Counseling Clients Involved with Violent Intimate Partners

The Mental Health Counselor's Role in Promoting Client Safety

Mental health counselors regularly counsel clients who are in intimate relationships with partners who are violent. There is a dearth of literature addressing safety-related considerations when counseling clients in relationships that involve intimate partner violence (IPV). The authors draw on the literature to address safety-related counseling considerations that can be applied when counseling these clients. This article provides information about how to accurately assess IPV, explores safety-related ethical issues that arise when counseling clients in IPV relationships, and explains the use of safety plans as a tool for promoting the safety of clients in IPV relationships.

Part 1: Introduction

Intimate partner violence (IPV) is the term commonly used to encompass violence perpetrated by any relationship partner, not just a spouse (Campbell, 2004). At some point in their lifetimes, 34% of women are victims of IPV (Browne, 1993; Tjaden & Thoennes, 2000). People from all socioeconomic, age, and racial backgrounds can become victims (Browne, 1993).

Intimate partner violence has significant short- and long-term consequences. For instance, 30-55% of female homicides are perpetrated by intimate partners (Campbell, 2004; Nicolaidis et al., 2003), and IPV is the direct cause of 21% of female emergency room visits each year (Browne, 1993). IPV also affects children; it is estimated that 3.3 million children each year witness IPV, and many of these children experience enduring long-term impacts (American Psychological Association [APA], 1996).

The psychological consequences of IPV for victims include depression, anxiety, and suicide (Coker et al., 2002). Victims of IPV often develop such psychological problems as increased rates of post-traumatic stress disorder, depression symptoms, self-injury, anxiety, psychosomatic complaints, substance abuse, and lowered self-esteem (Bacchus, Mezey, & Bewley, 2003).

The increased risk of psychological problems associated with experiencing IPV increases the likelihood that victims will seek out counseling services. Because mental health counselors often encounter clients who are involved in violent relationships with intimate partners, their ability to facilitate the client's safety, and accurately assess the potential for further violence is "a required professional ability" (Elbogen, 2002, p. 591).

A review of the counseling literature reveals no discussion of the counselor's role in assessing and facilitating the safety of clients who are experiencing IPV. This article provides information related to safety-related ethical issues, accurate assessment of violence, and the use of safety plans to promote the safety of clients who are in IPV relationships. Because women are most at risk for IPV (U.S. Department of Justice, 2002), the main focus of the article will be on women as victims.

A lack of training on IPV might help explain counselors' inability to accurately identify and intervene when counseling clients who are in dangerous relationships (Walker, 2004). In a recent survey of 500 American
Mental Health Counselors Association members, Bozorg-Omid (2007) found that 50% of those surveyed reported that they received no training in graduate school on the topic of IPV. Of the 50% of participants who did receive training, 78% reported that the training was inadequate. Therefore, it is important that increased discussion of this topic occurs within the professional literature and within counselor training programs. This article is an attempt to bridge this gap and contribute to the development of the literature base that might help educate counselors on issues associated with IPV and client safety.

**Part 2: Risk Factors for IPV**

**GENERAL PREDICTORS OF IPV**

Certain perpetrator characteristics correlate with engaging in IPV. Controlling behaviors and jealousy in the context of intimate relationships are predictors of later IPV (Campbell et al., 2003; Glass, Koziol-McLain, Campbell, & Block, 2004). Related to these characteristics, individuals who have ideologies that focus on having power and control over women are at increased risk of perpetrating IPV (Glass, Koziol-McLain, Campbell, & Block, 2004). Mossman (1995) provided a profile of individuals who may be at risk of doing so. The characteristics included being male, being youthful, having low socioeconomic status, minimal educational attainment, the presence of violent role models, having an abuse history, loss of a parent, experiencing violence during adolescence, a culture that regards violence as an acceptable way to resolve conflicts, the availability of weapons, lower intelligence levels, neuropsychological impairments, substance abuse/dependence, and the presence of a psychotic disorder.

**PREDICTORS OF ESCALATED VIOLENCE OR HOMICIDE**

The most serious IPV-related risk is partner homicide. The risk of female homicide is heightened when, for whatever reason, there is an increase in the severity or frequency of abuse (Campbell, 2003; Glass, et al., 2004). Various risk factors that predict escalated IPV and homicide have been identified. According to Campbell et al. (2003), stalking, strangulation, forced sex, abuse during pregnancy, a pattern of escalating severity or frequency of physical violence, perpetrator suicidality, a perception of impending danger on the part of the victim, and concomitant child abuse are predictors of escalated IPV and homicide. If the violent partner has recently experienced life stressors, crises, or transitions, there is also increased risk of serious harm to the partner. In one study, male partner unemployment was the most important demographic risk factor for female homicide (Campbell et al.).

Drug and alcohol use on the part of the violent partner has also been shown to heighten the woman's risk and is more likely to predict completed homicides (Campbell et al., 2003; Glass et al., 2004); violent partners who binge drink are especially at risk for murdering their partners (Campbell et al.). Similarly, Glass et al. found illicit drug use highly predictive of fatal IPV, and Block and colleagues (2000) found that women partners were especially vulnerable to life-threatening or fatal violence when the women were intoxicated at the time of the partner's assault.

Abuse during pregnancy has also been found to be a risk factor in female homicide; in one study of completed homicides, 23% of the murdered women had been abused during pregnancy (McFarlane, Campbell, Sharps, & Watson, 2002). McFarlane et al. found that abuse during pregnancy occurred in 4-8% of sampled women's pregnancies, and violence during pregnancy was more common than some other conditions for which health care professionals routinely screen. Due in part to a loss of mobility, abuse during pregnancy heightens the woman's risk of being murdered by a partner (Browne, 1993). The increased stress on couples during the life transitions that accompany pregnancy can also cause an escalation of IPV (Browne).

A victim's attempt to leave an abusive relationship can place her at especially high risk because attempts to leave abusive relationships can increase the risk of homicide (Campbell et al., 2003; Glass et al., 2004). Also, according to Campbell et al., women who separated from their abusive partners after a period of
cohabitation experienced increased risk of homicide. Also, violent partners are significantly more likely to perpetrate homicide if their partner is leaving them for a different partner.

Gun ownership by the violent partner is also associated with female homicide (Glass et al., 2004). While federal law prohibits persons convicted of domestic violence assault from owning firearms, many violent partners may still have guns or gun access (Glass et al.).

A thorough assessment of the risk of violence includes an ability to accurately assess IPV. A thorough assessment also includes assessing for risk factors that may place the client at risk for homicide. Haggard-Grann (2007) reported that risk assessment should go beyond the basic prediction of whether partner violence will occur, suggesting instead that counselors attempt to elicit more specific information related to the prediction of IPV such as "what, when, where, and to whom" the violence might occur (p. 299).

To predict the possibility of escalated violence or homicide, mental health counselors need first to be able to accurately assess client IPV experiences, including the nature and extent of the IPV and the presence of risk factors.

Part 3: Assessing Violence in Relationships

The assessment of relationship violence begins with accurate detection of abuse (Kropp, 2004). It is important to ask all clients about past or current abuse-related experiences. However, many women are not routinely asked about relationship abuse experiences as part of the assessment process (Bacchus et al., 2003). Generally, clients should not be asked about potential abuse experiences in the presence of a partner because they may not feel free to disclose information for fear of later retaliation (Bacchus et al.).

The first step in completing a thorough assessment of relationship violence is to communicate clearly to clients how abuse and violence are defined (Lawson, 2003). Many clients do not recognize or identify their experiences as IPV and thus may have difficulty recognizing the signs that violence has occurred, or escalated violence may soon occur (Lawson). Once a client becomes aware of what behaviors constitute violence and abuse, she is in a better position to help the counselor accurately assess the violence, thus facilitating identification of appropriate interventions.

A thorough assessment of IPV should include assessment of the nature, duration, extent, and intensity of violent and abusive acts (Lawson, 2003). Inquiries related to the following areas can help the counselor better identify the nature of the abuse and the potential for increased violence: Detailed description of a typical abuse experience, the most severe abuse experience, the most recent abuse experience, and the frequency of abuse (Lawson).

Although there are a variety of formal assessment measures that counselors can use to assess for IPV, screening checklists or assessments should never be part of a homework assignment because of the risk that may arise should the abusive partner have access to them. That is, if the abusive partner gained access to the assessment material, an acute escalation of violence could ensue.

The Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) is a 30-item self-report scale that measures both the degree of abuse and the potential for subsequent violence. The ISA also gives the client a description of types of violence - physical, emotional, and verbal. Scores on the instrument range from 0 to 100 for both physical and nonphysical violence. The instrument is brief; it can be completed in about five minutes. The ISA is one of the instruments most widely used to reliably screen for physical and psychological abuse (Samuelson & Campbell, 2005).

In both the original sample and a follow-up study with African-American women, the coefficients of internal consistency reliability were over .90 (Campbell, Campbell, King, Parker, & Ryan, 1994). However, the instrument was found to have three subscales instead of the original two when factor analysis was used with the sample of African-American women. While there are questions about the scale’s psychometric
properties, it can be useful to help clients identify abusive behaviors and engage them in the counseling process.

Counselors may also benefit from the use of the Spousal Assault Risk Assessment Guide (SARA; Kropp, Hart, Webster, & Eaves, 1994). This instrument is used to identify individuals at risk of future IPV. The SARA is a 200-item checklist designed to measure risk factors for spousal assault; counselors make a rating of low, medium, or high risk. According to the authors, individuals who were rated as at high risk for spousal assault were found to be more likely to engage in IPV. The four main sections on the SARA rate criminal history, psychosocial adjustment, spousal assault history, and current offense. In a study of 2,681 offenders, Kropp and Hart (2000) found that the instrument significantly discriminated between offenders with and without a history of spousal violence, and between individuals who engaged or did not engage in later spousal violence. Similarly, Grann and Wedin (2002) found the instrument to have significant predictive validity, which increased with individuals who had committed more severe crimes. This instrument may have use as an educational tool by allowing the counselor to discuss with the client items on the scale that would increase the probability of future IPV.

There are a variety of additional assessment measures that counselors may use to assess for IPV and its impacts on victims, among them the Abuse Assessment Screen (AAS; Helton, McFarlane & Anderson, 1987), the Conflict Tactics Scale (CTS; Straus, 1979), the Danger Assessment (DA; Campbell, 1986), the Domestic Violence Survivor Assessment (DVSA; Dienemann, Campbell, Landenburger, & Curry, 2002), the Prenatal Psychosocial Profile (PPP; Curry, Burton, & Fields, 1998), Psychological Maltreatment of Women (PMW; Tolman, 1989), and the Trauma Symptoms Inventory (TSI; Briere, 1996). Like the ISA and the SARA, these scales can be used from a psychoeducational perspective to help the client identify abuse, understand the risk factors, and work with the counselor to develop safety strategies and plans.

Arrigo (2000) has provided suggestions for communicating assessment/risk assessment information to clients and recommends that counselors refrain from using absolute language - they should avoid telling clients that they are in a situation that will absolutely result in further IPV or death. Instead, they should clearly present information about factors that enhance the risk for IPV, help clients process the information, and ultimately empower them to make their own decisions about their future. Counselors should discuss why each risk factor is relevant and explain how the risk factors were combined to develop an assessment of risk (Grisso, 1998). A thorough assessment of risk that is appropriately conveyed to the client is an important element in promoting her safety.

Part 4: Ethical Issues Associated with Counseling Clients in Violent Relationships

The American Counseling Association (ACA) and the American Mental Health Counselors Association (AMHCA) state that counselors have an obligation to promote the welfare of clients (ACA, 2005, Standard A.1; AMHCA, 2000, Principle I.A.1; Welfel, 2002). It is important that counselors thoroughly understand both their role and responsibility in promoting safety and how to assess and facilitate client safety. Counselors are encouraged to promote the autonomy and ability of clients to make their own choices. The concept of client autonomy - the idea that clients have inherent freedom and dignity - implies that clients are ultimately free to make their own personal welfare-related decisions (Welfel, 2002). A key component in the process, however, is that clients be aware of the abuse, the risk factors associated with its continuation and escalation, their options, and the ramifications of staying in the situation or leaving.

As this would imply, counselors are ethically obligated to manage and monitor their reactions to clients and to avoid actions that seek to meet their own personal needs at the expense of the client (ACA, 2005, Standard A.4; AMHCA, 2000, Principle 7.H.). Nonmaleficence - the do no harm principle - is a fundamental ethical principle that is highly relevant to counseling clients who are in abusive relationships (AMHCA, 2000, Principle 2.B.). Because women are at increased risk of abuse and homicide at the time they leave a relationship (Campbell et al., 2003; Glass et al., 2004), a counselor may inadvertently raise the risk by encouraging a client to leave a relationship before she has a clear safety plan and supports in place.
Respecting client autonomy and interests (AMHCA, 2000, Principle 1.A.1) is binding in all situations except when it is in conflict with equal or greater duties, such as ensuring client safety (Welfel, 2002). Then the question becomes: How do counselors respect client autonomy and do no harm, while also facilitating client safety and welfare?

While it may be a difficult ethical choice, counselors working with clients in violent relationships should not suggest that clients leave the relationship. The counselor's main concern when working with clients in IPV relationships should be on promoting their safety. It is important for counselors to recognize that at the time a client leaves an IPV relationship, her risk of being stalked or murdered escalates (Jewkes, 2002). In fact, 33% of women who are murdered are killed by a former partner after a relationship has ended (Rennison, 2003). Thus, some clients are safer in an IPV relationship until they are fully prepared to leave and have a thoughtful plan as to how they will move forward (Walker, 1994).

On average, women leave and return to an abusive relationship five to seven times before leaving permanently (Ferraro, 1997). Thus, even if counselor recommendations to leave an IPV relationship are met with initial compliance, there is a strong likelihood that the client will return to the relationship. The return may then isolate the client from the counselor; the client may blame the counselor for her having left the relationship, thus creating unproductive therapeutic tension.

Finally, professional counseling and its ethics codes are founded on a strength-based developmental model that emphasizes human resilience and empowerment (Kress, 2006). Thus it is important to appreciate that clients in IPV relationships are moving through a developmental process and are constantly assessing how they wish to proceed in managing these relationships. Also, consistent with a counselor's professional identity, clients should be empowered to make their own decisions related to proceeding in such relationships; to tell a client how to manage such relationships may disempower her.

Informed consent, confidentiality, and issues related to a client's children are additional ethical issues that should be considered in the context of client safety and IPV. Counselors need to obtain informed consent from their clients about the limitations to confidentiality (ACA, 2005, Standard B.1; AMHCA, Principle 3.A.). One limitation is the counselor's responsibility to prevent clear and imminent danger to the client or others (ACA, 2005, Standards A.9.c; AMHCA, Principle 3.C.). Certainly, it is important that counselors also be aware of the legal aspects of the duty to protect because there are differences by state (Welfel, 2002).

Partners who are violent toward significant others are at increased risk of being violent toward children (Tjaden & Thoennes, 2000). Therefore, women should be made aware of their own responsibility to protect their children and the counselor's responsibility to protect them if the children appear to be at risk of harm (Remley & Hurlhy, 2001; Waugh & Bonner, 2002). Counselors should be clear about the limitations of confidentiality if a client reports that children are involved when violent behavior occurs. There is a greater possibility that in these situations counselors may need to break confidentiality to protect the children.

Another legal and ethical counseling consideration when counseling victims in IPV relationships relates to notes and records. Walker (2004) stated that clients have a right to understand that the assessment process may yield information that can or will be made available to other people. The violent partner may obtain knowledge of the victim's participation in mental health counseling if the information is provided to an identifiable third party, such as private insurance companies or permanent health care records, and this could escalate violence (Walker). Clients and counselors should also understand the extent to which records or clinicians may be subpoenaed by the courts should the legal system become involved. Thus, counselors should be thoughtful in how they present information in client records.

Careful consideration of the ethical and legal issues is important in facilitating client safety. Because the ethical issues related to counseling women in IPV relationships can be complex, we suggest that counselors consult with others (e.g., supervisors, colleagues who regularly work with IPV situations, etc.) to ensure that their practice is ethical.
Part 5: Facilitating Client Safety

Once IPV has been established, and ethics-related issues have been considered, one of the most important actions a counselor can take to minimize risk and facilitate client safety is to help the client draft a safety plan (Lawson, 2003; Walker, 1994). This section discusses use of safety plans and general counseling considerations related to facilitating client safety.

A client in a violent relationship should not leave the counselor's office without having a comprehensive safety plan (Lawson, 2003). The initial counseling session may be the only one in which the counselor can help protect the client from future harm; the client may not be able or may choose not to return to counseling. Thus, it is critically important to emphasize safety and develop a safety plan in the first session.

A safety plan is a detailed plan that highlights the woman's role in making the safest decisions possible while in a violent relationship. The safety plan allows the woman to prepare in advance for managing such situations. It should be emphasized to the client that although she does not have control over her partner's violent behavior, she does have a choice in how to respond and how best to get herself and her children to safety. The safety plan should be tailored to the individual's unique needs (e.g., a client who does not live with the violent partner will have different safety considerations than one who lives with the perpetrator). The following are important aspects of safety plans (Lawson, 2003):

- Keeping a purse and car keys in a place that is easy to access for quick escape
- Deciding where she will go the next time she needs to leave the house or go somewhere safe (there should be a back-up safe place as well)
- Telling friends or neighbors about the violence and requesting that they call the police if they hear suspicious noises or witness suspicious events
- Identifying the safest rooms in the house, school, etc., where she can go if she fears an argument will develop (i.e., the lowest-risk places)
- Storing an escape kit (e.g., a copy of a protection order, extra keys, money, checks, important phone numbers, medications, social security cards, bank documents, birth certificates, change of clothes, bank and house information, address book, school and vaccination records, and valuables) somewhere safe (preferably not in the house)
- Processing the safety plan with children when appropriate
- Identifying individuals to call in a crisis and safe places to go when leaving (e.g., domestic violence crisis shelters)
- Identifying and practicing escape routes and rooms that are safe and not close to weapons (e.g., what doors, windows, elevators, stairwells, or fire escapes would you use?)
- Identifying safe places to go when leaving.

In relation to the safety plan, areas of discussion might be exploration of issues related to police protection, legal action, domestic violence shelters, community resources, and social supports (Browne, 1993). Counselors should become familiar with both the state laws that relate to IPV and local resources that may be helpful to clients.

It is also important to discuss the client trusting her intuition and judgment. Many women who are murdered by their partners had previously reported to others that they believed the partner would eventually seriously harm or kill them (Campbell et al., 2003). Moreover, many victims who are experiencing IPV have an
excellent understanding of their partner's abuse patterns and sense when more serious harm is a possibility. Encouraging clients to trust their instincts and to do what they can to de-escalate the situation may be helpful in promoting client safety and should be discussed in relation to the safety plan.

Part 6: Conclusions

This article has presented information about promoting the safety of clients in IPV relationships. It highlighted the counselor's responsibility to assess for and address IPV and emphasized the counselor's role in educating clients about IPV and the potential for continued risk of violence and escalated violence.

Counselors should be aware of the ethical issues associated with promoting safety and times when reporting may be mandated, as when children are endangered. Counselors should also monitor their countertransference reactions and not pressure clients to leave IPV relationships. While it can be personally frustrating when a client chooses to stay in an abusive relationship, the counselor must support her decision to stay or leave the relationship. The main concern of counselors working with clients in IPV relationships should be promoting their safety.

Counselors can be helpful in empowering clients to deliberately plan how they want to proceed in managing IPV relationships; clients can determine how they will choose to address the threat of violence. One of the most useful tools counselors can apply in promoting client safety is a detailed safety plan - a concrete plan that can help prepare clients to manage relationship violence.

Part 7: References


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Editor's Note: Below is additional information about safety planning with clients in abusive relationships.

Part 8: Safety Planning

Barriers to Leaving an Abusive Relationship

The most commonly asked question about victims of domestic violence is "Why do they stay?" Family, friends, co-workers, and community professionals who try to understand the reasons why a victim of domestic violence has not left the abusive partner often feel perplexed and frustrated. Some victims of domestic violence do leave their violent partners while others may leave and return at different points throughout the abusive relationship. Leaving a violent relationship is a process, not an event, for many victims, who cannot simply "pick up and go" because they have many factors to consider. To understand the complex nature of terminating a violent relationship, it is essential to look at the barriers and risks faced by victims when they consider or attempt to leave. Individual, systemic, and societal barriers faced by victims of domestic violence include:

- **Fear.** Perpetrators commonly make threats to find victims, inflict harm, or kill them if they end the relationship. This fear becomes a reality for many victims who are stalked by their partner after leaving. It also is common for abusers to seek or threaten to seek sole custody, make child abuse allegations, or kidnap the children. Historically, there has been a lack of protection and assistance from law enforcement, the judicial system, and social service agencies charged with responding to domestic violence. Inadequacies in the system and the failure of past efforts by victims of domestic violence seeking help have led many to believe that they will not be protected from the abuser and are safer at home. While much remains to be done, there is a growing trend of increased legal protection and community support for these victims.

- **Isolation.** One effective tactic abusers use to establish control over victims is to isolate them from any support system other than the primary intimate relationship. As a result, some victims are unaware of services or people that can help. Many believe they are alone in dealing with the abuse. This isolation deepens when society labels them as "masochistic" or "weak" for enduring the abuse. Victims often separate themselves from friends and family because they are ashamed of the abuse or want to protect others from the abuser's violence.

    Women living in rural or remote communities may feel that they would have to leave their communities - and everything familiar - to be safe. This isolation and lack of access to resources creates added barriers.

- **Financial dependence.** Some victims do not have access to any income and have been prevented from obtaining an education or employment. Victims who lack viable job skills or education, transportation, affordable daycare, safe housing, and health benefits face very limited options. Poverty and marginal economic support services can present enormous challenges to victims who seek safety and stability. Often, victims find themselves choosing between homelessness, living in impoverished and unsafe communities, or returning to their abusive partner.
• **Guilt and shame.** Many victims believe the abuse is their fault. The perpetrator, family, friends, and society sometimes deepen this belief by accusing the victim of provoking the violence and casting blame for not preventing it. Victims of violence rarely want their family and friends to know they are abused by their partner and are fearful that people will criticize them for not leaving the relationship. Victims often feel responsible for changing their partner's abusive behavior or changing themselves in order for the abuse to stop. Guilt and shame may be felt especially by those who are not commonly recognized as victims of domestic violence. This may include men, gays, lesbians, and partners of individuals in visible or respected professions, such as the clergy and law enforcement.

• **Emotional and physical impairment.** Abusers often use a series of psychological strategies to break down the victim's self-esteem and emotional strength. In order to survive, some victims begin to perceive reality through the abuser's paradigm, become emotionally dependent, and believe they are unable to function without their partner. The psychological and physical effects of domestic violence also can affect a victim's daily functioning and mental stability. This can make the process of leaving and planning for safety challenging for victims who may be depressed, physically injured, or suicidal. Victims who have a physical or developmental disability are extremely vulnerable because the disability can compound their emotional, financial, and physical dependence on their abusive partner.

• **Individual belief system.** The personal, familial, religious, and cultural values of victims of domestic violence are frequently interwoven in their decisions to leave or remain in abusive relationships. For example, victims who hold strong convictions regarding the sanctity of marriage may not view divorce or separation as an option. Their religious beliefs may tell them divorce is "wrong." Some victims of domestic violence believe that their children still need to be with the offender and that divorce will be emotionally damaging to them.

• **Hope.** Like most people, victims of domestic violence are invested in their intimate relationships and frequently strive to make them healthy and loving. Some victims hope the violence will end if they become the person their partner wants them to be. Others believe and have faith in their partner's promises to change. Perpetrators are not "all bad" and have positive, as well as, negative qualities. The abuser's "good side" can give victims reason to think their partner is capable of being nurturing, kind, and nonviolent.

• **Community services and societal values.** For victims who are prepared to leave and want protection, there are a variety of institutional barriers that make escaping abuse difficult and frustrating. Communities that have inadequate resources and limited victim advocacy services and whose response to domestic abuse is fragmented, punitive, or ineffective can not provide realistic or safe solutions for victims and their children.

• **Cultural hurdles.** The lack of culturally sensitive and appropriate services for victims of color and those who are non-English speaking pose additional barriers to leaving violent relationships. Minority populations include African-Americans, Hispanics, Asians, and other ethnic groups whose cultural values and customs can influence their beliefs about the role of men and women, interpersonal relationships, and intimate partner violence. For example, the Hispanic cultural value of "machismo" supports some Latino men's belief that they are superior to women and the "head of their household" in determining familial decisions. "Machismo" may cause some Hispanic men to believe that they have the right to use violent or abusive behavior to control their partners or children. In turn, Latina women and other family or community members may excuse violent or controlling behavior because they believe that husbands have ultimate authority over them and their children. A woman who is a recent immigrant may have additional fears, such as the fear of authority and deportation (for herself or her family) if she leaves her partner and/or her sponsorship relationship breaks down. She may feel marginalized from support systems available in her community. She may lack economic means to support herself. Language is often a common barrier experienced by immigrant women seeking help.

Examples of culturally competent services include offering written translation of domestic violence
materials, providing translators in domestic violence programs, and implementing intervention strategies that incorporate cultural values, norms, and practices to effectively address the needs of victims and abusers. The lack of culturally competent services that fail to incorporate issues of culture and language can present obstacles for victims who want to escape abuse and for effective interventions with domestic violence perpetrators. Well-intended family, friends, and community members also can create additional pressures for the victim to "make things work."

**Leaving Does Not Mean Safety**

Those who work with victims of domestic violence often put their emphasis on pushing the victim to leave the relationship. This approach may, in fact, put the victim at higher risk of danger. An appropriate response is to help her determine what her risks are and to help her to problem-solve how to minimize those risks. In some cases, staying within the relationship may be the safest response.

Statistics indicate that women are at a greater risk of becoming victims of domestic homicide when they attempt to leave the relationship. In fact, women who leave their batterers are at a 75 percent greater risk of being killed by their batterer than those who stay.²

Victims who attempt to leave are often hunted down - stalked, harassed, threatened, and pursued across county and state lines. Because abusers believe they are entitled to control the behavior of their partners, they may continue this behavior even after the petition for divorce is filed or granted. This is so common it is known as "separation violence."

The rate of attack against women separated from their husbands is about three times higher than that of divorced women and 25 times higher than that of married women.

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**SCREENING AND ASSESSING FOR THE PRESENCE OF DOMESTIC VIOLENCE**

**Points of Intervention**

The medical care system offers multiple settings where victims of relationship violence interact with providers. These include emergency rooms, primary care or family medicine, well-women gynecology, prenatal and antenatal clinics for pregnant women and new mothers, chronic pain clinics, sexually transmitted infection clinics, HIV screening, mental health clinics, drug, alcohol, and smoking cessation programs, and programs aimed at raising physical activity levels and weight loss.

Victims of abuse, particularly women, are much more likely to seek medical services than legal, social, family or clergy services,³ including emergency room visits.⁴ ⁵ ⁶ During these visits, health care providers have the opportunity to conduct screenings and assess for domestic abuse and sexual assault, as well as for alcohol abuse. Many providers, however, never ask questions or probe beyond the presenting problem to determine the underlying cause of a problem.

A number of studies show that mental health providers may not recognize intimate partner abuse and do not ask about its possible occurrence. For example, in one study mental health providers were asked how...
they would intervene in cases involving partner abuse. The majority did not identify violence as a presenting problem, and of those who did recognize violence, they often suggested interventions that were ineffective, or worse, harmful.\(^7\)

It is important that health care providers know about screening and assessment procedures for cases of relationship violence. This means knowing how to screen, what assessment instruments are available, how to understand the clinical presentations of individuals involved in abusive relationships, what methods are available for risk assessment, and what types of clinical interventions can be made based upon the assessment.

**Screening and Assessment Defined**

Screening and assessment are defined as follows:

- **Screening.** This is a brief procedure used to:
  1. Determine the presence of a problem (e.g., mental health disorder, domestic violence, substance abuse)
  2. Substantiate that there is a reason for concern
  3. Identify the need for further evaluation

  Screening is done early in the process of collecting information. It may be done by a questionnaire or checklist. Screening tools are not meant to provide a mental health or substance abuse diagnosis. Instead, they are used to collect initial information that will help in further assessing the problem.

- **Assessment.** This is a more comprehensive diagnostic and treatment planning process typically based on screening information. A detailed assessment may take hours to complete and should help to prepare a treatment plan. Some goals of assessment are to:\(^8\)
  1. Examine the scope and/or severity of domestic violence, mental health or substance abuse problems
  2. Identify other possible psychosocial problems that may need to be addressed further
  3. Provide a foundation for treatment
  4. Identify possible strengths of the patient that can become part of the treatment planning process

**Victims Often Don't Volunteer Information about Violent Relationships**

Victims are often reluctant to give information about domestic abuse. For example, one study showed that during intake, fewer than 5% of couples seeking marital therapy volunteered that violence was even an issue. Yet, as many as 66% of couples reported some form of violence on a written self-report evaluation.\(^9\) Reasons for not reporting can include:

- Individual’s reluctance to identify themselves as victims.\(^10\)
- Fear and shame because the victim feels responsible, or the perpetrator has underlying issues of shame.\(^11\)
- Couples’ belief that violence is not the problem because it is infrequent and seen as secondary to other problems.\(^12\)

Gay men and lesbian women are less likely to report relationship violence to the police than victims in heterosexual relationships because of fear that they will be further discriminated against.
Research indicates that in the area of hate crime, many gay men and lesbian women do not report verbal harassment or physical violence against them to the authorities because they fear that they will be subjected to additional victimization at the hands of police or others who may learn of their sexual orientation as a result of their having reported the original attack.\textsuperscript{14}

In some instances, it may be difficult to determine who the abuser is and who the victim is. However, it is important for the health provider to identify the abuser and the victim because the services provided to each party are necessarily different. With regard to same-sex couples, Tiffany Veinot provides useful questions to be used in screening for relationship violence. These questions can be found at http://www.springtideresources.org/resources/show.cfm?id=144.\textsuperscript{15}

**Asking about Abuse**

Although health care providers may discover that a person has been abused as a result of recognizing the signs and symptoms of abuse, being told by police or social services, reading the medical record, hearing about it in the community, or even witnessing it directly, the most important tool for identifying abuse is asking individuals directly if they have been harmed.\textsuperscript{16}

Studies indicate that asking about abuse increases detection:

"Experience in office practices has shown that a single direct question asked routinely and non-judgmentally in the course of the social history, can significantly increase the detection of abuse"\textsuperscript{17}

"...women are more likely to reveal abuse when asked by their primary care providers"\textsuperscript{18}

"...in a study of 691 pregnant women, 8\% self-reported abuse on an intake form, but 29\% reported abuse when asked directly"\textsuperscript{19}

Abused women report that one of the most important aspects of their doctor's visit was their ability to talk about the abuse.\textsuperscript{20}

Asking women about abuse also increases the chance of preventing further abuse. It indicates to victims that they are being taken seriously and that help is available to them.

It tells an abused woman that:

- she is believed,
- she is respected,
- she is not alone,
- the professional is willing to hear about this topic,
- abuse happens to a lot of women,
- abuse has been encountered before,
- the issue is being taken seriously,
- she can get help.\textsuperscript{21}\textsuperscript{22}

**Creating a Safe Environment**

When screening for domestic violence, health professionals should establish an environment of trust and safety, keeping in mind that protecting the victim's safety is of paramount importance. It is also important to remember that the abused person is the best judge of her personal safety.
Practical ways to foster a safe environment include ensuring that:

- all patients are routinely screened for domestic violence;
- there is a private space for interviewing and/or examining women. This means being prepared to offer “safe” reasons why it is necessary to see a woman in private (e.g., collection of a fresh urine specimen);
- there is access to appropriate translators or signers (who are not family members or someone she knows personally) if the woman speaks another language than the service provider, or if the woman has a hearing disability;
- women are informed about reporting requirements for child abuse and neglect before the screening so they can assess the implications for safety and confidentiality;
- there is a plan to enhance the safety of all staff involved in treating victims of abuse.

Who Should Be Screened Routinely?

- All females aged 12 years and older

Universal screening means asking every woman about abuse, not just asking women whose situations raise suspicions of abuse. Pregnant women should be asked about abuse as early as possible in their pregnancies.

There are many tools available to those professionals working with teenagers and dating violence. A few of them test acceptance of couple violence, gender stereotyping, and attitudes toward women.

Who Should Do the Screening?

At a minimum, screening should be done by a health care provider who:

- Has been educated about the dynamics of domestic violence,
- Is familiar with the effects of the violence on the victims, and
- Who is culturally competent.

This person should be trained to introduce the subject of abuse into conversation and should know how to intervene appropriately as well as have authorization to record in the medical record. The screener should attempt to establish a relationship or some level of trust with the patient before asking personal questions.

How Should Screening Occur?

Screening for domestic violence should be a regular part of a face-to-face encounter for the health care professional. Questions need to be direct and nonjudgmental, and the interview needs to be conducted in private. That means that no relatives or friends of the patient or children over the age of two years should be present.

Use professional interpreters, instead of a family member or friend, whenever possible.

Confidentiality and Reporting

Health care providers, social workers, psychologists, counselors, or any other professionals working with clients are required to follow their profession’s rules for confidentiality and mandatory exceptions to
confidentiality. Professionals should explain to clients/patients the limits to confidentiality before they begin a screening.

Generally, mandated reporters of child abuse, such as health care providers and mental health professionals, must report child abuse whenever they have knowledge of or observe a child whom they know or reasonably suspect has been the victim of child abuse or neglect. It is not required that the abuse be confirmed. A report is required whenever the mandated reporter has “reasonable suspicion” that abuse has occurred.

When Should Screening Occur?

- As part of a routine health exam or history
- During an initial visit for a new complaint
- During every new patient meeting
- At any visit after the client has started a new intimate relationship
- During every periodic comprehensive visit.

Where Should Screening Occur?

Trained health care providers should provide domestic violence screening as a routine part of patient care in at least the following settings: Primary care, urgent care, OB/GYN and family planning, mental health, and inpatient care.

Domestic Violence Screening Statements

In establishing a bond with the client or patient, the professional must achieve his or her goals in a way that is the least threatening or traumatic to the victim. The phrasing of the following statements can help defuse an otherwise uncomfortable (or even physically confrontational) atmosphere.

- "Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it."
- "I'm concerned that your symptoms may have been caused by someone hurting you."
- "Many of my clients are involved in abusive relationships. I don't know if this applies to you, but some people are too scared to bring it up themselves, so I now ask about it routinely." "Do you feel safe in your relationship?"
- "Statistics show some lesbian women are in abusive relationships. Does your partner ever try to hurt you?"  

Additional Statements of Support

If someone declines to discuss domestic violence issues, consider whether the silence may be due to a fear of the batterer, or to cultural, race, or gender issues that make it difficult to talk about such personal experiences. Again, gentle, yet clearly worded statements will achieve the best results:  

- "I am concerned about your safety."
- "You can talk to me about what is happening at home."
- "I am concerned about your children's safety. Domestic violence can harm your children."
- "Domestic violence is a crime."
Suggested Screening Tools

There are many abuse screening tools available. Professionals will need to select (or develop) the tool that is most appropriate for their work setting. Using appropriate screening tools, however, is only the first step. Appropriate information on options, resources and potential solutions must also be provided.

Below are samples of screening tools:

- **The "SAFE" Tool**

  Screening does not have to involve a long list of questions that may be inappropriate or difficult to use in some situations. The SAFE tool was designed to be memorized easily and used quickly:

  - S How would she describe her spousal relationship?
  - A What happens when she and her partner argue?
  - F Do fights result in her being hit, shoved or hurt?
  - E Does she have an emergency plan?

  (SAFE tool, n.d.)

- **The Psychological Maltreatment of Women Inventory (PMWI)**

  The PMWI is a 58-item test designed to measure the extent and nature of abuse toward women in a relationship. The questionnaire below is given to women survivors of abuse. The version for male perpetrators includes identical behaviors but reverses the pronouns and direction of abuse.

  **Women’s Scale Items**

  How often, if at all, did the behavior described in each item occur within the past 6 months (never, rarely, sometimes, frequently, or very frequently)?

  1. My partner criticized my physical appearance.
  2. My partner insulted me or shamed me in front of others.
  3. My partner treated me like I was stupid.
  4. My partner was insensitive to my feelings.
  5. My partner told me I couldn't manage or take care of myself without him.
  7. My partner criticized the way I took care of the house.
  8. My partner said something to spite me.
  9. My partner brought up something from the past to hurt me.
  10. My partner called me names.
  11. My partner swore at me.
  12. My partner yelled and screamed at me.
  13. My partner treated me like an inferior.
  14. My partner sulked or refused to talk about a problem.
  15. My partner stomped away during a disagreement.
  16. My partner gave me the silent treatment, or acted as if I wasn't there.
  17. My partner withheld affection from me.
  18. My partner did not let me talk about my feelings.
  19. My partner was insensitive to my sexual needs and desires.
  20. My partner demanded obedience to his whims.
  21. My partner became upset if dinner, housework, or laundry was not done when he thought it should be.
  22. My partner acted like I was his personal servant.
  23. My partner did not do a fair share of household tasks.
24. My partner did not do a fair share of childcare.
25. My partner ordered me around.
26. My partner monitored my time and made me account for where I was.
27. My partner was stingy in giving me money to run our household.
28. My partner acted irresponsibly with our financial resources.
29. My partner did not contribute enough to supporting our family.
30. My partner used our money or made important financial decisions without talking to me about it.
31. My partner kept me from getting medical care that I needed.
32. My partner was jealous or suspicious of my friends.
33. My partner was jealous of other men.
34. My partner did not want me to go to school or other self-improvement activities.
35. My partner did not want me to socialize with my female friends.
36. My partner accused me of having an affair with another man.
37. My partner demanded that I stay home and take care of the children.
38. My partner tried to keep me from seeing or talking to my family.
39. My partner interfered in my relationships with other family members.
40. My partner tried to keep me from doing things to help myself.
41. My partner restricted my use of the car.
42. My partner restricted my use of the telephone.
43. My partner did not allow me to go out of the house when I wanted to go.
44. My partner refused to let me work outside of the home.
45. My partner told me my feelings were irrational or crazy.
46. My partner blamed me for his problems.
47. My partner tried to turn our family, friends, and children against me.
48. My partner blamed me for causing his violent behavior.
49. My partner tried to make me feel like I was crazy.
50. My partner's moods changed radically, from calm to angry, or vice versa.
51. My partner blamed me when he was upset about something, even when it had nothing to do with me.
52. My partner tried to convince my friends, family, children that I was crazy.
53. My partner threatened to hurt himself if I left him.
54. My partner threatened to hurt himself if I didn't do what he wanted me to do.
55. My partner threatened to have an affair with someone else.
56. My partner threatened to leave the relationship.
57. My partner threatened to take the children away from me.
58. My partner threatened to have me committed to a mental institution.


Other questions you can ask include: 25

- What happens when you argue with your partner?
- How safe do you feel with your partner? How safe do you feel when you leave here?
- How does your partner try to control you?
- How does your partner show respect to you?
- Can you tell me about a situation with your partner when: (1) yelling and screaming occurred, (2) things were destroyed, and (3) your partner pushed, slapped, or hit you?

Besides physical signs, professionals should listen for:

- Any statements that suggest her partner won't let her do something (e.g., attend counseling, support groups, see family/friends, go alone to appointments),
- Evidence or reports of child abuse, and
- Inconsistencies or evasiveness.
Healthcare providers can also screen for physical abuse, sexual abuse and psychological abuse by having clients fill out simple questionnaires such as the following:

Assessing Sexual Abuse
Assessing Psychological Abuse
Assessing Physical Abuse


Also, the Family Violence Prevention Fund and the American College of Obstetricians and Gynecologists have created general screening policies for all health care providers to use. For more information or detailed recommendations for specific health care settings, please go to http://www.endabuse.org or http://www.acog.org.

**Assessment**

Important Areas of Assessment:

- **Assess the priority of safety for the victim.** Is there immediate danger? Where is the perpetrator now? Where will the perpetrator be when the patient/client is finished with the appointment?

- **Assess the pattern and history of the abuse.** Assess the perpetrator's physical, sexual, and psychological tactics, as well as the economic status of the client. How long has the violence been going on? Has the perpetrator harmed the client sexually? Does the perpetrator control the client's activities, money, or children?

- **Assess the connection between domestic violence and the client's health issues.** What is the impact of the abuse on the victim's physical, emotional, and spiritual well-being? What degree of control does the perpetrator exercise over the victim? How is the abusive behavior affecting the victim's health?

- **Assess the victim's current access to advocacy and support resources.** What does the victim need? Are there community resources available to the client, such as Information, support, shelter, counseling, support group, legal advocacy, mental health services, access to other resources? Has the client tried to use these resources in the past? If so, what happened? What additional resources (besides what you have been offered) are available now? Does the victim need help in accessing the resources? Are the resources you are suggesting sensitive to cultural and language issues, substance abuse, and gay and lesbian issues?

- **Assess the patient's safety.** Is there future risk of death or significant injury? Ask about the perpetrator's tactics: use of weapons, frequency or severity of abuse, stalking or suicide threats, use of alcohol. Are their warning signs that indicate danger to her or the children? Does she have a safety plan? Who can help her develop a safety plan?

If there are children, ask about their physical safety. Remember, a client must realize that if she tells the professional about child abuse or maltreatment, the professional is mandated, by law, to reveal the abuse to legal authorities or to Child Protection Services.

A compilation of assessment instruments for intimate partner violence, *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings*, can be found at http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVsscreening.pdf The document is divided into two sections. Section A includes intimate partner violence victimization tools. Section B includes sexual violence...
victimization tools. A table is included at the beginning of each section that lists each of the instruments included in the section. The actual instruments follow the table. Some instruments found in Section A are repeated in Section B if they include at least one item pertaining to sexual violence victimization.

Once it has been confirmed that a victim is being abused, it is important to validate her experience. Validation can include the following statements:

- I am concerned about your safety and well-being.
- I understand how difficult it is for you to make the necessary changes.
- You are not alone.
- The violence is not your fault. Only your abuser can stop his or her abusive behavior.
- No one deserves to be abused; there is no excuse for violence. You deserve better.
- There are options and resources available.

This material was adapted from the publication entitled, "Improving the Health Care System’s Response to Domestic Violence: A Resource Manual for Health Care Providers," produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence. Written by Carole Warsaw, M.D. and Anne L. Ganley, Ph.D., with contributions by Patricia R. Salber, MD. Carole Warsaw, MD, is the author of the section that is adapted.

Screening and Assessment section adapted from:


INTERVENTION

The Importance of Intervention

Professionals can provide an abused victim with information about abuse and the options that are available to her. They should also provide, or guide her to, the appropriate source for support as she makes her own decisions and choices about what is best for her and her children. Continuity of service and follow-up are essential.

Education, Information, and Referral

Health care professionals should look at ways of providing information that are best suited to their work setting. This may include providing written information, discussing this information with the woman, and/or providing referrals to other services in the community.
Time Considerations in Primary Care

Although it usually takes less than a minute to ask initial questions about abuse, listening to the patient and providing adequate assessment and intervention takes more time. The time spent by a primary provider can be brief when a social worker or domestic violence advocate is available to complete the evaluation. If the primary provider is sufficiently knowledgeable and comfortable, he or she can provide a more thorough assessment, initial intervention, and follow-up.

For the primary provider that has neither time, training, nor on-site resources, there are several options for working with battered women. Support can be offered by saying something such as:

- "I'm glad you felt you could tell me about what has been happening to you. I am very concerned about the issues you brought up, especially your safety. Although I don't have time right now to fully address your concerns, there is someone we can call who has a lot of experience with this issue. I hope you can stay and talk with her today."

- "I will give you the numbers of some community agencies that provide counseling, shelter and legal help. There are people there who can discuss your situation and possible options with you. You can use my phone to make some calls. Before you leave here, however, let's discuss how dangerous your situation is right now and make sure that you have a way to be safe."

This material was adapted from the publication entitled, "Improving the Health Care System’s Response to Domestic Violence: A Resource Manual for Health Care Providers," produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence. Written by Carole Warschaw, M.D. and Anne L. Ganley, Ph.D., with contributions by Patricia R. Salber, MD. Carole Warschaw, MD, is the author of the section that is adapted.

Written Information

Health care providers should compile and be prepared to offer an up-to-date list of community resources for referral and assistance, including shelter, crisis centers, hotlines, children's services, counseling, and legal options.

You may want to consider printing essential crisis hotline numbers or resources on business cards (small enough to be hidden in a wallet or shoe). These cards could be made available in restrooms, examination rooms, and any other private spaces.

Because it may be too dangerous for a victim to take written information, mention that resources to help abused women are listed in the phone book. She could also memorize numbers or leave a message at a friend's or at work.

Advise the victim that she should be careful about searching for information on her home computer as the batterer may be able to discover her search efforts.

While it is not recommended that professionals directly confront a potential batterer if abuse is suspected, they should look at ways of making information about local treatment programs for batterers available. This could include displaying information (such as posters, pamphlets on local programs, etc.) in examination or counseling rooms.

Safety Planning

Some women will decide that returning home is the safest option. Although each woman's options will depend on her particular situation, her priorities, and what she thinks will be best for her and her children, it may be possible to help her "problem solve" her concerns, including determining:
• whether to leave the situation;
• where she will stay if she leaves;
• how to protect herself and her children if she returns home;
• how she will protect herself if the abuser is removed from the home.

Encourage her to consider her options, which may include:

• going immediately to a shelter;
• going to stay with family or friends;
• taking home hidden information about resources that she could use later;
• getting a referral to counseling;
• going home, having arranged for a follow-up appointment;
• going home, having asked someone to stay with her;
• being referred to law enforcement, a lawyer or victim's services’
• applying for a protective order requiring the abuser not to contact the victim and her children.

However, do not:

• insist that she leave her partner;
• tell an abusive partner that the woman has revealed abuse;
• endanger her by providing information in an unsafe way (e.g., mailing it to her house or providing discharge instructions that an abuser may read);
• pressure her to report to police;
• call the police without her consent;
• delay telling her about a health provider's legal obligation to report child abuse until after she has already discussed the abuse.

The process of designing a personal safety plan may seem overwhelming, but there are four scenarios that will help the victim determine which actions are appropriate for her situation. Following these suggestions is not a guarantee of safety, but could help to improve the victim's safety situation. These scenarios include:

Safety During a Violent Incident

The victim may not be able to avoid all violence, but there are some things that may help her avoid being hurt and aid in her escape.

• If possible, plan a way to exit the house or room where the abuser is.
• If you think an argument may happen, do not stay in any room that may contain possible weapons, such as the kitchen, bathroom, and garage. Go to a room that has an exit.
• Practice getting out safely. What doors, windows, stairwells, and elevators will you use?
• Don't run to where the children are as your partner may hurt them as well.
• If violence is unavoidable, make yourself a small target; dive into a corner and curl up into a ball with your face protected and arms around each side of your head, fingers entwined.
• If possible, have a phone accessible at all times and know the numbers to call for help. Know where the nearest pay phone is located. Know your local battered women's shelter number.
• Don't be afraid to call the police.
• Keep your purse and car keys close by. Keep an extra copy of your car key hidden in a safe place.

• As hard as it may be, you will need to tell trusted neighbors, friends, or family so that they are able to call the police if they hear a suspicious noise from your house. Be careful not to tell someone who would share the conversation with your partner.

• If you have children who are old enough, teach them how to call 9-1-1. Choose a code word that your children and neighbors will recognize when you need them to call the police or when the children should leave the house.

• Practice how to get out safely. Practice with your children.

• Instruct them not to get involved in the violence between you and your partner.

• Tell your children that violence is never right, even when someone they love is being violent. Tell them that neither you nor they are at fault or cause the violence, and that when anyone is being violent, it is important to keep safe.

• Keep weapons like guns and knives locked up and as inaccessible as possible.

• Make a habit of backing the car into the driveway and keeping it fueled. Keep the driver's door unlocked and others locked — for a quick escape.

• Try not to wear scarves or long jewelry that could be used to strangle you.

• Identify alternative places you can stay after you leave, even if you don't think you'll need them.

• Create several plausible reasons for leaving the house at different times of the day or night.

• Call a domestic violence hotline periodically to assess your options and get a supportive understanding ear.

**Safety for Those Who Plan to Leave**

Some women decide that they need to leave to ensure that they and their children are safe. Because men often become more violent when they suspect a woman is leaving (because it indicates that he is losing his control), it is important to prepare carefully.

• You may request a police stand-by or escort while you leave.

• If you need to sneak away, be prepared.

• Know where you can go to get help; tell someone what is happening to you.

• Leave money, an extra set of keys, and copies of important papers (see list below) with someone you trust.

• Leave extra clothes with someone you trust. Try to avoid using next-door neighbors, close family members and mutual friends.

• Open a bank account in your name only, if you do not already have one. Otherwise, try to set money aside or ask friends or family members to hold money for you.

• Determine who might be able to loan you money or give you a place to stay.
• Keep change for a pay phone with you at all times. Remember, if you use a credit card for phone calls, the numbers will appear on the next phone bill.

• Acquire job skills as you can, such as learning to type or taking courses at a community college.

• Keep any evidence of physical abuse, such as pictures, etc.

• Keep a journal of all violent incidences, noting dates, events and threats made, if possible. Put this in a place where your abuser will not find it.

• If you are injured, go to a doctor or an emergency room and report what happened to you. Ask that they document your visit.

• Contact your local domestic violence program or battered women's shelter and find out about laws and other resources available to you before you have to use them during a crisis.

• Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out about your plan.

**Items to Take When Leaving (Leave the items with someone you trust)**

• Personal ID, licenses, Social Security cards
• Birth certificates of all children and yourself
• Keys (house, car, office, etc.)
• All bank cards, credit cards, savings and checking account information
• Lease, rental agreements, house deed, mortgage papers
• Insurance forms and information
• School forms/records of children's shots
• Medicine and any prescriptions for your children and yourself
• Immigration documents/green card/passport/visa
• Welfare documents
• Any documented evidence of physical abuse, such as photographs
• Clothing and comfort items for the children
• Valued photos, jewelry, or personal possessions
• Marriage license and divorce papers or other court documents (protective orders, etc.)
• Phone numbers and addresses of family, friends, and community resources

**Women Who Leave Are at High Risk**

If a woman is planning to leave the situation, warn her not to tell her abuser. "Women are at greater risk of severe violence or even of being murdered just after they leave their husbands or partners. A large majority of murders occur when a woman attempts to leave the relationship in order to escape her partner's attempts to control her." Assure her that the abuser will not be informed by the health provider that she is thinking about leaving.

**Assessing the Risk of Domestic Homicide**

The following "checklist" covers many identified risk factors for domestic homicide. Professionals should use appropriate language when asking risk assessment questions.

Have weapons been used or has there been a threat with weapons?

Is there access to, or ownership of, guns?
Have there been threats to kill?

Does the violence appear to be escalating or occurring more frequently?

Has there been destruction of property?

Has there been forced sex?

Has there been a threat to, injury of, or killing of a pet?

Is there a history of psychological problems?

Is there an obsessiveness to the partner?

Does the abuser manifest extreme jealousy?

Is there alcohol or drug abuse?

Has the relationship or marital situation changed recently? For example, has there been a separation (or threat of a separation), a job loss, a pregnancy or a change in finances? 

For additional information on risk factors for Intimate Partner Homicide, see the Danger Assessment Tool which can be found at http://www.ncjrs.gov/pdffiles1/jr000250e.pdf

Safety in Your Own Residence after Leaving the Relationship

- Obtain an ex parte, civil protection order, or peace order. Generally, they are all court documents that provide relief to individuals who are experiencing partner abuse. All protective orders require an abuser to stop threatening or committing abuse and make an abuser end all contact with the victim.

- Keep the ex parte, civil protection order, or peace order with you at all times.

- If the abuser left the home, tell neighbors and/or your landlord that your partner no longer lives there and ask them to call the police if they see him at your home.

- Give copies of the restraining order to employers, neighbors, and schools along with a picture of the offender.

- Inform friends, neighbors and employers that you have a restraining order in effect.

- Call law enforcement to enforce the order.

- Change locks on all doors and windows.

- Change your phone number.

- Install or improve your security system to include window bars, locks, better outside lighting, movement detectors, fire extinguishers, and smoke detectors.

- Purchase rope or chain ladders to escape from a second story window.

- Change work hours and route taken to work.
• Change route taken to transport children to school.

• Consider renting a post office box or using the address of a friend for your mail.

• Talk to all schools and childcare providers about who has permission to pick up the children. Provide these entities with copies of the certified orders.

• Use different stores and frequent different social spots.

• Contact the local domestic violence center to get advice from a lawyer who knows about family violence.

• In rural areas where only the mailbox can be seen from the street, cover the mailbox with brightly colored paper to make it easier for the police to find the house.

**Safety on the Job**

At some point, victims may need to tell their boss, workmates, or Employee Assistance Program professionals about the abuse. The more people who know of the situation, the safer the victim may be.

• Make sure you list your workplace on the ex parte, civil protective order, or peace order. Give copies to your boss and security staff at your job.

• Provide a picture of the abuser to your boss, coworkers, and security.

• Give out the name of a person to contact in an emergency should your boss be unable to contact you or should something happen at your job.

• Review the safety of the parking lot or garage. If possible, arrange for someone to walk with you to and from the parking lot and the office.

• If your desk is located in a public area or can be seen from the street, try to relocate to a less visible spot.

• Try to change your schedule so that you arrive and leave work at different times. This may discourage a potential stalker or abuser from confronting you.

• Have caller ID put on your work phone and save all faxes and e-mails that may provide legal proof that the man is disobeying the no-contact rule of the protective order.

• Review the safety of your childcare plan. Make sure you have included all addresses on the protective order that the abuser is required to stay away from. This would also include your child’s school and/or day care address.

**Sample Personalized Safety Plan**

This sample safety plan can be used to help victims plan for their safety and the safety of their children - http://development.athealth.com/wp-content/uploads/2014/02/SampleSafetyPlanB3007-B04.pdf

Part 9 adapted from:

REFERENCES


19. Modeland, Bolaria and McKenna, 1995
Part 9: Resources

California

California Partnership To End Domestic Violence
P.O. Box 1798
Sacramento, CA 95812-1798
Phone: 916-444-7163
Toll Free: 800-524-4765
Fax: 916-444-7165
http://www.cpedv.org/

Women's Rights Handbook
Violent Crimes Committed Against Women and Children
http://caag.state.ca.us/publications/womansrights/ch7.htm#7
This chapter deals with sexual assault; battering of spouses, cohabitants and the parents of one's children; and child and elder abuse. The chapter discusses the legal definitions of each of these violent acts, and gives information on the legal, medical and counseling resources available to survivors of such abuse.

Futures Without Violence
100 Montgomery Street, The Presidio
San Francisco, CA 94129
Phone: (415) 678-5500
Fax: (415) 529-2930
http://www.futureswithoutviolence.org/
Florida

Community Action Stops Abuse (CASA)
PO Box 414
St. Petersburg, FL 33731
24-Hour Help Line: 727-895-4912
E-mail: info@casa-stpete.org
http://www.casa-stpete.org/

Florida Coalition Against Domestic Violence
425 Office Plaza Dr.
Tallahassee, FL 32301
Phone: 850-425-2749
Hotline: 800-500-1119
http://www.fcadv.org/

Florida Council Against Sexual Violence
Toll Free Information Line: 888-956-7273
E-mail: information@fcasv.org
http://www.fcasv.org/

Florida Health and Human Services
Department of Children & Families
Florida Domestic Violence Hotline: 800-500-1119
http://www.dcf.state.fl.us/domesticviolence/

Betty Griffin House
Serving St. Johns County
24-Hour Crisis Hotline: 904-824-1555
E-mail: shelter@aug.com
http://www.bettygriffinhouse.org/

Refuge House
Serving 8 Counties: Franklin, Gadsen, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla
24 Hour Crisis Line: 850-681-2111 (Collect calls accepted)
Phone: 850-922-6062
http://www.refugehouse.com/

General Resources

National Center for Injury Prevention and Control
Mailstop K65
4770 Buford Highway NE
Atlanta, GA 30341-3724
Phone: 770-488-1506
http://www.cdc.gov/injury/index.html

The U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
Toll Free: 877-696-6775
http://www.hhs.gov/

National Coalition of Anti-Violence Programs (NCAVP)
http://www.avp.org/
Asian & Pacific Islander Institute on Domestic Violence
http://www.apiidv.org/

National Latino Alliance for the Elimination of Domestic Violence
http://www.dvalianza.org

Institute on Domestic Violence in the African American Community
http://www.dvinstitute.org

Additional State Resources

- Alabama Domestic Violence Crisis and Support Resources
- Alaska Network on Domestic Violence and Sexual Assault
  http://www.andvsa.org
- Arizona Domestic Violence Safety
- Arkansas Coalition Against Domestic Violence
  http://www.domesticpeace.com
- Colorado Domestic Violence Coalition
  http://www.ccadv.org
- Connecticut Coalition Against Domestic Violence
  http://www.ctcadv.org
- Delaware Domestic Violence Coordinating Council
  http://www.dcadv.org/
- District of Columbia
  http://www.dccadv.org
- Florida Coalition Against Domestic Violence
  http://www.fcadv.org
- Georgia Coalition Against Domestic Violence
  http://www.gcadv.org
- Hawaii State Coalition Against Domestic Violence
  http://www.hscadv.org
- Illinois Coalition Against Domestic Violence
  http://www.ilcadv.org
- Indiana Domestic Violence Crisis & Support Services
- Iowa Coalition Against Domestic Violence
  http://www.icadv.org
- Kansas Coalition Against Sexual and Domestic Violence
  http://www.kcsdv.org
- Kentucky Domestic Violence Association
  http://www.kdva.org
- Louisiana Coalition Against Domestic Violence
  http://www.lcadv.org
- Maine Coalition to End Domestic Violence
  http://www.mcedv.org
- Maryland Network Against Domestic Violence
  http://www.mnadv.org
- Massachusetts Coalition Against Domestic and Sexual Violence
  http://www.janedoe.org
- Michigan Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.org
- Minnesota Coalition for Battered Women Projects
  http://www.mcbw.org
• Mississippi Coalition Against Domestic Violence
  http://www.mcadv.org
• Missouri Coalition Against Domestic Violence
  http://mova.missouri.org
• Montana Coalition Against Domestic and Sexual Violence
  http://www.mcadsv.com/
• Nebraska Domestic Violence Sexual Assault Coalition
  http://www.ndvsac.org/
• Nevada Network Against Domestic Violence
  http://www.nnadv.org/
• New Hampshire Coalition Against Domestic and Sexual Violence
  http://www.nhcadsv.org
• New Jersey Coalition For Battered Women
  http://www.njcbw.org
• New Mexico Coalition Against Domestic Violence
  http://www.nmcdav.org
• New York State Coalition Against Domestic Violence
  http://www.nyscadv.org/
• North Carolina Coalition Against Domestic Violence
  http://www.nccadv.org
• North Dakota Council on Abused Women's Services
  http://www.ndcaws.org/
• Ohio Domestic Violence Network
  http://www.odvn.org/
• Oklahoma Coalition Against Domestic Violence and Sexual Assault
  http://www.ocadvs.org
• Oregon Coalition Against Domestic and Sexual Violence
  http://www.ocadsv.com/index.asp
• Pennsylvania Coalition Against Domestic Violence
  http://www.pcadv.org
• Rhode Island Domestic Violence
  http://www.ricadv.org/en/
• South Carolina Coalition Against Domestic Violence and Sexual Assault
  http://www.sccadvasa.org
• South Dakota Coalition Against Domestic Violence and Sexual Assault
  http://www.southdakotacoalition.org
• Tennessee Coalition Against Domestic and Sexual Violence
  http://www.tcadsv.org
• Texas Council on Family Violence
  http://www.tcfv.org
• Utah Domestic Violence Advisory Council
  http://www.udvac.org/
• Vermont Network Against Domestic Violence and Sexual Assault
  http://www.vnetwork.org
• Virginia Against Domestic Violence
  http://www.vadv.org
• Washington State Coalition Against Domestic Violence
  http://www.wscadv.org
• West Virginia Coalition Against Domestic Violence
  http://www.wvcadv.org
• Wisconsin Coalition Against Domestic Violence
  http://www.wcadv.org/
• Wyoming Coalition Against Domestic Violence and Sexual Assault
  http://www.wyomingdvs.org/index1.htm