

# **EMS Response to Domestic Violence**

**A Curriculum and  
Resource Manual**



**EMS RESPONSE TO DOMESTIC VIOLENCE**  
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## **ACKNOWLEDGEMENTS**

**Creation of the EMS Response to Domestic Violence Curriculum and Resource Manual was a collaborative effort among the New Mexico Department of Health, the EMS Bureau, the Community Health Services Division, the EMS Academy, and UNM's Department of Emergency Medicine.**

Funding for development of this manual was sponsored in part by the  
New Mexico EMS for Children Project, MCH #354002-02-02  
University of New Mexico Department of Emergency Medicine.

# **GOALS AND OBJECTIVES FOR PRE-HOSPITAL DOMESTIC VIOLENCE CURRICULUM**

## **GOAL**

To equip and train EMS personnel with the necessary tools to properly identify, treat, and refer patients who are victims of domestic violence.

## **LEARNING OBJECTIVES**

At the end of a four-hour in-service on EMS and Domestic Violence, the participant shall be able to answer the following questions:

1. What is the definition of Domestic Violence?
2. What is the magnitude of the problem?
3. What are the four (4) types of domestic violence?
4. What are five (5) “Red Flags” that would assist the field EMS personnel in recognizing domestic violence?
5. Who is at highest risk for domestic violence?
6. Give three (3) reasons why an individual may stay in an abusive relationship.
7. Give at least three (3) reasons why the pre-hospital provider may be reluctant to ask a patient about the possibility of domestic violence.
8. What questions, utilizing the SAFE acronym, can pre-hospital providers ask at the scene?
9. Identify three (3) strategies to promote scene safety for EMTs who are responding to a domestic violence call.
10. Identify three (3) possible prevention strategies for domestic violence.
11. Give two (2) reasons why EMS personnel can be an effective agent for change in identifying and preventing domestic violence.

# **EMS RESPONSE TO DOMESTIC VIOLENCE**

## **INTRODUCTION**

**EMS Response to Domestic Violence** is provided, as a guide to equip EMS Providers with the information needed to understand the issues involved in responding to domestic violence calls. While pre-hospital providers are trained in patient assessment and the care of physical illness and injuries, scenes of domestic violence can include issues often outside the provider's clinical training. Examples include scene safety for preservation of evidence at a crime scene, and resources and referrals for the victims of domestic violence. For many EMTs who respond to scenes of domestic violence, there are also sources of frustration in trying to understand: Why does a survivor of domestic violence stay? What can I do to prevent this from happening again? Could domestic violence be happening to someone I know; how can I help intervene? These and other questions are addressed in this manual.

## **DEFINITION**

There are many terms used to define the violence that occurs between intimate adults. The most common include: family violence, battering, domestic assault, marital violence, spouse abuse, wife beating, and domestic violence. Whatever term used, the key concept inherent to adult-to-adult violence is "control". Perpetrators of domestic violence have a specific goal: to establish and maintain power and control over another. During this course, we will be looking specifically at domestic violence between intimate partners. Domestic violence is defined as a pattern of assaultive and controlling behavior that one adult individual inflicts on another. There are four types of domestic violence: physical, sexual, economic, and emotional abuse.

Because domestic violence centers around intimacy, it is important to recognize that the violence that occurs between intimate adults is not exclusive to married partners but can also occur between boyfriend/girlfriend, ex-spouses, same-gender couples, and partners with an on-going or prior intimate relationships. Approximately 98% of documented domestic assaults are committed by men against women. As a result, throughout this text, we will refer to the perpetrator as "he" and the survivor or victim as "she" even though some domestic violence is initiated by women and some cases involve people of the same sex.

Battered victims and batterers or perpetrators come from all economic and education levels, all racial and cultural groups, all religions, and all ages. Regardless of who the victims or batterer is, battering is a crime. No one has a right to hurt another. Battering may begin insidiously, with a push or shove, or perhaps a sharp criticism or insulting remark. Once battering begins, however, it usually escalates – both in frequency and severity. Domestic violence can include bodily injury, destruction of property, intimidation, coercion, revenge, and punishment. Threats of violence lay a foundation of fear – all of which are methods to control the partner. When the batterer's threats put the survivor in fear for her safety or the safety of her family, children or property – he has committed a crime.

It has been noted that the family is perhaps more violent than any other American institution or setting. It is important to understand that family violence – child, spouse, and elder abuse – is the only category of crime in which the perpetrator voluntarily remains on the scene,

expecting no negative consequences and actually perceiving intervention as a violation of his rights. Historically, domestic violence has focused on the victim and the result was a tendency to view domestic violence as a “women’s issue”. The focus of intervention was to determine why she was beaten or why she stayed. As such, the violence against the women is viewed as her responsibility or fault – the batterer is not held responsible for his behavior.

Despite a recent increased awareness of domestic violence, significant misunderstandings about its nature and extent exist especially within the medical field. Medical response to battered women has been traditionally to focus on the presenting medical problem, not the violence that causes the injury. The following pages are designed to increase awareness among Emergency Medical personnel that domestic violence is a preventable, public health problem, and provide tools for EMTs to better identify and refer victims of domestic violence.

## **SCOPE OF PROBLEM**

Domestic violence is a significant public health problem. More than five (5) million women are battered annually. According to the American Medical Association, nearly one-fourth of the women in the United States (more than 12 million) will be abused by a current or former partner sometime during their life. The Federal Bureau of Investigation estimates that a woman is battered every 15 seconds in the United States. In 25% of homes where domestic violence occurs, the abuser will use violence against his female partner five or more times each year. Battering against women often increases during pregnancy. If these statistics seem horrific, even more disturbing is the fact that a National Crime Survey showed that 48% of all incidents of domestic violence against women were never reported to the police.

The public health impact of domestic violence is compounded by the fact that the violence escalates in frequency and severity. Three-fourths of the women who are injured once continue to experience ongoing abuse. Without appropriate interventions, these women are at high risk of developing serious, complex medical and psycho-social problems, including suicide attempts.

A recent study found that 12% of female patients with a current male partner who presented to an Emergency Department were recent victims of domestic violence. Battered women come in contact with other medical settings, including pre-hospital care providers, primary or ambulatory care centers, psychiatric services, and pre-natal care. Regardless of the health care settings, the traditional medical response to battered women has been to treat the presenting medical injury or illness without addressing the violence that may be at the root of the problem.

The cost of battering to the survivor, her children, the batterer, the health care system, criminal justice system, and society is staggering. Women who are abused have a much higher rate of alcohol and drug abuse, depression, suicide, anxiety, and miscarriage. The cost to children is both immediate and cumulative over time, from emotional disturbance during childhood to re-enacting the violence during adolescence and adulthood. And finally, the cost to the batterer is also significant, including employment problems, alcohol and drug abuse, homicide, arrests, fines and imprisonment. The cost to the community includes lost wages, sick leave, non-productivity, and absenteeism.

While financial costs may seem calculating, the emotional costs of domestic violence are immeasurable. Communities, like individuals, experience a collective loss of safety when domestic violence occurs and is not addressed. Both individuals and communities that experience and accept domestic violence as a way of life become increasingly isolated.

## **TYPES OF VIOLENCE**

Domestic violence includes physical, sexual, emotional and economic abuse.

*Physical abuse* is the most overt type of domestic violence. Physical battering includes kicking, hitting, biting, choking, pushing, hair pulling, throwing across the room or down on the floor, and assaults with weapons. Sometimes, particular areas of the body are targeted, such as the abdomen of a pregnant woman.

*Sexual violence* or “marital rape” includes physical attacks on the victim’s breasts or genitals, sexual sadism, and forced sexual activity or behaviors. Sexual violence are acts of aggression in which sex is the method used to humiliate, hurt, degrade, and dominate the women. The brutality in the sexual relationship usually escalates over time.

*Emotional abuse* can be just as traumatic as physical abuse although there are no visible injuries. The effects of psychological and emotional abuse are long lasting. Emotional abuse is not just a verbal argument. It is the systematic destruction of an individual’s self-esteem and includes actions, gestures, insults, and threats to the children. The perpetrator may belittle or degrade the victim or the children as a means of harassing or humiliating the victim. Perpetrators of emotional abuse often act like grown-up bullies with extreme controlling behavior.

*Economic abuse* allows one partner to have complete financial control over the other. The perpetrator has power over household finances and decisions. They may try to keep the survivor from working, thereby encouraging the survivor’s economic dependence upon them and ensuring the victim’s isolation. Even women who have their own source of money often have to account for every penny to the batterer.

## **ROLE OF EMS PROVIDERS**

Many EMTs are drawn to emergency medical services because of the opportunity to make a dramatic contribution to a person in need. With adrenaline pumping, we respond to the scene and get great satisfaction when the person in critical need receives medical care and improves during transport to the hospital. We become partners with emergency physicians and nurses in a daily struggle to save critically ill or injured patients.

But beyond the excitement of the moment is a more sobering reality. As health providers involved in our community, we must look beyond the occasional dramatic rescue. EMS professionals are often the first or only medical contact that an injured victim of domestic violence may have. In some rural communities, we may be the most sophisticated medical person available to identify or refer a victim of domestic violence.

Emergency, pre-hospital care providers are in a unique opportunity for intervention of domestic violence, specifically in the identification of abuse and referral to appropriate treatment. Unfortunately, the majority of battered women who are treated by EMS providers are not identified as victims of domestic violence and thus, are offered no assistance or information to deal with a potentially life-threatening problem. In addition, EMS may be the only witness to the home environment. EMS identification of domestic violence can be the first step in interrupting the progression of violence and prevent the development of a variety of other complex problems. To do this, EMS providers need an understanding of the definition, extent, and nature of domestic violence.

Historically, health care providers have dealt with domestic violence by ignoring it. Health care providers may feel intimidated by the batterer and reluctant to get involved. In a small community, we may know both the victim and perpetrator and feel intrusive if we say anything. We may feel this is a family issue, not a medical one. We may also feel frustration or disgust when we see the victim return to the batterer time and again. We may feel that there is little or no community support and that the health care system is ineffective if the legal system doesn't back their efforts.

The causes of violence are rooted in social issues -- poverty, drugs, decline of the family -- that often seem beyond our control. Efforts to address violence will require multi-disciplinary collaboration. Initial steps can be very simple. Individuals can examine their own behavior and educate themselves and their friends on violence-related issues. Careful consideration can be given to the content and messages of movies and television. We can encourage youth to avoid violence as a response and teach young girls that violence against them is unacceptable. We can support shelters that help battered women and refer suspected victims of domestic violence to these support services. We can begin the empowerment of the victim by asking "Domestic violence is such a serious health problem that you should ask: Has someone you know caused these injuries?"

Despite the criminal nature of domestic violence and unlike abuse inflicted upon children, battered women are independent and fully capable of making decisions that best meet their needs. The goal for intervention is to empower women with information, resources, and support. The decision to call police or pursue legal action is a decision that rests with the battered women alone. You may not be able to stop the violence within a relationship, but you can offer help. By heightening your own awareness and offering support services that may be available to the victim, you can acknowledge that she is not alone, that she does not deserve the violence, and that there are resources to help her when she decides to leave the batterer.

**DO NOT JUDGE THE SUCCESS OF YOUR INTERVENTION BY THE PATIENT'S ACTION. IT MAY BE FRUSTRATING TO YOU WHEN A PATIENT STAYS IN AN ABUSIVE SITUATION BUT THAT IS HER DECISION. IT MAY TAKE A LONG TIME BEFORE A VICTIM OF DOMESTIC VIOLENCE IS READY TO LEAVE. BE ASSURED: IF YOU HAVE ACKNOWLEDGED AND VALIDATED HER SITUATION AND OFFERED HER THE APPROPRIATE REFERRALS, YOU HAVE DONE WHAT YOU CAN TO HELP.**

## **UNDERSTANDING DOMESTIC VIOLENCE**

This section is provided to increase your knowledge of the dynamics of violent relationships and the characteristics of survivors and batterers. A comprehensive understanding of the cultural, familial, psychological and personal factors that create and perpetuate domestic violence will enable the EMS provider to recognize and more effectively manage domestic violence calls. This information is also provided to decrease the level of frustration and confusion experienced by providers, who inevitably find themselves asking, Why? Why do men batter? Why do women stay? Why does domestic violence exist?

Societies tend to assign males and females different expectations for personality traits, expressions of emotion, behaviors and occupations. In the United States, this differentiation has historically ranked the sexes in such a way that women are generally unequal in power, resources, prestige or presumed worth. When this occurs, both sexes are denied the full range of human and social possibilities. The more rigidly people believe in traditional sex roles, the more likely they are to support a male using violence toward a female in an intimate relationship.

While male and female sex roles lay the foundation for dominance/submission, they do not explain violence. Witnessing violence in the home is the most powerful model for the transmission of violence from one generation to another. Researchers report that boys who either watch adult-to-adult domestic violence or are battered themselves are, as adults, more likely to batter their female partners. Youth who live in violent families learn to accept some domestic violence as a legitimate means of discipline.

Drug and/or alcohol abuse does not cause domestic violence. Stopping drug abuse will not stop domestic violence. However, stopping domestic violence will go a long way toward reducing drug and alcohol abuse. Alcohol is a disinhibitor, but cannot be blamed for violence. Many abused women learn to use drugs or alcohol to numb themselves from the emotional and physical pain they are experiencing.

Sex roles, discipline, drug and alcohol abuses are a few of the more persuasive influences that affect the incidence of domestic violence. In addition to societal influences, understanding domestic violence requires the recognition of predictable aspects that affect both the victim and the perpetrator and allow abusive situations to continue.

## **CHARACTERISTICS OF SURVIVORS: WHY SHE STAYS**

Any person can be the victim of domestic violence. There is no one profile of who is likely to be abused. Survivor can be male or female, young or old, heterosexual. However, from numerous studies, some common characteristics among domestic violence victims have been derived:

- Σ Exhibits low self-esteem
- Σ Characterizes herself as a traditionalist in the home or by her strong belief in family unity and the prescribed feminine sex role stereotype
- Σ Accepts responsibility for the batterer's actions
- Σ Suffers from guilt, yet denies the terror and anger she feels
- Σ Presents a passive face to the world, but has the strength to manipulate her environment so that she does not get killed
- Σ Has moderate to severe stress reactions with psychological and physiological complaints;

- Σ Uses sex as a way to establish intimacy
- Σ Believes no one will be able to help her resolve her predicament except herself
- Σ Frequently believes she deserves the punishment she receives
- Σ Typically underestimates her abilities as the batterer repeatedly tells her she is incompetent and unable to function on her own.
- Σ Tends to minimize the violence and denies memories of past trauma as a way to reduce her constant fear.

Most women are socialized to believe it is their responsibility to keep their partners happy and the relationship together. Also, our culture supports the belief that a person can cause another to think, feel or behave in a certain way. As such, the survivor assumes responsibility for the batterer's responses. He reinforces this by pointing out what she did to "set him off". The survivor learns to believe that her happiness, safety and, ultimately, her life depend on her ability to please and fix his problems.

Battered women learn to stay within the known, or familiar, situation. They avoid responses – like escape – that launch them into the unknown. As the battering and isolation increase, a shift in the survivor's comprehensive of the situation occurs. She increasingly perceives escape as impossible. Surviving the battering relationship becomes the focus of her life. While she feels trapped and alone, she will likely develop a variety of coping mechanisms to help her and her children stay alive. These may include withdrawal, asking permission to do even trivial things, compulsiveness, manipulation, and substance abuse.

Both the batterer and victim depend upon each other: the batterer for his feelings of power and dominance, the victim for her life. The survivor develops feelings of fear and hopelessness about her situation. Since batterers are seen as having the ability to kill, they are seen as gracious for sparing the survivor's life. The batterer can also deprive the victim of essentials – the most common being human contact, food, or sleep. When a survivor experiences significant deprivation, she becomes dependent on her batterer for these things. Occasional unpredictable, brief respites make the survivor obligated to him. The good responses, mixed unpredictably with the abuse, encourages the victim to stay in the relationship and reinforces the batterer's control. The battered woman can't accurately predict when he will respond positively or negatively toward her or the children. These feelings of the unknown emphasize her sense of dread, a feeling of constantly walking on eggshells. It is a product of the cycle of violence: never knowing when he will be loving and gentle or when he will be abusive.

After time, a victim's perception of reality is significantly altered and leads to the psychological and behavioral adaptations described above. Survivors grow to fear change and outside interference which keeps them from reaching out for help. For the possibility of healing to occur, battered women need both the violence and the threat of violence to stop permanently.

One of the most difficult emotional decisions for "outsiders" to understand is why, at the first sign of aggression or mistreatment, a woman does not leave a man who abuses her. Relationships do not start with violence. Women do not enter into a relationship saying, "It's OK to hurt me." Even abusive relationships start romantically, sharing love and trust, building dreams together, and often having children. The abusive behavior starts slowly, over time, when the woman has already developed a sense of loyalty to her partner and has

made an emotional investment. Furthermore, once the violence begins, the bonds between the couple do not suddenly cease to exist.

Many factors combine to keep a survivor in an abusive relationship, including:

**LOVE.** She has an emotional investment in the relationship, and this commitment is often reinforced by societal or cultural expectations. She often still loves him and is emotionally dependent on him. Often, motivated by pity and compassion, she may feel she is the only one who can help him overcome his problem.

**LACK OF PERCEIVED ALTERNATIVES,** created by lack of self-esteem, socialization, isolation, economic and emotional dependence, or poor problem solving skills. Maybe society failed to exert negative sanctions against the batterer during an earlier abuse. Having no one to talk to, people in abusive relationships rarely see themselves as battered women or batterers. The couple may realize they have problems, but may not identify the battering as being the main problem. Often, batterers and survivors identify the “real” problem as his drinking or, more commonly, something she is doing. Neither the survivor nor the batterer may know there are domestic violence services to help them.

**ECONOMIC DEPENDENCE** is a powerful force that keeps many women in battering relationships. The batterer may control the couple’s money. She may have no access to cash, credit cards, checks or important documents, or she may have to account for every penny spent. The woman may have no or low-level marketable job skills, no savings, and no health insurance. From the perspective of the battered woman, it may be worth putting up with abuse to maintain economic security for herself and the children.

**SOCIAL ISOLATION** is another factor that keeps women in violent relationships. Often he has become her only human connection after having systematically destroyed her other friendships and family ties. Friends and family feel uncomfortable around his intimidation, hostility, jealousy or violence and withdraw from spending much time with either of them. Family members may have broken contact with the survivor after she repeatedly returned to the batterer. This isolation supports her perception of his power. She has no one, except perhaps the children, to validate her feelings and her perception of reality. Children may be unable to provide reality checks, since their reality may be distorted. Some children who are exposed to violence identify with the aggressor, blaming the mother for his violence.

**FEAR** plays an enormous role in keeping survivors in abusive relationships. Very often, the batterer has threatened to harm or kill not only the survivor but anyone or anything she cares for – children, friends, family, even pets. Survivors are often afraid of losing custody of their children. If an immigrant, she may fear deportation or arrest.

**RELIGIOUS BELIEFS** may encourage her to maintain the family unit at all costs. While more members of the clergy are gaining an awareness and understanding of domestic violence, many believe and perpetuate all the myths of domestic violence, and counsel the woman to be a better wife, mother or nurturer. She may be told it is her duty to keep her family together. The more a woman internalizes this advice, the more likely she is to stay.

**PHYSICAL DISABILITIES** present unique issues that prevent the woman from leaving. The battered woman may have a disability and not be mentally or physically able to leave under her own power. She may fear institutionalization. She may not have health insurance.

She may be physically restrained by the batterer, for example her wheelchair or wheelchair access taken away, doors locked, or phone disconnected if she is blind. He may be over/under medicating her to incapacitate her.

**AGE BECOMES A FACTOR.** If she is elderly, the physical injuries may be more extensive and more lethal than when she was younger. She may rely on his pension or retirement funds. She may fear that he will cut her off and that she will live in poverty, become a homeless bag lady, be institutionalized by the state or die. She also may be physically restrained or medicated to the extent that she cannot leave.

**CULTURAL DIVERSITY** creates differences in perceptions of abuse, gender roles, family and marriage values that may have an effect on a woman's ability to leave a violent relationship. For example, among Hispanic women, the family is the most important social unit. A crucial element of the family is that the members work together to meet the needs the family as a group. As a result, it may be harder for Hispanic female to leave a battering relationship. Other cultures may have different perceptions of marriage and violence. Tradition holds Asian and Pacific Islander women responsible for the success of their marriage. For them, failure in marriage is not an individual failure, but also brings shame and humiliation to entire family. Women who reveal family problems to outsiders are looked upon harshly. To confront the violence is synonymous with condemning themselves to isolation and ostracism.

**WHERE SHE IS IN THE CYCLE OF VIOLENCE.** The batterer may tell the survivor that this battering is the last, and she may believe him – even if he has promised the same thing after previous battering episodes. Generally, the less severe and less frequent the incidents, the more likely that she will stay. If he is also abusing alcohol and other drugs, she typically believes that he will stop battering her if he stops the substance abuse. Finally, the more benefits she receives from the relationship between the abusive incidents, the more likely that she will stay.

Typically, a battered woman will leave a relationship five to seven times before she perceives she is safe enough and has established enough resources to make the break. Because a batterer is most violent when he perceives his partner is leaving him, battered women know they must be very cautious in their preparations and in their leaving. Remember: **leaving is a process not an event.**

For all these reasons and more, we need to understand that when we offer referrals or support to a victim of domestic violence, she may not be ready to leave. It may be frustrating when a victim stays in an abusive or violent relationship but that is her decision. Our role, within the EMS system, is to treat the injuries, validate her situation, and let her know that resources are available to help her when she is ready to leave.

## **CHARACTERISTICS OF PERPETRATORS**

Gathering information from the about batterers is difficult. Most will evade questions or deny any memory of the incident. Although we cannot stereotype the batterer anymore than we can predict who will be a victim, general patterns and characteristics have emerged.

Paradoxically, the relationship batterers crave is the opposite of the one they create. Because he generally feels insecure or has low self-esteem, the man who batters fears his partner will leave or abandon him. Violence is the batterer's response to his fear, and in the short term, violence works. Violence is a strategy that gives him a sense of control and power. He alternates violence with lavish gifts or affection, he creates crisis and chaos, he isolates his partner from others – these are all strategies to maintain control.

The batterer is often jealous to the point of intrusion into every aspect of his partner's life. He is insecure about her love and loyalty. He is suspicious of her relationships with others even when there is no basis. Nothing she can do can provide sufficient reassurance that she loves him enough. Every challenge to his authority is interpreted as rejection. He will eventually isolate her from all her support systems. He monitors her every move. He may even prevent her from working. He blocks her making friends or continuing relationships with family. He feels he must discipline and control his partner to keep her.

The batterer tends to exhibit excessive behavior. When his trying to be nice or affectionate, he typically lavishes his partner with large quantities of the biggest and best, even if he cannot afford it. Many batterers are charming and personable. In a similar manner, when he uses violence, he far exceeds what is necessary to "get his point across." He may, especially right after the violence, express guilt, shame, fear or remorse. All of these emotions may seem extreme.

The batterer is unable to identify or express the majority of his feelings. He believes that showing feelings is a form of weakness. He tends to turn all unpleasant emotions into anger, and then is unable to express them in a non-violent way. To a man who lives in an emotional void, anger may feel good. Anger is a familiar and comfortable feeling. He is rarely in touch with any other feelings other than anger. Anger is an easy emotion, one that veils hurt, fear, pain, loss and anxiety.

But anger is an excuse, not a cause. Violence is not a loss of control. On the contrary, the batterer carefully chooses the target, time, place, and action. The violence is selective, calculated, and tied to a knowledge of possible consequences. This is evidenced by the fact that most batterers do not lose control at work. They do not batter their boss or the many other people with whom they interact during the course of their day.

The man who batters uses intimidation, violence and chaos to create emotional and physical distance. He creates unrealistic expectations, and deals with this chaos by working harder, demanding more of himself and others, bargaining, lying, denying, forcing, cutting corners, and perhaps having sexual liaisons with other women. He creates chaos. Subsequently, he may be friendless or relates to others in shallow ways. He can be very conscious of and deliberate about his behavior and demeanor in relation to the world from which he is actually disconnected.

Underneath, batterers typically feel frightened and inadequate. They also feel shame and guilt about their inadequacy. They assume that having a relationship with a woman will help them be less afraid, insecure or lonely. As these feelings remain and intensify, the batterer transforms them into anger or violence. After a violent explosion, shame, guilt, fear and inadequacy return. The feelings he was trying to avoid re-emerge to propel him into repeating his pattern.

Very much like the victim, the batterer has fears that perpetuate his behavior. His fear is that his partner will abandon him and tell family and friends of his behavior. This threatens his sense of power. He is afraid that he will lose the children if his partner leaves. He may believe that if they separate or divorce, she will get everything. He must control her in any way he can to maintain his economic and emotional security. He fears that she will expose him as the inadequate failure he secretly believes he is.

## **CYCLE OF VIOLENCE**

Although it is not the same in all relationships, the cycle of domestic violence usually consists of three phases: increased tension building, the acute battering incident, and a calm or a lessening of tension. Although a batterer will typically increase the frequency and severity of violence each time the cycle is repeated, there are no guarantees he will not use lethal force the first time he uses violence. The same is true of the second, or third incident, and so on. Therefore, every domestic violence incident must be considered potentially lethal.

### **Phase 1: Tension or Build Up**

The tension-building phase may last weeks, months or years. It is characterized by an increase in verbal or physical abuse, and a decrease in loving communication. This is a time when the survivor may be amenable to resources in the community and may even seek them by a visit to a member of the clergy, a physician or another authority figure she trusts. She tries to keep the man as calm as possible, fearing that any escalation in tension will also increase his dangerousness. Sometimes a battered woman who has been through the cycle before knows that an acute battering incident is about to occur. She may do things she believes he will explode over, sometimes in front of other people. Her goal is to get the abuse over with while his violence level is still relatively low. The batterer may also feel increased tension, but will deny this to himself. The batterer is unwilling to seek or listen to help at this point.

### **Phase 2: Battering Incident**

In the second phase, the tension has exceeded the batterer's ability or desire to control his anger and violent response. He knows, or will learn, that his use of violence seems to decrease his stress and change his partner's behavior. Either partner may initiate the acute battering phase. It is during this phase that law enforcement or EMS became involved. If there are serious injuries requiring medical care, they usually occur during this phase. Immediately following this phase, the batterer and the survivor may be amenable to intervention. She is hurt and frightened, and he often feels guilty, humiliated and ashamed. Both are highly motivated for the violence to stop.

### **Phase 3: Calm or Honeymoon**

In the calm or "honeymoon" phase there is a perception of reconciliation and resolution. The man is usually contrite, offers excuses such as drinking, and promises that it will never happen again. This phase tends to be shorter than the tension phase. The honeymoon phase does not exist in all relationships, and in other relationships decreases and disappears over time as the man's power and control needs are achieved by increasing frequency and severity of the violence. The survivor is least likely to be amenable to intervention at this time, because it is the period when she receives the most rewards for being in the relationship. She is reminded of the earliest period of courtship, when the batterer behaved in a loving and nurturing manner with no observable violence. In contrast, the batterer may be more

amenable to intervention at this time, because typically he is remorseful and wishes to keep his partner. Later in the phase, as soon as he believes he has again won over his partner, he is decreasingly amenable to intervention. During the height of this phase, both parties minimize the violence and may excuse, distort, or actually forget and what happened. When that occurs, repetition of the cycle is inevitable; it is impossible for people to learn from past experience if they do not remember it.

## **RESPONDING TO A DOMESTIC VIOLENCE SCENE**

Calls to domestic violence are considered among the most potentially dangerous of scenes. Law enforcement agencies dispatch two officers to answer domestic disturbances as a strategy to reduce the potential of danger. Law enforcement's approach to domestic disturbances require heightened awareness to all possible clues, ranging from the initial assessment of bumper stickers on vehicles (for example, This vehicle protected by Smith and Wesson) to tricycles in the driveway (presence of children) to recommendations to avoid bedrooms (most typical room for accessible firearm) and kitchen (room where most anything can be used as a weapon).

Similar warnings are relevant for EMS personnel. For example, the initial call may just not sound right – whether an “unknown” or 911 hang-up – or the calling party denies calling EMS when you arrive at the door. These are clues and should be used as signals to heighten your awareness in responding to the scene. As you approach, look around the yard. Notice which lights are on in the house. Wait and listen as you approach: do you hear yelling or sounds of struggle?

If law enforcement has not been called, call them now. **DO NOT ENTER UNTIL POLICE ARRIVE AND SECURE THE SCENE.** The personal safety of the EMS provider outweighs the need to respond – this might be the toughest judgement call you'll ever have to make. Your adrenaline is pumping, you are ready to respond, to stop the bleeding or save a life but remember: If you're hurt, you're not helping anybody, and you are adding to the burden of others who now need to respond to you as well as to the original patient.

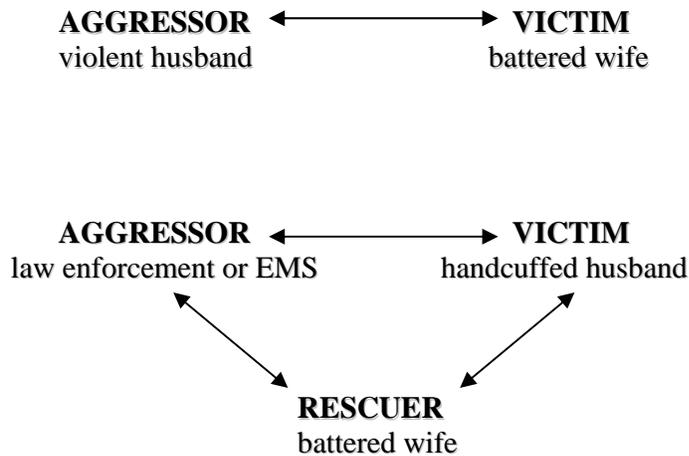
For these reasons and more, exercise caution and heightened awareness when responding to a scene of potential domestic violence. Ask yourself the following when responding to potentially high risk calls:

- Σ Should I approach?
- Σ Are there obvious dangers in approaching?
- Σ Who is the subject I will be dealing with? Is there prior history in responding?
- Σ Who am I? What are my limitations, my strengths, my own history?
- Σ What help is available?
- Σ When is the contact taking place? At night, during the day, in a trailer, etc.

Once inside, your awareness needs to continue. While the police may have already secured the scene, it is appropriate for you to do the same. Visually frisk everyone for weapons. Determine who is in the residence and where they are. Once identified, spectators should be asked to leave. Don't allow residents to get between you and an exit route. Don't let yourself be backed into a corner. Know where your partner is at all times. Don't get tunnel vision when

treating a patient; ensure that your partner is equally aware of what else is going on. Look at body cues, such as clenched fists, flared nostrils, and flushed cheeks. If weapons are present, you need to be able to ask that they be put away. It may help to practice a standard response to this type of situation, so that you will be prepared at the scene. One sample response is “For your safety and mine, I need to ask you to put the weapon away.”

EMS Personnel need to recognize and be aware that while they were originally called to help, their presence, along with law enforcement, changes the dynamics of the scene. Specifically, either the victim or perpetrator may turn on you or the police at any time. For example, before EMS or law enforcement arrive, the confrontation is between the batterer and the victim. The confrontation is the perpetrator’s attempt to obtain or maintain control over the victim. Once outside help arrives, the two-way tension changes and now involves three people.



Once the aggressor or violent husband is arrested, his role is changed and he becomes the victim. By the arrest procedure itself, the police officer now becomes the aggressor. This change effects the role of the victim, who becomes the rescuer and whose intent may be to rescue her husband for the new aggressor, law enforcement. During this change, the husband and wife become partners against the new aggressor. This is a primary reason why law enforcement officers are apprehensive to respond and intervene in these types of calls: they are injured at the scenes of domestic violence calls. Nationally, of all officers who are assaulted in the line of duty, one third occur at domestic violence scenes and domestic violence calls are accountable for an increase in the number of law enforcement deaths, from 3.1% of all deaths in 1986 to a total of 7.1% of police officer deaths occurring in domestic violence calls in 1995.

While EMS may have been called to provide medical care, it is important to recognize the change in dynamics and that the delivery of medical care may be viewed as a threat. The presence of a rescuer – whether law enforcement making an arrest or EMS providing medical care – changes the dynamics between the perpetrator and victim.

Part of the problem in responding to a domestic violence scene is that in all probability, the violence has been occurring for some time. The violence may have escalated over the years, to the point where the victim may be unaware of how lethal it has become. Victims consistently minimize the level of violence they experience. Also, many victims are embarrassed, shocked, or feel responsible and want to minimize the violence out of guilt and

shame. The victim may be fearful: a past arrest may not have been effective and violence was inadvertently encouraged. Finally, the victim may still love her partner. For these reasons, the victim may not be cooperative.

In addition to the dynamics of the scene, it may be necessary to diffuse aggressive behavior before you can even approach the victim to deliver medical care. Avoid touching or crowding an already hostile person since it may provoke more violent behavior. Be non-threatening. Stay calm. Don't get too close. Take a balanced stance. Take your time and take nothing for granted. Assume control of the situation **SLOWLY**. Introduce yourself, speaking directly to the patient. Explain what you're doing. Ask open-ended questions, allowing them to talk. Restore control to the victim. Do not be judgmental. If you can, separate yourself and the victim from the perpetrator – an explanation could be that you need to use equipment that is in your ambulance.

Pay attention for early warning signs of a potential attack. Sample behavior and physical posturing include: Conspicuous ignoring of questions and statements by you or police. Repetitious questioning. Looking around nervously. Excessive emotional attention. Ceasing all movement. Physical crowding. Assuming a pre-attack posture. Target glance. These are clues for EMS personnel to heighten awareness and to ensure your own personal safety.

## **RECOGNIZING AND TREATING VICTIMS**

The odds are very high that all of us, as EMTs, have treated victims of domestic violence during our career. Maybe we had no awareness of what we were responding to. Or just maybe, we had a very real suspicion of domestic violence but didn't know how to deal with the situation: should we have expressed our concern? What do we say or do? What if the patient denies being abused, what then?

Many victims of domestic violence will not volunteer specific details about their abuse. Battered women often create barriers to prevent others from recognizing that they are victims of domestic violence. Victims may be reluctant to disclose the true nature of their injuries – for many reasons. They may be embarrassed or ashamed. They may feel they have somehow “asked for it.” Many victims of domestic abuse have low self-esteem and believe they don't deserve help. Some may be afraid of retribution. Finally, some battered woman may still love their male partners and may lie to protect them from arrest.

While victims of domestic violence may not offer details on their own initiative; they may discuss it if asked simple, direct questions in a non-judgmental way and in a confidential setting. The patient should be interviewed alone. This cannot be emphasized enough: Question the victim directly about battering only if the suspected abuser is not present. Your ambulance may provide a safe environment for the victim of domestic violence to admit to a problem and ask for assistance. Your ambulance may provide the ideal opportunity for an EMS responder to question the patient and uncover any abuse that is occurring. Ask the patient direct, non-threatening questions in an empathetic manner, emphasizing that these questions are asked of all trauma patients.

You may want to think of sample questions ahead of time so that you will be comfortable and ready when the situation arises. Listed below are some sample direct and non-judgmental

approaches. Consider practicing or modifying these statements to see which ones feel appropriate for you:

- Σ Because domestic violence is so common in today's world, I've begun to ask about it routinely. Has your partner done this to you?
- Σ We often see people with injuries such as yours, which are caused by someone they know. Could this be happening to you?
- Σ You seem frightened and anxious. Has someone hurt you?
- Σ Sometimes when others are over-protective and jealous, they react strongly and use physical force. Has this happened to you?
- Σ Are you afraid of anyone in your household?
- Σ Has any household member physically hurt you or threatened to hurt you?

At first, you may find it difficult to ask these questions. You may find them intrusive or that you are being nosy. However, these kinds of questions should be part of your patient assessment. It may help to explain that questions of this sort are asked of all injured patients and that these questions are part of your protocols. Practice, and learn which ones work best for you.

The series of questions to ask can be easily remembered with the "SAFE" acronym.

- S** What **STRESS** do you experience in your relationship?  
Do you feel **SAFE** in your relationship?  
Should I be concerned for your **SAFETY**?
- A** Are there situations in your relationship where you have felt **AFRAID**?  
Has your partner ever threatened or **ABUSED** you or your children?  
What happens when you and your partner disagree or **ARGUE**?
- F** Are your **FRIENDS** aware that you have been hurt?  
Do your **FAMILY** members know about the abuse?  
Would **FAMILY** or **FRIENDS** be able to help or support you?
- E** Do you have a safe place to go in an **EMERGENCY**?  
If you needed to leave now, do you have an **ESCAPE** plan?  
Would you like to talk with a counselor to develop an **EMERGENCY** plan?

## ASSESSMENT OF INJURIES

Accurate and thorough assessment is the first step in establishing a trusting relationship with the victim of domestic violence. The assessment process is the first step in documentation of the injuries. Your assessment also allows you to provide information on resources and services available while you determine through sensitive questioning how lethal the situation is.

A survivor of domestic violence must be assessed in private, away from the partner. Assessment of injuries in front of the partner endangers the victim. Battering is a crime of silence and the EMS assessment of the injuries threatens the silence. It may help to maintain

eye contact with the victim; however, this may be inappropriate for some individuals or cultures. Trust is a necessary component of the assessment: do not badger or push the victim into disclosing what she may not be ready to share. In an environment of privacy and safety, allow the patient to describe her situation.

At the same time you are establishing trust, you are responding to the patient’s injuries. Injuries that should raise suspicion of domestic violence include those that follow a certain pattern to the face, chest, or abdomen. Perpetrators often, quite knowingly, strike areas of the body that are covered by clothing. Other suspect injuries include bruises or fractures to the forearm, suggesting a defensive posture. Be suspicious of isolated bruises to the abdomen or a “blowout” fracture of the face, especially if attributed to running into a household furniture. A blowout fracture, which involves a fracture of the fragile bone under the eye, typically indicates a direct blow to the face.

Documented studies of domestic violence generally report the following physical sites and percentages of injuries:

- 14.5% Head
- 33% Face and neck
- 12% Back and buttocks
- 10% Breasts
- 16% Arms
- 5.5% Abdomen (Increases during pregnancy)
- 4% Genitals

Another important aspect of injuries from domestic violence refers to victims who are repeatedly abused. Keeping this in mind, you may encounter injuries in different stages of healing. It may help to review how to estimate the age of a bruise:

COLOR	AGE
Red to Reddish Blue	Less than 24 hours
Dark Purple/Dark Blue	1 to 4 days
Greenish/Yellow Green	5 to 7 days
Normal tint/Disappearing	1 to 3 weeks

**DOCUMENTATION**

Throughout the delivery of medical care, EMS personnel need to be sensitive to preserving or documenting evidence that may be used in bringing charges against a perpetrator. Successful prosecution of the case depends to a great extent on the quantity and quality of evidence gathered at the crime scene. Well-documented cases are more likely to be pursued by public prosecutors and are more likely to result in appropriate legal actions against the offender.

Besides the obvious evidence of medical and police reports, documentation includes descriptions of damage to the house and statements from witnesses who heard or saw the abuse. If law enforcement has been called to the scene, the information in the EMS medical form supports the police documentation. If, however, EMS is called to a scene without police being present -- for example, if the victim is denying or minimizing the injuries as a

result of domestic violence—then the documentation collected by EMS is especially critical in supporting a future charge made by the victim.

The documentation you put in your report may be the most important piece of information when it comes time to support a victim's charges of domestic violence. Your report could be used in criminal prosecution, and you could be subpoenaed as a witness. Make sure you document details when responding to a domestic violence call.

Specifically, document inconsistencies between the victim's injuries and the history or description of mechanism of injury. Provide descriptive detail of injuries: if, for example, a bruise to the face has the imprint of a hand and fingers, make note of this. Also of note are the conditions of the residence, including broken furniture, holes in walls or doors, disarray, or broken glass. Make note of comments from the perpetrator or the demeanor of children if they were present. Identify weapons if present or used. Record alibi statements and even spontaneous outbursts: use quotes when possible. If the victim is transported to the hospital, you, as the responding EMT, may be the only one who can document the details of the scene. Lastly, remember: if it is not documented, it is hard to substantiate that it happened.

## **THE AFTERMATH**

After assessing a victim of domestic violence, treating her injuries, and documenting the situation, plans for her safety should be discussed. First ask her if she feels safe and help her look at available options:

- \*\* Does she have friends and family with whom she can stay?
- \*\* Does she want access to a shelter or would she prefer information for when she's ready.
- \*\* Does she want access to counseling?
- \*\* Does she want to return to her male partner?
- \*\* Does she want referrals to police or legal service?
- \*\* Does she have an extra set of clothes, important papers, and other essentials stored somewhere safe for when she needs to leave.

Use empathic and active listening skills when discussing options for the victim of domestic violence. The woman must have control of the conversation for the healing process to begin. A battered woman can and will evaluate her own situation. She may need help in identifying resources, but she also must make her own decision. If she's not ready, remember it is her choice. Battered women may leave their abusive situation anywhere from five to seven times before they actually leave for good. As a process, these trial "leave" give her the time to develop resources, test support systems, and gather strength. The pre-hospital health care provider can help the victim through this process by validating her decision making skills and informing her of her options.

Nine times out of ten, when police officers respond to a domestic violence call, the perpetrator has already left the scene. When the perpetrator leaves the scene, it can create a potentially dangerous situation for the victim, who may refuse to leave the residence. The perpetrator may then come back at a later time and possibly inflict more harm on the victim or any children or other people present. It is highly recommended for the victim to leave the residence for the night.

Victims and their children can be offered refuge at a local domestic violence shelter. First contact the shelter and advise them of the situation and they will meet you at the police department where they will pick up and transport the victim and his/her children. The location of the shelter is never to be given out over the radio or given to other people since this could place workers and clients at risk. Male victims can also receive services from the shelter, but special sleeping arrangements will need to be made. Victims can be transported to the residence of a relative or friend if they do not wish to stay at their residence. Police officers can “stand by” at the residence while the victim retrieves any immediate personal effects that are needed for herself or the children.

If the suspect has left the scene of the crime, law enforcement needs to have the victim actually file charges. It may be difficult to convince the victim that this is important. Arguments for filing charges include: domestic violence is a crime, filing charges documents the crime and starts the procedures for protecting the victim, and lastly, if charges are not made, then in effect, the behavior is condoned.

If the suspect is arrested by officers at the scene, charges are filed by the officers. The suspect will be taken to the local detention facility where he has the opportunity to bond out depending upon the type of crime committed and the location. If an offender has been arrested for violation of a restraining order, several jurisdictions will not allow the suspect to bond out until brought before the district court judge which is typically the next working day. If a suspect is to be released from a detention facility for domestic violence, a reasonable attempt will be made to contact the victim to inform her of the release of the offender.

It is critical to stress to the victim to document reports and the possible results of their actions. Explain that you understand the dynamics of domestic violence. That if some type of intervention does not occur, the frequency and the severity of the attacks will only increase. Assure the victim that she is not alone, that violence is not normal behavior, and that resources are available to her when she is ready to access them. And finally, if children are involved, emphasize the potential dangers to them.

## **DOMESTIC VIOLENCE AFFECTS CHILDREN**

The potential danger to children in households where domestic violence occurs is two-fold. The first is the immediate: children may become victims of the abuse. The second, or long-term effect, is much harder to measure: children learn their parents’ behavior.

In the immediate sense, children in homes where domestic violence occurs are often physically abused or seriously neglected. A large study of more than 900 children at battered women’s shelters found that nearly 70% were themselves victims of physical abuse or neglect. A child may receive physical injuries directly, as a result of the violence, or indirectly. Children can be hurt when household items are thrown or weapons are used. Infants may be injured if being held by their mother when the batterer attacks. Older children may be hurt while trying to protect the mother. As a result of the myriad of problems within a violent household, child neglect can occur and can result in both physical and emotional injuries.

In the immediate situation, EMS Providers can have a positive impact on children. Whether responding to a child's physical injuries or not, take the time to acknowledge the child's feelings with simple, clear statements. Samples include: "This must seem scary to you" or "This is not your fault". Taking the time to validate what the child may be feeling is important to the child's understanding of what is happening around him or her.

The long-term effects of domestic violence on children can be devastating. Like sponges, children may soak up the adults' problem-solving techniques. If no action are taken against the perpetrator, children may imitate violent behavior because that is what is common in their household and there appears to be no negative results. It is estimated that children who witness abuse are more likely to assault their mate. Witnesses of domestic violence learn that violence is an acceptable way to deal with conflict, and may assume that violence is the norm. Children in a family in which their mother is being abused learn both the victim role and aggressor role. This perpetuates the cycle of violence as children and then as adults.

Children also exhibit physical conditions, including headaches, stomach problems, or diarrhea. Other physical responses to witnessing domestic violence escalate around bedtime and include sleepwalking, bed-wetting, nightmares, separation anxiety, clinginess, and insomnia. Behavioral responses include aggressive behavior with other children, adults, or animals; regression in developmental behaviors already mastered, excessive crying, withdrawal or fantasy life, emotional neediness, over compliance, extreme passivity, self-mutilation, school problems and delinquency.

Studies have shown that children who witness violence are four times more likely to develop patterns of violent behavior later on in life. As the child matures into adolescence, these consequences may become more entrenched and more severe, including the ideation of suicide, substance abuse, depression, feelings of hopelessness, chronic anxiety, difficulty controlling anger, early marriage and early pregnancy. These children may be further victimized or blamed for having a psychological or behavioral problem, rather than receiving validation and support in coping with family problems.

When responding to domestic violence scenes that involve children, remember:

**YOUR ROLE AS EMS IS TO PRIMARILY PROVIDE MEDICAL CARE. YOU ARE NOT EXPECTED TO BE A COUNSELOR OR THERAPIST. HOWEVER, YOUR RECOGNITION OF OTHER POTENTIAL DANGERS CAN HELP YOU ENCOURAGE AND SUPPORT THE VICTIM TO TAKE THE NECESSARY STEPS TO STOP THE VIOLENCE AGAINST HERSELF AND OTHER FAMILY MEMBERS.**

## **LEGAL ASPECTS OF DOMESTIC VIOLENCE**

EMS responds to scenes of domestic violence, oftentimes knowingly but sometimes not. While the primary purpose of EMS is to provide medical care to the patients of these calls, it is important that the EMS provider has a basic understanding of some critical legal aspects of domestic violence scenes. Your understanding of the legal aspects will help you give appropriate information regarding different legal actions and what the victim may expect if a particular legal course of action is pursued. When you respond to a domestic violence call, it

is not only a medical scene but it is a crime scene as well. As a result, you may be subpoenaed as a witness if the case goes to trial.

New Mexico State statutes defines domestic abuse as any incident by a household member against another household member that results in:

- physical harm
- severe emotional distress
- bodily injury or assault or a threat causing imminent fear of bodily injury
- criminal trespass or criminal damage to property
- stalking, harassment, or repeatedly driving by a residence or work place
- harm or threatened harm to children.

The definition of household members includes: spouse, former spouse, family member, including relatives; child, co-parent or step-parent of a child, or a person with whom there is a continuing personal relationship. Definition of household member also includes same genders. Definition of household member does include dating relationships and juveniles involved in a violent relationship.

Please realize that this section provides a broad overview of the legal components in responding to a domestic violence scene. The following information is not definitive, and in no way does knowing this information allow you to make arrests or charges. It is meant to introduce you to a larger scope of a problem, within which EMS plays a specific and important role. If you have additional questions, please refer to the resources at the end of the module.

## **PREVENTION**

The causes and effects of domestic violence are rooted in social issues that often seem beyond our control. In Tennessee, the issues of poverty and cultural diversity add many challenges in our efforts to address the problems of domestic violence. In contrast to the myriad of problems, our state has made significant headway in providing resources to identify, assist, and prevent domestic violence. The very fact that this information is now provided to pre-hospital providers indicates an increased awareness and desires to respond to the problems of domestic violence.

One of the most important aspects of preventing domestic violence is identification of the issue. The first, manageable step to preventing domestic violence is identifying the victims. We all can begin the empowerment of the victim by asking “Domestic violence is such a serious health problem that I ask all my patients: Has someone you know caused these injuries.” By asking this question, we begin the process of healing. We acknowledge and validate the abuse.

The second most important aspect of preventing domestic violation is referring victims to resources that are available to help her cope and respond to her situation. The decision to call police, pursue legal action, or access resources rests entirely with the battered person. It is his or her decision to act; however, we can help make the victim aware of resources and support systems. By heightening your own awareness in identifying domestic violence and offering support services that are available to the victim, you can acknowledge she is not

alone, that she does not deserve the violence, and that there are resources to help her when she decides to leave the batterer.

The third point in preventing domestic violence is recognizing potential factors that may allow or accept violence in our own lives and our community. For example, we can examine our own behavior and educate ourselves and our friends on violence-related issues. We can give careful consideration to the content and messages of movies and television. We can encourage youth to avoid violence as a response. We can support programs that offer conflict resolution strategies other than violence. We can teach youth that violence against them is unacceptable. Many schools have violence prevention, conflict resolution or anger management programs. We can offer to speak or present to youth or school groups on the violence we see as part of our work.

## **SUMMARY**

You, as a pre-hospital health care provider, may be the first or only professional with whom a victim of domestic violence may have. In addition to patient care, you need to use your powers of observation to be able to “read between the lines” and be alert for clues.

When EMS personnel do suspect a violent—or potentially violent—situation, you should inform law enforcement and the emergency department staff of the situation. Safety for yourself, the victim and the children are the top priorities in these situations. Educate yourself about domestic violence. Given the magnitude of the epidemic of intimate violence in our country, it is likely that not only are our patients affected by the problem, but also that someone in your family, your neighborhood, or your workplace is being abused. Your sensitive questions and offer to help may be the impetus needed to turn these problems around.

# **EMS Response to Domestic Violence**

## Appendices



## **EMS SAFETY TO DOMESTIC VIOLENCE SCENES**

### **En route to call**

1. Has police been dispatched? How far away are they?
2. Have there been comparable calls to this residence in the past?
3. Are both you and your partner prepared and equipped for this call? Preparation includes not only equipment, but also mental and emotional preparedness. Have you and your partner practiced what to do in potentially dangerous scenes?

### **Approach of the scene**

1. Approach with your sirens and lights off. Stop your vehicle a half mile from the scene to gather additional clues before stepping from your rig.
2. What clues are evident before stepping out of your rig:
  - a. Are there items in the yard or driveway that indicate children might be present?
  - b. Are there any indications that firearms may be present at this residence, i.e., gun rack or bumper stickers on a vehicle?
  - c. If at night, what lights are on in the house?
3. Is your vehicle parked so that an escape route is available if needed?
4. What is the level or noise at the residence? Any yelling, screaming, or sounds of struggle?

### **Entry into the residence**

1. Don't stand in front of the open door. As you enter a room, turn on the lights. Leave lights on in every room if possible.
2. Are there indications of alcohol or drug use at this residence?
3. Visually frisk everyone for possible weapons when you enter.
4. Identify how many people are in the residence and where they are located; are there neighbors that could be asked to leave: the less people, the better. Never walk down a hallway with someone behind you. Let them lead.
5. If at all possible, do not work on people in kitchens or bedrooms:
  - a. Kitchens have numerous and a variety of weapons, including knives, heavy cooking pots, boiling water, glassware.
  - b. Bedrooms usually do not have an exit or escape route. Many people keep concealed loaded handguns in the bedroom. And finally, if the perpetrator has jealous nature, the bedroom may be viewed as an intimate and therefore, threatening place.
6. Do not assume that just because the offender has been arrested at the scene, that the situation is under control. The victim or members of the family, even children, have been known to assault police and EMS personnel. Always stay alert!
7. Keep your partner in sight at all times.
8. Maintain link with your dispatch or communication system.
9. Determine location and condition of victim; separate suspect and perpetrator, if still at scene. Interview victim and any witness separately, especially if both are injured.
10. Keep your exit path open at all times.

**EMERGENCY MEDICAL SERVICES  
DOMESTIC VIOLENCE INDICATORS OR RED FLAGS**

Patient is fearful of household member or exhibits increased anxiety when member is near.

Patient is reluctant to respond when questioned or is hesitant in providing information about how the injury occurred.

Patient is in an unusually isolated, unhealthy, or unsafe living environment.

Patient admits to frequent use of tranquilizers, sleep medication, illicit drugs or alcohol.

Patient and other household members give conflicting accounts of incident.

Patient offers history which is inconsistent with the injury or illness.

Patient presents with multiple vague complaints, such as headache, insomnia, pseudo-seizures, abdominal discomfort, muscle ache or non-specific pain.

Patient presents with injuries during pregnancy.

Patient complains of trauma without anatomic “evidence of injury”.

Patient exhibits old injuries or injuries in various stages of healing, particularly to the back, neck, and ribs.

Household member is angry or indifferent towards patient and refuses to provide necessary assistance.

Household member refuses or hesitates to permit patient’s transport to hospital.

Household members seeks to prevent the patient from interacting privately or speaking openly.

Household member appears concerned about a minor patient problem but not the patient’s serious health issue.

Delay in seeking treatment for injury is unexplained.

Police/EMS have responded to scene previously or repeatedly.

## IDENTIFYING A VICTIM OF DOMESTIC VIOLENCE

One of the most difficult steps a battered woman must take is to identify herself as a victim. Although experiences may differ, this checklist may help determine if she is battered.

Does her partner:

- \_\_\_\_\_ constantly criticize her and her abilities as a wife or partner or mother?
- \_\_\_\_\_ behave in an over-protective manner or become extremely jealous?
- \_\_\_\_\_ threaten to hurt her, her children, pets, family members, friends, or himself?
- \_\_\_\_\_ prevent her from seeing family or friends?
- \_\_\_\_\_ get suddenly or uncontrollably angry or lose his temper?
- \_\_\_\_\_ deny her access to family assets such as bank accounts, credit cards, or car?
- \_\_\_\_\_ control all finances and requires her to account for what she spends?
- \_\_\_\_\_ use intimidation or manipulation to control her or her children?
- \_\_\_\_\_ prevent her from going where she wants to when she wants to?
- \_\_\_\_\_ force her to have sex that makes her uncomfortable?
- \_\_\_\_\_ humiliate or embarrass her in front of others?
- \_\_\_\_\_ abuse alcohol or street drugs?
- \_\_\_\_\_ threaten to kill her?
- \_\_\_\_\_ have access to a firearm or weapon?

If the answer is “yes” to any of these questions, she may be a victim of domestic violence. She is not to blame. She is not alone. Millions of women are abused by their partners and often don’t know that help is available.

## DOMESTIC VIOLENCE PERSONAL SAFETY PLAN

### SAFETY PLAN WHILE PREPARING TO LEAVE

- \*\* Open a savings or credit card account in your own name to increase your independence
- \*\* Pack an overnight bag (see checklist below) with essentials and leave with someone you trust so that you can leave quickly.
- \*\* Determine where you can stay and who might be able to lend you some money.
- \*\* Decide where you will go and how you will get there if you need to leave home.
- \*\* Tell those whom you can trust about the violence.
- \*\* Develop a code word with your children or neighbors that lets them know that you need to get out now and they need to call the police.
- \*\* Document visits with the doctor, calls to the police, trips to the shelter, and any other help which you seek to stop the violence.
- \*\* Maintain positive thoughts about yourself, and assert your needs with others. Read books or articles that help you feel stronger.
- \*\* Keep close at hand the shelter or hotline phone number, as well as loose change or an extra phone card to make a phone call.
- \*\* Review your safety plan often so that when it comes time to leave, you will know what to do.
- \*\* Remember, leave-taking is the most dangerous time of all.

### CHECKLIST: WHAT TO TAKE WITH YOU WHEN YOU LEAVE

#### Identification:

Driver's license  
Children's birth certificates  
Your own birth certificate  
Social security card

#### Financial Items:

Money  
Credit Cards  
Bankbook or checkbook

#### Legal:

Your restraining order  
Rental agreement or house deed  
Car registration and insurance  
Health and life insurance papers  
Medical records for you/your children  
Work permit, green card, passport  
Divorce and custody papers

#### Other Essentials

House and car keys  
Toiletries  
Change of clothes  
Phone card  
Pictures of you, your children and your abuser  
Medications  
Jewelry  
Address book  
Small toys for the children

**DOMESTIC VIOLENCE QUESTIONS  
EVERY PROVIDER NEEDS TO ASK**

**S**

WHAT STRESS DO YOU EXPERIENCE IN YOUR RELATIONSHIP? DO YOU FEEL **SAFE** IN YOUR RELATIONSHIP/MARRIAGE? SHOULD I BE CONCERNED FOR YOUR **SAFETY**?

**A**

ARE THERE SITUATIONS IN THE RELATIONSHIP WHERE YOU HAVE FELT **AFRAID**? HAS YOUR PARTNER EVER THREATENED OR **ABUSED** YOU OR YOUR CHILDREN? HAVE YOU BEEN PHYSICALLY HURT OR THREATENED BY YOUR PARTNER? WHAT HAPPENS WHEN YOU AND YOUR PARTNER DISAGREE OR ARGUE?

**F**

ARE YOUR **FRIENDS** AWARE THAT YOU HAVE BEEN HURT? DO YOUR PARENTS, SIBLINGS, AND OTHER **FAMILY** MEMBERS KNOW ABOUT THIS ABUSE? DO YOU THINK YOU COULD TELL THEM? WOULD THEY BE ABLE TO GIVE SUPPORT OR HELP YOU?

**E**

DO YOU HAVE A SAFE PLACE TO GO IN AN **EMERGENCY**? ARE YOU AWARE OF RESOURCES AVAILABLE TO YOU AND YOUR CHILDREN IF YOU ARE IN AN **EMERGENCY**? IF YOU NEEDED TO LEAVE NOW, DO YOU HAVE AN **ESCAPE** PLAN? IF YOU ARE IN DANGER NOW, WOULD YOU LIKE HELP IN LOCATING A SHELTER? WOULD YOU LIKE TO TALK WITH A SOCIAL WORKER OR COUNSELOR TO DEVELOP AN **EMERGENCY PLAN**?

## **RESPONDING TO A DOMESTIC VIOLENCE PATIENT**

**If a patient answers YES to a question of suspected domestic violence, the following steps are suggested:**

Encourage her to talk about it in a confidential setting. Ask your partner if she would like to talk about what happened, how she is feeling, and what she would like to do next. Listen non-judgmentally. Emphasize the violence is not her fault. Allow an environment to begin the healing process. This will give you an idea of what kind of referrals your patient is receptive to.

Validate your patient. Victims of domestic violations are frequently not believed, and they believe that their fear is minimized. You can express concern and support through simple statements such as:

- \*\* You are not alone.
- \*\* You don't deserve to be treated this way.
- \*\* You are not to blame.
- \*\* You are not crazy.
- \*\* What happened to you is a crime.
- \*\* Help is available to you.

Document what has been done and said. Note patient's complaints and symptoms. Complaints should be described in the patient's own words when possible. Write a description of the injuries, including type, size, location, resolution, possible causes, and explanations given. Use a body map (sample attached). Make note if the injuries are inconsistent with the patient's explanation.

Assess the danger to your patient. Assess your patient's safety before she leaves the medical setting. Convey your concern that the violence against her will recur and may increase. The most important determinants of risk are the woman's level of fear and her appraisal of her immediate or future safety. Discuss the following indicators with the patient to determine if she may be in escalating danger:

- \*\* has there been an increase in the frequency or severity of the assaults?
- \*\* are there increasing or new threats of homicide or suicide by the partner?
- \*\* has the perpetrator threatened her children?
- \*\* is there a firearm present or readily available?

Treat the patient's injuries. Provide appropriate treatment referral. If the patient is in imminent danger, determine if she has friends or family with whom she can stay. If this is not an option, ask if she wants immediate access to a shelter. If she doesn't need immediate access to shelter, offer information about shelters or community resources. It may be dangerous for the women to have this information in her possession; don't insist she take them if she is reluctant. If she does accept written information, write the telephone number without the name of the support service. Encourage her to tuck it in her shoe. Don't push her to leave if she is clearly telling you she is not ready to do so.

**If the patient answers NO to a question of suspected domestic violence, or will not discuss the topic:**

Be aware of clinical findings that may indicate abuse such as injury to the head, neck, torso, breasts, abdomen, or genitalia; multiple injuries; delays between onset of injury and seeking treatment; explanation by the patient that is inconsistent with the type of injury; any injury during pregnancy, especially to the abdomen or breasts; chronic pain symptoms for which the source is unknown; psychological distress, such as depression, suicidal ideation, anxiety, sleep disorders; a partner who seems overly protective or who will not leave the woman's side.

If any of the above clinical signs are present, it is appropriate to ask specific questions. Be sure that the patient's partner is not present. Some example questions that may elicit more information about the patient's situation are:

\*\* It looks as though someone may have hurt you. Can you tell me how this happened?

\*\* Sometimes when people call 9-1-1 with physical symptoms such as yours, we find that there may be trouble at home. We are concerned that someone may be hurting you. Is this happening?

\*\* Sometimes when people feel the way you do, it's because they may have been hurt or abused by someone they love. Is this happening to you?

If the patient answers no and you strongly suspect that abuse has taken place, you can still provide referrals to local programs. Write the number of the domestic hotline on a blank piece of paper. Make sure you document inconsistencies between what the patient reports and the injuries.

## WHY THE VICTIM STAYS

### **Victims of domestic violence may have a number of reasons why they stay in the relationship:**

If she has experienced the cycle of violence many times (especially if police have been called and did not arrest him), she tends to believe the batterer to be omnipotent. She sees no way to protect herself from him, and she does not believe anyone else can or will protect her either. Many of these fears are justified; the violence exhibited by these men is terrifying and lethal.

She is likely to believe that if she, or even a neighbor, reports the batterer to the police, he will take revenge on her, the children, friends, family, pets or anyone or anything important to her. Often, he has threatened to do just this. She may believe that if she stays with him, he will hurt only her, and this is a more tolerable option.

Some women are afraid that if they report abuse their husband might lose his job. Often this is the only source of income and medical insurance for the family.

She is typically afraid that no one will believe her or the true extent of his violence.

She is afraid she will be blamed for the batterer's violence.

She is afraid she might lose the children because she couldn't stop the violence, and is therefore a bad mother. If he threatens to take them from her, if the court appears to be favoring him in a custody hearing, or if he does get the children, this fear becomes even greater.

Some women are afraid of incurring the wrath of the extended family or their community if they leave or report the batterer. Women with strong roots in a small town, or an ethnic or traditionally religious community, are particularly vulnerable.

She may have some hidden event in her past that, if brought into the open, would focus unwanted social or criminal action upon her (drug abuse, writing bad checks, welfare fraud, etc.).

If she is an undocumented person, she may fear arrest, deportation, or leaving the children behind.

If she is a woman of color, or a lesbian, she may fear that the system will treat her unfairly, possibly taking her children or putting her in jail.

She may fear that the police will beat or kill the perpetrator. While she may want the violence to stop, she usually does not want him hurt or killed, especially because of something she did.

She is typically afraid that if she leaves he will commit suicide. Generally, she does not want him dead; she just wants the violence to stop. She may still love him and is emotionally dependent upon him.

## **WHY THE VICTIM STAYS, (Continued)**

In some cultures, the police and social services are seen as the enemy, an entity to be feared. Only under the most extreme conditions would battered women, family members or neighbors in their culture call the police. Often they don't call the police until a death occurs.

In rural areas, she may fear the neighbors will talk. The sheriff, district attorney and judge might be his friends or drinking buddies. There may be fewer helpful resources in rural areas.

An elderly person or a person with a disability may fear not being believed or being viewed as incompetent or incapable of knowing the truth. She may not trust her abilities to protect herself.

A survivor may not reach out for help based on pride. She may not feel comfortable in asking for help. She may feel that what happens in the family, stays in the family.

“Outing” is the phenomenon of revealing the sexual orientation of a person without their consent or knowledge. This fear can be an immobilizing threat used to keep gay or lesbian survivors in abusive relationships. The threat by the batterer of outing the survivor to his/her family, friends, employer, church or even children can be potentially devastating to the survivor's life and livelihood, and very often can be more frightening than the abuse itself.

The batterer may tell that this battering incident is the last and she may believe him-even if he has promised the same thing after previous episodes.

She may have lived in a home where violence was accepted as natural or normal. She may have seen her father beat her mother or she may have been beat herself, either by her parents or siblings.

She may be economically dependent on her partner, it may be worth putting up with the abuse to maintain economic security for herself and her children. The batterer may control the couple's money. She may have no access to cash, credit cards, the vehicle, or important documents.

She may be isolated. Often, he has become her only psychological and emotional support after having systematically destroyed her other friendships and family ties. This isolation supports her perception of his omnipotence.

Having no one to talk to, people in abusive relationships rarely see themselves as battered. She may realize that the relationship has problems but may not identify the battering as being the main problem. Often victims identify the problem goes away, so will the violence. Often, motivated by pity or compassion, she may feel she is the only one who can help him overcome his problem.

She may have cultural or religious beliefs that say it is her duty to keep her family together. She may feel that she just needs to be a better wife, mother, nurturer, etc.

## BEHAVIORAL CHARACTERISTICS OF ABUSERS

The following is a list of behaviors typically seen among people who beat their intimate partners. In some cases, a batterer may have only a couple of behaviors that the woman can recognize but they are very exaggerated. Initially, the batterer will try to explain his behavior as signs of his love and concern, and a woman may be flattered. As times goes on, the behaviors become more severe in order to dominate the woman.

**Jealousy.** At the beginning, an abuser will say that jealousy is a sign of love. Jealousy has nothing to do with love; it's a sign of insecurity and possessiveness. As the jealousy progresses, he may call her frequently during the day, drop by unexpectedly, and even check her car mileage.

**Controlling behavior.** At first the batterer will say this behavior is out of concern for the woman's safety, her need to use her time well, or her need to make good decisions. As the behavior continues, he may not let the woman make any personal decisions.

**Quick Involvement.** Many battered women dated or knew their abuser for less than six months before they were engaged or living together. He comes on like a whirlwind, claiming love at first sight. He needs someone desperately and will pressure the woman to commit to him.

**Unrealistic Expectations.** He is dependent on the woman for all his needs, he expects her to be the perfect wife, mother, lover, friend. She is supposed to take care of everything for him.

**Isolation.** The man tries to cut the woman off from all resources, including friends and family. He accuses people who are her supports of "causing trouble". He may want to live in the country without a phone, he may not let her use the car, or may keep her from working.

**Blames others for his problems.** If he is unemployed, someone is doing him wrong or out to get him. He will tell the woman she is at fault for all that goes wrong. If he makes a mistake, he will accuse the woman for upsetting him or keeping him from concentrating.

**Blames others for his feelings.** He will tell the woman "You make me mad". He really makes the decision about how he thinks and feels but will manipulate and blame the woman.

**Hypersensitivity.** He is easily insulted or claims hurt feelings. He sees everyday events—traffic ticket, overtime work, being asked to help with chores—as personal attacks.

**Cruelty to animals and children.** He may expect children capable of doing things fear beyond their ability. He may not want children to eat at the table. He punishes animals brutally or is insensitive to their suffering.

**Dr. Jekyll and Mr. Hyde.** He has sudden changes in moods. Explosiveness and mood swings are typical of men who beat their partners and are used to control tactics.

## BEHAVIORAL CHARACTERISTICS OF ABUSERS, Cont.

**“Playful” use of force during sex.** He may want to act out fantasies during sex where the woman is helpless. He may show little concern whether the woman wants to have sex and uses sulking or anger to manipulate her into compliance. He may start having sex with the woman while she is sleeping or demand sex when she is ill or tired.

**Verbal abuse.** In addition to saying things that are meant to be cruel and hurtful, he made degrade the woman, telling her that she’s stupid and unable to function without him. He may even wake her up or not let her go to sleep through verbal abuse.

**Rigid sex roles.** The man expects a woman to serve him, that she must obey him in all things. The abuser sees woman as inferior to men, unable to be a whole person without a relationship. He is likely to view women as possessions.

**Past Batterings.** The man may admit he has hit women in the past, but will say they made him do it. The woman may hear from relatives or ex-spouses that the man is abusive. A batterer will beat any woman he is with; situations do not make a person an abuser.

**Threat of Violence.** This includes any threat of physical force meant to control a woman. Most abusers will try to excuse this behavior by saying “everybody talks like that.”

**Breaking or Striking Objects.** This behavior is used as punishment but also to terrorize the woman into submission. The man may beat on tables with his fist, throw objects around or near the woman.

**Any force during an argument.** This may involve a man holding a woman down, physically restraining her from leaving the room, pushing, or shoving. The man may hold the woman against a wall and say “you are going to listen to me.”

Other common characteristics of an abusive partner include:

- Witnessed abuse between parents or was a victim of abuse as a child.

- Is extremely fearful of losing partner.

- Believes that expressions of feelings indicate weakness and turns hurt, fear, loss into anger.

- Has low self-esteem.

- Has great difficulty trusting anyone.

- Does not feel own violent behavior should have negative consequences.

- Believes that the world is a hostile place where aggression is necessary for survival.

- May not view what he is doing is wrong.

Adapted from material from the New Mexico Coalition Against Domestic Violence

## **CULTURAL DIVERSITY**

The population of Tennessee reflects a broad and rich diversity of cultures and ethnicity. This variety can make the delivery of EMS care difficult or frustrating. It may help to remember that YOUR way of doing something is not the only way. This is especially meaningful when responding to domestic violence scenes and victims. The following are offered as a basic format to incorporate cultural diversity within your profession.

- \* Accept cross-cultural awareness as a professional skill.
- \* Expect cross-cultural competency as part of your EMS job performance.
- \* Recognize that each community owns cultural issues that may be different from yours.
- \* Identify your own issues – biases, prejudices, previous experience – and be able to put them reliably on the back burner while you are providing care.
- \* Pay attention to gender issues and how they work or don't work culturally.
- \* Find the least intrusive level of response or intervention and start there.
- \* Ask up-front for guidance if you are dealing with another culture.
- \* Experience yourself as an alien, a mindset where you pause and question everything you do.

## **NUTS AND BOLTS**

- \* Be humble
- \* Don't walk in the door talking
- \* Introduce yourself. Make it real, not canned
- \* Clean up after yourself. Show respect for their world.
- \* Ask the minimum number of questions, in non-threatening tones
- \* Do not respond to intimidation
- \* Count to 3 before answering any question
- \* If you're getting resistance, step back and let somebody else step in
- \* Know what you know, what you don't know, and don't pretend otherwise
- \* Don't order people around
- \* Taking a second more will not cost you the incident
- \* Pre-train and re-train:
  - \* Cross cultural
  - \* Confrontation and stress management
  - \* Team building
- \* Include local customs in your protocols
- \* Don't ever say "you people"
- \* If a team mate blunders, apologize for them
- \* Rehearse these skills in your training
- \* Learn your partner's yuks!
- \* Be clear when there is something you must do that goes against custom.
- \* Acknowledge conflict

Adapted from A. HORNE & P. KELFORD/DUKES FOR HONOLULU CISD, 1991

## **MYTHS ABOUT LESBIAN AND GAY DOMESTIC VIOLENCE**

Only heterosexual women get battered. Men are never victims of domestic violence and women do not abuse.

Domestic violence is more common in heterosexual relationships than in lesbian or gay male relationships.

It isn't violence when a same-sex couple fights. It is a lover's quarrel, a fair fight between equals.

It isn't really violence at all when gay men fight – it's just boys being boys.

The batterer will always be butch, bigger, and stronger. The victim will always be femme, smaller, and weaker.

People who are abusive under the influence of drugs or alcohol are not responsible for their actions.

Gay men's domestic violence has increased as a result of alcoholism, drug abuse and the AIDS epidemic.

Lesbian and gay domestic violence is sexual behavior, a version of sado-masochism. The victims actually like it.

The law does not and will not protect victims of lesbian and gay men's domestic violence.

Lesbian and gay male victims exaggerate the violence that happens to them. If it were really that bad, they could just leave.

It is easier for lesbian or gay victims of domestic violence to leave the abuser than it is for heterosexual battered women.

Domestic violence primarily occurs among gay men and lesbians who hang out at bars, are poor, or are people of color.

Victims often provoke the violence done to them. They are getting what they deserve.

Lesbian or gay male victims of domestic violence are co-dependent.

**THE ABOVE STATEMENTS ARE MYTHS. THEY ARE NOT TRUE.**

Adapted from the National Lesbian and Gay Health Foundation Conference, July 1990

## **SAME SEX DOMESTIC VIOLENCE**

How is lesbian and gay battering **similar** to battering in heterosexual relationships?

- \* No one deserves to be abused
- \* Abuse can be physical, sexual, verbal, emotional, or psychological
- \* Abuse is a pattern of behavior designed to maintain control over one's partner.
- \* Abuse often occurs in a cyclic fashion.
- \* Abuse can be lethal
- \* The abused partner feels isolated, afraid, and usually convinced that they are at fault.
- \* The incidence rate in relationships for gay and lesbian battering and heterosexual battering is approximately the same.

How is lesbian and gay battering **different** from heterosexual battering?

- \* Lesbians and gay men who are abused have much more difficulty finding appropriate support that heterosexual women do.
- \* The myth that lesbian/gay domestic violence is "mutual" prevails. No one would assume that heterosexual battering is mutual and therefore less important.
- \* Using existing services such as the legal system or battered women's movement is tantamount to "coming out" which is a major life decision.
- \* Lesbian and gay male support services themselves often minimize lesbian/gay domestic violence because service providers are ignorant of the severity of lesbian/gay battering, and because to acknowledge the abuse may destroy the myth of lesbian utopia or gay male enlightenment.
- \* Lesbian and gay survivors may know few or no other gays; leaving the abuser could mean total isolation from their community.
- \* The lesbian/gay community is small, and it is likely everyone the survivor knows will soon know of his/her abuse.
- \* The batterer can use blackmail to hold the victim in the relationship. Being "outed" at work or to parents is sometimes more threatening than the abuse.
- \* If there are children in the relationship, seeking help will mean the survivor may never see the children again since gays/lesbians have limited parental rights; if the children are the survivors, seeking help may mean separation from both parents.
- \* Often, for gays/lesbians sympathetic friends are hard to find since the gay/lesbian community is not eager to acknowledge weaknesses which the heterosexual world will use to support its homophobic stereotypes.

Adapted from the National Lesbian and Gay Health Foundation Conference, July 1990

## HISPANICS AND DOMESTIC VIOLENCE

Very little research has been completed on domestic violence in terms of cultural differences; however, despite the lack of documentation, two aspects remain clear; cultural diversity and ethnicity are not predictors of couple violence, nor do they contribute to higher rates of violence. This does not mean that difference do not exist. There are cultural differences in perceptions of abuse, defining gender roles, family and marriage values, and the nature and handling of abuse after the incident.

- Hispanic women in shelters tend to be the most disadvantaged economically.
- Hispanic women in shelters have been married longer and fewer times.
- Hispanic women are more likely to tolerate more abuse and to identify fewer types of behavior as abuse.
- Research has found no significant difference in the severity or frequency of wife abuse between Mexican Americans and Anglo Americans.
- When Hispanic women seek help, they are more likely to call the police.
- Immigration laws may interfere with a woman's ability to leave an abusive marriage or to access health services.
- The largest difference between racial groups is the influence of income: Hispanic women need more economic and educational support to help them through their crisis.
- As income increase, Hispanics report decreases violence, while Anglos report increases violence.
- The family belief system of many Hispanics must be understood and acknowledged to offer appropriate services and support. To most Hispanic women, the family is the most important social unit, even to the extent that she has to place herself, her own needs, and desires second. Devotion to family can give the individual a sense of emotional and material security. A crucial element of the family is that members work together to meet the needs of the family as a group. Each family member is expected to approach the family with their needs and to seek outside assistance only when the family lacks sufficient resources to assist. The traditional role of the Hispanic mother is to be supportive and self-sacrificing. She is respected because she minimizes her own needs in order to provide for the needs of her family. The treatment and safety and her children are very important to her.
- Acculturation influences the ways a Hispanic woman deals with domestic violence. An Hispanic woman more acculturated to the Mexican culture is more likely to tolerate abuse, while the more Anglo acculturated or younger generation of Latinas are less tolerant of abusive treatment from their partners.
- Many Hispanic women have not had previous experience with the systems – medical, legal, social – that assist victims of domestic violence. Consequently, shelters need to provide cultural sensitivity, including bi-lingual service providers, to the traumatized Hispanic victim in order to assist her effectively.

Adapted from *Hispanics and Domestic Violence* by Deborah Guadalupe Duran, Colorado Domestic Violence Coalition

## TENNESSEE DOMESTIC ABUSE STATUTES AND DEFINITIONS

Tennessee Code Annotated § 68-140-523. Training on domestic violence issues.

As a part of its training curriculum for emergency medical services personnel, the department shall approve and coordinate the use of materials concerning domestic violence.

[Acts 2001, ch. 3, § 3.]

Tennessee Code Annotated § 36-3-601 (3) defines "Domestic Abuse"-

(3) "Domestic abuse" means inflicting or attempting to inflict physical injury on an adult or minor by other than accidental means, placing an adult or minor in fear of physical harm, physical restraint, or malicious damage to the personal property of the abused party;

**Tennessee Code Annotated § 36-3-621. Reporting, by health care practitioners, injuries indicating domestic violence or domestic abuse.**

- (a) The general assembly finds that the incidence of domestic abuse and battering is on the rise in Tennessee and that measures should be taken to statistically document these incidents so that further study can be undertaken, and reasonable proposals to end the violence be put forth and considered in a rational and deliberate manner. The general assembly further finds that such statistics can be compiled only if health care practitioners are encouraged to report instances of domestic abuse when they examine abused patients. Such voluntary reporting will most likely occur if the law protects both the practitioner's duty to maintain confidentiality, with full civil immunity, and the patient from the types of violence, including acts of revenge, that may result when the batterer is reported. Such reporting system must be administered in a manner that ensures that abused patients are encouraged to seek adequate medical care for their physical and emotional injuries which result from acts of domestic abuse. The general assembly further finds that neither the law enforcement officials statewide, nor the courts, are adequately trained, or equipped by law, to fully address, or reduce, the incidence of domestic abuse and domestic violence.
- (b) Any health care practitioner licensed or certified under [title 63](#), who knows, or has reasonable cause to suspect, that a patient's injuries, whether or not such injuries cause a patient's death, are the result of domestic violence or domestic abuse, is encouraged to report to the department of health, office of health statistics, on a monthly basis. The report shall not disclose the name or identity of the patient, but should include the nature and extent of the patient's injuries, the substance in summary fashion of any statements made by the patient, including comments concerning past domestic abuse with the patient's current spouse or previous partner(s), that would reasonably give rise to suspicion of domestic abuse. The practitioner shall include any other information upon which the suspicion of domestic abuse is based.
- (c) If a patient is treated by more than one (1) health practitioner, it is the duty of the supervising practitioner of the unit or department providing treatment, or of any other health practitioner designated by the unit or department, to ensure that the reports are made on a timely basis and that duplicate reports of the incident are not made. In the event that the patient is referred to another health practitioner for treatment, the report shall be made only by the referring practitioner so that duplicate reports are not made.
- (d) Any person making any report pursuant to this part, including an employee or agent of a health care practitioner licensed under [title 63](#) in the reasonable performance of such person's duties and within the scope of their authority, shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal, that might otherwise be incurred or imposed including administrative actions for licensure revocation. Any person alleging lack of good faith has the burden of proving bad faith. Such reporter shall have the same immunity with respect to participation in any judicial proceeding resulting from such report, or in any judicial or administrative proceeding in which the information so reported is subpoenaed, examined, or considered.
- (e) (1) The identity of a person who reports domestic abuse, neglect, or exploitation, and the information so reported, as contemplated under this section are confidential and privileged and may not be revealed unless a court with jurisdiction under this part so orders for good cause shown.  
(2) Except as otherwise provided in this section, it is unlawful for any person, except for purposes directly connected with the administration of this part, to disclose, receive, make use of, authorize or

knowingly permit, participate, or acquiesce in the use of any list or the name of, or any information concerning, a practitioner participating in the voluntary reporting system.

(3) Nothing herein shall be construed to limit the duty of any person or entity to make any required report or to cooperate in any manner required by the provisions of the Tennessee Adult Protection Act, compiled in [title 71, chapter 6](#), part 1.

(4) A violation of this subsection is a Class B misdemeanor.

- (f) On a form to be created jointly by the Tennessee task force against domestic violence and the Tennessee Medical Association, in consultation with the department of health, each health care practitioner should file a summary report on a monthly basis, of the incidents of domestic abuse, to the department of health, office of health statistics. The office of health statistics shall compile such statistics in a meaningful fashion, in consultation with the Tennessee task force against domestic violence, and by presenting the information for each of the twelve (12) community health agencies statewide. At the end of each calendar year, the office of health statistics shall file a report of the incidence of domestic abuse with the speakers of both houses, the Tennessee task force against domestic violence, and the Tennessee Medical Association.

[Acts 1996, ch. 835, § 1; 1997, ch. 459, § 2.]

Death review teams established for domestic abuse death review are addressed in Tennessee Code Annotated § 36-3-624.

## **EMS RESPONSE TO DOMESTIC VIOLENCE**

### **LAW ENFORCEMENT'S PERSPECTIVE**

EMS may be only one part of a team to respond to a domestic violence scene. When EMS responds to a call where domestic violence is suspected, the following points can help the efforts of law enforcement:

1. Domestic violence is a crime. You are responding to a crime scene.
2. Every service provider on scene has the potential to remove or destroy evidence. Encourage all provider to approach the scene through a single entry and use one pathway as a way to limit the contamination of the scene.
3. Do not contaminate or remove evidence. If the patient has torn or bloodied clothing that you must cut to get to injuries, leave clothing or inform law enforcement of your findings.
4. If injuries are found during assessment that might not have been initially visible, inform law enforcement.
5. Communicate your treatment of injuries to law enforcement officers.
6. If patient needs to be transported immediately, leave your name and telephone number with the officers on duty in case they need additional information from you later.
7. Be aware of your demeanor. This may be the hundredth domestic violence call you've responded to; however, it may be the first for the victim.
8. Be aware of what you say. Law enforcement often carry tape recorders that can be used as evidence. What you say is part of the evidence.
9. Reinforce the victim's abilities to access resources and help.

**GOALS AND OBJECTIVES**  
**EMS RESPONSE TO DOMESTIC VIOLENCE – ANSWERS**

**GOAL:** To equip and train EMS personnel with the necessary tools to properly identify, treat, and refer patients who are victims of domestic violence.

**LEARNING OBJECTIVES**

1. What is the definition of Domestic Violence? *Domestic Violence is a pattern of assaultive and behavior that one individual inflicts on another.*
2. What is the magnitude of the problem? *Statistics vary but studies have found that nearly one-fourth of the women in the U.S. or more than 12 million will be abused by a current/former partner sometime during their life. More than 5 million women are battered annually.*
3. What are the four (4) types of interpersonal violence? *Economic, physical, emotional, and sexual.*
4. What are five (5) “Red Flags” that would assist the field EMS personnel in recognizing interpersonal violence? *History of trauma. Injury is not compatible with the mechanism. Multiple bruising noted in several stages in healing. The injured individual presents several days after the incident. Patients who do not present with complaints of trauma but with multiple vague complaints (such as headache, insomnia, pseudo-seizures, abdominal discomfort). Patients with chronic pelvic or abdominal pain. Patients or their children who call EMS at night on a regular basis. If the partner is present and will not leave the side of the patient even for a minute or who answers on behalf of the patient. Injuries inflicted during pregnancy,. A suicide attempt. Individuals with repeat 9-1-1- responses who may be mislabeled “accident prone”.*
5. Who is at highest risk for Interpersonal Violence? *Pregnant women. History of abuse. Isolation. Patient who has threats directed at them or their children, pets, belongings. Individuals who are socially/financially controlled.*
6. Give three (3) reasons why an individual may stay in an abuse relationship. *May be financially dependent on partner. May live in constant fear, and trust anyone. May have fear of escalating violence. May have children who depend financially and emotionally on them. May be embarrassed to let family or friends know what is happening. May have cultural or religious beliefs than encourage maintenance of the family at all cost. May still love the partner. May have grown up in an abusive relationship and doesn't know different.*
7. Give at least three (3) reasons why the pre-hospital provider may be reluctant to ask a patient about the possibility of domestic violence. *Fear of opening “Pandora’s Box”, i.e. asking could lead to many more issues. May be afraid that his type of questioning will offend the patient. May feel that they lack the proper training. May feel ill equipped to respond or refer the patient. May know either the victim or the perpetrator. May be a victim or have a history of interpersonal violence themselves.*

8. What questions, utilizing the SAFE acronym, can pre-hospital providers ask at the scene?

*S – Stress and Safety*

*A – Afraid and Abused*

*F – Friends and Family*

*E – Emergency*

9. Identify three (3) strategies to promote scene safety for EMTs who are responding to an domestic violence call. *Heighten awareness to surroundings. Make sure law enforcement has cleared the scene before entering. Recognize that the victim or perpetrator can turn on the EMT. Stay out of the kitchen (it is full of weapons). Ensure EMT partner maintains lookout watch while other is treating the patient. Keep victim and perpetrator separate if possible.*
10. Identify three (3) possible prevention strategies for domestic violence. *Better identification of victim. Referring victim to available resources. School based programs on violence prevention, conflict resolution or anger management programs. Mentoring programs for youth. Parenting skills. Better coordination of family services. Acknowledgment of community issue. Improve recognition and reporting of domestic violence. Strengthen police and court systems that acknowledge domestic violence as a crime. Support of Hotlines. Accessible shelters for victims. Counseling services.*
11. Give two (2) reasons why EMS personnel can be an effective agent for change in identifying and preventing domestic violence. *They can ask simple, direct questions, with a non-judgmental approach, in a confidential setting. They can validate the victim's experience. They can keep good records by documenting the mechanism of injury. They can refer. They can continue to improve skills by practicing basic counseling techniques, reviewing local hospital protocols, and assisting community violence prevention activities. EMTs see first hand the results of interpersonal violence. EMTs may be the only medical person who interacts with the victim.*

## TENNESSEE DOMESTIC VIOLENCE PROGRAMS

Abuse Alternatives, Inc.  
Elizabeth Owens  
Executive Director  
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## TENNESSEE DOMESTIC VIOLENCE PROGRAMS

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## TENNESSEE DOMESTIC VIOLENCE PROGRAMS

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