidence collection techniques for acute injury or sexual assault.

Laboratory and Other Diagnostic Procedures

Record the results of any lab tests, ex-ray, or diagnostic procedures and their relationship to the abuse.

Safety Assessment

Assess and record information pertaining to the patient's risk for suicide or homicide, and potential for seriously being harmed or injured. Determine if it is physically/psychologically safe for her to go home. Are the children or other dependents safe? Assess her degree of entrapment and level of fear and record.

Record options discussed and referral offered

Police Report

Note whether one was filed, and record the name of investigating officer and action taken.

Record Arrangements for Follow-up/Discharge Information

Handout #3–10

EVALUATION OF MODULE THREE

Module Three: Domestic Violence: Strategies for Screening, Assessment, Intervention, and Health Records Documentation

Your comments and suggestions will help us provide you with better trainings in the future

1) Will this information be useful to you in your current area of responsibility?
❑ Yes ❑ No

What was the most useful?

_____
_____
_____
_____

What was the least useful?

_____
_____
_____
_____

2) The information presented was:
❑ Too Complex ❑ Appropriate ❑ Too Simple

3) The presenter was:
❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Comments:

_____
_____
_____
_____
_____

MODULE THREE

Transparencies/Slides

TRANSPARENCIES / SLIDES FOR MODULE THREE

TRANSPARENCY #3–1

DEFINITION OF DOMESTIC VIOLENCE

Domestic Violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

TRANSPARENCY #3–2

GUIDING PRINCIPLES FOR AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Increase the safety of domestic violence victims and their children.

2. Respect the integrity and authority of victims for making their own life choices.

3. Hold perpetrators, not victims, responsible for both the abuse and for stopping it.

4. Advocate on behalf of domestic violence victims and their children.

5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence.

TRANSPARENCY #3–3

ELEMENTS OF AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Routine Screening for Domestic Violence Victimization

2. Assessment of the Domestic Violence

3. Intervention with Patients Who Are Domestic Violence Victims

4. Documentation of the Domestic Violence in Health Records

TRANSPARENCY #3–4

DOMESTIC VIOLENCE SCREENING TIPS

1. Screen only in privacy with the patient.
2. Screen only after establishing a connection with the patient.
3. If you are unable to converse in the patient's language, use a professional interpreter or another health professional as a translator.
4. Discuss confidentiality and any limits to confidentiality.
5. Present screening as routine.
6. Be calm, matter-of-fact, and non judgmental.
7. Gather behavioral descriptions of what happened.
8. Use open-ended questions initially.
9. Respectfully use the patients' language and vocabulary.
10. Listen.

TRANSPARENCY #3–5

DOMESTIC VIOLENCE ASSESSMENT TIPS

1. Assess the immediate safety needs of the victim.

2. Assess the pattern and history of the abuse.

3. Assess the connection between domestic violence and the patient's health issues.

4. Assess the victim's current access to advocacy and support resources.

5. Assess patient's safety: Is there future risk of death or significant injury/harm (lethality) due to the domestic violence?

TRANSPARENCY #3–6

DOMESTIC VIOLENCE INTERVENTION TIPS

Goals for effectively responding to domestic violence victims:

- ➤ increase victim safety
- ➤ support victims in protecting themselves and their children
- ➤ by validating their experiences
- ➤ provide support
- ➤ provide information about resources/options.

The goal is *not* to get them to leave their abusers or the "fix" the situation or the relationship for the patient, but to provide support and information.

1. Listen to the patient and provide validating messages.
2. Listen and respond to safety issues.
3. Provide information about domestic violence to the patient.
4. Make referrals to local resources.
5. Take follow-up steps.

MODULE FOUR

Domestic Violence:
Practical Applications Session

MODULE FOUR:

Domestic Violence: Practical Applications Session

by Anne L. Ganley, Ph.D.

TIME ALLOTTED: 90 MINUTES

GOALS AND OBJECTIVES

1. To provide models of effective screening, assessment, and intervention procedures for responding to domestic violence victims.

2. To provide an educational setting where participants have the opportunity to apply their knowledge about domestic violence and cultural issues to case examples.

3. To increase practitioners' use of culturally competent screening, assessment, and intervention procedures with domestic violence victims.

TRAINING TIPS

1. **Schedule this module based on the order of the other sessions.**
   This module's format is significantly different than that of the other training modules described in this manual. It is designed to be used in conjunction with the more content-driven modules on domestic violence dynamics, cultural competency, clinical strategies, and legal issues/community resources. Some trainers may want to schedule this module immediately after Module Three in order to give partici-

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pants a change in learning format. This may be particularly important if the modules are presented in a one- or one- and-a-half-day training format. However, trainers can also schedule this module after the session on legal issues and community resources.

2. **Schedule this module according to the purpose of the session.**
This session can also be offered in a variety of ways as part of a continuing education program about domestic violence.

   a. **It can be used as a review of the information provided in the other modules.**
   If practitioners have already taken Modules One through Three, then this module can be offered at a later date as an advanced, refresher session. In a refresher session, there would be little or no presentation of content. The participants themselves would identify the key points to remember about screening for and responding to domestic violence victims.

   b. **It can be used with staff seeking to practice their interviewing skills:**
   such as physicians, nurses, psychologists, social workers, residents, interns, trainees, and new employees.

   c. **It can also be used with experienced practitioners who are implementing a new protocol.**
   The practical applications session provides an opportunity for practitioners to put clinical skills into the context of a comprehensive protocol. Sometimes this session will uncover gaps in a system's response, which the participants can then address by making adjustments to the protocol.

3. **This module uses a different format than other modules described in this manual.**
The module is scripted, with the scripted material appearing in **bold** and regular font and the process instructions are marked with a pointer icon in the Tekton font. Interactive activities and alternative teaching methods and are boxed.

4. **The session uses a format of direct involvement of participants with case examples.**
Some health care providers initially report a reluctance to participate in trainings that involve role plays. Yet once participants complete them, these kinds of sessions often get the highest ratings on evaluation forms.

   Trainers are encouraged to use this training approach with *all* health care practitioners rather than creating divisions based on the discipline of the health care provider: MDs, RNs, medical social workers, PAs, psychologists, etc. Sometimes practitioners think that \other disciplines need the practical application sessions, while their own discipline does not. All providers involved in the response to domestic violence victims benefit from practicing these interviewing skills.

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5. **This module focuses on the practitioner's use of interview approaches for effective screening, assessment, and intervention with domestic violence victims.**
The most effective procedures for responding to this particular health problem are carried out through active listening to and talking with its victims. Using these interviewing skills and providing accurate information are the treatment procedures of choice to respond to domestic violence.

6. **Framing the sessions as case conferences or clinical applications workshops is usually more beneficial than referring to them as role-play sessions.**
Practice of procedures (such as CPR and surgical technique) is an integral part of health care education for all practitioners. This teaching approach is recommended because applying knowledge through the practice of the skill tends to facilitate the most behavioral change in individuals' clinical practice.

7. **As with the other modules, it is important that the trainer be familiar with the content of the *Resource Manual*, including the appendices.**
In particular, the trainer should be knowledgeable about the sections on the dynamics of domestic violence, clinical strategies, the *Cultural Competency Guidelines*, and JCAHO accreditation standards (See Module 5 Handout #5-5 for summary of JCAHO standards) as well as this *Trainer's Manual*. While there is only a 15-minute section in this module for presenting review points, the trainer will need to know all of the information to assist participants in debriefing the practice sessions. Sometimes in debriefing a particular interview approach, a participant will reveal some confusion or misconception about domestic violence (such as victim-blaming attitudes) or about a cultural issue. A trainer who is well-versed in the content can *briefly* clarify misinformation.

8. **If possible, trainers for the other modules should also participate in at least one session of the Practical Applications Module.**
Listening to participants attempt to use the information provided in the other modules often gives the trainers helpful feedback about what and how much is learned from the earlier sessions.

9. **Since this module requires participants to work in small groups, it is important to select a space that will allow the group to work comfortably in triads.**
Each triad should be able to form a small circle facing each other. The best space would allow individual triads to be sufficiently separated so participants can maintain their focus on their own triad and not be overly distracted by the work of the others. Participants need moveable chairs in order to be able to move away from conference tables. The room and chairs can be set up in advance.

10. **Trainers should decide in advance how participants will be divided into triads.**
Trainers should consider how they would prefer participants to be seated. They may want participants to be seated in configurations that ensure diversity of disci-

plines or encourage people to work with participants not well known to them. As participants arrive, they can be asked to seat themselves according to the trainer's directions, or this can be accomplished during the session (see Section IIA of this module).

11. Let participants take their seats in the triads and introduce themselves to the other group members before giving instructions for the session.

12. This module utilizes case scenarios.

This manual provides both sample case scenarios and suggestions to help trainers develop their own scenarios. (See sample scenarios in Appendix B or directions for developing customized scenarios at the end of this chapter.) Obviously, when trainers develop their own case scenarios, they can more specifically tailor the session to the specific training needs of the participants and the diversity of the providers and patients.

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PRESENTATION OUTLINE:

Domestic Violence: Practical Applications

I. INTRODUCTION
(5 minutes)

A. The purpose of this session is to give participants the opportunity to utilize knowledge and skills presented in the previous modules.

☞ TRAINER NOTE: The trainer can tailor the opening statement of purpose to the specific audience.

(For example, the purpose of the session may be to prepare for the implementation of new protocol or to review previous seminars.)

B. Review of the major points from Module One on the dynamics of domestic violence.

1. Domestic violence is a major health issue.

2. Definition of domestic violence and its impact on victims.

C. Review of the major points from Module Two on cultural competency.

1. Definition of cultural competency from Module Two, Section IIB.

2. Health care provision to domestic violence victims, as for all patients, must be culturally competent in order to be effective.

ALTERNATIVE TEACHING METHODS

OPTION A

The trainer may refer to handouts (or transparencies) stating major points for review. (See Handout #'s 4-1 through 4-4 and /or transparency #'s 4-1 to 4-3)

OPTION B

The trainer may ask participants to list, in brief, the major points they learned about domestic violence from the prior training sessions.

D. Review the major points from Module Three on clinical skills.

☞ TRAINER NOTE: Review the following components of an improved health care response to domestic violence.

1. Routine Screening
2. Assessment
3. Intervention
4. Documentation

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ALTERNATIVE TEACHING METHODS

OPTION A

The trainer may refer to handouts (or transparencies) stating major points for review about screening, assessment, intervention, and documentation. (See Handouts #4-5 through 4-8 and/or transparency 4-4).

OPTION B

The trainer may ask participants to list, in brief, the major points they learned about domestic violence from the prior modules. If the health setting has a written protocol covering these issues, it should be referenced here and a copy should be provided to participants.

E. This practical application session will help participants apply the information learned during previous modules to specific case examples.

ALTERNATIVE TEACHING METHODS

OPTIONS FOR CASE SCENARIOS:

OPTION A

You can provide three cases that have very detailed descriptions of the following: the health care setting, presenting health issue, patient demographics, the patient's interpersonal communication style, the patient's concerns, and the pattern of the domestic violence tactics.

OPTION B

You can provide case scenarios in which some of the case elements are left to be defined by the person taking the role of the patient. At minimum, you should provide information on the health care setting presenting health issue, and patient demographics.

See the instruction sheet for writing case scenarios for applications session at end of this module. Also see the sample case scenarios in Appendix B.

II. INSTRUCTIONS FOR PRACTICAL APPLICATION SESSIONS

(10 minutes)

A. Suggested method for dividing the group into triads

(if not previously done when participants arrived):

☞ TRAINER NOTES:

1. Counting off by number is often the most time-efficient approach to dividing the group. This creates some mix in the groups, which is helpful. If using this method, take the total number of participants, divide by three, then ask participants to count off to that number. (For example, a group of 30 people would count off from 1 to 10. All of the #1s would form a triad, and so on.)

2. When the participants are divided and seated in groups of three, ask triad members to face each other, introduce themselves, and wait for further instructions.

The following exercise instructions are scripted for trainer use.

B. During this session we will have time to practice screening, assessment, and intervention skills with three case scenarios.

C. For each scenario there are three different roles: patient, health care provider, and observer. You will have the opportunity to play each of the roles by the completion of the activity.

D. The Patient Role

1. When it is your turn to be the patient, silently read your case description.

2. Before the interview, please do not show your case description to your triad partners or tell them any specifics about the domestic violence. During the interview, it is your health care provider's job to elicit the information about

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whether there is domestic violence or not, and (if there is domestic violence) how the domestic violence is impacting you. Please read the case description carefully and assume the role of the patient as fully as possible.

3. When I give the instructions, you will select a provider from the triad (each member of the triad only does each role once). Give your provider a quick initial briefing about your name, demographics (age, marital status, children, etc.), and the reason for the appointment. This information is detailed in the first three sections of the scenario.

4. During the exercise, notice what your provider does or says that is helpful for screening, assessing, and intervening in any issues related to domestic violence. Notice if there are any cultural issues affecting the process. (By "cultural issues," we mean any cultural assumptions, beliefs or communication factors that influence the patient/provider interaction.)

E. The Health Care Provider Role

1. Your job is to interview the patient, screen for domestic violence, complete an appropriate assessment, and provide interventions in a culturally competent way.

2. Notice how you responded to this task and to this patient.

3. Notice if there are any cultural issues that are affecting the process.

F. The Observer Role

1. As the observer of this practice session, note the provider's specific behaviors/words that helped in effectively screening, assessing, and intervening in domestic violence issues.

2. Also note if there were any cultural issues that affected the process.

G. Each interview will last for only 10 minutes.

It is important that you stay in your roles during the entire interview. I will indicate when to begin the interview and when to stop it.

1. When I call time, I ask that you stop, even if you are in mid- sentence.

2. You will not debrief with each other immediately after the role play. That will come later.

3. First, I will ask you some questions and you will make some notes for yourself about your answers to those questions. Then you will be instructed to move onto the next scenario.

4. Then, after all three role-plays are completed, you will be given time to debrief within your triads.

H. At the end of the session, as a large group, we will discuss the provider's effective approaches used in the scenarios, taking into consideration cultural sensitivity and cultural appropriateness of the methods.

I. Any questions?

☞ TRAINER NOTE: The trainer should clarify, in brief, any questions about the steps of the process now.

III. PRACTICAL APPLICATIONS SESSION
(40 minutes)

☞ TRAINER NOTES:

1. Choose three case scenarios either from the sample cases in Appendix B or from those you have written for the trainings.

2. You may want to put each of the three scenarios on different colored paper for easy reference during the debriefing.

3. Distribute one of each of the scenarios to each triad. To minimize time in logistics, trainers can have case scenarios at the chairs prior to the start of the workshop.

4. It is very helpful for the trainer to use a mobile microphone, if available. A microphone allows the trainer to keep the attention of participants while giving instructions.

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A. Please silently read to yourself the scenario you have been assigned.

B. Will everyone who is patient #1 raise your hand?

1. Everyone else should put their scenario descriptions under their chairs.

2. Patient #1, you are the patient for the first scenario. Please ask someone else in your triad to be your health care provider and the other to be the observer. When I say begin, please read the patient description to yourself once again. Then read the first three sections (health care setting, presenting health issue, and demographics) to your provider.

3. Then the provider will begin the interview. The focus of this interview is to screen for domestic violence, and if present, to respond in culturally appropriate and effective ways.

4. Any questions?

C. Please begin the scenario.

☞ TRAINER NOTE: Give the triads 10 minutes for each interview. Quietly observe each of the triads to get a sense of how they are doing; what issues are being raised, etc. Stop scenarios after 10 minutes.

D. Stop and listen to my instructions.

Please do *not* debrief the scenario with your triad now. You will be given time to do this later.

E. On a piece of paper, please make notes for yourself.

We will use these notes later in the discussion of clinical approaches, including any cultural issues, by answering the following questions:

☞ TRAINER NOTE: Use transparency #4-5 or put debriefing questions up on butcher paper posted for reference during all of the discussions. Avoid using a slide that requires the lights to be turned off for this activity.

1. Is this patient experiencing domestic violence? What did the practitioner say or do that helped to elicit the information to make that determination?

2. If there is domestic violence, what did the practitioner say or do that helped in the assessment of the problem?

3. If there is domestic violence, what did the practitioner say or do that effectively responded to the domestic violence?

4. How did the cultural perspectives of the provider and patient affect the process? How did the practitioner include culturally sensitive approaches to ensure clinical effectiveness?

> ☞ TRAINER NOTE: These questions all focus on the providers' effective methods. This is intentional. Even though some mistakes may be made (which can be discussed later), the focus now is on the successful applications of learning.

F. Repeat steps A-E for each of the next two case scenarios.

G. Once the three scenarios are completed, give the triads five minutes to debrief about any aspects of the interviews they want to discuss (such as feelings, reactions to any role, etc.).

IV. LARGE GROUP DISCUSSION: DEBRIEFING THE THREE CASE SCENARIOS
(30 minutes)

> ☞ TRAINER NOTE: Caution: If you have less than 90 minutes for the session, you can either cut the number of scenarios used in the practice or decide which one scenario you will debrief. Do not attempt to debrief all in less than 30 minutes allotted for discussion. The discussion is to encourage participant self-reflection on these issues. Trying to rush through all of the case examples sometimes lessens the impact that occurs when one is done well.
>
> The following section is no longer scripted.

A. Ask the participants to reflect on the three cases as a large group.

☞ TRAINER NOTES: For each of the case examples, lead a discussion on the questions below:

1. To start the discussion, you may want all patient #1's to raise their hands; then ask the health care providers for the patient #1's to raise their hands.

2. Read some of the key facts from the scenario so that everyone is tuned to that particular case and then focus the discussion on the questions.

3. Take each question separately. List out the helpful behaviors or words identified by the participants for each question on butcher paper or chalkboard.

4. Part of the goal of doing the exercise this way is for participants to hear the multiple "right" ways to do this work.

Questions:

1. **Was this patient a domestic violence victim?**

   What did the practitioner say or do that helped to elicit the information needed to make that determination?

2. **If there was domestic violence,**

   what did the practitioner say or do that helped in the assessment of the problem?

3. **If there was domestic violence,**

   what did the practitioner say or do that effectively responded to the domestic violence?

B. Lead a discussion on the cultural issues that may have influenced the process.

☞ TRAINER NOTES:

1. When choosing cases for the scenarios, you may want to construct them in such a way that the cultural issues have an impact either on screening, assessment, or intervention strategies used by the health care provider. For example:

- In Sample Scenario #4 (see Appendix B), the fact that Alfred is a closeted, gay, African-American man raises issues regarding his willingness to be open in disclosing the domestic violence during screening. It may also raise significant issues in what intervention strategies the provider might deem appropriate.

2. Encourage participants to identify the cultural issues, rather than you as trainer presenting them. If, during the discussion, participants identify a negative impact from a provider's particular approach due to cultural issues, encourage them to list out more culturally appropriate approaches for that scenario. For example:

   - For a provider who simply told Alfred to call the police or his parents if assaulted again, the group might suggest a safety plan that does not involve reporting to authorities or family (i.e., to keep safe by immediately leaving area, to go to a friend's place, etc.). The group might suggest that the provider ask the patient what steps he would be willing to take to increase his safety.

3. Prepare in advance a list of possible cultural issues that may be identified for each case scenario. Sometimes participants will see cultural issues that the trainer does not see or did not intend to be part of that particular scenario.

4. Remember, in this activity we are looking at ways cultural issues may impact health care specifically through the lens of domestic violence screening, assessment, and intervention. The trainer may need to bring the participants' focus to that discussion goal.

Repeat discussion questions with each scenario.

V. SUMMARY OF MAJOR POINTS
(5 minutes)

☞ TRAINER NOTE: Encourage participants to:

1. **Practice different approaches in their own setting.**

   Sometimes just by doing a mini-role-play with colleagues, they may realize how they could approach the issue of domestic violence with a patient in a culturally appropriate manner.

2. **Consult with each other about domestic violence cases.**

   When doing so, reflect on the practitioners' beliefs and behaviors, not just on the patients' beliefs and behaviors.

3. **Consult with each other about the interface of a patient's and practitioner's cultural issues and its impact on the delivery of health care to domestic violence victims.**

4. **Recognize that learning and improving our clinical work is an ongoing process.**

TRAINER NOTE: Thank participants and ask them to complete the evaluation form on Handout #4-9.

SUGGESTIONS FOR DESIGNING CASE SCENARIOS FOR THE PRACTICAL APPLICATIONS SESSION

GENERAL TIPS:

1. **If trainers have sufficient preparation time, it is best to write your own case scenarios.**

   In this way, they are able to craft scenarios that meet the training needs of a specific audience. The better the trainer knows the audience and the communities they serve, the better they are able to customize scenarios that elicit the issues most relevant to the participants.

2. **The scenarios need to be written in accordance with the stated purpose of the session. For example:**

   ➟ If the purpose of the applications session is to develop empathy with diverse domestic violence victims, both the scenarios and debriefing instructions would be crafted with that purpose in mind, i.e. the debriefing discussion would focus on the victim's experiences during the process.

   However, for this module, the purpose of the applications session is to improve the clinical practice of diverse practitioners in their screening, assessment, and intervention approaches with diverse domestic violence victims. Therefore, the case scenarios need to contain information most relevant to participants honing those clinical skills.

3. **It is helpful to be intentional both about which elements and the number of elements included in a scenario.**

   Trainers should include only those elements that can be debriefed in the amount of time given to discussion. Also, it is helpful not to overload the participants with too many details or elements since the participants have a relatively short period of time to read, absorb, and work with the scenario. Short case scenarios also allow participants to add their own ideas to the role; this makes it somewhat easier to become the person in the scenario.

4. **The case scenarios may represent varying degrees of complexity.**

   When teaching new skills, it is not helpful to use either the easiest or the worst case. The scenarios need to be realistic and doable.

5. **It may be helpful if the scenario is designed around an example familiar to the participants or a case illustration that the trainer used in an earlier module.**

6. **It is also helpful to write all scenarios using the same format.**

What follows is a generic outline used to organize each case scenario, with some commentary on what to consider in writing your own case scenarios. See Appendix B for samples.

GANLEY, A., *DOMESTIC VIOLENCE: PRACTICAL APPLICATIONS SESSION. TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

SUGGESTED OUTLINE FOR CASE SCENARIOS

SCENARIO #___ **PATIENT NAME: _____**

☞ TRAINER NOTES: Numbering the scenario gives an easy identifier when the trainer is giving instructions or debriefing the scenario. Sometimes trainers will use the patient's name as the case identifier. Printing the scenarios on different colors of paper also helps distinguish them.

Sometimes the patient's name is preassigned to indicate cultural identification and background. Sometimes it is left blank and the participant who is playing the role of the patient is instructed to fill in their own name.

1. Health care setting:

☞ TRAINER NOTE: Trainers can use a variety of health settings in order to communicate that domestic violence is a health issue that can appear in any health care setting: primary care, emergency medicine, surgery, ob/gyn, family planning, STD clinic, dentistry, mental health, etc. Sometimes the settings used reflect the settings of the participants. It is helpful to have at least one setting that will challenge the expectations of the participants.

2. Presenting health issue:

☞ TRAINER NOTE: Design scenarios using a variety of health issues with a range of severity: injuries (such as bruises, broken bones, and internal injuries), health issues resulting from the perpetrator's abuse and coercion (such as unprotected sex leading to unwanted pregnancy or STDs), and health issues aggravated by the perpetrator's coercion (such as diabetes and lupus). Once again, you want to select health issues that are familiar to your participants' work and at least one that may challenge their expectations.

3. Demographics:

☞ TRAINER NOTES: Include variables such as age, ethnicity, socioeconomic class, occupation, religious affiliation, education, sexual orientation, physical abilities, children, AND status of relationship (married, cohabiting, dating, past, current).

Using a variety of cases will communicate the diversity of domestic violence victims. As a trainer you may want to demonstrate how cultural perspectives and realities affect the provider/patient interaction. Therefore, you should select demographics to illustrate those issues.

Remember that the demographics are part of the initial briefing to provider. Do not include any information that you do not want to be read to the provider by the patient.

Sometimes you may leave the demographics blank to allow participants to insert their own description.

4. Patient description and concerns:

☞ TRAINER NOTES: In this section, the trainer can describe how the patient is initially feeling and acting during the interview (such as fearful, withdrawn, rageful, or depressed) and briefly state what some of the patient's particular issues or concerns may be (e.g. children left home unattended, return of the batterer, particular medical complaints, etc.).

Note in this section if the patient has any particular cultural issue that may affect her/his response to the health care provider's approaches to screening, assessment, or intervention. (For example, one patient may go to those who are considered "natural helpers" within a specific culture or community, while another may resist using a particular community agency because of its racism or homophobia.)

5. Description and history of the domestic violence:

☞ TRAINER NOTE: Include information about the specific pattern of the perpetrator's coercive conduct (grabbing, shoving, hitting, isolating, stalking, attacks against pets or property, threats against victim, children, self, etc.). Indicate health impact of the abuse over time on the patient: injuries, illnesses, and medical problems. Also indicate if the patient has sought help in the past, from whom, and what the response had been (if known).

FOR THE TRAINER'S NOTES ONLY:
(These would not appear in the copy of the scenario distributed to the participants).

☞ TRAINER NOTE: After designing the scenario, list out the ways any cultural issues may impact screening, assessing, or intervening with this domestic violence victim. These notes may help guide the trainer during the debriefing of cultural issues.

GANLEY, A., *DOMESTIC VIOLENCE: PRACTICAL APPLICATIONS SESSION. TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

SAMPLE BLANK OUTLINE FOR CASE SCENARIO

INSTRUCTIONS TO PARTICIPANTS:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

SCENARIO #_____ PATIENT NAME: _____

1. Health care setting:

2. Presenting health issue:

3. Demographics:

4. Patient description and concerns:

5. Description and history of the domestic violence

FOR TRAINER'S NOTES ONLY:

Cultural issues/culturally appropriate approaches:

See Appendix B for sample case scenarios.

Module Four

Handouts

HANDOUTS FOR MODULE FOUR

All of these handouts, with the exception of the evaluation form, are from prior modules and are meant for reference. If the training is done in a one- or one-and-a-half-day series, then you will not have to reproduce them for each module.

HANDOUT #4-1	Domestic Violence as a Primary Health Issue
HANDOUT #4-2	Definition of Domestic Violence and Abusive Behaviors List
HANDOUT #4-3	Guiding Principles and Elelments of an Improved Health Care Response to Domestic Violence
HANDOUT #4-4	Definition of Cultural Competency
HANDOUT #4-5	Domestic Violence Screening Tips
HANDOUT #4-6	Domestic Violence Assessment Tips
HANDOUT #4-7	Domestic Violence Intervention Tips
HANDOUT #4-8	Essential Elements of Documentation of Domestic Violence in Health Records
HANDOUT #4-9	Evaluation Form

OPTIONAL HANDOUTS PROVIDED BY THE TRAINERS

- Copies of any state or JCAHO standards related to domestic violence and health care.

  If the health setting has reporting requirements, provide a handout on specific steps for following those requirements, while also following the guidelines for increasing victim's safety and respecting their autonomy as adults.

- If available, provide a copy of the health setting's protocol for responding to domestic violence victims.

Handout #4–1

DOMESTIC VIOLENCE: A PRIMARY HEALTH ISSUE FACT SHEET

DOMESTIC VIOLENCE:

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion, that adults or adolescents use against their intimate partners.

PREVALENCE:

Domestic violence is virtually impossible to measure with absolute precision due to numerous complications including the societal stigma that inhibits victims from disclosing their abuse and the varying definitions of abuse used from study to study. Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year[1] to 3.9 million women who are physically abused per year.[2]

On July 22, 1997, UNICEF released The Progress of Nations, 1997, which found that a quarter to half of women around the world have suffered violence from an intimate partner.[3]

One out of every four American women (26%) report that they have been physically abused by a husband or boyfriend at some point in their lives. 30% of Americans say they know a woman who has been physically abused by her husband or boyfriend in the past year.[4]

While women are less likely than men to be victims of violence crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner.[5]

INJURIES AND OTHER HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE:

The U.S. Department of Justice reported that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend.[6]

Domestic violence is repetitive in nature: about 1 in 5 women victimized by their spouse or ex-spouse reported that they had been a victim of a series of at least 3 assaults in the last 6 months.[7]

The level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required hospital admission, and 13% required major medical treatment. 40% had previously required medical care for abuse.[8]

In 1996, approximately, 1,800 murders were attributed to intimates; nearly three out of four of these had a female victim.[9]

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COSTS OF DOMESTIC VIOLENCE:

From 1987 to 1990, crime costs Americans $450 billion a year. Adult victims of domestic violence incurred 15% of the total cost of crime on victims ($67 billion).[10]

A study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to abused women, children and older people was $1,633 per person per year. This would amount to a national annual cost of $857.3 million.[11]

IDENTIFICATION OF DOMESTIC VIOLENCE:

92% of women who were physically abused by their partners did not discuss these incidents with their physicians; 57% did not discuss the incidents with anyone.[12]

In a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse or address the womanís safety in 92% of the domestic violence cases.[13]

Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse to pregnant women.[14] Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women.[15]

PREGNANCY:

Each year, at least 6% of all pregnant women, about 240,000 pregnant women, in this country are battered by the men in their lives.[16]

Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women[17, 18], as are maternal rates of depression, suicide attempts, tobacco, alcohol, and illicit drug use.[19]

POLICY RECOMMENDATIONS:

A national public health objective for the year 2000 is for at least 90% of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spousal abuse.[20]

The Joint Commission for the Accreditation of Hospitals and Healthcare Organizations (JCAHO) requires that accredited emergency departments have policies and procedures, and a plan for educating staff on the treatment of battered adults.[21]

Continued...

"DOMESTIC VIOLENCE VICTIMIZATION: A PRIMARY HEALTH ISSUE." *TRAINER'S MANUAL: IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE VICTIMS* , (1998) FAMILY VIOLENCE PREVENTION FUND.

Continued...

[1]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[2]The Commonwealth Fund, First Comprehensive National Health Survey of American Women, July, 1993.

[3]UNICEF, The Progress of Nations, 1997.

[4]Lieberman Research Inc., Tracking Survey conducted for the Advertising Council and the Family Violence Prevention Fund, July-October, 1996.

[5]U.S. Department of Justice, Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends, March 1997.

[6]U.S. Department of Justice, August 1997. Violence-related Injuries Treated in Hospital Emergency Departments. Michael R. Rand. Bureau of Justice Statistics.

[7]Zawitz, M. et.al. Highlights from 20 years of Surveying Crime Victims: The National Crime Victimization Survey, 1973-1992. Washington, D.C. U.S. Department of Justice, Bureau of Justice Statistics, October 1993.

[8]Berios, D.C. and Grady, D. Domestic Violence: Risk Factors and Outcome. The Western Journal of Medicine, Vol. 155(2), August 1991.

[9]Supplementary Homicide Reports, 1976-96.

[10]National Institute of Justice, 1996. Victims Costs and Consequences, A New Look. Washington, D.C.

[11]Meyer, H. The Billion Dollar Epidemic. American Medical News, January 6, 1992.

[12]The Commonwealth Fund, First Comprehensive National Health Survey of American Women Finds Them at Significant Risk, (News Release). New York: The Commonwealth Fund. July 14, 1993.

[13]Warshaw, C. "Limitation of the Medical Model in the Care of Battered Women." Gender & Society, Vol. 3(4) December 1989.

[14]Soeken, K., McFarlane, J., Parker, B. (1998). The Abuse Assessment Screen. A Clinical Instrument to Measure Frequency, Severity and Perpetrator of Abuse Against Women. Beyond Diagnosis: Intervention Strategies for Battered Women and Their Children. Thousand Oaks, CA: Sage.

[15]McFarlane, J., Parker, B., Soeken, K., Silva, C., & Reel, S. (1998). Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. Journal of Obstetrical, Gynecological and Neonatal Nursing, January 1998.

[16]Centers for Disease Control and Prevention, The Atlanta Journal and Constitution, 1994.

[17]Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during Pregnancy: Effects on Maternal Complications and Infant Birthweight in Adult and Teen Women. Obstetrics & Gynecology, 841, 323-328.

[18]McFarlane, J. Parker B., & Soeken, K. (1996). Abuse during Pregnancy: Association with Maternal Health and Infant Birthweight. Nursing Research 45, 32-37.

[19]McFarlane, J., Parker, B., & Soeken, K. (1996). Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birthweight. Journal of Obstetrical Gynecological and Neonatal Nursing, 25, 313-320.

[20]Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives—full report with commentary. Washington, DC: U.S. Department of Health and Human Services, Public Health Services, 1991.

[21]Joint Commission on Accreditation of Healthcare Organizations. 1997 Hospital Standards—Possible Victims of Domestic Abuse and Neglect.

Handout #4–2

DEFINITION OF DOMESTIC VIOLENCE AND ABUSIVE BEHAVIORS LIST

Domestic Violence is

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

Abusive Behaviors List

1. Physical abuse:
   ➟ spitting, poking, shaking, grabbing, shoving, pushing, throwing, hitting open handed, hitting closed handed, restraining, blocking escape, choking, hitting with objects, beating, kicking, using weapons, burning, controlling a victim's access to health resources, etc.

2. Sexual abuse:
   ➟ persistently pressuring for sex, coercing sex through a variety of tactics, forcing sex in front of others, forcing sex with children or third parties, physically forcing or harming the victim sexually, etc.

3. Psychological attacks:
   ➟ violent acts against children or others to control the intimate partner; threats of violence against victims, others, or self; intimidation through attacks against pets or property; yelling; stalking; controlling the victim's activities; isolating the victim; controlling the victim through immigration status; controlling the victim's access to resources (e.g. health care, medications, automobile, friends, schooling, jobs, child care, etc.); emotional abuse; forcing the victim to do degrading things; controlling the victim's schedules, including health appointments, etc.

4. Use of economics:
   ➟ withholding funds, spending family funds, making most financial decisions, not contributing financially to the family, controlling the victim's access to health insurance, etc.

5. Use of children to control an adult victim:
   ➟ hostage taking of children; physical and sexual abuse of children; forcing children to engage in physical and psychological abuse of the adult victim; custody fights; using visitation with children to monitor the adult victim, etc.

Developed by Ganley, A. & Schechter, S., for *Domestic Violence: A National Curriculum for Children's Protective Services*. Family Protection Fund, 1996

Handout #4–3

Guiding Principles for Improving the Health Care Response to Domestic Violence

1. Increase the safety of domestic violence victims and their children.

2. Respect the integrity and authority of victims for making their own life choices.

3. Hold perpetrators, not victims, responsible for the both the abuse and for stopping it.

4. Advocate on behalf of domestic violence victims and their children.

5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence victims.

Elements of an Improved Health Care Response to Domestic Violence

1. Routine Screening for Domestic Violence Victimization

2. Assessment of the Domestic Violence

3. Intervention with Patients Who Are Victims of Domestic Violence

4. Documentation of the Domestic Violence as a Health Issue in Health Records

Handout #4–4

DEFINITION OF CULTURAL COMPETENCY

CULTURAL COMPETENCY REFERS TO THE PROCESS BY WHICH HEALTH CARE PROVIDERS:

- Combine general knowledge with specific information provided by the patient,
- Incorporate an awareness of their own biases, and
- Approach the definition of culture with a self-reflective and open mind.

  Recognizing that individuals have different perspectives based on their diversity is the first step in a lifelong process of becoming culturally competent.

WHEN WORKING WITH DOMESTIC VIOLENCE VICTIMS, A SUCCESSFUL CULTURALLY COMPETENT INTERVENTION INCORPORATES:

- An understanding of the definition of cultural competency;
- An awareness of one's own biases, prejudices, and knowledge concerning patients and their culture; and
- A recognition of professional power (such as the power differential between provider and patient) in order to avoid imposing one's own values on the patient.

Handout #4–5

DOMESTIC VIOLENCE SCREENING TIPS

General Tips:

1. Privacy:
   Screen for domestic violence only when you have privacy with the patient, away from other family or friends.

2. Timing:
   As with other sensitive issues, screen for domestic violence only after you have established an initial connection with the patient.

3. Use of translators:
   If you are unable to converse fluently in the patient's primary language, use professional interpreters or another health professional as a translator. The patient's family or friends should not be used as translators on issues about domestic violence.

4. Discuss confidentiality and any limits to confidentiality.
   If there are reporting requirements for the health care provider, explain what those are and the implications of reporting.

5. Present screening of domestic violence as routine.
   This is something you ask all patients because of the prevalence of the problem for all people.

6. Be calm, matter-of-fact, and non judgmental of the patient.
   The style of our interview approach often increases or decreases a patient's willingness to disclose.

7. Gather behavioral descriptions of what happened rather than why it happened or its meaning.
   For example, ask if the patient was slapped, pushed, grabbed, threatened, or followed, rather than abused or battered.

8. Use more open-ended questions initially.
   Use behavioral examples in the follow-up inquiry.

9. Respectfully use the patients' language and vocabulary
   to gather information and to convey an understanding of their world.

10. Listening is one of the most important clinical skills for domestic violence. It is often a key element in using a culturally appropriate approach. Listening allows the patient to define the problem, which then assists the provider in developing the intervention.

Continued...

Handout #4–5

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Sample openings for domestic violence screening:

- "I am going to ask you some quick, routine questions that I ask all patients in order to understand their health. I may be jumping from topic to topic so I can get the big picture and then we can go back and talk about what is important to you."
- "I am concerned that your medical problem may be the result of someone hurting you. Is that happening?"
- Connect the inquiry to something patient has already said. "You mentioned your partner's substance abuse/temper/stresses. When that happens, has your partner ever physically hurt you, or physically fought with you, or threatened you?"
- "Many patients have health problems due to fights with their husbands. Do you know anyone who has had that problem? Has that problem ever happened to you? Is it happening to you now?

Sample screening questions to follow the opening:

- "Has your partner use physical force against you ... or property ... or against someone else when fighting with you?"
- "Has your partner (family member, etc.) physically hurt or threatened you?"
- "Have you been pushed, shoved, grabbed, or slapped by your partner? Has your partner attacked property, pets, or others when fighting with you?"
- "Are you afraid of your partner? If so, what is your partner doing that makes you afraid?"
- "Has your partner humiliated you? Has your partner controlled you in a harmful way?"

What if your patient denies domestic violence?

1. Accept the response.

   Not all patients are domestic violence victims. If a patient seems uneasy about the inquiry, reassure them that these were routine questions asked of everyone due to the prevalence of the problem. Many patients are appreciative of routine questions about their overall health.

2. If you are still concerned that domestic violence may be occurring,

   briefly let patients know that you are a resource if that problem should ever be an issue for the patient. Let them know where they can get more confidential information about domestic violence, and then move on to other topics. Routine inquiry often will open doors that domestic violence victims will use later.

GANLEY, A., *DOMESTIC VIOLENCE: PRACTICAL APPLICATIONS SESSION. TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

Handout #4–6

DOMESTIC VIOLENCE ASSESSMENT TIPS

1. Assess the immediate safety needs of the victim.

   Is the domestic violence victim in immediate danger? Where is the perpetrator now? Where will the perpetrator be when the patient is finished with the medical care? Does the patient want or need security to be notified immediately?

2. Assess the pattern and history of the abuse.

   Assess the perpetrator's physical, sexual, or psychological tactics, as well as the economic coercion of the patient.

   "How long has the violence been going on? Has your partner forced or harmed you sexually? Have others been harmed by your partner? Does your partner control your activities, money, or the children?"

3. Assess the connection between domestic violence and the patient's health issues.

   Assess the impact of the abuse on the victim's physical, psychological, and spiritual well-being: What is the degree of perpetrator's control over the victim.

   "Have there been other incidents resulting in injuries or medical problems? How is abusive behavior affecting your current health?"

4. Assess the victim's current access to advocacy and support resources.

   Are there community resources available to this patient? Has the patient tried to use them in past? If so, what happened? What resources (if any), in addition to the health care provider, are available now?

5. Assess patient's safety: Is there future risk of death or significant injury/harm (lethality) due to the domestic violence?

   Ask about the perpetrator's tactics: use of weapons, escalation in frequency or severity of the violence, hostage taking or stalking, homicide or suicide threats, use of alcohol or drugs as well as about the health consequences of past abuse. If there are children, inquire about the children's physical safety.

Handout #4–7

DOMESTIC VIOLENCE INTERVENTION TIPS

Goals for effectively responding to domestic violence victims:

- ➤ increase victim safety and
- ➤ support victims in protecting themselves and their children by validating their experiences, providing support, and providing information about resources/options.
- ➤ The goal is not to get them to leave their abusers or the "fix" the situation or the relationship for the patient, but to provide support and information.

1. Listen to the patient and provide validating messages:

   - ➟ "You don't deserve this. There is no excuse for domestic violence. You deserve better."
   - ➟ "I am concerned. This is harmful to you (and it can be harmful to your children)."
   - ➟ "This is complicated. Sometimes it takes time to figure this out."
   - ➟ "You are not alone in figuring this out. There may be some options. I will support your choices."
   - ➟ "I care. I am glad you told me. I want to know about domestic violence so we can work together to keep you safe and healthy."

2. Listen and respond to safety issues:

   a. Encourage victims to make their own safety plan for when a batterer is present in the medical setting, a victim fears leaving the medical setting, or a victim is returning to the batterer.

   b. See separate handout on safety planning.

Continued...

Handout #4–7

Continued...

3. Provide information about domestic violence to the patient:

   a. Domestic violence is health issue for patient (and children). Violence can escalate; damage from the abuse escalates over time.

   b. Stopping domestic violence is the responsibility of the perpetrator, not victim.

   c. Victims, with assistance and support from others, can increase their own safety (and their children's).

   d. List whichever supports are available: within the health system; legal options; community advocacy services, etc.

4. Make referrals to local resources:

   a. Advocacy and support systems within the health care setting

   b. Advocacy and support services within the community (if any).

5. Follow-up steps for health care practitioners:

   a. Schedule future appointments. Ensure the patient will have a connection to a primary care provider. Ask what happened after the last visit.

   b. Review medical records and asking about past episodes of domestic violence in order to communicate a concern for patient and a willingness to address this health issue openly.

   c. Domestic violence, like other health issues (smoking, poor nutrition, high blood pressure, etc.), often requires multiple interventions over time before it is resolved.

GANLEY, A., *DOMESTIC VIOLENCE: PRACTICAL APPLICATIONS SESSION. TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS,* FAMILY VIOLENCE PREVENTION FUND (1998).

Handout #4–8

Essential Elements of Documentation of Domestic Violence in Health Records

History

Chief Complaint/History of Present Illness: Elicit and record precise details of the abuse and their relationship to the presenting problem. Include relevant trauma history and relationship of abuse to any concurrent medical symptoms.

Past Medical History/Review of Systems: Ask about and record any medical, trauma, obstetrical or gynecological, psychiatric, or substance abuse histories that are related to domestic violence. Document conditions which will affect the patient's safety or ability to deal with the abuse.

Sexual History: Document any sexual assault, lack of barrier protection, STD's, unplanned pregnancy, abortions, miscarriages and ability to use birth control.

Medication History: Document any relationship between the abuse and the use of psychoactive, analgesic or other medication.

Relevant Social History: Document the relationship to abuser, living arrangement, abuser's access to victim.

In recording the abuse, whenever possible, use patient's own words, "Jimmy, my husband, hit me in the eye."

Physical Examination

Record precise details of findings related to abuse, including a neurologic and mental status exam. Use body map and photographs to supplement written description. Use standard evidence collection techniques for acute injury or sexual assault.

Laboratory and Other Diagnostic Procedures

Record the results of any lab tests, ex-ray, or diagnostic procedures and their relationship to the abuse.

Safety Assessment

Assess and record information pertaining to the patient's risk for suicide or homicide, and potential for seriously being harmed or injured. Determine if it is physically/psychologically safe for her to go home. Are the children or other dependents safe? Assess her degree of entrapment and level of fear and record.

Record options discussed and referral offered

Police Report

Note whether one was filed, and record the name of investigating officer and action taken.

Record Arrangements for Follow-up/Discharge Information

Handout #4–9

EVALUATION OF MODULE FOUR

Domestic Violence: Practical Applications Session

Your comments and suggestions will help us provide you with better trainings in the future

1) Will this information be useful to you in your current area of responsibility?
❑ Yes ❑ No

What was the most useful?

_____

_____

_____

_____

What was the least useful?

_____

_____

_____

_____

2) The information presented was:
❑ Too Complex ❑ Appropriate ❑ Too Simple

3) The presenter was:
❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Comments:

_____

_____

_____

_____

Module Four

Transparencies/Slides

TRANSPARENCIES / SLIDES FOR MODULE FOUR

TRANSPARENCY #4–1

DEFINITION OF DOMESTIC VIOLENCE

Domestic violence is:

- the pattern of assaultive and coercive behaviors,
- including physical, sexual, and psychological attacks, as well as economic coercion,
- that adults or adolescents use against their intimate partners.

TRANSPARENCY #4–2

GUIDING PRINCIPLES FOR AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Increase the safety of domestic violence victims and their children.

2. Respect the integrity and authority of victims for making their own life choices.

3. Hold perpetrators, not victims, responsible for both the abuse and for stopping it.

4. Advocate on behalf of domestic violence victims and their children.

5. Be willing to make changes in both individual practice and in the health care system in order to improve the response to domestic violence.

TRANSPARENCY #4–3

DEFINITION OF CULTURAL COMPETENCY

Cultural Competency refers to the process by which health care providers:

- Combine general knowledge with specific information provided by the patient,
- Incorporate an awareness of their own biases, and
- Approach the definition of culture with a critical eye and open mind.

Recognizing that individuals have different perspectives based on their diversity is the first step in a lifelong process of becoming culturally competent.

TRANSPARENCY #4–4

ELEMENTS OF AN IMPROVED HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

1. Routine Screening for Domestic Violence Victimization

2. Assessment of the Domestic Violence

3. Intervention with Patients Who Are Domestic Violence Victims

4. Documentation of the Domestic Violence in Health Records

TRANSPARENCY #4–5

PRACTICAL APPLICATIONS SESSION: DEBRIEFING QUESTIONS

1. Is this patient experiencing domestic violence? What did the practitioner say or do that helped to elicit the information to make that determination?

2. If there is domestic violence, what did the practitioner say or do that helped in the assessment of the problem?

3. If there is domestic violence, what did the practitioner say or do that effectively responded to the domestic violence?

4. How do the cultural perspectives of the provider and patient affect the process? How did the practitioner include culturally sensitive approaches to ensure clinical effectiveness?

Module Five
Part One

Domestic Violence: Legal Issues for Health Care Providers

MODULE FIVE: PART ONE

Domestic Violence: Legal Issues for Health Care Providers

by Ariella Hyman, J.D.[1]

TIME ALLOTTED FOR PART ONE: 60 TO 75 MINUTES

GOALS AND OBJECTIVES

1. To increase awareness of the legal options available to domestic violence victims so health care providers can discuss these with patients and facilitate their access to potentially lifesaving recourses.

2. To review legal requirements and considerations for health care providers and institutions that may be important for the care of victims of domestic violence and the practice of good risk management.

[1] Ariella Hyman, J.D. ia a staff attorney at the San Francisco Neighborhood Legal Assistance Foundation.

HYMAN, ARIELLA, J.D., *DOMESTIC VIOLENCE: LEGAL ISSUES FOR HEALTH CARE PROVIDERS.* TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS, FAMILY VIOLENCE PREVENTION FUND (1998).

FACULTY

Part One of this module should be taught by a legal advocate or attorney for domestic violence victims who is familiar with laws and legal resources in your locality. You might contact community domestic violence organizations, the state domestic violence coalition, and the local legal aid organization to find someone who accompanies, supports, or represents domestic violence victims in court and/or advises victims of their legal recourses.

TRAINING TIPS

1. **Format of the chapter:**
   Presentation material and activities are in outline format and written in bold and regualr font. Directions to the trainer are marked with an icon pointer and written in Tekton font. Interactive activities are boxed.

2. **Specific preparatory reading:**
   It is important that the legal expert teaching this session has read through all of the other modules presented to this group and, if possible, attended all previous training sessions.

3. **A common tendency when teaching this section is to go into too much detail about the law and legal matters.**
   The participants are health care providers, not lawyers or legal advocates. The goal is to give the participants a general overview of the important legal issues in a simplified manner. Try to refrain from detail and legal jargon, and rather concentrate on how to effectively emphasize and review the few major points that you want the health care provider to remember.

4. **If your state mandates health care providers to report to authorities when a patient has injuries due to domestic violence, expect participants to have many questions and concerns about this.**
   It is important to try to confine the discussion of reporting to a discreet section of your training and not let it overshadow the other information in your training. Practitioners need to understand that their role is much larger than reporting. It is to provide support, inform patients about their options, help in assessing safety, etc. The legal report is only one small piece of a much larger intervention.

5. **Trainers should develop and distribute handouts during the presentation as indicated in the outline.**
   For a list of community domestic violence resources (including legal resources) and information about calling the police, please *see Sample Handouts 5-1, 5-2, and 5-3*

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and tailor to your community, local laws, and practice. The legal expert presenting part one of Module 5 and the domestic violence expert presenting part two of Module Five should meet prior to the training and create or review these resource lists together. Handouts on Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and documentation are provided in Handout 5-4. Handout 5-5 summarizes documentation tips. Please see the *Resource Manual* Appendix F for sample documentation forms. Finally, you should develop and distribute summaries or copies of applicable laws, including reporting laws, and education and protocol requirements from your state.

6. **Part One of this section is designed to last 60-75 minutes and Part Two is designed to last 15 to 30 minutes.**
Together, both sections of Module Five are designed to last 90 minutes. If you would like to spend more time on the legal section, then present Part One, in 75 minutes, allowing 15 minutes for Part Two: Community Resources. Or, you could present the legal information in 60 minutes, leaving thirty minutes for the Community Resources section. The legal expert and domestic violence expert presenting Module Five should meet prior to the training to decide how much time will be spent on each section.

PRESENTATION OUTLINE: PART ONE

Domestic Violence: Legal Issues for Health Care Providers

I. INTRODUCTION

This workshop will cover:

A. Legal options available to domestic violence victims that health care providers can discuss with patients and thereby facilitate access to potentially lifesaving recourses.

B. Legal requirements and considerations for health care providers and institutions that are important for the care of domestic violence victims and the practice of good risk management.

II. LEGAL REMEDIES FOR DOMESTIC VIOLENCE VICTIMS (35-40 minutes)

A. Criminal Justice Intervention

☞ TRAINER NOTE: Project Transparency #5-1: Criminal Justice Intervention.

1. Patients experiencing domestic violence are most likely victims of crime.

☞ TRAINER NOTE: Give examples of crimes in your state that may have been committed against a patient by an abuser, such as assault, stalking, rape, threats, property destruction, forcible entry of a residence, kidnapping, or specific "domestic violence" or "spouse abuse" crimes.

2. Patients have the option of calling law enforcement.

a. Inform the patient that s/he may be a victim of crime and may consider calling the police.

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b. Be aware that there are various reasons why a patient may not consider this an appropriate option. For example:

- The victim may have had negative experiences with the police in the past.
- The batterer may be a police officer.
- Especially if the victim is a person of color, s/he may distrust law enforcement and not want to turn the batterer in to what s/he believes is a racist system.
- The victim may fear calling the police due to immigration status.
- The victim may not want the perpetrator in jail because the perpetrator may be a primary source of financial support.

3. Likely outcomes of calling the police:

☛ TRAINER NOTE: Review relevant laws, policies, and practices very briefly. Address the following:

a. What happens in practice when the police are called? What steps take place? What must the victim do to ensure case follow-up?

b. What are the domestic violence arrest laws or policies?

c. If the perpetrator is arrested, how soon may s/he be released?

d. Will prosecutors prosecute even without the victim's participation?

4. Victim rights when calling the police:

The better informed victims are of their roles and rights in the criminal justice system, the better off they will be.

☛ TRAINER NOTE: Provide a few examples of victim rights in your state. Do they have the right to demand a copy of the police report? The right to make a private person's arrest? The right to request a police stand-by until the victim's safety secured?

5. Potential protections for victims in the criminal justice system:

☛ TRAINER NOTE: Briefly mention any recourses available in your state, such as criminal stay-away orders, victim notification upon the perpetrator's release from jail, victim witness assistance, etc.

6. Safety considerations:

Violence often increases when victims attempt separation or seek help. When calling the police, the patient should take safety precautions. For example:

➟ If perpetrators are arrested, they may be released shortly. Patients should use this time to quickly gather their children and important belongings, find a safe place to stay, and call an advocacy organization.

Patients may reasonably believe that they would be at risk of retaliation if they call the police and would not be afforded adequate protection. Respect patient choices and safety assessment.

7. Advocacy support in the criminal justice system:

☛ TRAINER NOTE: Develop and refer participants to Handout #5-1 and #5-2 about community resources, and review organizations that can assist through the criminal justice process. Also develop and refer participants to Handout #5-3, an information sheet that providers can give to patients on rights and process when calling the police. See sample Handouts # 5-1, #5-2, and #5-3 for instructions on how to develop these handouts for your area.

Encourage a patient who wants criminal justice intervention to contact domestic violence programs. Advocates can give important information and support through the process.

B. Civil Protection Orders

☛ TRAINER NOTE: Develop and project Transparency # 5-2 (See Sample transparency #5-2 for instructions on how to develop this overhead)

Inform patients that they have the option of getting a civil protection order and explain how to obtain one in your community.

1. **What is a protection order?**

   a. **Types of relief available:**

   ☞ TRAINER NOTE: List the types of relief available in your state pursuant to a protection order. These may include: restraining the perpetrator from further violence; evicting the perpetrator from the household; ordering the perpetrator to stay away from or not contact the victim; awarding child custody, visitation, or support; ordering batterer's counseling; or prohibiting the perpetrator from possessing weapons.

   b. **Which relationships are covered:**

   ☞ TRAINER NOTE: Explain who is eligible to obtain a protection order in your state. For example, are only current and former spouses eligible? Or are all current and former intimate partners and household members, including same-sex intimate partners, covered?

   c. **Duration of a protection order:**

   ☞ TRAINER NOTE: Explain the duration of protection orders in your state.

2. **How to obtain a protection order:**

   a. **Available advocacy and/or legal assistance:**

   ☞ TRAINER NOTE: Refer participants to Handout #5-1 and review local organizations that assist with restraining orders. Explain to participants that other community resources will be discussed during Part two of this module.

   b. **Court process for obtaining order:**

   ☞ TRAINER NOTE: In brief (one or two sentences), describe the process for obtaining a protective order.

3. **How a protection order is enforced:**

   ☞ TRAINER NOTE: Describe local penalties for protection order violation.

   The patient can call the police to report a violation of the protective order. Health care providers might suggest that the patient carry the order at all times,

and give copies to employer, security at work or in the building, children's schools, and other places that are frequently visited.

4. Temporary and/or emergency protective orders:

☛ TRAINER NOTE: Explain what these are if they exist in your state. Note if one can obtain such an order by calling the police or court from the hospital in an emergency.

C. Child Custody and Visitation Orders

☛ TRAINER NOTE: Project Transparency #5-3.

1. Court orders clearly delineating custody and visitation arrangements can be critical to the safety of victims and their children.

Abusers often use children as a means of gaining access to or control over their former partners. If patients have children with their batterers, suggest that they seek legal consultation on custody and visitation orders. Give patients the resource list on Handout #5-1 (or other local resource list) and refer them to organizations that can assist with custody, divorce and other legal matters.

☛ TRAINER NOTE: Provide an example, such as a situation in which a batterer kidnaps a victim's child and the victim calls the police for assistance: the police may refuse to help without seeing a court order specifying that the victim has custody.

2. Visitation orders may be crafted to minimize safety risk.

➟ For example, orders may specify supervised visitation, transfer of the children through a third party so there is no contact between the parents, or other protective safeguards.

D. Divorce and Support Actions

Orders that distribute marital property and awards of child and spousal support may assist victims who are struggling financially to provide for themselves and their children. Referral lists should include organizations providing such assistance.

E. Immigration Remedies for Battered Women

Immigrant battered women often face severe obstacles in attempting to leave abusive partners. For example:

- A batterer may threaten reporting the victim to authorities or
- not assist the victim in applying for legal status if s/he leaves.

1. Legal recourses:

The patient may not have to rely on the batterer to obtain legal status.

- Example: Remedies may be available under the federal Violence Against Women Act (VAWA).

2. Referral:

Direct patients to resources for legal assistance with immigration issues.

☞ TRAINER NOTE: Handout #5-1 or #5-2 should include immigration referrals. If you need help identifying immigration resources in your area, call the National Immigration Project of the National Lawyer's Guild at (617) 227-9727 for referrals.

F. Summary Exercises

INTERACTIVE ACTIVITY

OPTION A

Give participants the following scenario: You have 5 minutes to tell a battered patient about legal options. What are 3-5 points you would make? After they have responded, refer to the following points as a model answer:

1. What happened is a crime: You can call the police.
2. Consider your rights and safety risks when calling the police. Seek advocacy assistance through the process and take this information sheet, "Calling the Police."

Continued...

INTERACTIVE ACTIVITY

Option A Continued…

3. You can get a protection order that orders the perpetrator to stay away from you. Call this agency for information and assistance.

4. (To a patient with children:) You might call this legal resource for information about custody/visitation orders, so that the batterer won't keep using visitation with the children as a way to put you at risk.

5. (To an immigrant battered woman:) You may not have to rely on a coercive spouse to obtain your legal status: Call this agency for legal recourses for immigrant battered women.

OPTION B

Domestic Violence and Legal Options Role-Play

If the group is small, you can play the battered woman and have one or more participants play the provider.

Alternatively, you can break them up into pairs and have one participant play the patient, the other the provider. Give them the following case scenario:

Your patient was beaten by her husband as recently as last night. He threatened that if she and their two children leave him, he will kill them. She plans on trying to get into a shelter with her children as soon as possible, but is afraid that her husband will retaliate. Talk to her about her legal options for approximately five minutes.

End with a discussion and review.

G. Questions and Answers

III. OTHER LEGAL CONSIDERATIONS FOR HEALTH CARE PROVIDERS AND INSTITUTIONS

(25-35 minutes)

☞ TRAINER NOTE: Review the following legal considerations, but do not spend more than 2-5 minutes on sections A-C below. Project transparency #5-4 if applicable (see sample).

A. Domestic Violence Protocol Requirements

1. JCAHO standards

☞ TRAINER NOTE: Refer participants to Handout #5-4.

The standards of the Joint Commission on Accreditation of Healthcare Organizations require policies and practices for identification and assessment of abuse victims, documentation and handling of evidentiary material, patient consent, and education for providers.

2. State laws regarding domestic violence protocols:

☞ TRAINER NOTE: Only a few states have laws requiring health facilities to develop and implement domestic violence protocols. If your state has such a law, explain the law or hand out a copy/summary of the law. Additionally, point out that there is a high correlation between domestic violence and sexual assault/rape; participants should be aware of any laws regarding rape and sexual assault protocols.

B. Domestic Violence Education Requirements

1. JCAHO standards requirement regarding staff education:

☞ TRAINER NOTE: Refer participants to Handout #5-4.

2. State laws regarding domestic violence education:

☞ TRAINER NOTE: Only a few states have laws requiring domestic violence education in health facilities or professional schools. If your state has such a law, explain the law or hand out a copy/summary of the law. Point out any laws regarding rape and sexual assault education as well.

C. Practicing Good Risk Management

Whether required to do so by law or not, it is wise for health care facilities to develop and implement domestic violence protocols and education standards. Providers who inquire about domestic violence, help battered patients assess safety, counsel patients about options, document abuse, and provide appropriate referrals are not only delivering critical care, but are practicing good risk management. This is increasingly the case as the standard of care in this area is improving.

D. Documentation of the Abuse

☞ TRAINER NOTE: This material is discussed in Module Three on clinical strategies. Briefly review it here only from a legal perspective. Refer participants to Handout #5-5 on documentation and to the *Resource Manual* Appendix F for Sample Documentation Forms.

1. Why documentation is important: Thorough documentation in the medical record is critical for the patient's ongoing health care.

a. Documentation may affect the outcome of a legal case. Often there are no witnesses to the violence and the victim may not have called the police. The medical record may be the only evidence for use in a criminal prosecution, custody, or immigration case. Even though patients may not want to pursue a case at the time of the visit, they may reconsider later, at which time the documentation may prove invaluable.

b. For practitioners, documentation may provide protection in demonstrating that they met an appropriate standard of care.

2. Helpful tips:

☛ TRAINER NOTE: Project transparency #5-5: Documentation of the Abuse

a. Document descriptions of violent incidents and resulting injuries, dates and locations of incidents, and the name and relationship of the abuser.

b. Use the patients' words, if possible. For example:

➟ "my boyfriend punched me in the eye" rather than "patient sustained blow to right orbit."

c. Describe the history and pattern of physical, sexual, and psychological abuse.

d. Offer to take photographs: Obtain patient consent and use color film (preferably Polaroid, so you can attach it to the chart). Mark photos with the patient's name and identifying data, date, time, and the name of the photographer.

e. Draw body maps of old and new injuries.

f. Write in clear handwriting. (Prosecutors will be less likely to subpoena you to testify if they can read your writing.)

g. Record opinions corroborating the abuse. For example:

➟ "trauma is consistent with being struck from behind with baseball bat.")

h. Preserve other evidence, such as torn clothing.

i. Follow appropriate protocols for evidence collection and forensic examinations in cases where the battered patient is also a victim of rape/sexual assault.

j. What to avoid: If not recorded with care, documentation may be misinterpreted or improperly used against a patient in a legal case. Refrain from noting mental health diagnoses without indicating the impact of the abuse on the patient's condition. Excessive detail that may conflict with a police report, and extraneous information, such as "It was my fault he hit me because . . . ," should also be avoided.

E. Reporting Law Requirements for Health Care Providers

☛ TRAINER NOTE: Refer participants to Chapter Two, Section X and Appendix N in the *Resource Manual.*

1. State Law:

State laws vary. Only a few states have reporting laws specific to domestic violence. Others require reports for weapon injuries, or injuries due to criminal acts, acts of violence, or non-accidental acts. These laws will apply in at least some domestic violence cases.

☛ TRAINER NOTE: If your state has some relevant law, you might address the following questions, if applicable, and create a hand out and/or transparency (see sample transparency #5-6 for instructions) with a summary of the law. Consider including the following information if you develop a handout or transparency on your local law:

a. What must be reported?

b. Who is obligated to report?

c. What level of suspicion is required of the reporter?

d. Who receives the report and are they required to do anything?

e. Are there penalties for failure to report?

f. Is immunity from liability granted for making a good faith report?

g. Are there provisions for confidentiality of reports?

2. Potential ramifications of mandatory reporting:

The goals of mandatory reporting may be to hold perpetrators accountable, enhance patient safety, and increase health care providers' awareness of the crime. It is critical to recognize, however, that reporting domestic violence to a governmental agency without patient consent may result in harm in some cases. The better health care providers understand the potential ramifications, the better they will be able to work with patients to minimize the risks.

☛ TRAINER NOTE: Project Transparency#5-7: Potential Ramifications of Mandatory Reporting

Among the potential risks of mandatory reporting are:

a. Putting patients at risk of retaliation;

b. Deterring patients from seeking health care or being candid about the abuse;

c. Prompting providers to abdicate responsibility for providing care if they view their role as passing the case to another agency;

d. Harming patients as the system of response to reports may not take patient safety into account, or may be inadequate and raise false expectations;

e. Infringing on patients' autonomy to assess risks and decide what's in their best interests; and

f. Infringing on provider-patient confidentiality, which may decrease the patient's trust in the provider and their ability to develop a relationship in which frank discussion of the abuse and the patient's options is possible.

3. Minimize harms to patients under current laws:

☞ TRAINER NOTE: Project Transparency 5-8: Strategies for Dealing with Mandatory Reporting Laws.

a. It is most important for health care providers to recognize that the critical intervention is not a mandatory report, but providing ongoing and supportive care, addressing safety, and guiding the patient through the available options.

b. Discuss with the patient your obligation to report the abuse.

c. Learn how authorities respond to reports and discuss this with the patient.

d. Address the risk of retaliation and the need for precautions.

e. Work with the patient and authorities to meet the patient's needs when reporting.

f. Maximize the role of the patient's input.

g. Work with advocates and authorities to implement a process for responding to reports that enhance safety and autonomy, and to address problems that arise in response to reports.

h. Don't view a report of domestic violence as a substitute for thorough documentation in the medical record. Documentation in the medical record is crucial for the patient's ongoing care, and may also prove more useful as evidence in legal cases than a reporting form.

F. Other Legal Considerations

1. Insurance discrimination:

A number of insurance companies have been denying insurance coverage to victims of domestic violence. Advocates for victims have been protesting these policies, and a number of states now have laws forbidding such practices.

☞ TRAINER NOTES:

a. Explain whether insurance companies in your state have particular practices regarding domestic violence. Explain that such policies are discriminatory and perpetuate the myth that victims choose to be abused. If these policies exist, discuss the impact of medical record documentation and reporting.

b. Specify whether there are state laws forbidding such practices.

2. Duty to warn:

If you have a patient who may be a perpetrator of violence, and who indicates an attempt to harm his or her partner, you may have a legal duty to warn the partner and/or police of the potential danger.

☞ TRAINER NOTE: State laws vary. You might direct providers to find out about their particular obligations from their facility attorney or risk management department.

INTERACTIVE ACTIVITY

➤ Take general questions and comments.

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IV. OPTIONAL SESSION: PANEL WITH A POLICE OFFICER OR PROSECUTOR

(Additional 30 minutes required)

☞ TRAINER NOTE: Some health care providers may be interested in hearing from a police officer or prosecutor about the criminal justice system's response to domestic violence. If this is the case, we recommend adding a separate 30-minute session, and invite this person to speak on a panel with the primary legal advocate presenter. (It is important to have the advocate present to explain the victim's perspective on these questions.) You might give the questions listed below to your speakers in advance so they will come prepared to address them.

A. What do the police do upon receiving a domestic violence call?

B. In what types of cases do the police make arrests? In what types of cases do they provide no follow-up?

C. How does the prosecutor decide which cases to prosecute?

D. What kind of documentation in the medical record is useful for the criminal case?

E. Is there any support or protection afforded the victim when the case is going through the criminal process?

F. Does the victim have a voice in whether an arrest is made or a case is prosecuted?

G. If alleged perpetrators are arrested, how short or long of a time before they are released? Is there a system for victim notification upon release?

H. For states with mandatory reporting to law enforcement laws:

1. What will the police do upon receiving a call or written report from a health care provider?

2. How will the provider's and patient's input regarding desired police action be handled?

TALKING/DISCUSSION POINTS: PART ONE

COMMONLY ASKED QUESTIONS AND DISCUSSION POINTS:

1. **"Can gay and lesbian victims of domestic violence and undocumented battered women obtain protection orders against intimate partners?"**

   ☞ TRAINER NOTE: Review your state law.

2. **"Do protection orders help?"**
   Some perpetrators will respect an order, some will ignore it or retaliate. It is best to inform patients of the option and respect their judgment about whether it will help.

3. **"When I document in the medical record what the patient describes to me about the abuse, is the correct language for me to use 'the patient alleges . . . ,''the alleged perpetrator . . . ,' etc.?"**
   You are the patient's health care providers and advocates in their care. You are not a prosecutor, police officer, or neutral arbiter. It is not your role to write an official police report or follow some prescribed legal standard when documenting in the medical record. The medical record should first and foremost be a vehicle to enhance the patient's health care. It may also prove useful in the future for legal proceedings. It is fine to document what the patient "says" or "states" occurred.

4. **"Will I ever have to go to court to testify regarding a case? What do I need to know?"**
   On rare occasions, health care providers may be called to testify about the contents of records or to give expert testimony or an opinion on the cause of the patient's injuries. Practitioners should: 1) prepare for such testimony with the patient's attorney, if the attorney thinks advisable; and 2) review laws regarding confidentiality and testimonial privileges before divulging any confidential information or opinions without the patient's permission.

5. **While discussing criminal justice intervention (Section II.A), you may get questions about reporting responsibilities.**

   ☞ TRAINER NOTE: Remind participants that later in the session you will review reporting obligations. Emphasize here that health care providers should inform all battered patients of their option to call the police and seek criminal justice remedies — regardless of whether any reporting law applies.

6. **Expect many specific questions about reporting duties in domestic violence cases.**

   ☞ TRAINER NOTE: There may be many questions about your state reporting law, so make sure to review the law and any case interpretations well. We are not aware of any court cases in which health care providers were held liable for failure to specifically report domestic violence. As such, it is difficult to give guidance on many particular questions. When there are no clear answers, it is best to suggest they turn to their own health care facility for reporting protocols.

HYMAN, ARIELLA, J.D., *DOMESTIC VIOLENCE: LEGAL ISSUES FOR HEALTH CARE PROVIDERS.* TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS, FAMILY VIOLENCE PREVENTION FUND (1998).

Module Five
Part Two

Community Resources for Domestic Violence Victims and Perpetrators

MODULE FIVE: PART TWO

Community Resources for Domestic Violence Victims and Perpetrators

by Lisa James, M.A.

TIME ALLOTTED: 15 TO 30 MINUTES

GOALS AND OBJECTIVES

1. To become aware of and familiar with the local services available to victims and perpetrators of domestic violence.

2. To develop a working knowledge of referral protocols in order to refer patients to the most appropriate domestic violence service agencies.

FACULTY

The information in this section should be presented by a domestic violence expert who is familiar with local domestic violence resources. You might contact your local community domestic violence organization to find someone who is knowledgeable about resources in your community.

JAMES, LISA, M.A., *COMMUNITY RESOURCES FOR DOMESTIC VIOLENCE VICTIMS AND PERPETRATORS.* TRAINER'S MANUAL FOR HEALTH CARE PROVIDERS, FAMILY VIOLENCE PREVENTION FUND (1998).

TRAINING TIPS

1. **Format of the chapter:**
   Presentation material and activities are in outline format and written in **boldface** and regular font. Directions to the trainer are marked with an icon pointer and written in Tekton font. Interactive activities are boxed.

2. **Specific preparatory reading:**
   It is important that the domestic violence expert teaching this session has read through all of the other modules presented to this group, the *Resource Manual* and if possible, attended all previous training sessions.

3. **This section is designed to last 15 to 30 minutes.**
   Together, both sections of Module Five are designed to last 90 minutes. If the trainer would like to spend more time on the community resources section, then the legal issues section can be presented in 60 minutes instead of 75, allowing 30 minutes for Part Two. The legal expert and domestic violence expert presenting Module Five should meet prior to the training to decide how much time will be spent on each section.

4. **Resources for perpetrators:**
   Because it is important for health care providers to be familiar with community resources available to perpetrators as well as victims of domestic violence, the trainer for Part Two of this module should include information about such resources if they are available. If the trainer or participants would like more information on perpetrators, please refer to Chapter Three of the *Resource Manual: Health Care Responses to Perpetrators of Domestic Violence.*

5. **Trainers should develop and distribute handouts during the presentation as indicated in the outline.**
   For a list of community domestic violence resources (including legal resources) and information about calling the police, please see Sample Handouts #5-1 and #5-2 and #5-3 tailor to your community, local laws, and practice. The legal expert and domestic violence expert presenting Module Five should meet prior to the training and create or review this resource list together.

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PRESENTATION OUTLINE: PART TWO

Community Resources Available for Domestic Violence Victims and Perpetrators

I. INTRODUCTION
(2 - 5 Minutes)

A. Domestic violence programs provide a variety of services to victims and their children, as well as to perpetrators of domestic violence. The scope of these services vary dramatically from one community to the next.

B. Health care providers should know local domestic violence services and be part of a coordinated system of response to domestic violence victims. Clinicians should think of domestic violence advocates as specialists, and make referrals to them regularly.

C. The goals of this session are:

1. To become aware of the local services available to victims and perpetrators of domestic violence, and

2. To develop a working knowledge of referral protocols in order to refer patients to the most appropriate agencies.

II. DESCRIPTION OF DOMESTIC VIOLENCE SERVICES AND THE REFERRAL PROCESS
(10 - 20 Minutes)

A. Community Resources Available to Victims and Perpetrators of Domestic Violence

☞ TRAINER NOTE: Develop and refer participants to Handout #5-1 on local domestic violence services. See sample Handout #5-1 for instructions on how to develop this handout. Trainers should tailor this handout to reflect the resources in the health care providers' community. Project Transparency #5-9.

1. Local domestic violence services

☞ TRAINER NOTE: Describe the roles of local domestic violence services, such as:

a. Telephone crisis services

b. Temporary shelters and transitional housing

c. Shelter-based support groups

d. Nonresidential or residential outreach services for battered women such as:
   - ➟ advocacy, case management, child care, and transportation services

e. Individual counseling

f. Legal advocates and victim services

g. Services for specific cultural or demographic groups such as:
   - ➟ ethnic groups, gay and lesbians, immigrants, monolingual non-English speaking groups, teens, etc.

h. Perpetrator intervention programs.

2. Domestic violence agencies and other local agencies that offer for services not specifically related to domestic violence:

☞ TRAINER NOTE: Develop and refer participants to handout #5-2. List local community services available such as the following:

a. Housing assistance

b. Advocacy/case management

c. Job-training and seeking services

d. Child care and other children's services

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e. Sexual assault services

f. Transportation services

g. Support groups for gay, lesbian, and bisexual groups

h. Substance abuse programs

i. Immigration services

j. Nutritional programs

3. Health care providers should call or visit local services and make contact with local advocates.

☞ TRAINER NOTE: Project transparency #5-10.

4. Aside from knowing what services are offered in your community, health care providers should know the following about each local service provider.

- What are the eligibility requirements
- What is the screening and referral process
- Are the services culturally and linguistically accessible to their patient population

B. Eligibility Requirements and Standard Policies

In addition to knowing what services are offered, health care providers should know about eligibility requirements and standard policies within service agencies.

☞ TRAINER NOTE: Briefly describe the policies and eligibility requirements of local domestic violence services by providing information about the following areas:

1. Telephone crisis services for victims
Describe any applicable eligibility requirements for accessing telephone crisis services.

2. **Domestic violence shelters**
   Briefly describe shelter rules. Address issues such as who is eligible to stay, what contact residents can have with family and community members, what confidentiality policies apply, etc.

3. **Services for children**
   Indicate which agencies will provide services to clients with children and which offer separate programs for children of domestic violence victims.

4. **Substance abuse**
   Indicate which services, if any, accept domestic violence victims with substance abuse problems and which have rules regarding victims who are taking psychiatric medications or other prescription and nonprescription drugs. Identify any agencies that offer substance abuse treatment programs.

5. **Perpetrator services**
   Describe any existing services for perpetrators, and discuss eligibility requirements.

C. Helping Patients Access Community Resources

Health care providers need to understand how patients gain access to domestic violence services and how to assist them in doing so.

☞ TRAINER NOTES: Describe local referral and screening procedures, such as the following:

1. **Services for domestic violence victims**

   a. Crisis telephone services
      Is there a service charge? What are the hours of availability? Is long- term telephone counseling available?

   b. Shelters
      Do local domestic violence advocates require that they talk to victims directly before admittance or can clinicians complete referrals on their own?

   c. Translation services for monolingual patients
      Describe how the health care provider can help the patient access local services and, if needed, AT&T translation services. (See Talking/Discussion Points)

2. **Services for domestic violence perpetrators**
   Describe how perpetrators can gain access to treatment. Do agencies take self-referrals, referrals by court mandate only, or referrals from health care providers?

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D. Referrals need to be appropriate and accessible to the patient.

1. Not all domestic violence services are accessible or appropriate for all domestic violence victims or perpetrators.

   ☞ TRAINER NOTES: Give a local example of a referral that was ineffective because the agency was inaccessible to the domestic violence victim. For example:

   - ➟ A victim was referred to a shelter where no one spoke her native language
   - ➟ A gay male victim of domestic violence was referred to a domestic violence service agency that only worked with women.

2. If services are not linguistically, culturally, or physically accessible, people will be less likely to access them.

3. Health care providers need to ask patients about their specific needs and refer them to the most appropriate services.

4. Local programs may provide services for specific demographic groups.

   ☞ TRAINER NOTE: Note any agencies that have made an effort to diversify staff to reflect the local population or agencies who conduct outreach to specific demographic groups. Describe any of the following services provided by local agencies such as:

   a. Programs designed to serve specific cultural or demographic groups. For example:

      - ➟ Support groups for African-American women
      - ➟ Programs for teens involved in abuse relationships
      - ➟ Same-sex domestic violence programs
      - ➟ Programs that address the transportation needs of rural women

   b. Programs that provide full- or part-time multilingual services

   c. Programs that specialize in providing services to immigrant communities

Some domestic violence services report undocumented clients to immigration authorities and therefore patients may be reluctant to approach them for help. Health care providers should know what the local service providers policies are on working with undocumented domestic violence victims.

d. Programs that are accessible to clients with disabilities

e. Programs that provide services to gay, lesbian, or bisexual clients

5. Lack of services

☞ TRAINER NOTES:
If these services do not exist in your area, identify other options that health care providers can explore with patients, such as referring them to local churches, community groups, friends, or family. Health care providers can also work with a domestic violence counselor via national or statewide crisis line/support groups.

Please see the Talking/Discussion Points section of this chapter for more information on what to do if your community lacks domestic violence services.

E. To provide an effective referral to a domestic violence victim, health care providers should do the following:

☞ TRAINER NOTE: Project Transparency #5-11.

- Ask and listen to what the patient needs and wants
- Express concern and support for the patient
- Alert the patient to any confidentiality issues or reporting requirements
- Know your local services and explain them to patients so that they can select the most culturally, linguistically, or physically appropriate services
- Ask patients if they want help contacting the service agency
- Remind patients that they can speak to the health care provider again about the violence

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F. For some patients, accessing community services may not be an option at the time of their visit.

1. The patient may not be ready to access any outside help at the present time.

2. Depending on patients' prior experiences with, and response to, the social service and criminal justice systems, they may decide not to approach these local domestic violence service agencies.

   ☞ TRAINER NOTES: Give an example of why a victim may choose not to access help from local community services. For example:

   - A close friend or family member may work at the only domestic violence service agency;
   - the victim may consider the police racist; or
   - the victim may have been raised to believe that asking for help was a sign of weakness.

3. Many women prefer turning to their friends or family members for help.

III. CONCLUSION
(3 - 5 Minutes)

A. Review of the main components of an improved health care response to domestic violence from Module Three:

1. Routine screening for domestic violence victimization

2. Assessment of the domestic violence

3. Intervention for the victims of domestic violence and referral

4. Documentation of the domestic violence in the health records

B. In order to provide an appropriate intervention and referral, health care providers need to know:

1. about the services available in their communities; and

2. how to direct patients to these resources if necessary.

C. Because many patients will not use referrals right away, and because local service agencies are often strained and have full caseloads:

1. Health care providers' direct intervention with victims during their visits is very important.

2. Knowing about domestic violence services should compliment and not replace effective intervention by the health care provider.

INTERACTIVE ACTIVITY

➤ Take geneneral questions and comments.

☞ TRAINER NOTE: Thank participants and distribute evaluation form. See Handout # 5-6

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TALKING/DISCUSSION POINTS: PART TWO

Commonly Asked Questions & Discussion Points

1. **"What should I do if a patient refuses referral?"**
   If patients do not wish to contact a domestic violence service agency at the time of the referral, then health care providers should: 1) offer them educational materials in case they change their mind; 2) reiterate their concern; and 3) inform them that they are available if the patient would like to talk in the future.

2. **"What if there are limited or no services available in my community?"**
   If you live in an area where there are very limited domestic violence services, you should spend more time identifying other options for domestic violence victims. For example, health care providers can connect victims to domestic violence counselors through national or statewide crisis lines and support groups, or they can recommend that victims talk to family or friends. If a person needs emergency shelter, health care providers can recommend hotels, local churches, or possibly using a hospital bed for one night.

   In areas where there are limited services, it is particularly important to emphasize on-site interventions by the health care provider. Trainers should organize more detailed training for health care providers on how to develop a safety plan with the patient. This session should also include a detailed review of Module Three of this *Trainer's Manual,* covering clinical interventions.

3. **"What if the available services are inaccessible?"**
   The National Domestic Violence Hotline at 1-800-799-SAFE (7233) can provide multilingual domestic violence services. Services for the hearing impaired can be obtained by calling 1-800-787-3224. Trainers should also encourage participants to call local domestic violence agencies and work with them to develop accessible services, or explore how to develop new networks and create new services if there are none.

4. **A referral to a domestic violence service agency is not the only intervention that health care providers should conduct.**
   Upon identification of domestic violence, often health care providers may want to refer a patient immediately to a community agency. Remind participants of the importance of their individual intervention in addition to a referral to a domestic violence program.

5. **Reiterate the definition of success.**
   The goal of the health care provider should not be to convince patients to go into a shelter but to express concern, identify resources available to patients, and explore options with them. Use a personal example of a successful health care-based referral.

6. **Encourage collaborations with local domestic violence agencies.**
   If participants are interested in exploring collaborations with community organizations, refer them to Appendix B of the *Resource Manual*. As part of a description on how to develop a domestic violence response program within your health care setting, this appendix also offers ideas for collaborative projects between health care and domestic violence agencies.

Module Five

Handouts
for Part One and Part Two

HANDOUTS FOR MODULE FIVE:
PART ONE AND PART TWO

SAMPLE HANDOUT #5-1	Legal and Community Resource List *(To be created by the trainers, instructions attached)*
SAMPLE HANDOUT #5-2	Other Social Services Available *(To be prepared by the trainer, instructions attached)*
SAMPLE HANDOUT #5-3	Information Sheet: Rights and Process When Calling the Police *(To be prepared by the trainer, sample attached)*
HANDOUT #5-4	Summary of JCAHO Standards
HANDOUT #5-5	Essential Elements of Documentation of Domestic Violence in Health Records
HANDOUT #5-6	Evaluation Form from Module Two

OTHER HANDOUTS PROVIDED BY THE TRAINERS

- Summaries or Copies of Applicable Laws
  (i.e. protocols, education, reporting, and any others).

Sample Handout #5-1

Sample

LEGAL AND COMMUNITY RESOURCES LIST

(To be provided by trainer)

Prepare a list of information about community resources available to domestic violence victims and perpetrators in the area. For each agency or service on your list, include the agency name, phone number, address, hours of operation, summary of services offered (including a description of services for clients with disabilities, multilingual and/or multicultural services, programs for same-sex domestic violence, etc.).

THE LIST SHOULD INCLUDE THE FOLLOWING:

- Telephone crisis services: National Domestic Violence Hotline (1-800-799-7233, or 1-800-799-3224 for the hearing impaired) and other local numbers
- Temporary shelters and transitional housing
- Shelter-based support groups
- Nonresidential or residential outreach services for battered women (such as advocacy, case management, child care, and transportation services)
- Legal advocates and victim services
- Individual counseling
- Perpetrator intervention programs
- Services for specific cultural or demographic groups (such as ethnic groups, gay and lesbians, immigrants, monolingual non-English speaking groups, teens, etc.)

Sample Handout #5-2

Sample

OTHER SOCIAL SERVICES AVAILABLE

(To be provided by trainer)

Prepare a list of information about domestic violence agencies and other local agencies that offer programs for services not specifically related to domestic violence. For each agency or service on your list, include the agency name, phone number, address, hours of operation, summary of services offered.

THE LIST SHOULD INCLUDE THE FOLLOWING:

- Housing assistance
- Advocacy/case management
- Job-training and seeking services
- Child care and other children's services
- Sexual assault services
- Transportation services
- Gay, lesbian, and bisexual support groups
- Substance abuse programs
- Immigration services
- Nutritional programs

Sample Handout #5-3

Sample

INFORMATION SHEET:

RIGHTS AND PROCESS WHEN CALLING THE POLICE

Handout #5-4

SUMMARY OF JOINT COMMISSION ON ACCREDIDATION HEALTHCARE ORGANIZATION REQUIREMENTS:

PE.1.8

Victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Nevertheless, hospital staff members need to know if a patient has been abused, as well as the extent and circumstances of the abuse, to give the patient appropriate care.

The hospital has objective criteria for identifying and assessing possible victims of abuse and neglect, and they are used throughout the organization. Staff are to be trained in the use of these criteria.

The criteria focus on observable evidence and not on allegation alone. They address at least the following situations:

a. Physical assault;

b. Rape or other molestation;

c. Domestic abuse; and

d. Abuse or neglect of elders and children.

When used appropriately by qualified staff members, the criteria prevent any action or questions that could create false memories of abuse in the individual being assessed.

Staff members are able to make appropriate referrals for victims of abuse and neglect. The help them do so, the hospital maintains a list of private and public community agencies that provide help for abuse victims.

In addition, the assessment of victims of alleged or suspected abuse or neglect is conducted consistent with standard PE.6 in this chapter.

Examples of implementation for PE 1.8

1. Staff members question whether abuse may have occurred if a patient's story for his or her injury(ies) does not match the actual injury—for example, x-rays show an unexplained broken bone. Physical findings are compared to the hospital's approved procedure containing criteria that outline objective evidence of possible abuse or neglect.

Continued...

Continued...

2. Staff members observe the behavior of those who brought a child to the emergency room (for example, does the child cling to one parent and avoid the other?). Staff members question the child in a nonthreatening manner, look for bruises on the body, and listen to explanations to see if there is balance between the physical evidence and story.

PE.18

Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process.

Intent of PE.8

As part of the initial screening and assessment process, information and evidentiary material(s) may be collected that could be used in future actions as part of the legal process. The hospital has specific and unique responsibilities for safeguarding such material(s).

Policies and procedures define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material(2). The following are documented in the patient's medical record:

- ➤ Consents form the patient, parent, or legal guarding, or compliance with other applicable law;
- ➤ Collecting and safeguarding evidentiary material released by the patient;
- ➤ Legally required notification and release of information to authorities; and
- ➤ Referrals made to private or public community agencies for victims of abuse.

Hospital policy defines these activities and specifies who is responsible for carrying them out.

Joint Commission on Accreditation of Healthcare Organizations: Comprehensive Accreditation Manual for Hospitals. Update 3. Oakbrook Terrace, Il. Joint Commission, 1997, PE-10, PE-34.

Handout #5-5

ESSENTIAL ELEMENTS OF DOCUMENTATION OF DOMESTIC VIOLENCE IN HEALTH RECORDS

History

Chief Complaint/History of Present Illness: Elicit and record precise details of the abuse and their relationship to the presenting problem. Include relevant trauma history and relationship of abuse to any concurrent medical symptoms.

Past Medical History/Review of Systems: Ask about and record any medical, trauma, obstetrical or gynecological, psychiatric, or substance abuse histories that are related to domestic violence. Document conditions which will affect the patient's safety or ability to deal with the abuse.

Sexual History: Document any sexual assault, lack of barrier protection, STD's, unplanned pregnancy, abortions, miscarriages and ability to use birth control.

Medication History: Document any relationship between the abuse and the use of psychoactive, analgesic or other medication.

Relevant Social History: Document the relationship to abuser, living arrangement, abuser's access to victim.

In recording the abuse, whenever possible, use patient's own words, "Jimmy, my husband, hit me in the eye."

Physical Examination

Record precise details of findings related to abuse, including a neurologic and mental status exam. Use body map and photographs to supplement written description. Use standard evidence collection techniques for acute injury or sexual assault.

Laboratory and Other Diagnostic Procedures

Record the results of any lab tests, ex-ray, or diagnostic procedures and their relationship to the abuse.

Safety Assessment

Assess and record information pertaining to the patient's risk for suicide or homicide, and potential for seriously being harmed or injured. Determine if it is physically/psychologically safe for her to go home. Are the children or other dependents safe? Assess her degree of entrapment and level of fear and record.

Record options discussed and referral offered

Police Report

Note whether one was filed, and record the name of investigating officer and action taken.

Record Arrangements for Follow-up/Discharge Information

Handout #5-6

EVALUATION OF MODULE FIVE

MODULE FIVE: DOMESTIC VIOLENCE: LEGAL ISSUES FOR HEALTH CARE PROVIDERS AND COMMUNITY RESOURCES AVAILABLE FOR VICTIMS AND PERPETRATORS OF DOMESTIC VIOLENCE

Your comments and suggestions will help us provide you with better trainings in the future

1) Will this information be useful to you in your current area of responsibility?
❑ Yes ❑ No

What was the most useful?

_____
_____
_____
_____

What was the least useful?

_____
_____
_____
_____

2) The information presented was:
❑ Too Complex ❑ Appropriate ❑ Too Simple

3) The presenter was:
❑ Very Effective ❑ Somewhat Effective ❑ Not Effective

Comments:

_____
_____
_____
_____
_____

APPENDICES

Appendix A

Sample Case Scenarios for Module Two:

Domestic Violence: Cultural Competency in the Health Care Setting

SAMPLE CASE SCENARIOS FOR MODULE TWO
CULTURAL COMPETENCY IN THE HEALTH CARE SETTING

Case Scenario #1

A 23-year-old Chinese woman is a patient in the health care setting. She is two months pregnant and complains of a three-day history of vaginal bleeding. Presenting with a male companion, she appears withdrawn and afraid. She states, "Please don't let me lose my baby." As you begin the history and physical examination, she begins sobbing uncontrollably.

ASSUMPTIONS:

What assumptions do you have regarding this patient presentation and her culture?

BELIEFS:

What are your beliefs regarding this patient and her culture?

COMMUNICATION:

What are the communication issues relevant to the patient/provider interaction?

DIVERSITY:

What additional aspects of diversity may be present which have not been examined by your reflection of assumptions and beliefs?

EDUCATION/ETHICS:

What educational recommendations do you have for the health care provider? What are the ethical issues, if any presented by this case scenario?

DISCUSSION:

- Review beliefs about "who" are the victims of domestic violence.
- Highlight the fact of increased incidence of domestic violence during pregnancy.
- Discuss barriers to communication that were raised during the case scenario.
- Discuss the patient's ethical right to confidentiality.

CULTURALLY COMPETENT INTERVENTION:

- What could the health care provider say to reflect an openness about cultural differences and the power differential?
- What could the health care provider do to reflect an openness about cultural differences and the power differential?

SAMPLE CASE SCENARIOS FOR MODULE TWO
CULTURAL COMPETENCY IN THE HEALTH CARE SETTING

Case Scenario #2

A 42-year-old Mexican man is a patient in the health care setting. He presents tearful, and is evaluated following an overdose of a mild tranquilizer. He has previously healed superficial lacerations to both of his wrists. You do not speak his language (Spanish). His elderly mother is at his bedside (she speaks Spanish and some English). A Spanish translator will be available within 15 minutes.

ASSUMPTIONS:

What assumptions do you have regarding this patient presentation and his culture?

BELIEFS:

What are your beliefs regarding this patient presentation and his culture?

COMMUNICATION:

What are the communication issues relevant to this patient/provider interaction?

DIVERSITY:

What additional aspects of diversity may be present which have not been examined by your reflection of assumptions and beliefs?

EDUCATION/ETHICS:

What educational recommendations do you have for the health care provider? What are the ethical issues, if any presented in this case scenario?

DISCUSSION:

- Discuss assumptions about the patient's medical history and reasons for repeated suicide attempts.
- Discuss the difficulty of assessing patients without an identifiable physical injury.
- Discuss the use of family members as translators.
- Ask the participants if it can be assumed that the patient and his mother share the same "culture"?
- Discuss the patient's ethical right to confidentiality.

CULTURALLY COMPETENT INTERVENTION:

- What could the health care provider say to reflect an openness about cultural differences and the power differential?
- What could the health care provider do to reflect an openness about cultural differences and the power differential?

SAMPLE CASE SCENARIOS FOR MODULE TWO
CULTURAL COMPETENCY IN THE HEALTH CARE SETTING

Case Example #3

A 33-year-old female immigrant from Vietnam is a patient in the health care setting. She presents with visible discomfort from a migraine headache. Her extended family is at her bedside. The patient has been seen three times previously within the past four months for her headaches. All previous tests and examinations are unremarkable and inconclusive as to the cause of the headaches.

ASSUMPTIONS:

What assumptions do you have regarding this patient presentation and her culture?

BELIEFS:

What are your beliefs regarding this patient presentation and her culture?

COMMUNICATION:

What are the communication issues relevant to this patient/provider interaction?

DIVERSITY:

What additional aspects of diversity may be present which have not been examined by your reflection of assumptions and beliefs?

EDUCATION/ETHICS:

What educational recommendations do you have for the health care provider? What are the ethical issues, if any presented in this case scenario?

DISCUSSION:

- Discuss assumptions regarding this patient's medical history and the reason for her headaches
- Discuss difficulty of assessing patient's without identifiable physical injury.
- Discuss communication barriers.
- Contrast the rights of the family to be present versus the patient's right to confidentiality.

CULTURALLY COMPETENT INTERVENTION:

- What could the health care provider say to reflect an openness about cultural differences and the power differential?
- What could the health care provider do to reflect an openness about cultural differences and the power differential?

SAMPLE CASE SCENARIOS FOR MODULE TWO
CULTURAL COMPETENCY IN THE HEALTH CARE SETTING

Case Example #4

A 22-year-old HIV-positive Caucasian woman is a patient in the health care setting. She presents with moderate fever and chills, and a green productive cough. Her skin is hot and very sweaty. She has small abscesses on her arms due to injection of heroin. She admits to working as a prostitute to support her drug dependency. She tells you that her "boyfriend" takes all her money. She appears concerned about her inability to pay for any necessary medication.

ASSUMPTIONS:

What assumptions do you have regarding this patient presentation and her culture?

BELIEFS:

What are your beliefs regarding this patient presentation and her culture?

COMMUNICATION:

What are the communication issues relevant to this patient/provider interaction?

DIVERSITY:

What additional aspects of diversity may be present which have not been examined by your reflection of assumptions and beliefs?

EDUCATION/ETHICS:

What educational recommendations do you have for the health care provider? What are the ethical issues, if any presented in this case scenario?

DISCUSSION:

- Discuss assumptions regarding lifestyle choices.
- Review basic beliefs about domestic violence, such as anyone can be a victim.
- Discuss patient's safety and risk with respect to her cultural frame of reference.
- Discuss the patient's ethical right to confidentiality.

CULTURALLY COMPETENT INTERVENTION:

- What could the health care provider say to reflect an openness about cultural differences and the power differential?
- What could the health care provider do to reflect an openness about cultural differences and the power differential.

Appendix B

Sample Case Scenarios for Module Four:

Domestic Violence: Practical Applications Session

SAMPLE CASE SCENARIOS FOR MODULE FOUR
PRACTICAL APPLICATIONS SESSION

Scenario #1 — Patient Name: Martha

Instructions to Participants:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

1. **Health care setting:**
   The setting is a primary care clinic in a large Health Maintenance Organization.

2. **Presenting health issue:**
   This is your yearly ob/gyn exam. You also report back pain and have fading bruises along the outsides of both legs. You would like some medications to help with the back muscle spasms.

3. **Demographics:**
   You are a 27-year-old white female. A part-time secretary, you have four children (ages 8, 6, and 4 years old from your first marriage and a 9-month-old baby with your boyfriend Wayne). Wayne is a marketing manager at the Emporium and makes good money. You are planning to marry soon.

4. **Patient description and concerns:**
   You are withdrawn and very tired, not having slept well in a month. You do not want to talk about the bruises or what Wayne has been doing to you. You are very concerned about the amount of time you have been gone from home for this clinic appointment. The three older children are with a sitter, and the baby, who is with you, is getting fussy.

5. **Description and history of the domestic violence:**
   The domestic violence has been going on for the two years of the relationship. You do not think it is so bad because your first husband was extremely violent. About a year ago, you went to the local shelter because Wayne broke your arm. You returned to him primarily for financial reasons and because he promised to stop the violence. He has been nonviolent most of the year until he knocked you down two weeks ago, kicking you on both sides of your legs. You want to keep the children together and do not think you can make it without Wayne.

Scenario #2 Patient Name: Pacita

Instructions to Participants:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

1. Health Care Setting:
The setting is an emergency department.

2. Presenting health issue:
You have fractured small bones in your right hand.

3. Demographics:
You are a 40-year-old Filipina. You work as an RN in a nearby nursing home and have been married five years to an American man who is an unemployed salesman. You have two adolescent sons and one 10-year-old daughter from a first marriage in the Philippines (your first husband is deceased). After several years separation due to your move to the U.S. to get employment as an RN, the two sons now live with you and your husband. Your daughter still resides with the paternal grandparents in the Philippines.

4. Patient Description and Concerns:
You are very angry about the injury since you have already used a lot of sick leave from the nursing home. You are matter-of-fact about how the injury happened, but you are very impatient with the emergency room staff since you are due at work in two hours.

Your husband has brought you to the emergency department and is insistent that you get care immediately. When the clerk asked what happened, your husband said that he broke your hand. You are very protective of your husband. You are resistant to any suggestions that the police be notified. Your husband is a recovering alcoholic who has been in recovery for three years, and you are afraid that he will blame you for any problems and may start drinking again. You also partly blame yourself for the incident because you had been arguing with him about his not looking harder for a job. Furthermore, you are worried that if the authorities get involved in this that your daughter's pending immigration to the U.S. will be jeopardized. You desperately want to keep your family together and get back to work since everyone is depending on you.

5. Description and history of the domestic violence:
You report that you and your husband got into argument about his not looking for employment and his being late picking you up from the night shift at the nursing home. He grabbed and threw you against couch, your sons came out to stop the yelling, and when he lunged at them, you stepped in his way. He grabbed your hand and squeezed it until you promised to back off and apologize to him. Two hours later, you noticed your hand was swollen and you could not move your fingers. You do not drive and he brought you to the emergency department.

This is the third incident in your five-year marriage where you have required medical attention due to his assaults, but it is the first assault since he stopped drinking three years ago. Since then he often pushes or shoves you, but has not injured you until now. Also he yells a lot, but so do you. Sometimes he will leave for hours and he often threatens to withdraw his spousal support or your citizenship application.

Scenario #3 Patient Name: Gloria

Instructions to Participants:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

1. Health care setting:

The setting is an Indian Health Services Clinic.

2. Presenting health issue:

You have high blood sugar levels and are an insulin-dependent diabetic. You have partial loss of hearing/sight on your right side due to an assault many years ago. You express concern about losing your hearing in your "good ear" on the left side. Examination reveals a bruise along the left side of your head under your hair.

3. Demographics:

You are a 61-year-old Native American woman. Married 42 years, you are the mother of four children and grandmother to eight children. Currently you are raising the three children (ages 2, 3, and 4) of your deceased daughter. You worked for 20 years as a part-time employee at a church day care center. Your husband is a member of the Tribal Council.

4. Patient Description and Concerns:

You are very concerned about your current health and its effect on your ability to care for the grandchildren. You haven't been able to work outside the home since they moved in with you a year ago. Even though you and your husband take part in tribal activities, you feel isolated.

You are somewhat evasive about your high blood sugar levels, but well informed about diet, exercise, and medications to control diabetes. You are also evasive about your early history relating to the assault. Initially you report that your current bruise is from a fall when picking up your granddaughter; finally, you acknowledge that it is the result of your husband striking you.

You are very concerned about anyone finding out about your husband hitting you. You alternate from saying 1) nothing, to 2) no one will believe you because he is a respected Tribal Council member and an elder in their church, to 3) you are afraid that Children's Protective Services (CPS) will take your grandchildren from you because of his violence.

5. Description and history of the domestic violence:

Your husband has abused you throughout your 42-year marriage. In the first 10 years, you often received medical attention for a variety of injuries due to the assaults. The most serious assault occurred 20 years ago when he beat you so severely about the head that you lost hearing and sight on one side and had a broken jaw. During that hospitalization, your diabetes was diagnosed. You have required insulin only in the last five years. When you told health care providers of the assaults, they ignored the information and merely treated the injuries. They also said you would be less emotional once the diabetes was under control.

The most serious of your husband's physical assaults stopped after the assault left you partially deaf. He has continued to push and shove you; and berates you in front of the grandchildren. Recently he has taken to hiding your medications and making fun of you when you cannot find them. He tells you that he will report you to CPS for not taking good care of the grandchildren and the children will be placed with another family in the tribe.

Scenario #4 — Patient Name: Alfred

Instructions to Participants:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

1. Health Care Setting:

This is a private health clinic in a suburban setting.

2. Presenting health issues:

You have bruises on your forearms and two black eyes. You are highly anxious about your injuries and pose multiple questions to your provider about possible broken ribs, duration of the bruises, and need for medications. You also report insomnia and chronic gastrointestinal problems.

3. Demographics:

You are a 39-year-old African-American male. You are a stockbroker.

4. Patient description and concerns:

You are highly anxious in the interview. You do not volunteer any information; instead you are evasive and do not tell the truth unless directly asked. When asked about the source of your injuries, you report that you got them in a fight with a neighbor over your dog barking in the morning when the neighbor was sleeping after his night job.

If asked, you say that you are not married and live alone. The truth is that your lover, John, beat you up. You are terrified of anyone finding out that you are gay. Your job and status in the community are very important to you.

5. Description and history of the domestic violence:

John has been abusing you for the past year. This is a three-year relationship that you want to make work. You are at your wit's end about what to do about the abuse.

This is the fourth time you have sought medical care for the injuries from his assaults. John has pushed you (against walls, down a flight of stairs), punched you, slapped you, and in one incident repeatedly kicked you after throwing you on the floor. He calls you repeatedly at work and one time threatened to "out" you at your firm. Six months ago, he broke your nose and you got very disoriented from the pain medications, which dramatically impacted your job performance. For the injuries from these assaults, you went to different health providers for care to avoid too many questions about the injuries.

If it comes out that your boyfriend beat you, blame the violence on his stress. John is 28, just finished law school, and is not yet employed.

Scenario #5 Patient Name: Shirley

Instructions to Participants:

Read the entire scenario to yourself. Do not initially share the details with others in your triad. When instructed by the trainer, you will only read the information contained in sections 1-3 to your provider. Your provider's job is then to interview you and to elicit the rest of the information.

1. Health Care Setting:

This is a family planning clinic.

2. Presenting health issue:

You want to discuss birth control options. Bruises are noticeable on your upper arms when your blood pressure is taken. You also express concern about vaginal discharge. Your manner is intense and highly anxious.

3. Demographics:

You are a 17-year-old Latina college student. The youngest of eight children, you are the third in your family to go to college.

4. Patient Description and Concerns:

You want to finish college and become a teacher like your father. You are very afraid of becoming pregnant and of sexually transmitted diseases. One sister had to drop out of school because she was pregnant with the first of her four children. Your oldest brother died of AIDS. You have had a relationship with your 22-year-old boyfriend for four years, but did not become sexually active with him until three months ago since you were carefully chaperoned by your family until your graduation from high school. You have tried to convince your boyfriend to use condoms and he refuses. He says he loves you, that he has been faithful to you, and that his wearing a condom would mean you don't trust him … and that he has waited "too long for you" to have sex with a rubber. In your last talk about this, he grabbed your arms, shook you, and threatened to leave you if you brought the topic up again. You love him and want to marry him after you finish college.

5. Description and History of the Domestic Violence

Your boyfriend is very possessive. Throughout your four-year relationship he has given you rules to follow about your appearance; making eye contact with him; and not speaking in groups if he is present. Whenever you inadvertently broke one of his rules, he has punished you by flirting with your sisters in front of you or by pinching the back your arms black and blue. While he appeared to accept your family's requirements for a chaperon, he would tell you privately that you needed a chaperon until you were ready for him to take over from your father the role of your protector. Since being released from the watchful eyes of a chaperon, the number of his rules have increased and so have his punishments.

APPENDICES