**Chapter 60  
Intimate partner violence**

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**Introduction**

Woman abuse, wife assault, domestic violence, relationship terrorism, and intimate partner violence (IPV) are all terms that have been used to describe the violence that occurs between two people in an intimate relationship. Although domestic violence includes IPV, it also refers to violence against other family members; therefore, for the purpose of this chapter, the term IPV will be defined as the intentional use of tactics to gain and maintain power and control over the thoughts, beliefs, and conduct [1] of an intimate partner. The term partner may be defined as a current or former girlfriend, boyfriend, spouse, or common-law spouse.

Tactics used to gain control in IPV create fear, isolation, and the entrapment of one partner. The majority of non-fatal intimate partner victimizations occur at home [2]. The EMT or EMS physician is in the unique position to attend to the patient in the home and observe the environment in which the violence took place, as well as the behaviors of the victim and abuser along with their interactions with each other. Being aware of these behaviors will allow the EMS provider to identify situations in which abuse may not yet have escalated to physical violence, thereby allowing early intervention.

**Scope of the problem**

Violence against women is well documented by the World Health Organization (WHO). IPV occurs in all countries, regardless of social, economic, religious, or cultural status [3]. Although it is recognized that violence occurs against men in both opposite and same-sex relationships, the prevalence of women as victims is overwhelmingly greater than men. Therefore, this chapter will focus on male violence against female partners.

About one in four women and one in seven men have experienced severe physical violence [4]. Women are three times more likely to report that they have been beaten, choked, sexually assaulted, or threatened with a gun or knife [5] and therefore more likely to require medical attention. Domestic violence is a leading cause of injury to American women between the ages of 15 and 44 and is estimated to be responsible for 20–25% of emergency department (ED) visits by women [6]. One in five homicides involves killing of an intimate partner [7].

**High-risk groups**

Part of identifying IPV is awareness of the high-risk groups. Although it already has been established that women are a risk group, there are subgroups that are at even higher risk. Women who are separated or divorced report higher rates than women of other marital status [2]. Aboriginal women are three times more likely to experience spousal violence than non-aboriginal [7]. Visible minorities report a rate of IPV of 5% [8]. Women with disabilities are 1.5–10 times as likely to be abused as non-disabled women, depending on whether they live in the community or in institutions [9]. At least 4–8% of pregnant women report suffering abuse during pregnancy [10], and 39.2% of same-sex cohabiting women, and 23.1% of men, reported being raped, physically assaulted, and/or stalked by a marital or cohabiting partner at some time in their lifetime [11].

**Understanding intimate partner violence**

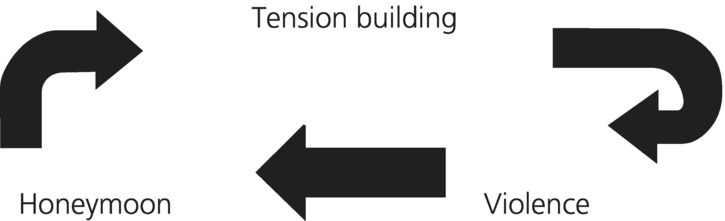
Abuse often begins in a close, mutual relationship, which over time becomes exclusive, allowing the abuser to isolate the victim. Violence can appear gradually or suddenly, but generally there is a period of “testing [12].” This may begin with verbal abuse and then progress to sexual and physical abuse ([Box 60.1](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fea-0001)). Shoving and pushing can escalate to punching, kicking, and assault with blunt and penetrating weapons.

**Box 60.1 Forms of abuse found in intimate partner violence**

|  |  |
| --- | --- |
| Physical | Use of physical force often resulting in injury (e.g. hitting, slapping, punching) |
| Verbal | Attacking someone’s self-esteem by calling her derogatory names (e.g. stupid, slut) |
| Emotional/psychological | Emotional trauma experienced by the victim (e.g. making threats, putting her down, blackmail, or continuous blaming) |
| Sexual | Any form of sexual activity with another person without their consent |
| Spiritual | Denying the ability to practice or express her religion or spirituality or being forced to practice another religion |
| Financial/material | Controlling someone through the restriction of financial or necessary material items (e.g. not being able to work or being forced to hand over her paycheck, being denied material things such as food and/or medications) |

**Cycle of violence**

Many abusive relationships undergo a cycle of violence, which occurs in three stages ([Figure 60.1](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fig-0001)) [12]. In phase one, tension builds and the woman increases her efforts to please the abuser in hopes of avoiding violence. The woman may intentionally trigger the abuse at a time when she feels the violence is inevitable to decrease the stress she feels about the impending violence, or to be in control as to where and when the violence will occur. In phase two, violence erupts and may increase in frequency and severity over time. Phase three represents a “honeymoon” phase in which the abuser apologizes for the abuse, may purchase gifts, blames the victim, and offers rationalizations (e.g. “If you only didn’t… I wouldn’t….”). This phase may become shorter over time.



[**Figure 60.1**](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#R_c60-fig-0001) Cycle of violence.

The cycle of violence can also occur generationally because it is passed through the family. Children witnessing abuse learn that it is tolerated or even appropriate behavior and a way of gaining power and control, and therefore may repeat the behavior in their own relationships.

**Intimate partner violence as a health care issue**

Studies report that about one in four women seeking care in the ED for any reason is a victim of violence (one in three treated for trauma), and 37% of female patients who are treated in the ED for violent injury have been injured by intimate partners [13].

Health care providers are being encouraged to universally screen for violence in the ED and primary health care settings. This means that all women over the age of 12 are asked about abuse, not only those in whom injuries appear suspicious. The National Violence Against Women survey revealed that 125,000 (17.5%) female victims of assault used ambulance services [14]. Because EMS personnel are often the first responders to situations that involve violence, it is critical to be able to identify, ask about, and respond appropriately to the unique situations that involve IPV. If violence can be identified early then there is an opportunity to intervene, thereby improving the health and lives of women and children and stopping the cycle of abuse.

**Health effects of abuse**

Many women living with abuse experience more than just physical injuries such as fractures and soft tissue injuries; they may present with psychiatric and medical conditions such as those listed in [Box 60.2](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fea-0002) [1]. Between 2001 and 2005 the US Department of Justice statistics reported that fewer than one-fifth of victims reporting an injury sought treatment following the injury. Approximately 8% of female and 10% of male victims were treated at the scene of the injury or in the home. Females who experienced an injury were slightly more likely than their male counterparts to seek treatment at a hospital [2]. EMS might be called to a scene at which the patient is experiencing any of the aforementioned conditions. Through noticing the environment, patient injuries, and/or interactions between the patient and her partner at the scene, the EMS provider may be able to identify IPV.

**Box 60.2 Health effects of intimate partner violence**

|  |  |
| --- | --- |
| Physical effects | Broken bones, burns, bruises, headaches, chronic (often abdominal or pelvic) pain, gastrointestinal problems |
| Emotional/psychological effects | Anxiety, insomnia, low self-esteem, phobias, flashbacks, memory loss |
| Psychiatric effects | Self-harm, suicide, eating disorders, depression, dissociation, posttraumatic stress disorder |
| Sexual effects | Multiple pregnancies close together, unwanted pregnancy, miscarriage, sexually transmitted infections, sexually addictive behaviors |

**Emergency medical services provider safety**

If EMS is activated through a 9-1-1 call for IPV, it is important to have law enforcement secure the scene before EMS access. If EMS personnel arrive at the scene of a non-disclosed IPV situation and feel that they are at risk, law enforcement should be called. Once the scene is secure, the providers can proceed with assessing safety in the immediate area where the patient is located to provide medical assistance. Patients should be assessed in the appropriate sequence with the primary survey, ABCs, and life-saving interventions undertaken, followed by a secondary survey and further history.

While on the scene, EMS providers should keep the following in mind.

* Avoid confronting the abuser.
* Do not place yourself physically between a couple who are arguing.
* Ensure that an escape route such as the door is available.
* Do not let the abuser get between you and your escape route.

Be aware of your jurisdiction’s legal requirements with respect to reporting to law enforcement. Some states require EMTs responding to an injury sustained during a crime to report to police; others will allow or mandate the patient to decide the best action to take. Requirements may be different for physicians.

**Assessment and examination**

On the initial interaction with the patient, EMS personnel may find there was a delay in seeking help and/or that this patient may have experienced repeated calls and visits to the ED for injuries.

**Physical assessment**

The physical assessment may reveal injuries such as abrasions, bruises, burns, dislocations, lacerations, bites, fractures, abrasions, or marks on the neck consistent with strangulation, petechial hemorrhage in the eyes, a combination of old and new injuries, and/or patterned injuries to the head, face, neck, throat, chest, breasts, back, abdomen, or genitals. Injuries that suggest a defensive posture, such as those found on the hands or ulnar aspect of the arms, are suspicious. Patients may also experience mouth and dental trauma. It may also be found that the patient’s or partner’s description of accident is inconsistent with the observed injury. If this is the case, EMS should document both what is reported and objective observations.

**Behavioral assessment**

Once the patient is medically stable, EMS personnel should observe the environment as well as the behaviors and interactions between the people at the scene. The abusive partner’s behavior may include: hovers over her, insists on being present while she is being examined, answers for the woman [15], is overly friendly with the care provider, or appears kind or overly concerned. Conversely, he may also minimize the injury, lack sympathy, make remarks about her, or blame her for the violence/accident. The woman’s behavior may be evasive and guarded interactions, including saying nothing in front of her partner, minimizing the seriousness of her injury, avoiding eye contact, and looking to her partner for guidance [1].

**Asking about abuse**

Once an EMS provider has made a determination that this call or injury could be a result of IPV, as part of the overall patient assessment, he or she should ask about abuse in a confidential environment, and respond appropriately to support the patient. The goal of asking about abuse is to make a supportive connection and convey the message that abuse is a health issue. This may help to lessen the patient’s isolation. Options may then be reviewed so that the patient is empowered to make informed choices for herself and her children. If the patient denies abuse, she will at least be left with the awareness that she can access EMS assistance when required, if and when she chooses to disclose.

**Separating couples**

Asking about abuse must be done in private, away from anyone who may intimidate the victim. Ideally, children should not be present because they may repeat information they hear to others. This could create a dangerous situation if disclosed information were repeated to the abuser. Separating the abuser may require some creativity and is a challenge in the out-of-hospital setting. Two options are to have one EMT take the partner into another room to ask more health history questions or wait until the patient is alone in the back of the ambulance. It is important to make clear to the partner beforehand that the ambulance is for patients only. The EMT should be conscious of what he or she is saying and tone of voice. Do not inadvertently give messages that the patient is to blame or should follow your advice, such as saying, “What did you do to cause this?” or “How can you love this guy?”

**Encouraging disclosure**

There is no question that will elicit a disclosure if the patient is not ready. Do not force a disclosure. Should the EMS provider suspect abuse based on physical or behavioral observations, use the observation in the question, such as, “I am concerned that this injury may have been caused by someone hurting you. Did someone hurt you?” or “I noticed your partner doesn’t like to leave you alone, how do you feel about that?” If the EMS provider is practicing universal asking/screening, then something that contextualizes the question would be more appropriate, such as, “Violence against women has become a health care issue; therefore, I ask all my female patients if they have ever experienced abuse/violence as a child, adolescent, or adult.”

If she says “yes”, the EMS provider can respond with the following questions.

* “Are you safe now?” (Determine the location of the perpetrator.)
* “Would you like to talk about it?” (If the EMS provider does not have the time, then provide 24-hour IPV hotline/helpline numbers for support.)
* “Have you talked to anyone else about this?” (This helps determine the patient’s support systems or just how isolated she may be.)
* “What do you need right now?” (Demonstrates that the EMS provider is focused on her and her needs at this time and can pass the information to ED staff.)

If she says “no”, the EMS provider can respond with the following message: “I ask all my patients about violence and want to make sure they are aware of resources that are available to them in case their relationship changes.” The patient may deny abuse because she is experiencing barriers to disclosure such as fear the abuser will find out, fear that the police and/or a child protection agency will become involved, or shame and embarrassment. Or she may not have been abused; in any case, most patients appreciate the question. Again, do not force a disclosure.

When people experience IPV their power and self-determination are taken away. EMS care should endeavor to empower the patient. Ways in which this can be done are explaining and asking permission before performing medical procedures, if the patient’s condition allows; sitting at or below the patient’s eye level; building trust by being direct and compassionate in responding to her questions; and being clear about violence against women being a crime and that this was not her fault.

Even in the out-of-hospital environment, women need a supportive, non-judgmental atmosphere in which to feel safe disclosing abuse. Expressing concern, conveying that you believe her, and providing validation for her experience are effective ways of offering support. If possible, provide options such as a sexual assault/domestic violence care or response center, police involvement, safety planning, and shelter referrals. The EMS provider should respect the decisions the patient makes; it might not be what the provider would have done given the situation, but the patient is the expert of her life and knows what she can deal with at this time.

**High-risk indicators and concerns**

Factors that have been shown to be related to increased risk of further violence in relationships include increasing frequency and severity of violence, using or threatening to use a weapon or to kill the woman, access to guns, perpetrator using drugs and alcohol excessively, and violence in pregnancy [16].

Women who have been injured through IPV often decline transport to the hospital [17]. Therefore, they will not have the availability of resources such as nurse examiners or social workers to provide them with support or referrals. Hence, the EMS provider’s knowledge of safety plans and the resources in the local community may be beneficial.

**Culture and domestic violence**

North America has become very culturally diverse and continues to attract people with a range of cultural norms, values, attitudes, and beliefs about illness and violence and the treatment response to a variety of conditions. As each individual responds to stress and violence differently, much of each person’s reaction will be influenced or affected by his or her cultural background. During times of physical/emotional stress, verbal understanding may be decreased whether or not the patient is English speaking. It is important to have as accurate an account of the events as possible in order to collect appropriate evidence and medically clear the individual. It is helpful to limit the amount of technical language, professional jargon, and common expressions that may be interpreted literally, such as “tachycardia” or “I am feeling under the weather.” Speak slowly, not loudly. Face the person; it may or may not be appropriate to make/sustain eye contact. Use short, simple sentences. Repeat and/or rephrase questions and summarize often to ensure your understanding. Ask open-ended questions. Questions that require only a “yes or no” answer do not tell you if the questions have been correctly understood [18].

If the interpreter is a spouse or other family member, bear in mind that not all facts may be disclosed due to the potential ramifications of reporting a domestic violence call. Abusive men of all cultures use similar power and control tactics. However, when a family has immigrated to North America there may be some additional tactics employed such as those listed in [Box 60.3](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fea-0003).

**Box 60.3 Control tactics relevant to immigrants experiencing intimate partner violence**

|  |  |
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| Isolation | Not allowing her to learn English, isolating her from anyone who speaks her language |
| Emotional | Failing to file papers to legalize her immigration status or lying about her status, writing her family lies about her, calling her racist names |
| Intimidation | Withdrawing or threatening to withdraw papers filed for her residency, threatening deportation, hiding/destroying important papers |
| Economic | Threatening to report her if she works “under the table,” not allowing job training or schooling |
| Children | Threatening to send children to their country of origin or report them to immigration |
| Sexual | Calling her a prostitute or “mail-order bride,” alleging she is a prostitute on legal documents |

It is important to consider the family structure in diverse cultures, particularly what is the hierarchy and who has the power within the family. On an individual level, women may feel fear, shame, and powerlessness, and therefore remain silent. Their view on marriage may be that they are there to provide a sexual service and therefore sexual assault does not exist in a marriage. They may also be struggling with how they will be perceived if they disclose; going against the family and getting a spouse in trouble may be interpreted as a sign of weakness, as may seeking help [18].

When considering the impact on the family/community, the family may deny that sexual/domestic violence exists in the desire to succeed and reestablish oneself. Other considerations are [18]:

* fear of being ostracized for bringing shame upon the family
* fear of retaliatory violence from the perpetrator and his supporters
* fear of being shunned by the community
* uncertainty and mistrust about how the police/system will respond
* fear of deportation.

Cultures differ in their styles and attitudes toward decision making and disclosure. Assume there will be differences between cultures and within cultures. Use your power and privilege to empower others. Create safe spaces for these sensitive conversations and respect others’ decisions even if you do not agree.

**Safety planning**

Women seek strategies aimed at preventing and responding to violence [17]. The EMS provider should ascertain what she has done in the past to keep herself safe, what is working, and what is not working. Because a woman’s level of risk may change over time, safety plans need to be flexible. Assess what the patient’s major concerns are at this time by asking open-ended questions such as, “What are you worried about most right now?” This aids in building a trusting relationship and views the patient not as a victim but as a strong capable participant in her future. The more she directs the safety planning, the more likely she is to adhere to it. The resources listed at the end of this chapter provide more information about safety planning.

**Referrals**

There are many options that EMS and other emergency providers may offer to victims of IPV. The EMS physician should make referrals in a way as to empower the patient to make her own decisions. The person in the situation is the best judge of what is safe to do right now. It is important for emergency providers to be aware of crisis lines, along with the appropriate agencies and organizations in their jurisdiction which offer services for victims of IPV. Sexual assault/domestic violence care or response centers can offer crisis intervention and support, documentation of injuries and photographs, safety planning and risk assessments, referrals to shelters, and other advocacy services. There may be mandatory reporting policies in your jurisdiction and all EMS personnel should be familiar with police services and mandatory reporting requirements. Shelters usually have counselors available 24 hours a day and provide a safe place for someone to flee relationship violence. Child protection agencies offer protective and referral services as well. Legal agencies may be available for victims of IPV.

**Preserving evidence and documentation**

When performing a physical assessment, the EMS provider may note patterns of blunt injury, lacerations, or penetrating wounds. It is therefore important to know these patterns and appropriately document if the injury does not fit the mechanism described. Be careful not to disturb the crime scene or destroy possible evidence, such as by removal of the patient’s clothing. If anything needs to be removed to attend the patient, describe the condition of the clothing and place it in a paper bag. Cut around bullet holes or stab wounds, not through them [12]. The manner in which clothing is removed or altered should be noted (e.g. “during resuscitation, patient’s shirt torn open, tearing off four buttons”). If any furniture needs to be moved to get to the patient, this should also be documented.

Use the patient’s own words when describing how she received the injuries, who assaulted her, and when. A detailed history of all aspects of the assault need not be taken as part of immediate care. The EMS provider should write what is pertinent to the care and treatment of injuries. Documentation should occur at the scene or as soon as possible after attending to the patient. Should a case go to court, the patient care record will be the only documentation the EMS provider will have of this event ([Box 60.4](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fea-0004)). Documentation should be objective, without accusations or value statements, accurate, specific, legible, and complete.

**Box 60.4 Key aspects of IPV documentation**

* Location of injuries (best done on body diagrams)
* Full description of all injuries (type, color)
* Size of injuries; if no measuring device is available, compare with a well-known item like size of a quarter
* Other injury characteristics (e.g. scabbed, bleeding, or presence of foreign body)
* Mechanism of injury
* Areas of tenderness/pain
* Injury patterns
* Distinguish between her or the partner’s reports and your observations
* Excited utterances made by the patient such as, “I really thought I was going to die this time”
* Patient's/perpetrator’s behaviors
* Other persons (such as children) present and their behaviors
* Police officers’ names and badge numbers
* Any safety planning information or referrals provided
* If drugging is suspected, any body fluids such as emesis or urine should be collected and preserved if possible

**Realistic expectations**

It can be difficult to bear witness to abuse. Often health care providers feel powerless in their efforts to make a significant difference in someone’s life. It is important to remember that dealing with abuse is a process and each person has the right to set his or her own agenda and work at his or her own pace. The role of EMS is to provide medical treatment and support and empower patients to make the decisions that are right for them at a time when they feel it is safe. EMS cannot “fix” a victim or the situation. At times, providers may not agree with the decisions patients make, but they are the experts of their lives.

Domestic violence does not always end when women leave the relationship. Statistics show that the most dangerous time is when she has decided to leave or soon after she has left [19]. Women can be trapped in and may return to relationships many times for a variety of reasons before making a final break ([Box 60.5](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/c60.xhtml?favre=brett#c60-fea-0005)).

**Box 60.5 Potential reasons why a victim of IPV may return to an abusive relationship**

* Fear of personal safety and/or safety of their children/pets
* Low self-esteem, fear of the unknown
* Economic issues
* Isolation, no friends, no support system
* Cultural/religious beliefs
* Fear of deportation, unsure of legal rights
* Family pressures, blame for failure of the relationship
* Unsure of options
* Abuse may be considered “normal”
* Threat of sexual orientation revealed
* “He’s not always abusive”
* Systemic barriers

Understanding why people stay in abusive relationships and how to keep them safe is key when providing care to a victim of IPV. A strong multidisciplinary team approach is essential and will result in the most appropriate and beneficial patient-focused care for people experiencing violence in their lives. Therefore, ensure that all essential information and impressions are communicated to ED staff.

**Conclusion**

A call to a residence where IPV has taken place can be one of the most difficult calls to which EMS respond. It is vital for the scene to be secure before the EMS personnel enter the premises. On calls where IPV is not initially identified in the call, but is suspected once on the scene, it is the responsibility of EMS personnel to ask and assess the patient’s immediate safety. In instances where the patient declines transportation, knowledgeable EMS personnel can provide support and resources and suggest immediate safety planning. If the patient accepts transport to the ED, ensure that all relevant information is reported to the health care provider taking responsibility for the patient.

Complete the call report as soon as possible to ensure that documentation provides an accurate, comprehensive, and timely account of the call. EMS documentation of the events/injuries could be vital if and when the patient chooses to press assault charges. All providers should be aware of and compliant with local legislative requirements.

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**Recommended resources**

1. Peel Committee Against Woman Abuse (safety plans in a variety of languages). Available at: [www.pcawa.org](http://www.pcawa.org/)
2. National Centre on Domestic and Sexual Violence (a variety of power and control wheels). Available at: [www.ncdsv.org/](http://www.ncdsv.org/)