Family Violence Nursing Curriculum

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Position Statement

Nurses are in a unique position to make a significant impact on the problem of family violence. Caring is the essence of nursing and sets the stage for a partnership, which fosters the autonomy and strengths of individuals, families, and communities, supporting them toward health. It has been established that the most important determinant of people being able to discuss the abuse experience is a supportive, nonjudging attitude (McCauley, York, Jenckes, & Ford, 1998).

Despite the increased emphasis on the importance of including interpersonal violence content in nursing curricula, many nursing programs in Minnesota lack the necessary integration of violence content across the lifespan. In addition to the American Association of Colleges of Nursing (1999) and the American Nurses Association (1991), several nurse scholars have directly identified this need and how to address it (Blair & Wallace, 2002 ; Gayan, 2003 ; Woodtli & Breslin, 2002).

The content of this curriculum grew out of the 1999 AACN competencies. While working as members of the Practice Guidelines Committee of the Minnesota Healthcare Coalition (1996-2001), we informally surveyed Minnesota nursing faculty about their inclusion of family violence education in their curricula. This document was developed in response to those findings to provide Minnesota nursing faculty essential curricular information to develop student competence in preventing, assessing, and responding to family violence across the lifespan. Our names as authors are placed in a circle at the beginning of this document to illustrate the collaborative nature of the process of synthesizing the literature on family violence into a meaningful curriculum outline. We met for hours and sometimes days at a time over a two-year period and all information in this document was collaboratively written in an iterative process.

While nurses must be able to respond skillfully to victims of all types of violence, responding to victims of family violence requires sensitivity rooted in understanding how it differs from other types of violence. Distinguishing features of family violence include the

- parties' intimate knowledge of one another;
- perpetrator's ongoing access to the victim;
- secret nature of the problem, generally happening out of public view;
- perpetrator's ability to avoid being caught; and
- perpetrator's ability to influence consequences if caught.

While this document does not address assaults by strangers, many of the skills taught in working with victims of family violence are transferable to working with victims of stranger violence.

Key points to consider when utilizing this material include:

- A significant percent of students and faculty will have or are experiencing personal violence and have been deeply affected by the experiences. Faculty members who have experienced family

violence will benefit from self-awareness and self-care when teaching this content. Recognizing that there are survivors in the classroom sets the stage for an open, supportive, nonjudgmental, and sensitive learning environment. Making affirming statements and providing resource information benefits survivors in the classroom.

- The material builds on, but does not include, content on family systems and working with families with limited adaptive ranges and boundary issues.

- When working with patients with a history of family violence, nurses must respect the validity of the patient's point of view rather than imposing their own view of what is best for the patient. The role of the nurse is to be a source of support and resources. Patients make informed decisions when provided with objective and relevant information. However, when children and vulnerable adults are being victimized, nurses have a legal and ethical obligation to intervene.

- Nurses can effectively establish trusting relationships with their patients if they understand the basic dynamics of abusive relationships. This includes understanding the process of change from victim to survivor. The term victim legitimately refers to anyone who has experienced family violence, however some take offense at the term *victim* and prefer to be called *survivor* because it recognizes their accomplishment in overcoming the violence.

- Perpetrators of violence may also have been victims of violence. Nurses provide care to victims and perpetrators alike and need to know helpful nursing responses to all patients.

- Legal references are current at the time of writing. Since law is an expression of public will, it changes and evolves over time. Most recent legislative changes can be accessed on the Internet at https://www.revisor.mn.gov/pubs/ [https://www.revisor.mn.gov/pubs/]

How to Use this Curriculum

Although some nursing curricula have a specific course on family violence, most nursing programs in Minnesota place the content into a number of courses. The standard to strive for is weaving it in a purposeful way throughout the curricula. In considering where and how to integrate family violence content, Gayan (2003) suggests that, "placement of content reflects faculty's value of the content and sends a message to students about relevancy" (p. 48).

Some ways to integrate family violence include

- incorporating signs and symptoms of abuse into physical and psychosocial assessment classes and labs;

- teaching dynamics of violent relationships and helpful nursing responses in mental health courses;

- emphasizing ways of phrasing family violence assessment questions when teaching communication skills;

- using role-plays in clinical conferences to teach screening skills;

- including screening questions for abuse in health history interviews students conduct with peers;
- having students complete independent study assignments on-line (see Section III: Dynamics: teaching strategies); and
- including the health effects of abuse when discussing physical and psychological disorders. Examples might include
  - the prevalence of irritable bowel syndrome in patients who have a history of physical and/or sexual abuse;
  - the risk of being abused during pregnancy; and
  - the high rate of depression, suicide, eating disorders in patients who have a history of family violence.

Competencies

Family Violence Screening and Intervention Competencies for Registered Nurses

The following competencies were extracted from the *Position Statement on Violence as a Public Health Problem, Competencies Necessary for Nurses to Provide High-Quality Care to Victims of Domestic Violence, Appendix C,* American Association of Colleges of Nursing (1999, pp. 12-13). The AACN competencies were revised with AACN permission to reflect best practices in the state of Minnesota. Changes are indicated in bold.

1. Competencies related to acknowledging the scope of the problem.
   1. Recognize the prevalence of **family** violence in all its forms.
   2. Recognize risk factors for both victimization and perpetration of **family** violence.
   3. Recognize **the potential** significant physical and mental health effects of both ongoing and prior **family** violence.
   4. Recognize the effects of violence across the life span, including the long-term effects for children who are either victims or witnesses of **family** violence.
   5. Recognize one's own attitudes about **family** violence, including the possibility of one's own friends' or family members' victimization and the need to address ongoing issues arising from such experiences.
2. Competencies related to explaining the dynamics of abusive relationships
   1. **Demonstrate understanding of the concepts of power and control in relationships.**
   2. **Demonstrate understanding of the cycle theory of violence and its misapplications.**

   3. **Demonstrate understanding of common myths and facts related to abusers and survivors.**

   4. **Demonstrate understanding of the process of change.**

3. Competencies related to identification and documentation of abuse and its health effects.

   1. **Recognize the necessity and value of universal screening of all patients---male and female, all ages, all conditions.**

   2. **Articulate** developmentally appropriate questions to be used in screening in various settings.

   3. If physical violence **has occurred, recently or in the past,** assess particularly for **nonconsensual sexual contact,** mental health status, old undiagnosed injuries, risk of suicide and/or homicide **through interviews, review of medical records, and physical examination.**

   4. **Assess for current and/or past threats and acts of family violence, particularly child abuse and neglect; intimate partner violence; elder/vulnerable adult abuse, neglect, and financial or material exploitation.**

   5. Thoroughly document all findings related to abuse, neglect and exploitation.

4. Competencies related to interventions to reduce vulnerability and increase safety, especially of women, children and elders.

   1. Know local, state, and national domestic violence referral resources, including shelters and safe houses.

   2. Communicate non-judgmentally and compassionately.

   3. Conduct safety planning.

   4. Refer to **community advocacy programs,** social worker, shelter and legal counsel as appropriate.

   5. **Know the role of community advocates.**

5. Competencies related to ethical, legal and cultural issues of reporting and treatment.

   1. Know state and national legal mandates regarding **family** violence, including mandatory reporting responsibilities and limitations.

   2. Know appropriate methods for collection and documentation of data so that both the patient and the provider are protected.

   3. Know the ethical principles that apply to patient confidentiality.

   4. Recognize that ethical dilemmas often arise from cultural differences.

5. Recognize that cultural factors are important in influencing the occurrence and patterns of and responses to violence in individuals, families, and communities.

6. Provide culturally competent assessment and intervention while maintaining human rights.

7. **Understand the ethical implications of public policy which fails to protect people who are immigrants, particularly those who are undocumented.**

6. Competencies related to prevention activities.

    1. Increase public awareness of **family** violence.

    2. Promote activities to address prevention with populations at risk (e.g. child witnesses, pregnant women, **vulnerable adults,** and dependent-frail elderly).

    3. **Empower individuals and families to prevent and/or reduce violence and to promote family health.**

    4. Recognize the need to establish programs to support victims, their family members, and the abuser.

Scope of the Problem

Statistics

Since it is essential that nurses understand the magnitude of family violence, statistics are a necessary part of the curriculum. However, it should be emphasized to students that the numbers themselves are not as important as the overall impact of violence on individual and family systems.

Underreporting, as well as variations in definitions of violence and abuse account for the differences in statistical data often found in the literature. In addition, care must be taken when interpreting racial and ethnic differences in reported rates of violence. The ANA (1998), in its *Culturally Competent Assessment for Family Violence* , clearly points out that differences in rates of violence between racial groups tend to disappear when income is controlled.

Reliable family violence sources: Bureau of Justice Statistics: http://bjs.ojp.usdoj.gov/ [http://bjs.ojp.usdoj.gov/] National Center on Elder Abuse: http://www.ncea.aoa.gov/ [http://www.ncea.aoa.gov/] Futures Without Violence (formerly Family Violence Prevention Fund): http://www.futureswithoutviolence.org/ [http://www.futureswithoutviolence.org/] Minnesota Center Against Violence and Abuse: http://www.mincava.umn.edu [http://www.mincava.umn.edu] National Center for Injury Prevention and Control: http://www.cdc.gov/ncipc/wisqars/ [http://www.cdc.gov/ncipc/wisqars/] Child Welfare Information Gateway https://www.childwelfare.gov/ [https://www.childwelfare.gov/] Office of Juvenile Justice and Delinquency Prevention: http://www.ojjdp.gov/ [http://www.ojjdp.gov/]

Obtain local statistics through your community health department, advocacy programs, law enforcement agencies, and state department of health and center for crime victim services.

Health care cost

Intimate partner violence (IPV) is an enormous health problem, with annual excess health care costs of billions of dollars annually in the U.S (NCIPC, 2003). There is an increased relative risk of both overall and diagnosis-specific hospitalizations among abused women. Intimate partner violence has a significant impact on women's health and use of health care (Kernic, 2000). Among female Medica enrollees within the Allina Health Care System alone, it is estimated that over $6 million excess dollars are spent annually to provide health care services to female victims of IPV (Bohn, 2001).

Wisner, Gilmer, Saltzman and Zink (1999) found female victims of IPV to incur health care costs approximately 92% greater than a random sample of female patients. Contrary to the findings of other studies, use of emergency room services was not a driving factor in the higher cost.

Heterosexual

A wide range of studies conducted in the past 20+ years have found that 89-100% of *reported* cases of physical IPV involve women abused by men. While it is known that abuse occurs in gay, lesbian, bisexual, and transgender relationships, and there are men who are abused by female partners, the vast majority of abuse victims who *report* IPV are women abused by men. Health care professionals should realize that IPV is perpetrated primarily by men whether against male or female partners and the vast majority of IPV victims are women (Tjaden & Thoennes, 1998).

Some statistics documenting the incidence include:

- In a survey of 8,000 men and 8,000 women, 25% of women and 8% of men reported rape and/or physical assault by an intimate partner in their lifetime. Ninety-three percent of women and 86% of men who were raped and/or physically assaulted since the age of 18 were assaulted by a male (Tjaden & Thoennes, 1998).

- In large prospective emergency department (ED) studies, 37% to 54% of women seen in the ED have been abused by an intimate partner at some point in their lives. (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1998 ; Dearwater, Cohen, & Campbell, 1998).

Lesbian, Gay, Bisexual, and Transgender (LGBT)

Limited research has been conducted on the rate of LGBT domestic violence. Early research suggested that LGBT domestic violence was more prevalent than violence in heterosexual relationships. However, the National Violence Against Women Survey found that women living with female intimate partners experience less intimate partner violence than women living with male intimate partners and men living with male intimate partners experience more intimate partner violence than do men who live with female intimate partners (Tjaden and Thoennes, 2000).

Greenwood, Reif, Huang, Pollack, Canchola, and Catania (2002) studied the prevalence of battering victimization among 2,881 men who have sex with men. They found that 39% of the men, who were from four major urban areas, reported experiencing at least one type of intimate partner battering during the previous five years. The strongest demographic correlate of overall violence was being 40 years of age or younger. The strongest demographic correlates for physical and psychological/symbolic violence were education and HIV serostatus. Race, ethnicity, income, sexual orientation, and city of residence were not correlated with violence.

Child and Teen

a. Child abuse

Child abuse is a serious public health problem due to children's vulnerability and the potential adverse long-term health outcomes. In a survey of more than 15,000 adults conducted by Vincent Felitti, Robert Anda, Dale Nordenberg and colleagues, 10.8% of adult patients acknowledge child physical abuse, 22% said they experienced sexual abuse in childhood, 12.5% indicated childhood exposure to domestic violence, and approximately 33% reported being emotionally abused (Groves, 2001).

Young children are at the greatest risk for physical abuse. Forty-one percent of children killed by parents or caretakers are under 1 year of age and only 10% of child fatalities are over 4 years of age. Younger children are not only more physically vulnerable and less able to seek help, but they are also more likely to be suspected as victims and diagnosed as abused when injured, resulting in increased reporting rates (Gelles, 1997).

Girls aged 10 to 12 are the most likely victims of sexual abuse by adults. Adolescents are underreported as victims of physical and sexual abuse. Not only are they less likely to be diagnosed and receive help, but they also are often considered delinquent, troublemakers, and contributors to their victimization (Gelles, 1997).

These cases represent the following distribution of maltreatment types* (NCCAN, 2001):

Neglect	77.4%
Physical abuse	24.8%
Sexual Abuse	7.3%
Medical Neglect	4.5%
Psychological Maltreatment	1.0%

some cases involved more than one type of abuse/neglect

It is important to remember that these are only the rates of substantiated (reported, investigated, and adjudicated by law) cases. Physical and sexual abuse are difficult to substantiate because children are not brought in for medical care until signs of the abuse have disappeared. Furthermore, in cases where physical markers are present, it is often difficult to prove who is responsible.

b. Teen dating violence

Recent studies have pointed to intimate partner violence as a significant health issue for adolescents. It is associated with increased risk of substance use, unhealthy weight control behaviors, sexual risk behaviors, pregnancy, and suicidality. Approximately 1 in 5 female high school students report being physically and/or sexually abused by a dating partner (Molidor, Tolman, & Kober, 2000 ; National Center for Injury Prevention and Control, 2001 ; Silverman, Raj, Mucci, & Hathaway, 2001).

A study done by Ackard and Neumark-Steiner (2001) reports results from the 1998 Minnesota Student Survey on dating violence. They found that one in ten girls and one in 20 boys report being raped or physically abused on dates and approximately six percent of Minnesota boys and girls report some type of date-related violence by the ninth grade. Youth who have been victimized by dating partners are more likely than their non-victimized peers to report having experienced emotional problems including suicidal thoughts, poor emotional well-being, low self esteem, and eating disorders.

Elder: domestic abuse, vulnerable adult abuse, and caregiver stress

These three categorizations or terms are often used interchangeably, but generally speaking refer to different situations. Studies have found that a significant portion of elder abuse is spousal abuse continuing into older age (Brandl & Raymond, 1996). Elders can also be victimized by adult children, or other caregivers (Brandl & Raymond, 1997).

The National Center for Injury Prevention and Control (2003) reports the following breakdown of elder maltreatment *substantiated* by adult protection agencies.

Table 1. Percent of Substantiated Cases of Elder Abuse in US

Neglect	49%
Emotional/psychological abuse	35%
Financial/material exploitation	30%
Physical abuse	26%
Abandonment	4%
Sexual abuse	0.3%
Other	1.4%

Table 2. Relationship of Perpetrators to Victims in Elder Abuse (Percent of substantiated cases in the US)

	Neglect	**Psych.**	**Phys.**	**Finan.**	**Aban.**
Child	43%	54%	49%	60%	80%

	Neglect	Psych.	Phys.	Finan.	Aban.
Spouse	30%	13%	23%	5%	6%
Grandchild	9%	9%	6%	9%	7%
Other relative	4%	12%	5%	10%	0%
Friend/neighbor	1%	10%	10%	9%	0%
Sibling	9%	2%	5%	1%	0%
In-home service provider	4%	1%	0%	2%	7%

Relationship of family violence to societal violence

The "---isms"

It is important to understand the dynamics of abuse in relationships in the societal context of what are known as the "---isms:" racism, classism, homophobia and heterosexism, ageism, and ableism. The "---isms" are personal or institutional forms of discrimination committed by members of the dominant, often majority, culture against individuals or groups from whom they are different, based on characteristics over which neither has any control, such as skin color or physical ability.

There can be multiple intersections between the experience of family violence and the experience of the "---isms." Examples include

- *isolation* (the victim of family violence being denied a social network is akin to the heterosexism of a gay person being forced to remain closeted by family pressures);
- *economic abuse* (the victim being put on 'allowance' is akin to the sexism of a woman earning 76 cents on the dollar compared to $1 for the same work by a male counterpart); and
- *threats and intimidation* (the victim being yelled at and cornered is akin to the racism of racial profiling or the classism of a caseworker who threatens to terminate benefits of someone on public assistance).

The barriers abuse victims face are confounded by experiences of racism for people of color, homophobia and heterosexism for lesbian, gay, bi-sexual and transgendered (LGBT) people, and so on. This is why ongoing development of cultural competency skills is so critical to effective nursing practice.

Evolution of health care response

The role of health care professionals in the area of primary, secondary, and tertiary prevention of family violence has slowly evolved as societal awareness has increased. Laws mandating the reporting of child abuse emerged in the 1960's (see appendix A, History of Child Protection). The first battered women's shelters were founded in the 1970s. In the late 1980s and early 1990s most states

enacted elder abuse laws (Haywood & Scott, 1999). In Minnesota, health care professionals are mandated to report all cases of suspected abuse of vulnerable adults. With the genesis of the community responses to domestic violence, partnerships evolved between health care organizations and domestic abuse advocacy services.

While research clearly documents the major impact of family violence on health, many clinics, hospitals, and other health care sites across the country still resist universal screening. In fact, despite health care professionals in the US being in an optimal position to intervene, most states, including Minnesota, receive a failing grade in terms of training, screening, protocols, reporting, insurance, and legislation and public policy (Family Violence Prevention Fund, 2001). There is much more that policy makers can and should do to improve the health care response. For example, something as simple as a best of practice standard has yet to be agreed upon. Nursing can and should take leadership in crafting those policies.

International trends

The occurrence of family violence is strongly influenced by cultural forces. Rates of family violence vary from country to country. It is difficult to make accurate country to country comparisons of the incidence of family violence because methods of data collection are not held constant. Generally speaking, cultures that value the care of children and elders, have strong social welfare policies, protect the rights of women, and have strong social sanctions against violent behavior have lower rates of family violence.

The United Nations Children's Fund (UNICEF, 2000) reported that even with "spotty" statistics, one-fifth to one half of the female population in a given country has been abused by a family member or intimate partner, or dangerously neglected in childhood. Violence against women and girls continues to be a global epidemic that kills, tortures, and maims-physically, psychologically, sexually and economically.

Sports

More questions than answers exist in the area of sports and violence. However, violence experts frequently express concern about the behavior of athletes in general, and the lack of positive role modeling that exists in sports. Violent behavior by professional and amateur athletes, including assault, rape and domestic violence has been well documented (Benedict, 1997 ; Benedict & Yaeger, 1999).

There are at least two areas of concern for nurses. The first is the experience of violence for youth involved in sports (i.e. win at all costs, intimidation and humiliation surrounding their performance, etc.). Nurses should take the opportunity to educate and intervene with children and teens involved in sports. Education could include principles of respect, good sportsmanship, and conflict management. Perhaps the most important task for nurses is to help parents encourage positive attitudes towards competition and physical activity, recognize signs of anxiety and aggressive behavior, and promote realistic expectations for their child's performance (Hellstedt, 1988).

The second area of concern for nurses is the dynamic of college and professional contact sports athletes who commit violent acts and the failure of society to hold them accountable. Women victimized by professional athletes are highly pressured to keep silent.

Workplace

a. Domestic violence in the workplace

Domestic violence knows no boundaries. With the increasing number of working women, there is a correspondent increase in the incidence of domestic violence in the workplace. In a study of 118 battered women, Stanley (1992) found that 69.5% were employed at the time of the abuse. Of that number, 96% stated they experienced problems at work due to their abusive situations. 37% of women personally affected by domestic violence report that the abuse has had an impact on their work performance in the form of tardiness, missed work, a lost job or missed career promotions. (EDK Associates, 1997)

Intimate partner violence crosses the boundary of home and work in numerous ways. There are two issues to consider in this category. The first issue surrounds the effect intimate partner violence has on the workplace of the victim/survivor. Absenteeism, security concerns related to abusive partners, productivity, and the emotional impact on co-workers can affect workplaces. The second issue involves perpetrators in the workplace. Perpetrators often use the resources of their place of employment to harass their partner (phone calls, emails, etc.). Furthermore, perpetrators may exhibit the same abusive behavior at work as at home, targeting customers, coworkers, and others.

The total health care costs of family violence are estimated in the hundreds of millions each year, much of which is paid for by the employer (Pennsylvania Blue Shield Institute, 1992).

In a survey commissioned by Liz Claiborne, Inc., Roper Starch Worldwide (2000) found that corporate leaders have grown more aware of domestic violence as an issue that affects their employees and have become less likely to dismiss the issue's bottom-line impact on business, according to a survey conducted for Liz Claiborne Inc, nine in ten senior executives (91%) believe that domestic violence affects both the private lives and the working lives of their employees (this is up from 44% in a similar study conducted in 1994 by the same company). Yet only 12 percent of corporate leaders surveyed say that corporations should play a major role in addressing the issue-the same percentage as when this question was first posed in 1994. Roper Starch Worldwide (2000) also point out that corporate leaders now rank domestic violence on par with terrorism (68%) as a major issue that affects society. But today, they are also significantly more likely to say that they are aware of employees in their company who have been affected by domestic violence (56% in 2002; 40% in 1994). And, while half thought that domestic violence had a negligible impact on the bottom line in 1994, this percentage has dropped significantly to just one-third (33%) saying so today.

b. Abusive work environments

In addition to the problems presented when domestic violence spills over into the workplace, employers are beginning to address abuse issues within the workplace itself. Often referred to as 'bullying' or 'incivility,' what these behaviors are actually describing is abuse.

Healthcare workplaces are known for harsh, abusive behavior within and between the allied professionals in those environments, particularly physicians and nurses. The Joint Commission on Accreditation of Healthcare Organizations has begun to examine this long-silent issue, and guidelines on "Diagnosing and Treating Workplace Abuse and Neglect in Health Care Organizations" are being written for publication by the American Medical Association. Leadership from the nursing profession will provide needed perspective on the nature of the problem and how to respond to it.

Bullying

There is a growing body of research pointing to the prevalence of childhood experiences of bullying. Children who are experiencing maltreatment at home are at increased risk for both victimization and perpetration of bullying (Shields & Cicchetti, 2001). Childhood bullying may be an indicator of more extensive family violence and recognize the opportunity for screening and intervention.

Of over 15,000 children surveyed, 10.6% reported bullying others "sometimes" and 8.8% admitted to bullying others once a week or more, with children who bully showing significantly poorer psychosocial adjustment, such as loneliness, difficulty making friends, fighting, smoking, and using alcohol (Nansel, Overpeck, Pilla, Ruan, Simons-Morton, & Scheidt, 2001).

Media

The correlation between exposure to media violence and aggressive behavior has been the subject of numerous studies (Huesmann, Moise-Titus, Podolski, & Eron, 2003). According to the American Academy of Pediatrics (1995) the vast majority of studies conclude that there is a causal relationship between exposure to media violence and real-life violence. For children exposed to violent behavior in their homes, the effect of media violence is more profound.

Sample Teaching Strategies: Scope of the Problem

Timed reminder

During the segment on statistics, consider using timed sounds to illustrate the frequency of the incidence of abuse, loss of life, or a similar statistic. Use a taped recording of a hand slapping loudly every 15 seconds to signify how often a woman is assaulted by an intimate partner in the U.S. (FBI, 1995). Play it as you cover the statistics section.

Participant Cards

As students come into the classroom, give them an index card with a statistic about family violence. Begin discussion of each of the various topics that the statistics address by having the student with the corresponding statistic read it out loud.

Videos

- *Tough Guise: Violence, Media, and the Crisis in Masculinity* (82 minutes). 1999. Media Education Foundation. 1-800-897-0089, http://www.mediaed.org [http://www.mediaed.org]
- *Don't Laugh at Me* School Anti-Bullying Program. Available from http://www.operationrespect.org/curricula/index.php [http://www.operationrespect.org/curricula/index.php]

Web sites

- Center for Cross Cultural Health: http://www.crosshealth.com [http://www.crosshealth.com]
- National Clearinghouse on Child Abuse and Neglect Information (Now known as Child Welfare Information Gateway 2/08/11): https://www.childwelfare.gov/ [https://www.childwelfare.gov/]
- Minnesota Coalition for Battered Women: http://www.MCBW.org [http://www.mcbw.org]
- Silent Witness Project: http://www.silentwitness.net [http://www.silentwitness.net]
- Speaking Out Against Global Violence: http://www.feminist.com/violence/spot/ [http://www.feminist.com/violence/spot/]
- UNICEF: The State of the World's Children, 2001: http://www.unicef.org/sowc01 [http://www.unicef.org/sowc01/]
- Abuse-free workplace resources: http://www.mincava.umn.edu/categories/943#A101410100 [http://www.mincava.umn.edu/categories/943#A101410100]

Assessment and evaluation resources on the health of work and home environments as it relates to violence and providing direction to employers in seeing their role in addressing this issue:

Respond2, Inc. 1809 Lincoln Ave. St. Paul, MN 55105. 651.699.6565 Deborah Anderson, President

Definitions

Various definitions exist of the types of violence that occurs among intimates.

Violence

Violence is the threatened or actual use of force against a person or a group that either results in or is likely to result in injury, death, emotional damage or coerced behavior (Governor's Task Force on Violence as a Public Health Problem, 1996).

Domestic/intimate partner/family violence

There is little consensus on how to define these terms and what to call the various forms of abuse and violence among intimates (Tjaden & Thoennes, 2000).

We have found the following to be a good general working definition:

"A systematic pattern of repeated psycho-social/emotional abuse, coercive control, progressive social isolation, intimidation and violence, injury or sexual assault. The intention of this behavior is to punish, abuse, and ultimately control the thoughts, beliefs and actions of the victim" (*Minnesota Coalition for Battered Women*).

Elder abuse

An elder can be a victim of family violence without meeting the legal criteria for being a vulnerable adult in the state of Minnesota. A significant portion of what is typically identified as 'elder abuse' is actually abuse by a partner in long-term, intimate relationships. Elders may also be victims of abuse by adult children or others living in their home. In long-term abusive relationships, physical violence/threats as a tactic of control may diminish with old age, but other controlling behaviors often replace them in order to maintain the same control.

Other types of violence and neglect of older persons exist but are not domestic violence. Domestic violence is *not*

- self-neglect,
- stranger abuse (muggings, scams),
- abuse by paid caregivers (institutional elder abuse),
- caregiver stress (e.g. overburdened adult children), or
- abuse by a partner whose abusive behavior is caused by a medical or mental health condition or reaction to medication.

Vulnerable adult abuse

Minnesota statute defines vulnerable adult abuse as physical, sexual, or emotional abuse; neglect, or financial/material exploitation of a person who is at least 18 years of age and is dependent on others for care. Health care professionals are mandated by Minnesota statute to report abuse of vulnerable adults by people responsible for their care and acts of violence resulting from a failure to protect vulnerable adults.

Categories of abuse

1. Physical: actual or threatened infliction of physical harm which is intentional. Physical violence can include a range of threatened or actual behaviors from slapping and hitting to using a gun.
2. Sexual: any actual or threatened unwanted or coercive sexual contact and/or penetration. Sexual abuse also includes sexual contact with a minor child or vulnerable adult by someone responsible for their care (or, in the case of minors, by someone in a position of authority or in a significant

relationship with them). Routine care provided in accordance with standards of practice for health care professionals, and commonly accepted care by parents, guardians, etc. is not sexual contact.

3. Emotional/psychological: the use of coercion, threats, put-downs, insults, and other verbal or nonverbal measures which control another person and results in the loss of self esteem as well as victims believing they deserve the abuse.

4. Neglect: a failure to protect or a failure to fulfill any part of a person's obligations or duties to a vulnerable adult or a child. Neglect also includes abandonment of a child or vulnerable adult on the part of the person who is legally responsible for that person.

5. Financial and material exploitation of vulnerable adults: the illegal or improper use of a vulnerable adult's funds, property, or assets. Examples include but are not limited to: cashing checks without authorization/permission; forging a signature; misusing or stealing money or possessions; coercing or deceiving a vulnerable person into signing any document (e.g., contracts or will); and the improper use of conservatorship, guardianship, or power of attorney.

Sample Teaching Strategies: Definitions

Definition word scramble: Take your definition and divide it into relevant phrases. Put each phrase on a separate large post-it note or flip chart sheet. Scramble them up. Add words and phrases that don't belong in the definition on other post it notes. This is much like a magnetic poetry game. This could be done by teams with a prize awarded to the winning team.

Definition development: Tell the students you will give them a standard definition for the types of family violence, but you'd like them to create their own. Have students work together to create the most inclusive, yet concise definition possible. Have each group present their definition and see how it compares to the commonly accepted definition.

Websites

- Minnesota Coalition for Battered Women: www.mcbw.org [http://www.mcbw.org] Phone: 651-646-6177

- Minnesota Statutes are available at: www.leg.state.mn.us/leg/statutes.htm [http://www.leg.state.mn.us/leg/statutes.htm]

Dynamics

The ability to provide supportive care is dependent upon understanding the factors influencing individuals in abusive relationships.

Cultural/societal attitudes, beliefs, myths

Survivor myths and facts

See Appendix B: Family violence: Myths and misconceptions

There is a great deal of misinformation and many false assumptions about individuals in abusive situations. Health care professionals who understand the error of these myths are better equipped to provide care, support, and resources to individuals who indicate they are experiencing abuse.

Myth	Fact
1. Family violence occurs only in the lower socioeconomic class	Although poor families are likely to experience interpersonal violence, it occurs at all income levels. Poor families may be identified more often because they often have more contact with social service agencies.
2. Alcohol and drugs are the cause of family violence	There is an association between drinking/drug use and family violence, but it is not the root cause. Abusive individuals are abusive whether they are sober or intoxicated (Kantor & Strauss, 1990).
3. Family violence is rare	Research consistently shows that women and children are more likely to be assaulted in their homes than on the streets of the most violent American cities (Bachman & Satzman, 1996).

Abuser myths and facts

See Appendix C: Myths About Batterers, Appendix D: The ABCs of Men Who Batter, and Appendix E: Men who Sexually Abuse Children.

Many believe that only 'sick', 'evil' people are abusive. On the contrary, abusers usually lead 'normal' lives in most respects except they believe they are entitled to use violence and abuse to control the lives of their partners and families. Abusers come from every walk of life, every culture, and every socioeconomic level. They do not recognize their behavior as being violence. Often, these unacceptable behaviors are not challenged by society (Bennett & Williams, 1999).

The primary treatment objective for abusers is for the abuser to take responsibility for the abusive behavior and to be held accountable through a variety of measures such as legal consequences and reeducation programs. According to the *Standards for Batterers Treatment Programs-Philosophy Statement* issued by the Domestic Abuse Project in Minneapolis, effective batterer reeducation includes

- violence can never be condoned under any circumstances;

- abusive behavior is the sole responsibility of the batterer;
- provision for the safety of victims/survivors and their children should be utmost in any decision or policy;
- violence as a choice is a learned behavior response and can be unlearned in an educational/ therapeutic group setting;
- the primary goal of treatment programs for batterers is to end the violent, abusive, and controlling behaviors; and
- domestic violence and alcohol abuse are often intertwined, however a causal relationship has not been established. They must be treated as separate issues and perpetrators must address the chemical abuse issue before beginning a domestic abuse program.

Power and control

Domestic violence is much more than simply physical violence. Emotional and psychological abuse is present in all family violence situations. Many survivors of emotional abuse describe it as being more difficult to name, access support for, and ultimately overcome than physical abuse.

There are various Power and Control Wheels that describe the dynamics of family violence (see Appendix F: Power and Control Wheels). The behaviors, which form the spokes within the wheel depend on and reinforce each other. Sexual and physical violence, forming the outer rim, reinforce the entire system of control. Physical and sexual violence are not always present in abusive relationships; however, emotional abuse is always present. The wheels illustrate the interdependent and systematic nature of violence in relationships.

Economic abuse prevents victims/survivors from gaining financial freedom, which could help them escape the violence. Isolation destroys the support system of relatives and friends who might be able to provide information, support and resources. Threats instill fear. The interweaving of these dynamics builds barriers that prevent escape from an abusive relationship (see Appendix G: Challenges to Change: Issues Keeping Family Violence Survivors from Seeking Help).

Wheels have also been developed to illustrate how to achieve relational health (see Appendix F: Power and Control Wheels). In addition to the wheels appended in this document, wheels from a Native American perspective, for nurturing children, and Spanish language wheels can be accessed from the Minnesota Program Development, Inc. website on the Duluth Model at www.duluth-model.org [http://www.duluth-model.org]

Limitations of the Cycle of Abuse Theory

When studying current theories, thoughtful consideration should be given to the perspective of those experiencing battering (see Appendix H: Thoughts on the Cycle Theory of Violence and the Dynamics of Domestic Abuse and Appendix I: Theories on Domestic Violence) for in depth analysis of current thinking on the cycle theory.

Although most nursing texts present the *Cycle of Abuse Theory* (Walker, 1979) there are serious limitations to this theoretical framework. The cycle is described in three phases: tension building, acute battering incident (explosion), and honeymoon. While individuals in abusive relationships may relate to some or all of the elements of this cycle, many survivors experience only parts. Ellen Pence (1987) points out that, the process of education must constantly compare theory to the real experiences of women so that we do not operate from false assumptions. Such assumptions lead us to actions that do not result in changing the system. Perhaps there is no better example of this than the cycle of violence theory and the many theories that have in the past few years dominated the work with batterers, resulting in hundreds of men's groups forming around the country which focus on teaching men who beat women into submission to reduce their stress level, to cope with anger differently, to express feelings differently rather than working with batterers on issues of power and dominance. These theories focus on the psychology of battering rather than on the political and social context of battering, and they analyze battering piecemeal (p. 22).

Understanding the process of change

It is very important that nurses recognize that their role is not to prescribe, decide, or judge what a patient should do, but rather to partner with the patient to provide information and resources for informed decisions. In perhaps no other health care situation is respect for patient self-determination as critical.

When working with people in abusive relationships, there is a temptation to jump to a "you've got to get out!" approach. This judgmental stance robs patients of the right to their own choices and creates a barrier between the nurse and patient that may never be overcome.

Key elements of nursing partnership include the following caring nursing actions:

- talking with the victim/survivor in private;
- accepting patient choices in a nonjudgmental manner;
- expressing concern for safety;
- making supportive statements (e.g. "you don't deserve this," "I'm sorry this happened to you," etc.); and
- offering assistance *when the person is ready.*

Actions which could be harmful include

- telling people what to do;
- blaming the victim;
- violating confidentiality; and
- talking to the abuser about the abuse.

Considerations for various populations

Immigrant, refugee, undocumented

For immigrants experiencing family violence, nurses need to consider the cultural and familial context in which the violence occurred and how it is viewed by the victim. This underscores the imperative to engage the services of a professional interpreter when the nurse does not fluently speak the patient's language. Family, friends, and members of the extended community should not be used to assist in these cases. If a professional interpreter is not available on site, a phone interpreter should be utilized. Community pressures and language barriers can keep women trapped and isolated in violent relationships. Fear of immigration sanctions compound this isolation and entrapment.

It is important for nurses to consider the ramifications of actions taken to end the abuse, particularly when involving the legal system. In cases where the patient does not have full legal status in the U.S., contact with local law enforcement and the legal system is advised (without revealing the patient's identity) to ascertain whether the patient would be re-victimized by being reported to immigration.

Victims/survivors should be fully informed of the possible outcomes of various actions they might take to deal with the abusive situation. If a person without legal documentation reports a domestic assault to the police and is later deported to where she had been tortured as a political prisoner, reporting the domestic abuse was more dangerous than not reporting (Jang, Marin, & Pendleton, 1997).

Many immigrants feel as though they must choose between freeing themselves from the abuse and maintaining connection to their family and cultural community (see Appendix F: Immigrant and Refugee Power and Control).

Teens

Adolescence is a time when independence, autonomy, sexual identity, and intimacy are mastered-all of which can be disrupted by an abusive relationship. Teens, whose major social goal is to "fit in," are often very reluctant to reveal abuse when it occurs. Some may not even know that they are being abused. Denial is often the only coping mechanism in their repertoire. While they attempt to suppress the cognitive recollection of the abuse, it becomes manifested in their actions. At least 10% will attempt suicide after the abuse (Pharris & Nafstad, 2002). A nurse who develops rapport with the teen and specifically asks about victimization will be able to guide the teen toward healing.

A more effective way of dealing with teen violence is to prevent it. Nurses must look for opportunities to teach teens to differentiate between respectful and violent behavior. Several good resources exist for teaching teens about sexual abuse, healthy dating relationships, and teen dating violence (Center for the Prevention of Sexual and Domestic Violence, 2000 ; Levy, 1998 ; Levy & Giggans, 1995 ;Quiet Storm Project, 2001).

Rural Populations

One study of 136 women seen in two rural medical clinics found 20-28% of the women had experienced recent intimate partner abuse (Johnson & Elliot, 1997). Another study of 1693 Minnesota women showed the prevalence of physical, sexual and emotional abuse in rural women to parallel that of their urban counterparts (Kershner, Long & Anderson, 1999).

Rural victims of violence have some unique challenges, including:

- lack of access to public transportation and/or phone service;
- lack of anonymity and confidentiality;
- unavailability or ineffectiveness of legal and social services;
- more hunting weapons in the home; and
- fewer resources, such as jobs, child care, etc.

(Kershner & Anderson, 2002 , Kershner, Long, & Anderson, 1999).

Communities of Color

Family violence has been referred to as an "equal opportunity" problem because it happens to people in all demographic categories. Unfortunately, current research on the prevalence, health consequences, and responses to family violence in communities of color in particular has been limited, at best. For example, Torres, Campbell, Campbell, et al. (2000) point out that "few studies have specifically examined the relative prevalence of abuse during pregnancy in different ethnic groups" (p. 304). Campbell, Sharp, Campbell, and Lopez (2002) further note that "the theories currently used in domestic violence practice and research generally are one-dimensional in nature and applied uniformly across cultural groups...overall, the applicability of these theories...remains uncertain" (p. 5).

Nurses need to understand the diversity within and between racial/ethnic groups, that family violence happens in a larger cultural context, and the nature of institutional racism experienced daily by people of color. Nurses' responses to patients of color are informed by their own understanding and experiences of racism. The inclination of patients of color to disclose abuse is influenced by their perception of the race and the cultural sensitivity of the individuals and institutions caring for them. They are also influenced by the relevance and accessibility of the resources offered them.

Nurses demonstrate cultural competence through

- an awareness of their own biases, prejudices, and knowledge;
- an awareness of the extent to which racism is experienced by the people they serve;
- a recognition of professional power, in order to avoid imposing one's own values on the patient;

- knowledge concerning patients and their cultures; and
- openness to listening to and respecting new ideas and different perspectives (Fazio & Ruiz-Contrereas, 1998).

Regardless of the racial/ethnic background of nurses and patients, the nursing profession and healthcare organizations must prioritize implementation of cultural competency education relevant to the communities in which they operate. This is best accomplished through partnership with community organizations.

People with disabilities

People with disabilities have more frequent contacts with health care professionals. It is important not to make any assumptions about people with disabilities and the nature of their relationships with others.

The greater the degree of dependence on others, the greater the likelihood of abuse and exploitation people with disabilities experience (Pharris, 1999). In 1995-96 Berkeley Policy Associates conducted a survey of women with disabilities which found that women with disabilities were more likely to experience abuse by health care professionals and personal assistants, family members, intimate partners, or friends (Curry & Navarro, 2002). Children and elders with disabilities are also more likely to be abused by people responsible for their care.

Factors to consider regarding the abuse of people with disabilities include:

- Leaving abusive relationships may be more difficult because of the presence of a disability. Curry and Navarro (2002) make this point by drawing on the words of a survivor who states, *"You finally say, 'Okay, this is it. I'm going to do whatever I can to change this marriage. And by the way, can you bring my scooter to me so I can leave you?'"*
- The traumatic stress of the abuse often compounds the sense of vulnerability that some people with disabilities feel. Coming to terms with this can be intense and further disabling.
- People who have just gained some independence may be at risk for losing their newly gained independence and self-confidence.
- Prosecuting a legal case may depend on proving the extent of the disability, in which case the person may become further stigmatized by the system in the process.

Lesbian, gay, bisexual, transgender (LGBT)

Abuse thrives in silence and isolation. Due to the compulsory secrecy many LGBT people experience about their sexual orientation and relationships, LGBT domestic violence is often referred to as 'the closet within the closet.' "Straight" is the assumed sexual orientation of "a battered woman" in the traditional health care model. LGBT patients fall outside the care model historically designed for non-battered members of the white, heterosexual population. Regardless of sexual orientation, many battering victims commonly face barriers of ignorance and prejudice in receiving supportive,

appropriate care and services in medical settings. Battered LGBT patients often face barriers that can literally mean the difference between life and death.

There are many similarities in the dynamics of the abuse of power and control of LGBT and heterosexual relationships. It is important to understand, however, that LGBT domestic violence happens in a cultural context characterized by factors such as:

- homophobia and heterosexism;
- ignorance about LGBT people;
- understanding that LGBT women can be perpetrators and LGBT men can be victims;
- limited self-reporting ; and
- limited-to-non-existent services for LGBT people.

Nurses can eliminate bias by not assuming the sexual orientation of patients and by using gender neutral language in relationship to the patient's partner. In accordance with the *Code of Ethics for Nurses* (ANA, 2001), nurses must provide equally sensitive care to each patient.

Correlates

The impact on children who witness family violence.

In families where there is intimate partner violence, children are at high risk for being abused. There is a significant correlation between intimate partner abuse and abuse of children.

Children's responses to witnessing adult domestic violence vary considerably depending on the child's age, gender, level of violence in the home, degree of the child's exposure, whether or not they are abused, and the presence of other risk and protective factors. Some children have such resilience that they are able to cope with the chaos of a violent home in constructive ways. While children are affected by violence in their lives, not all experience long-term negative consequences.

Studies of children who witness domestic abuse have shown that the experience can have long-lasting emotional, behavioral, cognitive, spiritual, and physical effects. Children in violent homes may experience harmful circumstances

- observing a parent being abused, which some have suggested may be as harmful as being abused themselves;
- being abused themselves. It is often assumed the abuse in these circumstances is perpetrated by the abuser of the parent, however, sometimes the victimized parent is the one who abuses the child; and
- being neglected

Kolbo (1996) points out that children from violent homes exhibit more aggressive and delinquent behavior, and more withdrawn, anxious behaviors compared to children from non-violent homes. They also perform significantly below their peers in academics, school sports and social activities. Studies have shown that children exposed to domestic violence have a significantly higher rate of psychiatric problems than other children. Exposure to violence in the home has been found to be one of the most significant predictors of an adolescent's later use of violence in the community (Singer, Mille, Guo, Slovak & Frierson, 1998). Childhood exposure to domestic violence is the major predictor for being a perpetrator or victim of domestic violence in adulthood.

Behaviors vary in different age groups:

- less than 1 year: crying, failure to thrive, exaggerated startle response, frozen posture, stillness, sad and withdrawn facial expression, and lack of interest in exploration.
- Toddlers and preschoolers: aggression to adults and peers, defiant, noncompliant, night terrors, temper tantrums, intense separation anxiety, hyper-vigilance, multiple fears, emotional withdrawal. Toddlers become reckless and accident-prone.
- School children and adolescents: all the same behaviors as younger children as well as early and excessive experimentation with sexuality and illegal substances, problems with authority figures, school failure, and criminal behavior (Lieberman, 2000).

Child protective service and health care professionals often interpret children witnessing of domestic violence as a failure to protect on the part of the mother who is being battered. It is critical to remember, however, that this line of reasoning does not recognize that the perpetrator is responsible for creating the dangerous environment in the first place, and must be held accountable for stopping the violence. Generally speaking, the children are safe when the mother is safe.

Abuse of animals

Abusers use the threat or actual killing of animals as a way to establish or maintain control of their victim(s). Maiming or killing a pet is more than an act of aggression against the animal. Animal abuse is a likely indicator of abuse of family members. In the case of children who beat, torture, or mutilate animals, such behavior suggests serious psychopathology (Robin, 1999).

Substance abuse

Abusers who use drugs and alcohol are more likely to inflict injury on family members (Grisso, Schwarz, Hirschinger, Sammel, Brensinger, et al, 1999). However, while substance abuse may be a contributing factor, no evidence has been found to support a causal relationship between substance abuse and family violence. Not all batterers abuse substance and not all those who use substances batter. Abusers often use alcohol as an excuse for their violence and as a way to avoid responsibility for their behavior. Substance abuse treatment will not stop the violent behavior. Shared characteristics of alcoholism and family violence are denial, minimization, isolation, and intergenerational patterns.

Coping through substance abuse is a common response to family violence. Some women who have been battered also have substance abuse problems; however, this is not the reason they are being battered. Women who abuse substances have experienced more violence as children and experience significantly more abuse as adults compared to the general population (Miller, Downs, & Gondoli, 1989 ; Miller & Downs, 1993).

Mental health

A review of the literature does not reveal a causal relationship between serious and persistent mental illness and the perpetration of abuse and violence. However, research indicates that intimate partner violence and child abuse increase the risk for mental health problems, particularly post traumatic stress disorder and depression, in those who have been abused (Golding, 1999).

"Co-dependency"

Explaining family violence in an addiction framework is problematic because battering is neither an addiction nor a symptom of addiction; they are separate problems requiring separate solutions. Their relationship is sometimes contributory, but not causal. Equating them is dangerous for the victim and does not hold the perpetrator accountable. Furthermore, "co-dependency", an extension of addiction theory, is refuted by the following:

- society still sanctions violence in intimate relationships,
- the batterer is responsible for causing the power imbalance in the relationship by violating the standards for healthy, respectful relationships,
- a change in the "co-dependent's" behavior will not stop the coercive control and violence;
- "enabling" and "co-dependence" are simply euphemisms for survival tactics; and
- the victim needs more than the perpetrator's sobriety alone to be safe.

Caregiver stress

Caregiver stress is commonly used to explain why a person is abused by a family member on whom they are dependent for care.

Three problems with naming this dynamic *caregiver stress* include:

- it absolves the abusive party of responsibility for their abusive behavior;
- it suggests that if the victim were not dependent on the caregiver, there would be no stress or abuse, thus blaming the victim for the situation; and
- it prevents appropriate interventions from taking place (e.g. making a mandatory report to protective services, safety planning, offering information about power and control, and resource options) (Practice Guidelines Education and Training Committee, 1998).

Sample Teaching Strategies: Dynamics

Interactive case scenarios: MINCAVA, Global Prevention (http://www.globalvp.umn.edu/cgi-bin/index.pl). This is an independent and interactive learning case scenario involving various aspects of community responses to a family violence situation. Students have an opportunity to answer questions about the scenario and refer to linked online articles for further information.

Survivor story: Hearing from someone who has experienced abuse is powerful and contributes significantly to the learning experience. A guide for preparing survivors to share their story is available (see Appendix J: Speaking to Health Care Professionals: Notes to Survivors). In the absence of having an individual who is comfortable sharing their story and willing to answer questions, various videos are available. Discussion could include identifying elements of power and control as well as barriers to change.

Slide show of images drawn by children who have witnessed domestic violence. The Domestic Abuse Project of Minneapolis has put together a slide show of children's art and commentaries. This work is available and may be downloaded from the Internet at: www.mincava.umn.

Interactive power and control discussion

- Introduce the concept of the power and control wheel.
- Define and/or give an example of one of the quadrants (e.g. the economic abuse section).
- Ask the group to give examples of economic abuse (e.g. "can you think of examples of economic abuse in a power and control situation?").
- Continue group discussion on other quadrants of the wheel.

Understanding dynamics

- *Gloria's story*: A brief and very effective interactive skit to involve students in understanding the difficulties survivors face (Appendix K).
- *Quiz: Have you ever...*: A series of questions designed to increase student awareness of abuse dynamics (Appendix L).
- *Family Violence Awareness Exercise*: Reflective questions to help students explore their attitudes towards victims and perpetrators of abuse (Appendix M).

Videos

- *All Ways Welcome* (1990). Active Living Alliance for Canadians with a Disability. Ontario Ministry of Citizenship, Culture, and Recreation (1-800-771-0663).
- *Broken Vows: Religious Perspectives on Domestic Violence* (1994). Seattle, WA: Center for the Prevention of Sexual and Domestic Violence.

- *Elder Abuse: Five Case Stories.* Terra Nova films. This film follows the real-life experience over time of five elders who are victims/survivors of family violence. Available from www.terranova.org [http://www.terranova.org]

- *Domestic Violence Hurts Us All: Improving Accessibility for Domestic Abuse Victims among the Deaf and Hard of Hearing Community.* This 25 minute film reviews dynamics of domestic abuse, myths and facts about people who are deaf or hard of hearing, and provides a tour of a battered women's shelter for women who are deaf or hard of hearing. Available from the Community Action Council, 15025 Glazier Ave., Suite 100, Apple Valley, MN 55124 and the B. Robert Lewis House (612-452-7466, TTY: 612-405-9455, FAX: 612-452-8027).

- *Just to Have a Peaceful Life.* Pat's story: this is the true story of a life-long abusive relationship and the challenges that people face. This film powerfully illustrates the dynamics of leaving an abusive relationship for people in their 70s-80s. Available from www.terranova.org [http://www.terranova.org]

- *Love---All That and More* (2001). A set of three videos: *What Do You Want* (22 minutes), *Let's Talk About Sex* (19 minutes), and *Putting it All Together* (23 minutes). Center for the Prevention of Sexual and Domestic Violence, Seattle WA. Phone: 206-634-1903, fax: 206-634-0115, website: www.cpsdv.org [http://www.cpsdv.org]

- *My Girlfriend Did It.* Real-life stories of lesbian battering. Available from *Casa de Esperanza* 651-646-5553.

- *The Quiet Storm Project* (2001). This video, produced by a coalition of domestic abuse service programs in Minnesota, could be used by faculty and students to teach teens in the community or on the college campus about the dynamics of teen dating violence. It tells the story of a young woman who becomes involved in a relationship in which control and violence unfold. There is also a segment of victims and perpetrators of teen dating violence discussing the dynamics of the abuse. Available through www.thequietstormproject.com [http://www.thequietstormproject.com]

- *Reflections from the Heart of a Child.* 1996. This video deals with the relationship between substance abuse and child development. The father in this video drinks and abuses the mother. Students experience the family dynamics through the eyes of the children in this family. Available from Hazelden Foundation.

- *When Help is There.* This film has five multicultural scenarios of real-life elders who are survivors of family violence and how they were helped in their journey out of the violent situation. Available from Terra Nova films www.terranova.org [http://www.terranova.org]

- *Elder Issues: Nutrition, Falls, and Abuse.* (2002). ConceptMedia

- *The Vulnerable Young Child: Child Maltreatment, Part I: Neglect and Sexual Abuse and Part II: Psychological and Physical Abuse* (2000). Available from Concept Media.

Additional Resources

- Animal Rights Coalition: 612-822-6161
- The Humane Society of the United States: 1-888-213-0956
- Physicians for a Violence Free Society (2003). *Abuse assessment response course: Systems approach to partner violence across the life span.* San Francisco: Author. This curriculum is available on a CD. It is a comprehensive, well-organized multimedia educational tool with power points, videos, participant handouts, and instructor guides.
- MS Foundation for Women (http://forwomen.org/) has published *Safety and Justice for All,* a report that examines the role that the state's criminal justice system can play in preventing violence against women, particularly poor women, immigrant women, and women of color.
- Minnesota Advocates for Human Rights is scheduled to release a report in Spring of 2004 entitled, "State and Community Responses to Domestic Violence Against Immigrant and Refugee Women in the Twin Cities." Minnesota Advocates for Human Rights, 650 Third Ave. South, Suite 550, Minneapolis, MN 55402-1940, 612-341-3302, hrights@mnadvocates.org [mailto:hrights@mnadvocates.org] , http://www.theadvocatesforhumanrights.org/

Websites

- Center for Cross Cultural Health: www.crosshealth.com [http://www.crosshealth.com]
- Center for Research on Women with Disabilities (CROWD): http://www.bcm.edu/crowd/ [http://www.bcm.edu/crowd/]
- End Abuse (a newsletter of the Family Violence Prevention Fund): www.endabuse.org (No longer available online. Family Violence Prevention Fund is now known as Futures Without Violence, 1/28/13)
- Institute on Domestic Violence in the African American Community: www.idvaac.org [http://www.idvaac.org/]
- Minnesota Center Against Violence and Abuse: www.mincava.umn.edu [http://www.mincava.umn.edu]
- Women's Rural Advocacy Programs: http://www.letswrap.com/dvinfo *(Site no longer available as of 6/15/11)*

Health Care Implications: "It's Not Just a Social Problem"

Health care role

Ethical considerations

Family violence violates human rights, has a major impact on health and causes great suffering. Physical and sexual abuse is illegal; emotional abuse is unethical and robs people of their basic rights to dignity and individuality.

Nursing practice is driven by a unique set of ethical principles focused on patient advocacy and empowerment. The 2001 American Nurses Association *Code of Ethics for Nurses* includes statements that say nurses should

- practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual;
- promote, advocate for and strive to protect the health, safety and rights of the patient; and
- safeguard the patient and the public when health care and safety are affected by incompetent, unethical or illegal practice of any person (ANA, 2001)

Ethical principles that apply to family violence include:

- patient well being;
- patient self-determination;
- fairness;
- non-malfeasance (*non-infliction of harm*);
- beneficence (*production of benefit*)
- fidelity (*including confidentiality and non- deception*); and
- reparation (*restitution or compensation for wrong*).

Standards for hospital accreditation (JCAHO, 2002)

Objective criteria must be in place and staff must be trained in the use of these criteria to identify and assess possible victims of

- abuse and neglect;
- physical assault;

- rape or other sexual molestation;
- domestic abuse; and
- abuse or neglect of elders and children.

Staff must be able to make appropriate referrals for victims of abuse and neglect. A current list of private and public community resources for such victims must be available to staff.

Quality improvement

Adherence to abuse screening and intervention standards (JCAHO, 2002) should be measured on an ongoing basis. It is not possible to know if the job is being done well without measurement. Nurses should be cognizant of screening compliance, skill levels, perceptions of patients and their families, and effectiveness of screening and intervention. Studies have shown that implementation of abuse screening, while initially successful, often deteriorates to baseline. It is theorized that on-going education and evaluation helps to prevent this kind of deterioration.

Measurement indicators include, but are not limited to:

- percentage of patients screened;
- number of referrals made;
- patient perceptions of the screening experience; and
- patient perceptions of referrals (were their needs met?).

Advanced measurement involves research on the value of screening and intervention and what patients do and do not find helpful.

Risk management

Consideration must be given to issues of privacy and confidentiality. Particular concerns are

- potential for liability of health care professionals who do not screen or provide information to people who are at risk (see American Health Lawyers Association, 2000); and
- safety of the patient who is being abused (e.g. taking measures to protect the patient from the abuser in the health care setting, maintaining strict confidentiality so as not to disclose information that would place the patient at greater harm, and planning for safety upon disposition).

The effect of family violence on health

Physical, sexual, and/or emotional abuse can impact any system of the body. Because the effects can be manifested in many ways, nurses must be well aware of the wide range of potential health effects, which can include anything from headaches, to chronic pain, irritable bowel syndrome,

fibromyalgia, depression, and other disease entities that are difficult to treat. Appendix N (Systems Review) includes a review of the physiological, psychosocial, and behavioral effects of abuse on the neurological, orofacial, respiratory, cardiovascular, gastrointestinal, genitourinary, musculo-skeletal, and integumentary systems.

Selected empirical evidence of health care implications

1. Chronic pain

Fifty-three percent of patients presenting with pain and 65% of women examined for chronic headaches report a history of sexual or physical victimization (Koss, & Heslet, 1992). Fifty-three percent of the 150 women who presented to one hospital-based chronic pain center showed a history of physical and/or sexual abuse. A majority sought medical attention repeatedly (Haber, 1985).

2. Pregnancy

Homicide has been found to be the leading cause of pregnancy-associated death (Horon & Cheng, 2001). Pregnancy-associated death is defined as all deaths occurring up to one year after termination of pregnancy (Frye, 2001). In reviewing violent deaths of women between the ages of 15 and 50, in the District of Columbia over a 12-year period, Krulewitch, Pierre-Louis, de Leon-Gomez, Guy, and Green (2001) found homicide to be the most common manner of death for both pregnant and non-pregnant women, with pregnant women experiencing a slightly higher homicide rate. A survey of prevalence rates for abuse during pregnancy reveals a range between 0.9% to 20%, with most studies between 3.9% to 8.3% (Gazmararian, Lazorick, Spitz, Ballard, Saltzman, & Marks, 1996).

Gazmararian, Lazorick, Spitz, Ballard, Saltzman, and Marks (1996) point out that "...there is reason to believe that violence may be a more common problem for pregnant women than pree-clampsia, gestational diabetes, and placenta previa, 3 conditions for which pregnant women are routinely screened and evaluated"(p. 1919).

Parker, McFarlane, and Soeken (1994) studied 1,203 multiracial women and found that one in five teens and one in six adult women experience abuse during pregnancy. They also found that abuse is related to low birth weight and late entry into prenatal care.

3. Gastrointestinal

An association exists between abuse history and gastrointestinal illness. Health care professionals should therefore ask patients with severe or refractory illness about abuse history (Drossman, Talley, Leserman, Olden, &. Baerreiro, 1995).

Forty-four percent of patients in a gastro-enterology clinic reported a history of sexual or physical victimization during childhood or adulthood. Symptoms consistent with irritable bowel syndrome were evident in more than 60% of gynecologic referrals for chronic pelvic pain. As in pelvic pain, victimization histories are common in patients with irritable bowel syndrome (Drossman, Talley, Leserman, Olden, & Baerreiro, 1995).

4.Substance abuse

Compared to men, women are more likely to use alcohol to self-medicate mood and to cope with trauma, and less likely to use substances as a means of aggression (Miller, Downs, & Gondoli, 1989 ; Miller & Downs, 1993).

5. Mental health

Existing research supports the hypothesis that family violence increases the risk for mental health problems. In a review of the literature among women who have been abused, the prevalence of mental health problems was as follows (Golding, 1999):

- 48% depression (18 studies);
- 18% suicidality (13 studies);
- 64% PTSD (11 studies);
- 19% alcohol abuse (10 studies); and
- 9% drug abuse (4 studies).

The long term consequences of childhood abuse and neglect vary depending upon such factors as relationship to the abuser, frequency and duration of abuse, ages of victim and abuser, response by parents/guardians, and adequacy of the social, medical and legal response systems.

Emotional, physical, and/or sexual abuse of children may result in a number of psychological consequences, including but not limited to

- anxiety;
- repetitive nightmares;
- feelings of guilt and shame;
- psychosomatic symptoms, such as headaches, stomachaches, bedwetting;
- depression;
- social withdrawal;
- decreased self-esteem; and
- disturbed sleep.

Behavioral problems resulting from abuse and neglect seen in childhood and adolescence include:

- developmental delays;

- extreme shyness and clinging behavior;
- difficulty socializing with peers;
- disruptive classroom performance;
- poor academic performance;
- truancy and running away;
- early use of drugs alcohol;
- eating disorders;
- suicide and suicide attempts;
- fear of intimacy;
- difficulty trusting others; and
- overly sexualized relationships (Loos and Alexander, 1997).

Continued exposure to abuse may lead to more serious levels of anxiety, anger, hostility, and guilt. Adolescents and adults with a history of abuse are over represented in the prison population and have more psychiatric diagnoses like post traumatic stress disorder (PTSD) and major depression. (Silverman, Reinherz, & Gianconia, 1996).

Untreated sexual abuse and assault during adolescence is associated with increased sexual dysfunction, school failure, poor contraceptive use, PTSD, anxiety, eating disorders/obesity, somatization, insomnia, nightmares, poor self-esteem, depression, prostitution, multiple sex partners, interpersonal problems, sexual relations problems, substance abuse, psychiatric admissions, teen pregnancy, and risky health behaviors (ACOG, 1998). Males who have been abused as children are more likely to respond by externalizing (fighting, swearing, guns, reckless use of cars, etc.), whereas females internalize (depression, suicide attempts, anxiety, withdrawing, etc.) (Pharris & Nafstad, 2002).

6. Fibromyalgia

People with fibromyalgia are significantly more likely to report episodes of lifetime sexual abuse than randomly selected matched controls (53% versus 42%). Fibromyalgia patients also report physical abuse either in childhood or as an adult with much greater frequency than control patients (Boisset-Pioro, Esdaile, & Fitzcharles, 1995).

7. Hospital admissions

Kernic, Wolf, and Hold (2000) compared 1355 women known to be exposed to intimate partner violence to non-abused women and found an increased risk of hospitalizations among abused women.

In a five-year follow-up study comparing 117 battered women to a control group of 117 non-battered women, those battered had a dramatically higher use of 'somatic' hospital care. Categories of admissions included non-traumatic surgical disorders, trauma, gynecological disorders, induced abortion, medical disorders, and suicide attempts (Bergmen & Brismar, 199l).

	Battered Women (n=117)	**Control Group (n=117)**
One hospital admission	77%	50%
Total # of admissions	420	119
Psychiatric admissions	69	1

Source: Bergmen & Brismar, 199l

Sample Teaching Strategies: Health Care Implications

Have students assess their clinical setting for adherence to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards as they relate to training, assessment, treatment, and referral for violent victimization. (e.g. is training in place?, do nurses do universal screening?, are referrals readily available?, etc.).

Integrating into Routine Assessment

Many articles describing the effects of family violence encourage health care professionals to incorporate universal screening into their practice (Campbell, Cohen, McLoughlin, Dearwater, Nah et al., 2001 , Davis & Harsh, 2001). While a best-of-practice model in the area of routine screening has not been universally adopted or standardized, and barriers to screening still exist in many environments, universal screening has been strongly advocated by nurse and physician leaders throughout the country. It is *now* recommended that all clients, adolescent and older, be screened for family violence as follows (Family Violence Prevention Fund National Advisory Committee for the National Consensus Guidelines, 2002, p.13):

- as part of the routine health history (e.g. social history/review of systems);
- as part of the standard health assessment (or at every encounter in urgent care);
- during every new patient encounter;
- during periodic comprehensive health visits (screen for current IPV victimization only);
- during a visit for a new chief complaint (screen for current IPV victimization only); and
- when signs and symptoms raise concerns or at other times at the provider's discretion.

A holistic nursing needs assessment and intervention grid has been developed by Marlene Jezierski, BAN to guide nurses in their work with victims of violence and is available as a reference (see Appendix O: Victims of Violence: Nursing Needs Assessment and Interventions).

The manner in which assessment is conduct has been found to be extremely important in facilitating disclosure of abuse. In a study of women in group therapy for domestic violence, McCauley, York, Jenckes, and Ford (1998) found that while 86% of the women had seen their regular health care professionals in the prior year, only 1 in 3 had discussed the abuse during that visit. The most important determinant of whether to disclose the abuse was found to be "a supportive, nonjudgmental clinician attitude" (p. 554).

According to a consensus report issued by the Family Violence Prevention Fund in partnership with the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, Child Witness to Violence Project of Boston Medical Center, and the National Association of Pediatric Nurse Practitioners, all health care professionals seeing children and adolescents in public health, private practice, and managed care settings should incorporate intimate partner violence screening into their routine patient assessment (Groves, Augustyn, Lee, & Sawires, 2002).

Barriers to discussing family violence

Numerous barriers exist for health care professionals when screening for family violence. These barriers may be due to a variety of factors, including lack of education and comfort, personal biases, personal experiences with abuse, systems barriers, lack of privacy, or adherence to various cultural myths (see Appendix P: Barriers to Abuse Assessment and Intervention).

Many health care professionals do not screen because they believe there is no evidence that their intervention would be of any help, especially in the area of intimate partner violence. However, Holt, Kernic, Lumley, Wolf, and Rivara (2001) studied 2,691 adult females and found that women who seek permanent protection through legal no-contact orders experience significantly less subsequent violent victimization, as evidenced by police reports.

It is incumbent upon nurses to find ways to overcome barriers to discussing family violence in order to optimize patient care.

The health care professional

Nursing barriers include:

- uncertainty about how to respond to affirmative responses;
- fear that the patient will become angry;
- belief that it is not the responsibility of the professional to ask questions about family violence; and
- time constraints.

The Patient

Patient barriers include:

- reluctance to disclose unless asked directly;
- fear of the abuser;
- feelings of shame; and
- perception of the professional as hurried or not really wanting to hear about the abuse.

The system

System barriers include:

- non-supportive workplace;
- lack of specific institutional policies; and
- lack of privacy.

Process of screening

Screening must be done with sensitivity, objectivity, and insight. Without an understanding of the dynamics and issues victims of violence face, nurses cannot provide effective interventions. When nurses possess adequate knowledge and sensitivity, patients are more likely to feel comfortable disclosing abuse. A patient, understanding, and respectful tone of voice and an open body posture create an environment conducive to patient disclosure.

In some cases, it may be preferable or necessary to use a written form to screen for family violence (see http://www.pvs.org/npn_sample.html for a screening tool developed by David McCollum, MD).

Setting the stage

The authors suggest that prior to the preface statement, when time permits, nurses use a funneling technique to ask a few broad, non-threatening questions about how things are going in the family and/or with intimate partners, such as:

- "How are things going in your relationship with family members?"...with your partner? at home?
- "How do you feel about how differences are solved in your family/relationship?"

If there is an indication of potential family violence, more direct follow-up questions are asked. Because some patients may react negatively to the words "abuse" and "violence," naming a range of abusive behaviors and experiences may be more useful. For example:

- "Are you experiencing any stress or anger problems in your relationships?"
- "All people argue, how do you and your partner handle disagreements?"

- "Do your fights ever become physical?"

Prior to asking specific abuse screening questions, a preface statement is recommended, such as:

- "We at _____ hospital/clinic/agency are concerned about the effect that difficult or harmful relationships have on the health of our patients, so we ask everyone the following confidential questions", or

- "We recognize that many people experience events in their lives that affect their physical and mental health, such as difficult or harmful relationships."

Stated in this manner, the patient is more likely to view the questions as a reflection of the nurse's concern than as someone being singled out.

Principles of effective screening

Questions should be phrased in such a way as to invite disclosure and not convey judgment. For example, asking a patient, "you're not being abused, are you?" is both leading and potentially stigmatizing and unlikely to elicit an honest response.

Questions should be specific enough so that the patient understands exactly what is being asked. Many authors suggest asking, "are you safe?" yet this question may be interpreted in a number of ways (i.e. are you using safe sexual protection or do you have a burglar proof house). A more appropriate question is "Is anyone important to you hitting you, kicking you, punching you, or hurting you in any other way?" followed by "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?" (Feldhaus, Koziol-McLain, Amsbury, Norton, Lowenstein, & Abbott, 1997).

When someone responds with a vague answer, the nurse needs to follow up with a clarifying question. For example, if a patient responds to a question about being hit, kicked, punched, or otherwise hurt by someone important to them by stating, "well, not really..." The nurse can respond with a clarifying question, such as, "you sound uncertain about that, would you tell me more about what you mean by *not really.* "

See Appendix Q: Family Violence Screening and Response Tool.

Special Considerations

1. Elders

1. Older adults often experience other forms of abuse (neglect, financial, medical), therefore it is appropriate to ask one or two different questions such as:

    - has anyone ever refused to take care of you when you needed help? (e.g. withholding food/water, medications or basic cares such as bathing or toileting? Denied you visits to your doctor?);

- have you signed any documents in the last year that you did not understand?; or
- If someone is helping you with your finances, are you uncomfortable with their assistance? (Anoka County Community Health Nursing, 1999).

2. Nurse researchers have identified tools for elder neglect assessment (Fulmer, Paveza, Abraham, & Fairchild, 2000) and elder abuse and neglect (Fulmer, 2002). A thorough physical exam of older adults should include assessing for not only physical abuse, but also signs of neglect and financial exploitation. Health care professionals should look for changes over time---findings that are new or unusual for the patient. However, in families with abuse and neglect, care is often episodic and sought from different providers. Changing health care provider frequently is also a red flag for possible abuse and/or neglect.

2. Children

1. Every child seen for any reason should have a nonverbal assessment for possible child abuse. A head to toe physical assessment should be done to detect patterned injuries, patterns of injuries, and injuries that are inconsistent with the history given. Psychological abuse is associated with "poor appetite, lying and stealing, encopresis and enuresis, low self-esteem or negative self-concept, emotional instability or emotional maladjustment, reduced emotional responsiveness, inability to become independent, incompetence or underachievement, inability to trust others, depression, prostitution, failure to thrive, withdrawal, suicide, and homicide" (Meyers, Berline, Briere, Hendrix, Jenny & Reid, 2002, p. 86).

2. Interviewing children about abuse is a complex process that requires a highly skilled practitioner. The American Professional Society on the Abuse of Children (Meyers, Berline, Briere, Hendrix, Jenny & Reid, 2002) gives the following guidelines for interviewing children who have been victims of abuse:

   - ideally, forensic interviewing teams provide for the child to share the story just one time (a child asked repeatedly may think that they did not answer the question correctly the first time);
   - ask open-ended, nonleading questions. A poor question would be "Where did he touch you?" when the child did not say anyone touched him in the first place, or "He touched you, didn't he?" A good question would be "Did anyone touch you here?" (Meyers, Berline, Briere, Hendrix, Jenny & Reid, 2002, p. 252);
   - open-ended questions are not a panacea. Typically, young children's response to free recall and open-ended questions provide accurate but overly succinct information rather than error-ridden information;
   - While not leading, follow up with questions that are intended to obtain more information e.g. "were your clothes on or off" "describe how they got off" "Did this happen one time or more than one time?" etc.
   - if sexual abuse is suspected, ask about pain, bleeding, dysuria, other physical symptoms;

- when physical injuries are present, the question "What caused this mark here?" should be directed to the communicating child and parent for all injuries. The answers to the question should include details about what objects caused the injury or came in contact with the child;.

- if injury is highly suggestive of abuse, additional questions must be asked to determine when the injury occurred, where it occurred, who witnessed the injury, the child's developmental abilities related to the injury (e.g. The parent of a two-day-old says "My baby rolled off the bed"); and

- children's accuracy declines when asked yes-no questions. Conclusions from research suggest (Meyers, Berline, Briere, Hendrix, Jenny & Reid, 2002, p. 352):

  - yes-no questions should be avoided altogether with preschoolers;

  - 5-year-olds are 89% accurate in responding to yes-no questions; and

  - young children can be expected on average to make more errors in their statements than older children and adults.

Screening for intimate partner violence in the pediatric setting

The Family Violence Prevention Fund national consensus guidelines for child and adolescent health (Groves, Augustyn, Lee, & Sawires, 2002, p. 21) recommend the following screening guidelines in the public health and clinical pediatric setting:

1. screen female caregivers/parents who accompany their children during new patient visits; at least once per year at well child visits and thereafter, whenever they disclose a new intimate relationship;

2. screen female and male caregivers/parents known to be in same-sex relationships who accompany their children during new patient visits, at least once per year at well-child visits, and thereafter, whenever they disclose a new intimate relationship;

3. ask pregnant teens at first prenatal visit; at least once per trimester; and at the postpartum visit; and

4. also ask whenever signs and symptoms raise concerns. Specifically, screen when the child or adolescent has:

   - obvious physical signs of physical or sexual abuse;

   - behavioral or emotional problems, such as increased aggression, increased fear or anxiety, difficulty sleeping or eating, or other signs of emotional distress; or

   - chronic somatic complaints.

Also screen when care-giving adults present with obvious physical injuries or a history of intimate partner violence.

Cultural considerations

Nurses should be able to conduct a general cultural assessment with members of different ethnic and cultural groups before attempting to understand their experience of family violence. Nursing faculty must repeatedly stress the importance of listening to the patient's unique experience, cultural beliefs, values, and traditions. Cultural knowledge cannot be assumed solely by a person's race or ethnicity.

Nurses' cultural competence is as important for best practices in family violence interventions as is any technical skill. Students should be given basic information about culturally competent interventions, which begin with (Fazio & Ruiz-Contrereas, 1998)

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

Use of a family member or someone from the patient's community to interpret during the screening process is inappropriate; only trained objective interpreters should be used.

Perpetrators

In many settings, particularly in public health, nurses are working with entire families in which power and control are an issue. The Duluth Domestic Abuse Intervention Project (2002) has developed an excellent guide for interviewing perpetrators of domestic abuse.

Sample Teaching Strategies: Integrating into Routine Assessment

Scenarios

One of the most effective learning strategies is participation in the skill being learned. Role-playing provides immediate application of principles. Role-play can be made significantly less threatening by using multiple small groups that involve everyone rather than a performance in front of the class by a few people. Our post course evaluations consistently reflect a high value for the role-play experience (See Appendix R: Small Group Case Scenario Discussions, Physicians for a Violence Free Society and Appendix S: Culturally Sensitive Response to Victims of Intimate Partner Violence, created by Marlene Jezierski, BAN, RN for role play exercises).

Videos

One Voice/Domestic Violence: Identifying Victims and Batterers (1998). Concept Media, Intercollegiate Center for Nursing Education.

Additional teaching resources

Physicians for a Violence Free Society (2003). *Abuse assessment response course: Systems approach to partner violence across the life span.* San Francisco: Author. This curriculum is available on CD. It is a comprehensive, well-organized multimedia educational tool with power points, videos, participant handouts, and instructor guides.

Interventions

Essential elements of a sensitive nursing response include attentive listening, unhurried presence, a manner that expresses interest and conveys openness to any response, an ability and willingness to help, and utilization of community resources. There are three generally agreed upon guiding principles for interventions with family violence:

- the safety of victims is of primary importance;
- autonomy of adult victims to direct their own lives is respected; and
- effective interventions hold perpetrators, not victims, responsible both for the violence and for stopping it.

Responses to suspected child abuse

Responses to screening

When child abuse is suspected, the role of the nurse becomes more complex and emotionally charged, as nurses go through the mandatory reporting process to child protective services and/or the police (see chapter VII for mandatory reporting guidelines). It is difficult to maintain an objective, caring presence when the nurse knows or suspects that parents have abused their children, however, it is important to consider that this is often part of a transgenerational pattern of victimization and abuse. This does not excuse the behavior, but rather puts it into a context that provides for a more caring and helpful response. It is helpful to remind students that they are not the judge, jury, or police, but rather nurses charged with caring for a vulnerable family, prioritizing the safety and well-being of children, and painting an objective picture in case the legal system is involved.

The way nurses respond when children disclose physical, sexual, or emotional abuse can open the door for a healthy physical, emotional, and legal response to the abuse. Helpful communication principles for responding to a child who discloses abuse include (Reilly & Martin, 1995):

- Find a place to talk where there are no physical barriers between you and the child.
- Be on the same eye level as the child.

- Don't interrogate or interview the child.
- Be tactful. Choose your words carefully, don't be judgmental about the child or the alleged abuser. Listen to the child. Do not project or assume anything. Let the child tell her own story.
- Find out what the child wants from you. A child may ask you to promise not to tell anyone. Be honest about what you are able to do for the child..
- Be calm. Reactions of disgust, fear, anger, etc., may confuse or scare a child. Assess the urgency of the situation. Is the child in immediate danger? Safety needs may make a difference in your response.
- Confirm the child's feelings. Let him know that it is okay to be scared, confused, sad, or however he is feeling.
- Believe the child and be supportive.
- Assure the child that you care. Some children will think you may not like them anymore if they tell you what happened. Let her know that you are still her friend and that she is not to blame.
- Tell the child it is not his fault. Many children will think that the abuse happened because there is something they did or did not do. Don't over dramatize.
- Tell the child you are glad he told.
- Tell the child you will try to get her some help.
- Let the child know what you will do. This will help build a sense of trust, and he will not be surprised when he finds out that you told someone.
- Tell the child you need to tell someone whose job it is to help with these kinds of problems.
- Report your suspicions to the appropriate agency.

When child abuse is suspected, the legal medical forensic assessment and exam should be done by a multidisciplinary team skilled in responding to child maltreatment. If, when doing an initial assessment it becomes evident that a key piece of evidence to corroborate the parent's story of what happened is present in the home, the police should be notified of its existence (e.g.a child has a pattern injury and the parents state, "he fell against the safety gate" inform the police so that they can take pictures of the position of the gate prior to the parents' return home). Evidence is more credible from a "hot crime scene" (i.e. one that is undisturbed) than from one that is "cold" (i.e. may have been tampered with).

Safety assessment and planning

If a nurse believes that it is not safe for the child to return to the home (i.e. the child has been severely abused or neglected, there is imminent danger of death or harm, abuse has occurred and

is likely to escalate or recur, and/or there is imminent risk to the child if she/he returns), in addition to involving the police and/or child protective services, the nurse must assure a safe disposition. If a child protection worker is consulted and approves disposition back to the home where the abuse occurred, and the nurse's assessment reveals that the child is at risk for harm, it is incumbent upon the nurse to advocate for alternative placement, which might include an overnight admission into the hospital until a more in depth risk assessment and referral can occur.

Documentation

a. Description of injuries

Nursing documentation of victims of child abuse should include a thorough and precise description of injuries, including type, location, size, color, and shape. Rather than stating "belt marks" or "hand marks on the buttock," describe what you see; do not speculate.

Photos of injuries are extremely valuable in legal prosecution of cases. The photos, combined with thorough charting, paint an accurate picture for the defense attorney, prosecutor, judge, and jury. Body maps may also be useful, particularly when there are multiple injuries.

b. Description of alleged abuser, when present.

Description of the behaviors and comments of the alleged abuser should also be included in the legal evidentiary report. For example, "Father refuses to leave patient's side. Answers questions for patient."

When documenting injuries that corroborate or fail to corroborate the history given, the following statement should be included: "This injury is/is not consistent with the history given and the child's developmental stage."

Resources and referrals

It is the responsibility of the nurse to make referrals to community resources when a child is the victim of abuse or is at risk for being abused. Programs directed toward the prevention and treatment of child abuse fall within the public health model of levels of prevention.

Primary prevention activities can be carried out by nurses in a variety of ways including education on effective parenting, stress management, growth and development. Referring families to programs such as Head Start or Minnesota Early Learning Design (MELD) also falls within the primary prevention focus.

An example of secondary prevention is home visitation with new parents by public health nurses, a strategy that has been proven in several studies to significantly reduce the rate of documented child abuse cases. Home visiting is deemed to be the most effective strategy for preventing child abuse (Finkelhor, as cited in Barnett, Miller-Perrin, & Perrin, 1997).

Finally, tertiary prevention in the form of family support initiatives is directed toward stabilizing families once child abuse has occurred. Nurses can provide referrals to crisis intervention and counseling services to assist in breaking the cycle of family violence.

Examples of resources are:

- emergency telephone numbers, such as the national child abuse hotline (1-800-422-4453);
- emergency child care facilities, such as crisis nurseries;
- respite programs to give parents some relief from child care;
- home visits by public health nurses;
- parent education programs; and
- family support programs, such as the Family Support Network (1-800-CHILDREN, www.familysupport.org [http://www.familysupport.org]).

Websites related to child abuse:

- Child Welfare Information Gateway https://www.childwelfare.gov/ [https://www.childwelfare.gov/]
- Child Protection Network http://child-abuse.com [http://child-abuse.com]
- National Committee to Prevent Child Abuse: www.childabuse.org [http://www.childabuse.org]
- American Academy of Pediatrics: www.aap.org [http://www.aap.org/en-us/Pages/Default.aspx]

Cautions for informing parents of mandatory report

While the student may find that many clinicians are reluctant to inform parents of their intention to file a mandatory report, it is important to consider the following:

- Given the high likelihood that children still remain with their parent(s) when child abuse reports are filed, an important focus of nursing care is developing a trusting relationship through which parenting can be nurtured. The best way to uphold the integrity of the nurse-parent relationship is to inform the parent of the report in a caring, nonjudging, and matter of fact manner. In this process it is helpful to convey to the parent the importance of their role in their child's life.
- If there are concerns for the safety of the child or others in response to informing the parent(s) of the child abuse report, or if parental drug or alcohol use might distort their reactions, informing parents of the child abuse report should be done in a manner that assures the safety of all involved.

Responses to adolescent and adult victims of intimate partner violence.

Working with victims who are in an abusive relationship takes time and patience. For each survivor the journey is different. It is often difficult to understand the decisions patients make, such as deciding to remain in an abusive relationship; and there is a tendency for nurses to assume they know what is best for the patient. However, if the patient senses the nurse does not approve of what she is doing, she will be less likely to discuss her situation with the nurse and she may lose confidence in herself. The nurse must understand the necessity of providing vital information without the patient feeling judged or pressured.

Responses to screening

Response Type	Patient Response	Nurse Response
Affirmative: Current	"Yes, I am in an abusive situation"	Supportive, nonjudgemental, caring, assesses patient safety, offers options and resources
Affirmative: Current, but patient minimizes abuse	"Yes, he hits me, but he promised me he won't do it again"	"Typically these behaviors only get worse without intervention. I fear for your safety!"
Affirmative: Past	"Yes, I was in an abusive situation" or "I am an incest survivor"	Explore past experience with resources and present need to speak with someone. Offer resources
Affirmative: Exposure	"I know someone who is being abused"	Offer to answer any questions and provide information/resources.
Affirmative: Patient abuse of another	"I sometimes hit my child."	Provide resources (support groups, crisis nursery, parenting tips, identify stressors). [See child abuse section for nursing responses to suspected child abuse.]
Affirmative: Possible abuse by child	"I am afraid of my son."	Supportive, nonjudgmental, caring, assess patient safety, offer options and resources
Negative response, but nonverbal cues indicate possible abuse	Change in affect after question asked, seeming sad and fearful. Startles easily.	Opportunity to educate and raise awareness about community resources
Negative response, no concerns		Opportunity for primary prevention through community education.

Response Type	Patient Response	Nurse Response
Patient gets angry or defensive	"You have no business asking me that question!"	Reaffirm purpose of screening. "I'm sorry you feel that way; we ask because abuse impacts people's health and many people are experiencing family violence and want help." The nurse should not feel any guilt for asking.

Safety assessment and planning

Assessment of the degree of lethality is essential. Research shows that people are at greater risk of homicide when guns are in the home. However, even in the absence of such risk factors, a survivor may still be at serious risk. People have different levels and expressions of fear. The risk of danger may be high, yet some people may not recognize that risk or display a fear response. Nurses should verbally and nonverbally express concern regardless, since survivors are often unable to see the danger they are in.

Several danger assessment and safety planning tools exist which can provide students with examples on which to base their practice. One of the most widely known danger assessment tools has been developed by Jacquelyn Campbell, PhD, RN and can be accessed at: http://www.dangerassessment.org/DA.aspx [http://www.dangerassessment.org/DA.aspx] For a sample safety plan, see Appendix T: Safety Plan (Alexandra House, Blaine, MN).

Documentation

As in any other medical record documentation, the nurse must be objective and thorough. Even if a survivor is convinced she will never report her abuser, she might change her mind in the future. The thorough, accurate documentation of her injuries and other assessment findings will be available to the court to demonstrate the seriousness of the case over time. It is important for nurses to understand the difference between subjective and objective data for legal evidentiary purposes. For example, describing the survivor as "anxious" could be interpreted in the courtroom as subjective. Subjective data should be presented as direct quotes (e.g. "I'm afraid and feel anxious-I know he's going to kill me (sobbing)"). Good nursing documentation simply describes what is observed, such as "Patient's hands shaking and respirations rapid as she speaks. Patient pacing back and forth from door to window. When a door slammed down the hall, patient turned wide-eyed toward the door and jumped back."

The National Institute of Justice has developed guidelines for documentation of domestic violence (Isaac & Enos, 2001 , www.ojp.usdoj.gov/nij [http://www.ojp.usdoj.gov/nij]).

a. Description of injuries

Nursing documentation of survivors of intimate partner violence should include a thorough and precise description of injuries, including type, location, size, color, and shape. Rather than stating "choke marks" or "finger marks", describe what you see; do not speculate.

Photos of injuries are extremely valuable in legal prosecution of cases. The photos, combined with thorough charting, paint an accurate picture for the defense attorney, prosecutor, judge and jury. Body maps may also be useful, particularly when there are multiple injuries.

b. Description of abusive partner, when present.

Description of the behaviors and comments of the abusive partner should also be included in the medical record. For example, "Partner refuses to leave patient's side. Answers questions for patient."

Resources and referrals

Nurses should identify the key agencies in the community that serve abuse victims. These include both in-house and community resources (e.g. hospital/clinic social workers, victim service organizations, crisis hot lines, batterer treatment programs, child and adult protective services, etc.). When the patient desires support, arranging an immediate personal contact is always preferable. The national domestic violence hotline number is 1-800-799-SAFE.

Abuse victims benefit greatly when nurses partner with domestic abuse advocates. Domestic violence advocates are very knowledgeable and provide numerous supportive services (See appendix U: The Role of a Domestic Violence Advocate).

Cautions

a. Contraindications for couples counseling*

Battered women's advocates have long understood and advocated against the use of couples counseling in cases of domestic violence due to its lack of effectiveness and the danger in which it places the victim. Physicians for a Violence-free Society (2002) points out that "joint counseling is generally inadvisable and should be attempted only when the violence has ended. If joint counseling is undertaken, both partners must give independent, voluntary consent. The counselor should have adequate skills and training to deal with domestic violence without further escalating the violence.

Joint counseling should only be considered when

- the violence has completely stopped;
- the victim and family are no longer fearful;
- the batterer has successfully completed a batterer's program;
- both parties desire to work on their relationship; or
- co-morbid alcohol or substance abuse issues have been addressed" (PVS, 2002, p. 5).

*couples counseling is also referred to as marriage counseling, family therapy, conjoint therapy, and joint therapy.

b. Cautions when applying behavior change models to the lives of victims of family violence.

Several authors (Brown, 1997 ; Frasier, Glowa, Slatt & Kowlowitz, 2000 ; Kramer, 2001) have recently advocated for the use of the transtheoretical model of behavior change (Prochaska & Velicer, 1997) to guide practitioners when working with victims of domestic violence. The transtheoretical model presents behavior change stages: pre-contemplation, contemplation, preparation, action, and maintenance. This model encourages practitioners to assess their patient's readiness to implement changes in their lives and to tailor interventions to be of maximal help.

The transtheoretical model was originally conceptualized for people with addictions (smoking, alcohol, drug use, etc.). It therefore needs modification when being applied to victims of family violence, where the abuser has total control and responsibility. For example, Frasier, Slatt, Kowlowitz, and Glowa (2001) caution against using the concept of "relapse," substituting instead "returning." In addition, they argue that the problem behavior does not lie with the victim of family violence, but rather with the abuser. In the nurse response, the message that the abuser is responsible for change must come through loud and clear. Frasier et al. (2001) apply the transtheoretical model to teach health care professionals helpful responses to victims/survivors as they move through the various stages of change.

Potential responses to suspected abuse of elders/vulnerable adults/ those with disabilities

Knowledge of the legal and functional definitions of vulnerability are essential for effective nursing assessment and response to situations where abuse of adults is suspected. (See Appendix V: "'Elder domestic abuse', 'Vulnerable adult abuse' and 'Caregiver stress.'")

Responses to Screening

Patient Status	Intervention
Patient has mental and physical capacity to protect self & declines referral	• Accept patient's decision. • Listen and be respectful. • Discuss the tendency for abuse to become more frequent and severe over time. • Provide emergency contact numbers.
Patient has mental and physical capacity to protect self & accepts referral	• Discuss the tendency for abuse to become more frequent and severe over time. • Arrange for on-site or telephone advocacy.

Patient Status	Intervention
	• Offer written emergency numbers and appropriate referrals. • Develop and review safety plan.
Patient cannot adequately care for or protect self due to physical or mental disability	• Contact Adult Protection to address guardianship and related matters. • Address immediate safety concerns.

Safety assessment and planning

Safety assessment and planning is essential regardless of the patient's vulnerability status. Assessment of the degree of lethality is essential. As previously stated, even when the risk of danger is high, some patients may not recognize the risk or display a fear response. Nurses should verbally and nonverbally express concern since patients are often not able to see the danger they are in.

The extent to which nurses involve patients in safety planning depends on their capacity to adequately care for and protect themselves. It is incumbent on the nurse to advocate for the patient's safety. Possible options include but are not limited to hospital admission, order for protection, and safe home placement.

Documentation

As with any other medical record documentation, the nurse must be objective and thorough. It is important for nurses to understand the difference between subjective and objective data for legal evidentiary purposes. For example, describing the survivor as "anxious" could be interpreted in the courtroom as subjective. Subjective data should be presented as direct quotes. Documentation for this population may include statements such as "She won't fill my prescriptions," or "I'm only allowed to go to the bathroom twice a day," or "I only get $5 a week allowance."

a. Description of injuries

Nursing documentation of family violence should include a thorough and precise description of injuries, including type, location, size, color, and shape. Rather than stating "choke marks" or "finger marks," describe what you see and hear; do not speculate.

As already stated, photos of injuries are extremely valuable in legal prosecution of cases. Body maps may also be useful, particularly when there are multiple injuries.

When documenting injuries that corroborate or fail to corroborate the history give, the statement, "This injury is/is not consistent with the history given" provides a nursing assessment of the injuries seen.

b. Description of alleged abuser, when present

Description of the behaviors and comments of the alleged abuser should also be included in the legal evidentiary report. For example, "Daughter refuses to leave patient's side. Answers questions for patient."

Resources and referrals

Nurses in any location should identify the key agencies in the community that serve vulnerable adults and elders victims of intimate partner violence. These include both in-house and community resources (e.g. public health agency/hospital/clinic social workers, adult protective services, victim service organizations, crisis hot lines, batterer treatment programs, etc.).

- National Center on Elder Abuse: http://www.ncea.aoa.gov/ [http://www.ncea.aoa.gov/]
- Elder Abuse Prevention and Treatment Resources: http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/EA_Prevention/Index.aspx [http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/EA_Prevention/Index.aspx]
- National Committee for the Prevention of Elder Abuse: www.preventelderabuse.org [http://www.preventelderabuse.org]
- Elder Abuse Law Center: http://www.noelderabuse.com/ [http://www.noelderabuse.com/]
- American Society on Aging: http://www.asaging.org/
- National Institute on Aging (the primary NIH organization for research on elder abuse): www.nia.nih.gov [http://www.nia.nih.gov]

Cautions (See Appendix V: "Elder domestic abuse," "Vulnerable adult abuse" and "Caregiver stress").

The terms elder domestic abuse, vulnerable adult abuse, and caregiver stress are often used interchangeably but generally speaking refer to different situations.

Regardless of the terms used, screening for risks and signs of abuse/neglect among the elderly and vulnerable adults should be a routine part of patient assessment by health care professionals. All such screening should be conducted privately to ensure confidentiality for the patient and protection from potential retaliation by the abusive party.

Sample Teaching Strategies: Interventions

Scenarios (See assessment section teaching strategies)

Assign literature searches on nursing interventions for family violence in various racial/ethnic groups. This is an instructive way for students to learn about the paucity of such research, as well as to illustrate the cultural competence needed for effective nursing practice.

Interactive web-based case scenario: MINCAVA, Global Prevention www.globalvp.umn.edu [http://www.globalvp.umn.edu/cgi-bin/index.pl] This is an instructive interactive independent learning case scenario involving various aspects of community responses to a family violence situation. Students have an opportunity to answer questions about the scenario and refer to linked online articles for further information.

Present case/photos for students to document

Teaching Resources:

Physicians for a Violence Free Society (2003). *Abuse assessment response course: Systems approach to partner violence across the life span.* San Francisco: Author. This curriculum is available on CD. It is a comprehensive, well-organized multimedia educational tool with power points, videos, participant handouts, and instructor guides.

Family Violence Screening and Response Tool (Appendix Q.)

Creating a Safe Place. Video on assessing for and responding to intimate partner violence. Available through Allina Media Services, 612-775-7921.

Domestic Violence: How to Ask and What to Say for Health Care Providers. A HealthPartners domestic violence video is available for $10.00 at: HealthPartners Center for Health Promotion at 952-967-7453.

Elder Abuse: Five Case Stories. Terra Nova films. This film follows the real-life experience over time of five elders who are victims/survivors of family violence. Available from www.terranova.org [http://www.terranova.org]

Just to Have a Peaceful Life. Pat's story: a video available from Terra Nova films tells the true story of late-life life-long abusive relationship and the challenges that people in this age group face. This film powerfully illustrates the dynamics of leaving an abusive relationship for people in their 70s-80s. Available from www.terranova.org [http://www.terranova.org]

Elder Issues: Nutrition, Falls, and Abuse. A 27 minute video on elder abuse released in 2002 by Concept Media

Websites:

The Greenbook Initiative web site (www.thegreenbook.info [http://www.thegreenbook.info]) focuses on the intersection between child abuse and domestic violence and outlines steps that helping agencies and court systems can take to better meet the needs of families experiencing violence.

Legal and Ethical Issues

Standards of Care

The Code of Ethics for Nurses (ANA, 2001) clearly delineates the nurse's obligation to promote, advocate for, and strive to protect the health, safety, and rights of patients. Failure to effectively assess for and address family violence constitutes irresponsible health care.

Beyond the ethical mandate to uphold nursing standards of care, there is also a rising legal concern when health care professionals fail to adequately protect their patients. A liability case was settled out of court in favor of a woman who was obviously battered and seen in an emergency department. She had been discharged accompanied by her abuser, who exhibited violent behavior at the time of discharge. After returning home from the ED, the woman was set on fire by her abuser and sustained second and third degree burns to 62% of her body. In reporting this case, the American Health Lawyers Association (2000) concluded that the health care professionals failed to satisfy several duties that they owed to their patient, including:

- "duty to evaluate, diagnose, and intervene appropriately to ensure the patient's safety, as well as the
- duty to implement and comply with policies and protocols for the appropriate management of domestic violence, as well as their
- failure to appropriately intervene in order to ensure the safety of their patient" (para. 8).

Mandatory reporting requirements in Minnesota

Minnesota law mandates healthcare professionals report suspected abuse and/or neglect of children and vulnerable adults who are in their care. There are two criteria that constitute mandatory reporting for child/adult protection situations. First, the victim is vulnerable as defined by law, and second, the alleged offender was in some way responsible for the vulnerable person's care or protection. See Minnesota Statutes for current law related to maltreatment of minors (MN Stat. § 626.556) and vulnerable adults (MN Statute § 626.557). Since law is an expression of public policy, it changes and evolves over time. The most recent changes can be accessed at www.revisor.leg.state.mn.us Information on responding to child and vulnerable adult abuse is also available from the Minnesota Department of Human Services at http://mn.gov/dhs/

Basically, nurses must ask themselves, "Is the patient vulnerable as defined by law?" and "Does the alleged offender meet the mandatory reporting criteria?" If the answer to both questions is yes, a report must be filed. For children, the report is filed with either child protective services (CPS) or the police. For vulnerable adults, a report is filed with either the adult protective services (APS) or the police. The report is filed with the protective service in the county where the child/vulnerable adult resides and with the police jurisdiction where the abuse occurred. If a child or a vulnerable adult is abused in a facility licensed by the state of Minnesota, the nurse must assure that CPS or

APS will notify the appropriate state investigatory agency, such as the Office of Health Facilities Complaints for the State of Minnesota.

Exceptions to mandatory reporting

Domestic abuse

Health care professionals are not mandated to and should not report domestic violence, unless the patient is a vulnerable adult as defined by law. Decisions to involve law enforcement are strictly the victim's to make (the use of law enforcement can result in greater harm to the victim, which is why the victim is the best person to determine whether or not to involve them).

Elderly in vulnerable situations who do not meet vulnerable adult criteria

People often confuse being elderly with being vulnerable, but this is not necessarily so. Take the example of an 80-year-old man who is healthy, lives an active independent life, and requires no medical or social services. He is in a relationship with a 50-year-old woman and gives her gifts and money. His children believe she is taking advantage of him. He does not meet the legal definition of a vulnerable adult and a report is not mandated.

Child witnesses of domestic violence

Children who witness domestic violence are at risk for many negative outcomes. There is considerable debate about what is in the best interests of the children in such situations, considering the risk for further harm to both children and their mothers if separated. However, as of this writing, health care professionals are not mandated to report child witnessing of domestic violence.

Children sexually abused by non-familial/non-custodial individuals

Reporting of assaults on minors is not always mandated. A report must be made only when the perpetrator is one or more of the following:

- responsible for care of the minor,
- in a position of authority over the minor,
- in a significant relationship with the minor, or
- the assault was the result of parental or institutional neglect

As an example, an 8-year-old girl is raped by a neighbor. Her parents take her in for medical attention. Unless the circumstances of the rape were a result of parental neglect (e.g. no one was watching the child or the parents entrusted the child to the neighbor's care), no child protection report is necessary and the health care professionals must not make a police report unless the parents request that the police be contacted. In fact, it may be a violation of data privacy to call the police and share patient information.

In summary, many situations meet criminal definition, but not mandatory reporting definition and nurses must know the difference so that they do not violate patient data privacy laws by reporting victimization which does not meet state mandatory reporting criteria, especially when patient state they do not want law enforcement notified.

Sample Teaching Strategies: Legal and Ethical Issues

Case scenarios

Use case scenarios to help students think through ethical implications of various situations and nursing responses.

Videos:

"Broken Vows: Religious Perspectives on Domestic Violence" (1994). Center for the Prevention of Sexual and Domestic Violence, Seattle, WA.

Websites:

Minnesota Statutes, available at: https://www.revisor.mn.gov/pubs/ [https://www.revisor.mn.gov/pubs/]

Prevention

Levels of Prevention

The generally accepted approach to addressing health care issues in community health incorporates three levels of prevention: primary, secondary, and tertiary. Primary prevention involves strategies to prevent the health care problem before it begins. Secondary prevention focuses on screening people who are at risk. Tertiary prevention is aimed at preventing further negative health outcomes for people already impacted by the health care problem. Due to rising health care costs, insurers and practitioners working in care environments, which traditionally have only provided care at the tertiary level (clinics, hospitals, etc.), are turning toward primary and secondary levels of prevention to contain costs.

Primary

1. Education: childbirth education, positive parenting, healthy relationships, conflict resolution, bullying prevention, decreasing societal glamorization of violence, etc.

2. Creating nonviolent environments/role modeling respectful, nonviolent behavior in health care settings, schools, WIC clinics, community agencies, etc.

3. Advocating for public policy that puts public health nursing visits at the center of a coordinated community system to support parents (Finkelhor as cited in Barett, Miller-Parrin, & Parrin, 1997).

Secondary

1. Routine screening for abuse of all patients in every health care setting.
2. Identification of families at risk (violence in the family of origin, excessive family stress, inadequate family resources).
3. Identification of children at risk as a result of witnessing violence in the home and provision of early, age-appropriate intervention.

Tertiary

1. Referral to community resources (safe houses, counseling, etc.).
2. Public health nurse home visiting of families in which abuse has occurred.
3. Assessment and treatment of co-morbid conditions.

Prevention strategies consistent with the MDH Public Health Nursing Section public health nursing intervention wheel

The Public Health Nursing division of the Minnesota Department of Health (2001) has published a pioneering book on public health strategies to address societal issues, which conceptualizes population focused public health interventions to be carried out on three different levels: individual/family-based, community-based, and systems-based. Examples include but are not limited to:

Individual/family-based Strategies

1. Screening: Screening for violence and using that screening as an opportunity to educate about community resources.
2. Referral and follow-up: Referral to domestic violence programs.
3. Counseling: Partnering with families to discern ways to create a violence-free family.
4. Health teaching: Using opportunities to educate regarding the roots of violence, conflict resolution, and healthy relationships in a variety of settings including childbirth education and parenting classes, community meetings, schools, and senior citizen centers.

Community-based strategies

1. Outreach: Developing and facilitating community education programs.
2. Coalition building: Serving on community groups which challenge societal norms such as coaching practices, degrading images of women in advertising and violent video games.
3. Consultation: Serving on interagency committees and policy-making bodies.

4. Community organizing: Working with a community group that has identified a goal of violence reduction.

5. Advocacy: Speaking on behalf of the voiceless victims of family violence who need to remain anonymous in their communities.

Systems-based strategies

1. Policy development and enforcement: Working with legislators to author legislation that further protects women, elders, and children who have survived violence.

2. Collaboration: Working collaboratively within healthcare to create healthy abuse-free medical workplaces.

3. Consultation: Working with the insurance industry to promote screening for violence as a quality assurance issue.

4. Surveillance: Working with a statewide coalition to improve collection of health data on survivors of family violence.

5. Health teaching (provider education): Developing and teaching professional education programs on family violence. Working to change health care practices that perpetuate myths about violence against women.

6. Outreach: Working with hospitals and clinics to establish screening protocols and networking with domestic violence advocacy programs.

Sample Teaching Strategies: Prevention

Case scenarios

- Based on a hypothetical family situation, have the students develop teaching plans which include strategies that strengthen family coping skills.

- Based on a hypothetical community situation, have the students develop a community prevention plan incorporating all three levels of prevention.

See Appendix W: Elder Intimate Partner Violence Chutes and Ladders, which is an interactive exercise to teach students the dynamics of how social support and financial resources increase a victim's/survivor's ability to free herself from an abusive relationship and can generate a discussion of how to mobilize helpful resources at a community level.

Assign literature searches on family violence prevention in various racial/ethnic groups. This is an instructive way for students to learn about the paucity of such research, as well as to illustrate the cultural competence needed for effective public health nursing practice.

Guest speakers are available from the Positive Parenting program, University of Minnesota Extension, 651-704-2058.

How to be a Violence-Free Family brochures are available in English and Spanish from the Initiative for Violence-Free Families, Family and Children's Services at 612-728-2090 or www.thefamilypartnership.org/ [http://www.thefamilypartnership.org/]

Videos

"One Voice/Domestic Violence: Institutionalized Interventions" Concept Media, Intercollegiate Center for Nursing Education, 1998

"Portraits of Promise: Preventing Shaken Baby Syndrome." Shaken baby video in English and Spanish created and produced by the Junior League of St. Paul, Inc. and Midwest Children's Resource Center at Children's Hospitals and Clinics. Available from Midwest Children's Resource Center, 651-220-6750.

Appendices

Appendix A: History of Child Protection

- April 1874---Historic case of Mary Ellen Wilson. Mary Ellen's father died in the civil war and she was abandoned at age 8. Her adoptive parents routinely beat, starved, imprisoned, and kept her in rags. Neighbors were outraged and feared the family would move prior to intervention. They contacted several agencies, none of which took action. Finally the Society for the Prevention of Cruelty to Animals was contacted and responded. As a result, the New York Society for the Prevention of Cruelty to Children (NYSPCC) was organized.

- 1964, C. Henry Kempe introduced "battered child syndrome" to the American Academy of Pediatrics. Within 4 years every state passed laws mandating identification and reporting of suspected victims of abuse.

- Early child abuse models proposed that parents who abuse their children were mentally ill-this is not true. Research suggests that only 5% of all abusive parents have serious mental illness (other than depression and post traumatic stress).

- 1974, The Child Abuse Prevention and Treatment Act was enacted Mandated a full national study Created the National Center on Child Abuse and Neglect (NCCAN)

- Over time, definitions of child abuse have varied and affected incidence. As the definition changed, the incidence changed.

    - In 1980, NCCAN defined child abuse as "demonstrable harm incurred to a child that was non-accidental, avoidable, and committed by a parent(s), parent substitutes, or other adult caretakers."

- In 1986 NCCAN revised the definition of child abuse to be "both demonstrable harm and child endangerment, specifically including children whose health and well-being were endangered through acts that are non-accidental, avoidable, committed by parent(s)/parent substitutes, other adult, and/or adolescent caretakers."

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Appendix B: Family Violence: Myths and Misconceptions

Many myths are associated with domestic violence. Myths about domestic violence perpetuate bias against survivors, prohibit the development and dissemination of accurate information and divert attention from the real issues. Eradication of these myths brings enlightenment and greater ability for societal and individual support.

Eradicating Myths

Eradicating the myths associated with violent relationships requires our understanding and acknowledgment that there is no "typical" batterer/abuser, or victim/survivor. While many abusers love their partners and do not want to use violence, others do not love their partners, feel comfortable using violence and do not care whether their partners stay or leave. Likewise, many survivors love the partner who is beating them, do not want to see the partner get hurt and just want the beatings to stop; others hate their batterer and would like the batterer to go away and leave them alone or to die.

Myth l: Only a few people are affected by domestic violence.

More than one fourth of all couples are involved in domestic violence sometime in their lives. This impacts children and families significantly. Domestic violence is the leading cause of injury to women between ages 15 and 44 in the United States--more than car accidents, muggings and rapes combined.

Myth 2: Battered women are masochistic.

Battered women do not want to be beaten. Survivors have begged the abuser to stop, sought help and tried to leave. Belief in this myth reflects a lack of understanding of the physical and emotional trauma the survivor has experienced and lack of awareness of how the survivor has tried to stop it. The abuser is responsible for the violence, it is not the survivors' fault. What is viewed as masochism may be an adaptation for survival.

Myth 3: Abusers and survivors are crazy, lower-class, minority, dysfunctional, uneducated people with few social or job skills and no religious belief. It could never happen to anyone you know.

Domestic violence is an equal opportunity crime. Lack of education or wealth, or social background do not make battered people. Perpetrators and survivors come from every walk of life. Many doctors,

ministers, psychologists, police, attorneys, judges and other professionals are abusers. Even though some mentally ill people are battered, most survivors live in crazy-making situations in which they can become confused and overwhelmed. They tend to blame themselves because so many others blame them, yet through it all, they remain remarkably sane.

Myth 4: Love and violence cannot exist together in a relationship.

Many abusers act in loving, caring ways some of the time. Many survivors love the abuser and just want the battering to stop. However, over time, the loving periods lessen, change or fade as physical damage, learned helplessness, post traumatic stress disorder, and Stockholm Syndrome take their toll.

Myth 5: Once a battered woman, always a battered woman.

Women who receive positive intervention can move past the victim stage, rebuild their sense of self and rarely choose another battering relationship.

Myth 6: Once a batterer, always a batterer

Although the prognosis for change may be dim, some men do stop their violent behavior. Men have more success at stopping physical violence than they do at stopping verbal and emotional violence. It is estimated that it will take between three and five years of weekly therapy for a man to make a significant, lasting change in all aspects of his violent behavior.

A recent authoritative evaluation of batterer programs has showed that 31% of the men re-assaulted during the follow-up. Rates of verbal abuse (70%) and threats (43%) are much higher, but 73% of the women report feeling "very safe." Nearly half of the men who re-assaulted did so within 3 months after program intake. "Voluntary" participants were significantly more likely to re-assault (44% vs. 29%), as were program dropouts (40% vs. 28%). The "well-established" batterer programs appear to contribute to a short-term cessation of assault in the majority of batterers. However, a small portion of the men are unaffected by or unresponsive to the intervention. [Adapted from "Patterns of Re-assault in Batterer Programs," by Edward Gondolf. *Violence and Victims, 12* (1997), pp. 373-387.]

Myth 7: "I just lost it."

Batterers often say they could not stop themselves from using violence. Most batterers use other methods of dealing with frustration, anger, or "provocation" when it is convenient for them to do so. Angry batterers do not beat up the boss, secretary, neighbor, a stranger on the street or children playing in the next yard. Only in the privacy of the home, or when it is perceived there will be no negative consequences, will the batterer choose to use violence towards the partner and possibly the children. In the vast majority of cases, the batterer hurts no one else (Ewing et al., 1984 ;Ptacek, 1988 ;Stordeur & Stille, 1989).

When the perpetrator uses violence, it is because there has been an assessment of the situation and the batterer has determined that:

- What I am doing is not wrong.
- If it is wrong, I will not get caught.
- If I get caught, I can talk my way out.
- If I cannot talk my way out, the penalties will be minor. I will decide what the penalties are.

In these "I just lost it" episodes of violence, batterers say and do things they know will hurt their victim. They yell obscenities and threats. They kick the pregnant woman in the stomach. They hit the victim in places that will be seen or hidden, depending on the message to be delivered by the violence. Batterers use violence because they know they can and no one will stop them or apply negative consequences.

Myth 8: Survivors of family violence can always leave.

This myth is based on the erroneous belief that leaving the relationship will stop the violence. In fact, batterers are likely to stalk their victims who leave them, often making good on their threats: "If I can't have you, then no one can." Separation is the most likely time for batterers to kill the partner, the children, themselves, and anyone who gets in the way.

Two major concerns block survivors from leaving: financial and emotional. Most survivors have not been allowed access to information about finances or control of assets, including their own, if they work outside the home. In a society where the average woman earns 60 cents for every dollar the average man earns, even if she has marketable skills, she is likely to have great difficulty supporting herself and her children.

Because of the violence, the survivor has probably been isolated from friends and family, leaving few if any emotional support systems. In addition, the batterer has, in the vast majority of cases, threatened murder of the survivor, children, parents, friends, boss or anyone special or will threaten suicide.

Myth 9: Children need their father, even if he is a batterer. Some abusers are good fathers and should have joint custody of their children.

Male children who see their father beat their mother are 7 times more likely to be violent as adults than those who did not witness such violence (Straus et al., 1981). Children need healthy role models. Unhealthy role models damage children now and in the future. Men who batter women are more likely to batter children physically, sexually, and emotionally. Their need for power and control of family members often stifles the healthy development of their children.

Nearly 90% of children who grow up in abusive homes witness the assaults. Nearly half of the batterers also abuse their children.

Myth 10: Stress causes violence

Neither stress nor drugs nor heredity cause domestic violence. Domestic violence is "caused" by a person choosing to use violence. That person has learned from the culture and interpersonal relations to use violence and that violent behavior is legitimate, necessary and appropriate at that moment in time. Like drug and alcohol abuse, many people use stress as an excuse to be violent.

Many people who experience stress do not use violence. Violence is only one of a myriad of responses to stress.

Myth 11: The source of the violence and the source of the conflict are not the same.

Violence is one choice for conflict resolution. The source of the batterer's violence is complex and results from experience, training and permission. Using violence to resolve what is perceived to be conflict is a choice the batterer makes.

Myth 12: Battering is caused by bad relationships. Women would not get beaten if they did not nag. Men are forced to be violent because women do not behave properly.

Battering is an individual issue. Many men who batter have acted that way with several partners. Men in poor relationships have a choice not to batter. Battering is not about how women do or do not behave, it is about poor choices involving power and control on the part of the abuser.

Myth 13: Women are just as violent and abusive as men.

While there are a minority of females abusing males, in approximately 95% of assaults, the man is the perpetrator. There are frequent instances of females using self-defense against their male abuser. Battering also occurs in lesbian and gay relationships. Domestic violence throughout life is experienced as child abuse and neglect, dating violence, spouse abuse, and abuse of the disabled.

Myth 14: When there is violence in the family, all family members are at fault to a certain extent and therefore all must change for the violence to stop.

Only the abuser has the ability to stop the violence. Battering is an attitude and chosen behavior. Many survivors try to change their behavior and their children's in the hopes of stopping the abuse. Changes in family members' behavior will not cause or influence the abuser to be non-violent.

Myth 15: Drinking or using other mind-altering drugs causes battering.

Substance use is a factor in battering but it is best described as being a trigger or excuse to be abusive rather than a cause.

Myth 16: Batterers are abusive because they cannot control themselves or because they have poor impulse control.

Abusers are usually not violent toward anyone but their partners or their children. They can control themselves sufficiently enough to pick a safe target. Many assaults are planned and can last for hours.

Myth 17: People who are being battered could leave if they want to by simply calling the police.

Police traditionally have been reluctant to respond to domestic assaults, or to intervene in what they think is a private matter. They temporarily separate the couple, leaving the survivor vulnerable to further violence later. Laws have been improved and some law enforcement agencies have had more education and are more sensitive than others in responding to domestic assault cases, but considerable change is still needed in law enforcement and the court system.

Myth 18: People who are being battered could leave if they wanted to by simply asking for help from her minister or other clergy.

Some clergy have been extremely supportive of survivors. Others ignore the abuse, are unsupportive, or actively support the assailant's control of the partner. Sometimes this is based on the defense that a man has a right to be head of the household.

The preceding was developed by Marlene Jezierski, BAN, RN. It was adapted and expanded from numerous sources including the Colorado Coalition Againt Domestic Violence's DOMESTIC VIOLENCE: A Guide for Health Care Providers, Lenore Walker, 1979. July, 2001.

Appendix C: Myths about Batterers

People who batter must be sick.

Battering is a learned behavior, not a mental illness. The perpetrator's experience as a child and messages received from society contribute to a batterer's perception that violence is an effective and appropriate way to achieve power and control over a partner's behavior. Anyone who batters is accountable for any actions.

Battering is an organic defect, like a disease.

Group facilitators who work with men who batter often hear the excuse "I lost control of my emotions." One facilitator responds, "At the point you lost control and decided to start hitting your partner, who decided to start hitting? When you stopped hitting, who decided the beating would stop?" Batterers remain very much in control.

It is worth noting that in an extremely small percentage of cases, violent behavior may stem from a brain disorder or damage. However, people with this condition commit violent acts at random toward anyone with whom they're in contact. This is not the situation in the vast majority of battering relationships. While some batterers use excuses such as physical problems, drinking and war flashbacks to justify their actions, these "afflictions" usually do not cause them to harm anyone else except their partners. Battering is not a disease but rather a learned behavior. Abusive behavior is within a person's control. A person uses violence to obtain and maintain control over another person. More importantly, battering can be lethal; a deadly crime that can be perpetrated by social institutions unless they intervene to stop it.

The batterer has a drinking problem that is the cause of the violence.

Studies reveal that 40 to 80% of the time alcohol is a factor in incidents of domestic violence. Some abusers do not use chemicals at all. However, researchers agree that alcohol is not the cause of domestic violence. Drinking lowers one's control or inhibitions. Chemical use is known to intensify violent behavior but it is not the root cause of the choice to batter. Perpetrators typically make excuses for their violence claiming a loss of control due to chemical use or stress. Batterers who use chemicals need chemical dependency treatment. However, this treatment will not stop the abuse. The treatment is a first step which should be followed by specific work on the violent behavior. A key point: battering is a choice and has nothing to do with loss of control but rather stems from a desire to exert power and control over a partner.

Abusers batter because they have low self esteem.

Many people believe that batterers are violent because they feel bad about themselves. They pick on their partners to make themselves feel better. While it may be true that many or all batterers have low self-esteem, this does not explain why they batter. There are many men and women with low self-esteem who are not violent.

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Appendix D: The ABC's of Men Who Batter

By Barbara Corry, M.A., 1994

Abused as children

Most batterers were beaten, verbally abused, or sexually abused as children. The majority of batterers also were "under-fathered" i.e. they had fathers who neglected or rejected them, or fathers whom they could never please. Treated like objects, batterers were taught, by example, specific techniques to hurt and humiliate others. In addition, batterers learned that violence is "normal" in families: they were taught that bigger people get to hit and abuse smaller people. In turn, batterers discipline their children with violence, thus perpetuating the cycle of abuse.

Believe in traditional sex roles

Batterers hold to traditional sex roles (i.e. macho men, subservient women). They believe that a woman is there to take care of them, feed them, bear their children, keep their house clean, accept their infidelities, and tolerate their drinking. Batterers believe that women should be disciplined if they "disobey their husband" or "forget their place". Abusive men often talk about their rights as husbands and their role as head of the family. They believe that their wives are theirs to do as they wish. Batterers also hold attitudes consistent with male privilege such as, "a little slap will do her good" or "I'll show her who's boss" or "what she needs is for someone to teach her a good lesson."

Controlling

Battering is purposefully controlling behavior by someone who wants total control. A man who batters may control where his spouse goes, whom she sees, what she reads, when she eats, and what she buys. He may monitor her phone calls, mileage, clothing and make-up. A batterer fears abandonment, and, therefore, he tries to control his mate's actions by controlling the money and by limiting her access to family and friends. These men control their partners in order to feel like they have some control in their lives and some power in the world. Their need to dominate stems from a need to reassure themselves that they are special, valued by others, and worthy of appreciation --- all things they did not get as children. A batterer's fear of not being in control also is related to the fear of death or injury he experienced as a child in a violent home.

Deny, minimize and blame

A batterer does not want to be responsible for his violent actions or for the harm he causes. Abusive men learn to deny wrong doing, minimize injury and blame others. Men who batter will blame others for their actions and say things like "If she didn't want a beating, why did she interrupt me when I was on the phone?" or "She knew not to disrespect me in public" or "You're really asking for it when you make me crazy like this" or "I don't get this way with anyone else. It's your fault." Batterers will also deny hurting their partners with comments like "She tripped and fell" or "I was swinging at the air and she walked into it" or "I was just trying to push her away" or "She's fair skinned and bruises easily."

Finally, batterers will minimize their violent actions with excuses like "It was just a bump" or "I just twisted her arm a bit" or "I only slapped her a couple of times last year" or "Compared to what some other men do it's not so bad." A batterer also may say "I didn't know what I was doing" or "I was out of control" as if someone else was responsible. In reality, battering is target specific: the batterer aimed at his spouse, not the mailman or the grocer, and he even may have aimed for specific parts of her body.

Emotionally abusive

Battering is not limited to physical abuse. Emotional abuse may include repeatedly criticizing his spouse: shouting at her, swearing at her, putting down her opinions, blaming or shaming her; making her feel stupid; treating her like a servant; accusing her unjustly; undermining her self-confidence; calling her names; insulting her family, embarrassing her in front of others; withholding encouragement; flirting openly or having affairs; and not discussing events which damage the relationship.

Feel powerless

Batterers are actually frightened men who are afraid to be alone in the world. Like marshmallows, they are crusty on the outside but soft (scared and insecure) on the inside. Feeling powerless as children, batterers learned how to bully and dominate in order to feel less afraid and avoid being victimized any further.

Grew up with violence

Batterers learned early on that they could gain control and get power by throwing things or by raising their voice. Violence became an acceptable way to express their emotions or get what they wanted. Slapping, punching, etc. became normal, taken-for-granted ways for spouses to relate to one another and to resolve conflicts. They also learned early on, by example, that men get to hit and that women tolerate it.

Have a negative belief system about women

Batterers lump all women together and do not see women as individuals. In addition, they have negative stereotypes about women such as: "all women are manipulative" or "all women see men as paychecks". Batterers also dismiss women's ideas and opinions. Furthermore, they believe that a man must control his woman or she will control him.

Insecure

Abusive men have a deeply rooted fear that they are inadequate. They don't believe they have a lot to offer. Batterers are unhappy with who they are and see themselves as failing to live up to their image of manhood. All of their bullying and intimidation serve as a smoke-screen to keep others from seeing how insecure they really feel. Their violence is controlling behavior designed to keep themselves from feeling inadequate and powerless. Batterers are actually very lonely, alienated men.

Jealous

Batterers tend to be extremely jealous and have difficulty trusting others. They believe that jealousy is natural in men.

Kill or torture what they cannot possess

In the worst cases, battering involves extreme physical or mental cruelty, such as tying up the woman's hands and feet; beating her so badly that you break a shotgun in three pieces; stabbing her repeatedly so that she requires hundreds of stitches; cutting her throat; fracturing the roof of her mouth; and making cigarette burns on her breasts. Other batterers stalk and kill what they can no longer possess. These tragedies are usually portrayed as crimes of passion caused by the man's intense love for and inability to live without the woman. However, murder is actually the ultimate expression of the batterer's need to control the woman.

Lack relationship skills

Men who batter have had very poor role models for important relationship skills such as problem solving, conflict resolution, and establishing intimacy with a partner. If they do not learn new skills, batterers tend to repeat the destructive patterns which they observed in their respective families. Batterers don't know how to ask directly for what they need. They also do not know how to tell their partners that they are not feeling appreciated or that they are not feeling heard. Batterers have poor skills to resolve differences over money, disciplining the children, etc; without intervention these areas often become major battlegrounds. It is important to note, also, that in the content of

an unequal and violent relationship, the woman is usually discounted and unable to be more assertive. And, with both parties unable to express themselves effectively, little communication or conflict resolution occurs in battering relationships.

Master manipulators

A batterer is someone who knows exactly how to convince his partner to feel sorry for him. He becomes very skilled at telling his partner exactly what she wants to hear. He will beg and plead and promise and say all the right things. The batterer's worst fear is that his partner will leave, and he tries to be charming enough to make sure this doesn't happen. Just as his violence was overblown so are his apologies and gifts. However, unless the batterer is made to be accountable for his violence and unless he becomes committed to personal change, his manipulation and his abusive behavior will not end.

Not able to nurture

Batterers have difficulty giving and receiving love. They find it hard to make themselves vulnerable and, without treatment, they are not able to empathize with their spouse's pain.

Overly dependent on their spouses

Batterers become overly dependent on their partners for their unmet emotional needs. They seek from their mates the nurturing and security they did not receive as children. When his mate cannot meet his needs, the batterer becomes frustrated. As one man put it, "I felt I needed her to 'make' me happy; if I wasn't happy, I thought it was her fault."

Prior history of violence

If you listen carefully, you might hear a batterer's friends say that he is frequently "moody" or "has a hot temper." He may have a history of being a bully at work or school. He may also have an obvious or subtle track record of mistreating other women. If a man's anger is out of proportion or if he acts impulsively when he is angry, e.g., by punching walls, throwing things, or breaking objects, these signs say that he needs professional help to control his rage and express his anger in non-violent ways.

Quickly change from Dr. Jekyll to Mr. Hyde

Batterers can be extremely passive and very charming one minute and explode in anger the next. The violence can be triggered if he feels threatened, shamed, powerless, or humiliated. Drugs or alcohol are often used as an excuse for "losing control" or "going off."

Regard spouses as easy targets

Most batterers would not think of doing to other men what they do to their spouses. A batterer knows he can easily vent his anger on his spouse in the privacy of his own home and that she probably won't tell anyone. A female partner is most likely someone smaller and weaker, someone who is economically dependent on him, someone who cares about him, and someone whom he can

bully into not going to the police. If he intimidates her sufficiently, and she doesn't tell anyone, he knows he can get away with abusing her.

Self-centered

Batterers lack consideration for others. As one batterer put it, "I had the 'Do what I want, when I want, why I want, and because I want' syndrome."

Try to punish and control with subtle forms of abuse

Batterers often use subtle forms of abuse to punish, humiliate, and control their partners. A batterer may say things to create fear such as: "If you EVER gain weight, I will leave you." or "If you EVER let the housework go, you'll be sorry." In addition, a batterer's verbal abuse and criticism often become chronic. He will repeatedly complain about the way his spouse takes care of him or the children, and he will find other things wrong - even after his partner has turned herself inside out to lose weight, stay within the budget, cook his favorite foods, etc. A batterer feels so small inside (i.e., he has such low self-esteem), that he will repeatedly put his spouse and/or children down in order to feel more important or feel better about himself.

You must follow his orders and do things to his satisfaction---or else

As one battered woman put it, "You have to follow his commands, e.g., take his shoes off, stay away from his electronic equipment, heat his dinner, NOW, or else, like he was king and this was his domain and everybody else in the family were little ants made to serve him." Batterers will beat or verbally abuse their mates for things like forgetting to put the butter on the table, burning the meat, not ironing the shirts correctly, not sewing clothes to his satisfaction, making scrambled eggs instead of eggs over-easy, serving limp lettuce on a sandwich, or not getting dressed fast enough.

Zeroes in on spouses' vulnerabilities

Men who batter often betray the trust of their spouses and break their confidences. They are skilled at knowing how to use their mates' vulnerabilities against them.

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Appendix E: Men Who Sexually Abuse Children

Bud Lewis of the Los Angeles Times in 1985 studied 1,260 randomly selected men. He conducted a poll utilizing a randomized response technique that depends on a flip of a coin. A set of 2 questions was posed. The first was whether they were labor union members or whether they rented their homes and the second was whether they had ever sexually abused a child. He came up with 1 in 10 men being child molesters with a margin of error from 1 in 5 to 1 in 15. With an added margin of error to account for the men not understanding the complicated coin toss directions, the absolute minimum figure is 1 in 25 American men who have sexually abused a child.

Most therapists continue to classify men who sexually abuse children into one of two very broad categories developed by A. Nicholas Groth, a psychologist whose research involved primarily men in prison in the state of Connecticut.

Regressed Child Abuser: Adult male who has led a pretty normal life. Had teenage girlfriends when he was a teen and adult women friends when he became an adult. Marries and becomes a father. At some point, usually in his 30s, his sexual interest expands to children. Because he is most likely to be a heterosexual, his victims are usually girls. Most fathers who abuse their daughters fall into this category by default. The regression is usually a mystery to the abuser, however it usually involves distancing from his partner and getting his affectional needs met by a daughter. He usually was suffering some unaccustomed stress at the moment he turned toward his children for sex.

Fixated Child Abuser: His sexual interest in kids develops early on and he is never sexually attracted to anyone his own age. Rarely married, therefore he perpetrates on other peoples' kids. Yet, a sizeable number of men who have sex with their own children are fixated pedophiles. This is probably a third category of abusers or "crossover" abusers: fathers whose primary sexual attraction is to children in general. Gene Able and Judith Becker of the New York State Psychiatric Institute tested 142 men who appeared to be regressed child abusers of their own children (they had denied abusing other children). Using a plethysmorgraph (small collar filled with mercury to measure the erection of the penis), many tested positive and over a half of these finally admitted to abusing other children.

Common characteristics of all child sexual abusers:

- **40-80%** of child sexual abusers had been sexual assault victims themselves.
- **Nearly all** were badly **mistreated** by someone when they were children (sexually abused, beaten, made to feel worthless).
- The major characteristic they all have in common is narcissism (self-image is so grossly unrealistic, that the borderline between a healthy personality and unhealthy one is traversed).
- **On the surface:** he has a sense of superiority and that everyone is as interested in him as he is in himself, childish and unrealistically inflated sense of himself (intelligence, abilities, appearance, etc.), lies, etc. They often seem like very nice guys.
- **Beneath the surface:** insecure, unsure of himself, desperate for external reinforcement, misreads cues, feels powerless, unworthy, ashamed. They want to be loved and idolized, therefore they manipulate their victims. Sex with children becomes a compulsion.

[Source: Crewdson, J. (1988) Silence Betrayed: Sexual Abuse of Children in America NY: Harper & Row.]

This fact sheet compiled by M. D. Pharris, College of St. Catherine, St. Paul, MN.

Appendix F: Power and Control Wheel

Appendix F-1: Duluth Power and Control Wheel

Appendix F-2: Equality Wheel

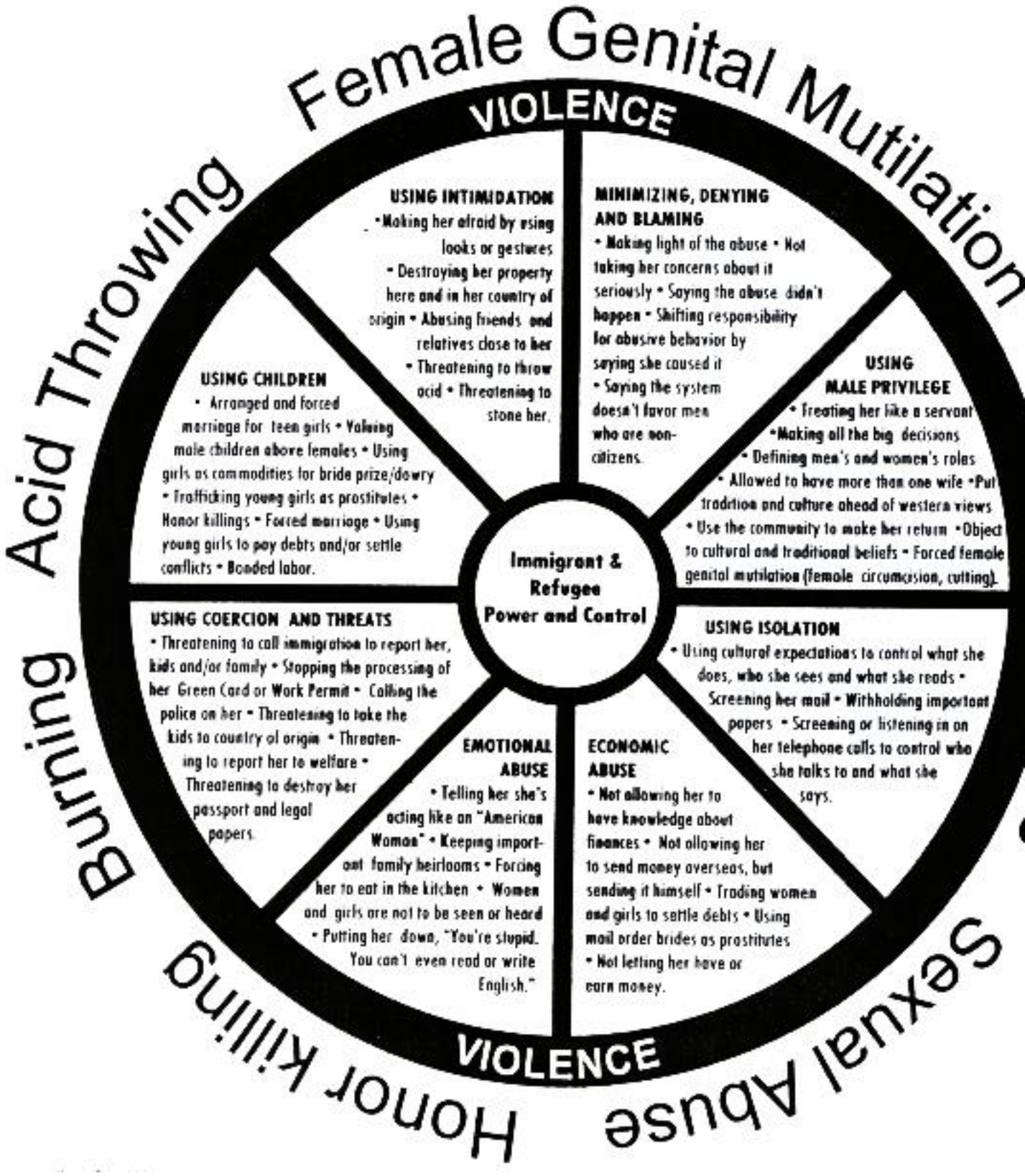
Appendix F-3: Teen Power and Control Wheel

Appendix F-4: Children's Domestic Abuse Wheel

Appendix F-5: Power and Control Wheel for Elder and Disabled

Appendix F-6: Power and Control Wheel for Gay, Lesbian, Bisexual and Transgender

Appendix F-7: Immigrant Power and Control Wheel



Appendix F-8: Power and Control/Culture Wheel

Appendix F-9: Medical Power and Control Wheel

Appendix G: Challenges to Change

Issues keeping family violence survivors from seeking help

Challenges in getting help are varied, complex, valid and compelling. Some survivors may find it difficult to see alternatives while still enmeshed in the relationship.

Fear

1. Fear of retaliation.

When a person makes a decision to leave an abusive relationship, the chances of being seriously physically hurt or killed increase 75%. Many times the partner may have threatened to hunt the person down and kill her/him and the children.

"I always took the blame. I believed his violence was because of something I did or didn't do. And he was wonderful when he wasn't violent. One night he pulled me out of bed, punched me all over, and threatened me with a gun. I realized my life was at stake. It took 20 years." "I feel trapped, threats of abuse make me too afraid to take action." "If I leave, he'll kill me. He said he'd hunt me down." "if I'm with him, at least I know his mood and what he's up to." "It's not possible to be safe, ever, any more."

2. Fear of making it alone

"I'm afraid of being alone." "I'm afraid no other man will want me." "Single parenting scares me."

Finances

The survivor may have no financial resources, access to the resources or job skills. Many are not employed outside the home, have not been allowed to work. If there are dependents, it becomes more difficult to leave without having the ability to get affordable housing, transportation, etc.

"I don't think I can provide for myself and my children financially."

Faith

Many times people stay in a relationship because of religious beliefs. Separation or divorce may ostracize the person from the religious community. Some clergy are trained to focus on the goal of saving the marriage at all costs rather than stopping the violence.

"After I told my pastor about my husband's physical abuse, my pastor asked me, 'And what is your sin?'"

Family

The partner may have convinced the family that everything is good in the relationship, that problems are the survivor's fault. It may also be that the family of origin has also experienced violence, violence in the home may be considered normal.

" I don't want to lose his family." "I don't want to disappoint family and friends."

Children

They may believe that any father is better than no father at all. They may have the belief that the children will be negatively impacted by the family breaking up. Some fear being charged with desertion and losing their children. Abusers sometimes threaten to kidnap them.

"He'll get custody of the kids. He'll turn the kids against me." "My kids need a father." "My kids will resent me."

Fidelity

Many times the person does not want the relationship to end, just the violence. Sometimes the survivor loves the abuser and believes the batterer will change. They may rationalize the abuser's behavior by blaming stress, alcohol, problems at work or other issues. Abusers rarely physically batter all the time. Often the relationship can be romantic and satisfying.

"He loves me. I love him." "I made a commitment to work things out: marriage vows." "I failed. I made my bed, now I must lie in it." "I feel responsible for the relationship and what's gone wrong." "I can usually control his anger. I'm used to his behavior." "I keep hoping things will get better, that he'll get help." "He will have nowhere to go. I'll ruin his life. He'll lose his job." "He put me in the hospital twice but I melted when I saw him crying. I thought hitting me showed he cared. I believed him when he said he would change."

Frailty. (e.g. Seniors)

Elders are frequently less likely to take steps to leave an abusive relationship and start over. The violence may have gone on throughout the relationship and been kept "secret" or hidden for years. They are often isolated from friends, family, and other support systems.

Fatigue

"I never think about leaving. I've been brain washed." "People think he's so nice. They'll think I'm crazy." "I don't have any real options that will work." "My depression immobilizes me. Nobody cares anyway."

Isolation

There is often no access to support systems available from friends and family,

"I have nobody to help and protect me." "I don't want to lose our friends. They'll think I'm terrible." "He turned everyone against me. I had no friends, no social life, no support. He got our boys to keep track of my movements and tell him what I'd been doing and who I'd talked to."

Shame

Frequently, survivors feel shame about being abused, blame themselves, believing they deserve it. This contributes to reluctance to let anyone know abuse is occurring.

"He'll spread rumors around the community about me."

Challenges to Changing Circumstances In Diverse Populations

The goal is to stop the abuse, which may mean leaving, but not in every case. In order for the family to stay together the safety of the abused must take priority and the abuser must take responsibility for his or her actions. This challenge exists for many victim/survivors, not just those in specific cultural groups. Some of the following may be typical of victim/survivors from any culture but may be more of a factor in some ethnic groups.

Racism

- Racism can make it more difficult to find housing, jobs, and even to become eligible for community resources.
- Some victim/survivors have been alienated when they experienced discriminatory treatment from service people in mainstream agencies
- Reluctance to call police because of racism on the part of law enforcement officers, they fear maltreatment of their partner because it has happened in the past.

Cultural variations

- Feminist concepts of empowerment are alien to some cultural norms. Commonly, Hmong women believe it is their behavior that needs to be modified.
- Frequently the sanctions against leaving are so great that the conflict becomes unbearable and they do not leave
- Many immigrants are the prime supporter of their families in their home countries, leaving may result in loss of essential financial support to their families.
- There may be a strong commitment to mediating conflicts within the family/clan/tribe when a husband is violent rather than separating the couple.
- Risk of the loss of family and/or community support.
- The immigrant population has restricted access to resources.

- Sometimes the elders or "aunties" excuse abusive behavior saying something like "it's just the way a man is" or "this is their right" or "women need to be good wives so it won't happen".
- Abuse may be minimized or denied by community leaders or elders.
- It may be difficult to seek help outside of the community: it is a matter of pride and or shame.

Language barriers

- Some people may be friendly and nod when you are speaking to them but may not be comprehending much if anything of what you are saying. Establish their comprehension through verbal exchange which indicates they do understand.
- Illiteracy
- The use of interpreters is a controversial, complex issue due to varying availability and skills of interpreters in regards to domestic abuse. Use of family or friends is not advised nor even allowed in some health care settings.
- Even if the interpreter speaks the same language, she may come from a vastly different culture than the patient. Each country has its own unique cultural practices and norms. For example, a Spanish interpreter from Venezuela may be interpreter for a patient from Mexico.
- Generally speaking, interpreters do not have domestic violence training.
- While interpreters are obligated to be objective, neutral, impartial, this does not always happen. For example, many advocates in court cases have experienced court-appointed interpreters who are selective about what they communicate to the court.
- The best option whenever possible is to access your local advocacy agency and see if they have someone on staff or otherwise available to serve as an interpreter.
- Females would more than likely prefer to have a female interpreter.

Resource availability

- Inability to demonstrate reliable rental history
- Lack of knowledge of resources
- Lack of knowledge of laws protecting them
- Leaving home means loss of financial support
- Transportation limitations: can't afford cars, poor access to public transportation, and limited funds making it difficult to access advocacy services and support groups.

Culturally Specific Challenges to Achieving Change

Latina

- At issue is often the experience of being labeled "illegal" or a migrant; they are rarely afforded the label of refugee, which carries some status of a protected group.

Native American

- If they live on the reservation, responders may be relatives or friends
- Leaving the reservation may mean leaving supports and family and possibly ostracism for leaving partner
- If the couple is traditional, particularly if married in a traditional ceremony
- If the man is a "born again" Indian, he may twist cultural values to justify abusive behavior such as preventing her from using birth control.

Hmong

- Fear of loss of respect of their family and clan is a significant factor. Leaving brings shame to the family. Losing face is a powerful deterrent.
- The failure of a marriage is traditionally blamed on the woman.

African American

- The fact that a high number of African American men are incarcerated can impact whether or not women seek help, not wanting to put yet another African American man in jail or place him in the hands of a racist system. Law enforcement is seen as a racist system in many communities of color.
- Abusers may use a guilt-producing tactic by saying *"Go ahead and call the police, it's your fault if I get arrested and go to jail."*
- Some are trapped by an abuser who creates a Bonnie and Clyde situation... *"It's you and me against the world." "No one else cares about us, all we have are each other."*

Developed by Marlene Jezierski, BAN, RN. Comprised of information from numerous sources including "Why Women Stay", Alexandra House, Anoka County, MN and five multicultural groups' contribution through a Health Disparities Grant from the Minnesota Department of Health, 2003.

Appendix H: Thoughts on the "Cycle Theory of Violence" and the Dynamics of Domestic Abuse

by Maura K. Lynch

Make no doubt about it: how we name things matters. The power of language and how we use it can make all the difference in the world in how we understand ourselves and others. Here, the theory of the "cycle of violence," is one of the most common descriptors---and in my opinion, a misnomer---for the dynamics of domestic violence. To describe something that happens over and over and over, including the dynamics of abuse in intimate relationships, 'cycle' makes sense. I am still mystified and disappointed after so many years, however, when I hear people (especially professionals working with the issue) use the tension building-explosion-honeymoon "cycle" as an explanation of the dynamics of domestic violence.

Because what we call things is important, I offer several major provisos which form the infrastructure of my analysis of "the cycle," not the least of which is that the ideas here are intended to stimulate discussion about where we are professionally and as a society in dealing with the problem of domestic violence. Everything I put forth here was written and is going to be interpreted through many interconnected lenses of understanding influenced by qualities such as race, class, gender, sexual orientation, age, ability, and the like. In the spirit of examining this issue from a new perspective, consider throughout---whatever your gender---whether or not your fundamental reaction to what I say would be different if I were a man, and if so, how---and why?

Abuse in glbt relationships not withstanding, I will refer here to the victim as she and the perpetrator as he. The reason is for what Dobash, Dobash, Cavanaugh and Lewis (2000) refer to as the 'asymmetry' of domestic violence. Widely supported by empirical evidence, this asymmetry they assert refers to the overall pattern of violence among intimates "[which is] dominated by men as abusers and women as the abused" (p. 3)---not to mention the larger U.S. context of cultural support in which men's violence against women takes place (pornography, sexual harassment and assault, and prostitution come to mind). Furthermore, Stark and Flitcraft (1988) (pioneers like the Dobashes), assert the gendered nature of domestic violence, finding that "women battering reflects the erosion of male authority, that domestic violence stands on a continuum with normative forms of male domination, and...grows out of women's struggles to overcome their contradictory status, not *from their compliance with or dependence on men* " (ital. mine; p.6).

The next caveat relates to the need to acknowledge the dual (and sometimes dueling) contexts in which domestic violence happens. One is the reality that intra-relationship variations in the dynamics of abuse can be based in part on cultural influences and differences---particularly racial and ethnic, but also those of class, age, and the like. There is also variation in *intra-community* responses to domestic violence among communities of color. On the other hand is the second context, which is the historic societal-scale prerogative taken by the dominant White culture, myself included, of defining the rubric in which domestic violence is framed, both its root causes and how to stop it. Dominant culture solutions haven't solved the problem for many dominant culture victims and perpetrators, much less for people of color, for whom it would not be an exaggeration to say that the 'solutions' have often exacerbated circumstances already problematic because of differential treatment by 'the system.'

My third caveat is that while it is true that women can and in some cases do use violence in their intimate relationships, there are a number of ways in which the nature of why they do so can differ from men. Reasons include but are not limited to some of the following: first, a woman who is being

abused in her relationship is likely to use violence to defend herself in response to violence that is the connective tissue of an already woven, multi-faceted web of coercive control over her in the relationship. Second, she is highly likely to suffer and be injured at significantly greater rates than the primary aggressor, for whom she is often mistaken. Third, she is likely to have her self defense turned against her and suffer from further and even more severe violence as punishment for resisting her abuser. Fourth, she is likely to be unhesitating in admitting she has used violence and accept responsibility for it. None of these are hallmark characteristics of men who perpetrate domestic violence. Finally, the overarching cultural support that passively or overtly encourages---or tacitly condones---men's violence against the women they are intimate with (coupled with the lack of notable social rewards for men who are not abusive to women), does not similarly exist for women to be violent toward their husbands or boyfriends.

Finally, my analysis is rooted in, though not exclusively attributable to, my nearly twenty years as a student of women who have been battered (and their abusers) of every conceivable demographic configuration. And without question, professional colleagues of all types-known or not-and with whom I agree or not-inform my perspective almost as much as the experts themselves.

Having articulated the vantage point from which I stand, I believe that the extent of the value of the "cycle of violence" theory is its use as a tool to explain the tactical sophistication of men who abuse the women they say they love, and as a launching point for understanding the concept of power and control as the foundation upon which the house of abuse is built.

To be certain, I would never discredit what a woman who has been battered identifies as her experience, especially when what she is describing is a pattern of behavior that looks like the tension-building, explosion, and honeymoon stages of "the cycle," happening repeatedly. Instead, I would ask questions to help her think about the ways in which the perpetrator's behavior in the cycle could be another set of strategies for coercing and controlling her. How is he making the cycle's behaviors---the silent treatment, door slamming, or "the look" (tension building); smashing a fist in the wall, hurting pets, or assaulting her (the explosion); crying crocodile tears, being 'vulnerable,' swearing he's sorry and promising 'it will never happen again' (the honeymoon)---how is he using these behaviors to his advantage? How does he use explosive outbursts of 'anger' to manipulate the victim and perpetuate his sense of entitlement that in one way or another he had a right to act that way, that he "had no other choice," or that she 'made' him do it? How is the behavior of the moment setting up the behavior to come in the next phase of the 'cycle'?

Batterers demonstrate daily the skills of being loving, caring, competent, capable, charming people---who also happen to choose the use of controlling and/or violent behavior when they think it will get them what they want. In short, as Chuck Derry of the Gender Violence Institute in Clearwater, MN says in presentations, abusive men have an "I want" problem. Moreover, Derry argues, many of them do not question their behavior as a moral issue-why apologize for behavior which you don't see as wrong, to which you believe you are entitled, or which you believe is justified?

Men who batter also demonstrate daily outright denial of their abusive behavior---they deny its intent, minimize it, make excuses for it, deflect responsibility for it, and use it to the extent they have the opportunity to get away with it and are willing to face possible consequences for it (all

too often, the proverbial 'slap on the wrist'). They use their behavior because they know it works. They have learned that domestic violence is a generally acceptable social behavior---witness the overall gaping absence of public challenges to it---in deference to the unwritten rule of staying out of others' 'private business.'

In short, beating up a wife or girlfriend can be a very effective, albeit emotionally immature, politically corrupted, and morally compromising way for abusive men to get what they want. It is emotionally immature, among other things, for its gross lack of empathy; politically corrupted for its 'dirty pool collusion in perpetuating inequality in gender relations; and morally compromising for its offense to the dignity of, and right relationship with, the victim, the community, and within the perpetrator himself. If abusers happen to get caught, especially if they are White, their mental math includes any number of calculations including but not limited to the possibility of influencing the outcome by talking an officer out of an arrest; getting bailed out by themselves, family members or friends; pleading guilty to a lesser charge; or counting on limited-to-no tracking of their non-compliance with 'treatment' mandates (depending on the jurisdiction). Power in their relationship, therefore, is not obtained or maintained solely by their personal use of physical violence but by a pattern of coerced or coercive control in which the community is all too easily and frequently complicit.

Perpetrators of battering would have us subscribe to the cycle theory because "things (the stress of the relationship, work, etc.) just kept building up and building up," they "couldn't help it"---they "just lost control," and really, they are "so sorry." Unfortunately, this is another attempt to get outsiders to collude with them to justify their behavior. Part of their goal is to have us believe that if we were in the same situation, well, we would react that way too---we had no other choice, it just reached a boiling point we couldn't stop, and, since we're all human, we should have the chance to redeem ourselves (without question, of course we should, but promises made and broken time and again sound less like commitment to change and more like manipulation).

The explosion (clinically speaking, the "acute battering phase") frames the abuser as out-of-control when in fact the batterer is completely in control---of himself and his partner. It also suggests that the abuser has an anger problem, which he may well have: men who are abusive often have an ax to grind about anyone and everything. Yes, he knows all about anger management: he manages his anger to get his way, the anger his tool of manipulation and coercion. If he was really out of control, how could he so conveniently check his 'impulse control' skills at the door of any number of social settings---places of worship, restaurants, workplaces and so on---places where the price for not using them could be high?

Of course, any of us can make the same choice to be abusive and violent like men who batter the women they say they love. But under the same circumstances, with the same pressures, we don't. It is not for lack of good interpersonal skills, either, on the part of batterers that they make their choices. As David Adams of EMERGE in Boston reminds us in Ann Jones' (1994) outstanding *Next Time She'll be Dead*, "the violent husband's selectively abusive behavior indicates an established set of *control skills* " (emphasis his; p.89). In other words, they weren't born late last night---they know what they are doing, even if spontaneously.

Unfortunately, the cycle theory of violence minimizes the agency, free choice, intentionality and willfulness of the abuser. Yes, all of those things. He *did* choose the behavior---freely---and it is intentional (even if on occasion there happens to be a truly unintended consequence). If he is so out of control as to justify the (euphemistic) diagnosis of 'intermittent explosive disorder', how is it that he can so precisely and selectively choose the when, where, how, and perhaps most importantly, the intended *who* of his behavior? And if he truly "didn't have any other choice" or was so "out of control" of himself, he cannot possibly accept authentic and complete responsibility for his behavior and thus fundamentally change it.

The cycle theory is also problematic in its proscribed predictability and predetermined phases, which battered women do not universally assert as their experience. For example, in some abusive relationships there is constant tension without explosions, or explosions with no honeymoon (see 'why apologize?' above). The honeymoon phase is another tactic of coercive control. As Derry says, the question to ask about the honeymoon is: a honeymoon for whom?

The cycle theory is predicated on the theory of learned helplessness, which posits in part that the worse things get, the more paralyzed battered women become in breaking the cycle (thus perpetuating it, and indirectly blaming her for still being in the relationship and not ending the violence; as someone once said, this is akin to locking someone in a basement and telling them to be their own locksmith). In fact, research supports the lived experiences of countless battered women, namely that they demonstrate amazing creative problem solving strategies in the face of intensifying abuse. All too often it is the systems which purportedly exist to support them which can fail them and keep them trapped.

Because battering takes place in multiple cultural contexts, forces outside the relationship often unwittingly support the behaviors described in the cycle, and all too often inconsistently and/or inappropriately intervene in an attempt to end them. Coordinated community responses to domestic violence have evolved precisely because it is the web of support by *the community* (in its fullest sense and by its countless means) that is the antidote to 'intermittent explosive disorder.' If we are to give women who are battered their long overdue respect for being survivors of and experts about domestic terrorism, we in the community have to hold batterers accountable for their behavior. If we do not, we will inadvertently reinforce the unthinkingness they would have us believe underlies their behavior, battered women won't be the only ones 'sleeping with the enemy.'

Maura Lynch is the Coordinator of the Community Violence Prevention Institute in the College of Professional Studies at Metropolitan State University in St. Paul, Minnesota. copyright 2004

Appendix I: Domestic Violence Theories

All of these theories have some truth or meaning to many people. The theory you believe will shape how you respond to violence. However, theories and academic studies on the cause of violence can easily distract from the real purpose of violence: **It works!** In the short term, violence is the most effective tactic to get your way.

Pathology

Men's violence is seen as a symptom of biology, deviant personality types, abusive family of origin, alcoholism or drug addiction. Psychopathology sees violence as a symptom of mental illness. Clinical categories are diagnosed using a medical model. Intervention may include medication or psychiatric treatment.

Psychodynamic concepts

Sees violence as a symptom of an underlying psychological disorder. Poor impulse control, rage attacks resulting from childhood trauma or family inadequacies are other reasons. In-depth diagnosis and long term therapy is considered the most appropriate way to heal the sickness.

Family systems approaches

Sees violence as a symptom of a dysfunctional relationship. The violence is addressed by creating healthier interaction between the parties. Skills training of both parties is a key intervention.

Inner tension

Violence is seen as being expressive of "impulsive forces from within." This is explained as an instinctive or genetically inherited trait, sometimes seen as stronger in males. Alcohol may allow the triggering of violence at a lower tension level so is seen as a contributor but not a cause. The cycle of violence is a tool used to explore the "tension-building," "explosion" and "make up" phases. Triggers of violence are identified and anger management skill building, for example "time-out," is seen as the most effective response.

Social structure theory

Sees violence as more prevalent in "lower socio-economic groups" as a symptom of frustration over limited life opportunities, lack of education and skills. Violence can therefore be addressed by policies that address poverty, inequality and unemployment.

Violence as learned behavior

If nonviolent behaviors have not been modeled or taught, and violence has been reinforced (especially in the family of origin), then an individual uses violence to get what they want. Anger management aims to relax and reduce stress, identify emotions and think about them differently and develop interpersonal communication skills that stop the violence.

Violence as a consequence of the social system

Sees men's violence as a result of patriarchal norms of western society. Men are violent to women as a result of shared beliefs about their superiority over women and their innate right to dominate. Sex role stereotypes, homophobic attitudes among men, and cultural traditions that devalue women are all parts of the culture. Exploring shared belief systems and hierarchical social systems are steps towards building relationships based on equality. The Domestic Violence Centre believes that men's violence against women is best explained by this theory.

Domestic Violence Centre---Te Whare Whanau Whakaoho Patron: The Hon Justice Silvia Cartwright DBE PO Box 106 126, Downtown, Auckland Crisisline 64 9 303 3939 Office 64 9 303 3938 Fax 64 9 303 0067 Website: http://www.dvc.org.nz [No longer available as of 11/7/11],

Appendix J: Speaking to Health Care Providers: Notes to Survivors

It is the hope and mission of many health care institutions that facilities providing health care be safe places for survivors of domestic violence. Health care professionals are being taught to:

- ask all adult patients (and sometimes teens) abuse screening questions;
- provide support and assess safety;
- offer domestic violence resource information.

Your contribution to family violence education, sharing your story, is **the** most important part of our education. Your willingness to share is greatly appreciated. Through your message, people will understand power and control and be motivated to begin doing abuse screening. You will find that many will be deeply grateful to you. Others in the audience have shared your experience themselves. Before deciding to share your story, be sure you are ready to speak about such painful experiences to others.

In order to optimize your presentation's effectiveness, consider the following:

Preparation

- Practice so you are comfortable with the words and know how long the talk is.
- Use an outline, notes, cards, or read from a written text.
- Tell your own story sequentially, from the beginning to the present.

Suggested speech outline and structure

- Background of past relationship: length, children, good times
- Current status: working, housewife, living situation
- Your childhood history
- When the abuse began and specific examples of what your abuser did
- What you did when these things happened, how you felt
- How you were controlled, hurt, humiliated, downtrodden
- What happened when you reached out to others? What helped? What did not?

- **ANY health care experiences that were negative OR positive***
- How you came to get help. Did someone help you?
- How the system failed or helped you.
- The healing process

Tips

- It is invaluable for health care providers to hear you say they should ask their patients if someone is hurting them physically, sexually, or emotionally.
- Tell people in the class what words and actions were especially helpful for you.
- Specific examples are a strong educational tool, they help provide insight and motivation.

* Extremely helpful!!

Developed by Marlene Jezierski, RN, 1997. Rev. 2001.

Appendix K: Gloria's Story

This is a simple scenario that describes a possible real-life situation. It is intended to elicit discussion resulting in increased understanding of difficulties survivors face. Consider having a total of 9 volunteers come to the front of the room. Assign roles as follows: Gloria, the primary reader; Oliver who does not read; and 7 people to whom Gloria reaches out. Using ribbon, toilet paper or string, give a length to each person except Gloria. Give the ends of each to Gloria. She will then be holding 8 ends which attach her to the other 8 people. Instruct the participants to, after they respond to Gloria, drop the ribbon and sit down.

"I'm going to read a story about a woman who is just like many of us. Take special note of how she reaches out time and time again for help. When I refer to the person on the card such as landlord or doctor, please read the response written on the card."

Each of the individual responses (on the next page) should be placed on one of 7 cards

Gloria---Read the following out loud:

"My name is Gloria. I am 70 years old. I was married to Harold for 48 years. We have 4 children, all who live in different states. Harold was a wonderful husband and a good provider. Harold died last year from lung cancer."

"Ten months after Harold's death I met Oliver. Oliver was funny, caring, compassionate and romantic. I introduced him to my children and grandchildren. They all loved him. My friends thought I was lucky to have found someone who was so charming."

"Before we got married, I sold my home. We planned to live in Oliver's apartment until we could find a place of our own. Once I moved in, we never went to look for another place."

Gloria says to her sister: *Oliver isn't the same as he used to be.*

She says to law enforcement: *I'm afraid of my husband.*

She says to her clergyman: *Oliver seems angry.*

She says to her landlord: *I'd like to talk about my lease.*

She says to her friend: *Oliver likes me to stay home.*

She says to her banker: *I'd like to talk about my account.*

She says to her doctor: *I've been feeling stressed lately.*

Brief Group Discussion "How do you think Gloria felt?"

After discussion, summarize key learning points. *"Oftentimes, we only know a little of the whole story. This is not unusual for people in abusive situations, they may tentatively reach out to many and get this kind of response."*

"Think about anyone in this kind of a situation. How do you suppose Gloria, or anyone else, feels as they reach out for help, support or affirmation?"

Participant responses to Gloria's story:

Suggested card format:

Please read the following when Gloria speaks to you.

Doctor says: Well, your heart checked out okay. You seem nervous and depressed. I am sending you to a nutritional counselor since I noticed you appear to bruise easily.

Sister: You're so lucky to have Oliver. I'm so lonely now that my husband is gone.

Law enforcement: Unless there's physical proof of an assault, fear isn't enough.

Clergy: I've explained to you that second marriages are tough. Oliver must be having difficulty adjusting.

Landlord: I've received complaints about another loud argument last night. If you two don't keep it down, you'll be asked to leave.

Friend: I know that you and I have met for lunch every Monday for years. but, you newlyweds need your time together.

Banker: I understand why you share an account with your husband. It really secures your finances. You're lucky to have a man like Oliver.

Doctor: Well, your heart checked out okay. You seem nervous and depressed. I am sending you to a nutritional counselor since I noticed you appear to bruise easily.

Appendix L: Quiz: Have You Ever?.....

- Said you would *never* forgive someone, then did anyway?
- Said you would *never* give someone a chance, and then decided it wouldn't be right to refuse one more sincere attempt?
- Thought it wouldn't be reasonable to refuse to talk over a situation that you were clearly wronged?
- Stayed in a job where you were being badly treated?
- Stayed in a job where you were being well paid?
- Stayed in a job because you had no alternative?
- Stayed in a job because you thought it would get better?
- Resisted saying what you thought because you might get punished?
- Gone along with an authority figure because it was your duty?
- Gone along with an authority figure because they were paying your way?
- Gone along because you didn't want to cause trouble?
- Decided not to point out someone's error because it might embarrass them?
- Inhibited your objections to the behavior of someone who seemed to be "crazy"?

.....So, why do women stay in abusive relationships?

Developed by and used with permission from Gail Holdeman, M.S.W., LICSW, Central Center for Counseling, Blaine, MN

Appendix M: Family Violence Awareness Exercise

Following is a tool to consider using at the beginning of one or more components of family violence studies. It is an exercise intended to facilitate student (as well as faculty) examination of personal beliefs and attitudes about family violence. Ask your students to write down the first thing that comes into their mind. After covering some of the basic material, consider asking students to review their initial thoughts and discuss any insights gained.

Reflective questions

1. When I think about abused children I feel_____

2. When I think about parents who abuse their children, I feel_____

3. Parents who abuse their children should be _____

4. Men batter their partners because _____

5. Women who stay in abusive relationships are_____

Developed by Judi Sateren, MS, RN, St Olaf College

Appendix N: Systems Review

Conditions associated with physical, sexual or emotional abuse or neglect. Compiled by Marlene Jezierski, BAN, RN, Partners for Violence Prevention

1. "Red flags" - seen in patients

   - Substance abuse
   - Depression, suicide attempt
   - Pregnancy complications
   - Chronic pain: headache, chest, abdomen, pelvic, back
   - Series of injuries
   - Bruises with patterns (cigarettes, shoes, belt buckles, cords, hands, fingertips)
   - Many seemingly minor but continual and/or varied physical problems
   - Delay in seeking treatment OR doesn't seek treatment for serious injury
   - Injury doesn't fit with patient's or others' description

2. "Red flags" - behaviors associated with abusers

   - Patient flinches in presence of abuser
   - Abuser excessively attentive and responsive to patient
   - Patient seeks permission from abuser
   - Patient demonstrates increased anxiety in presence of abuser

- Refusal of abuser to leave patient alone

3. Neuro
   - Ear or eye problems secondary to injury
   - Subdural hematoma
   - Chronic brain syndrome
   - Neurologic deficits
   - Headaches
   - Hyperactive reflex response
   - Tremors
   - Memory loss
4. Respiratory
   - Asthma
   - Shortness of breath
   - Hyperventilation
5. Cardiovascular
   - Palpitations
   - Hypertension
6. Gastrointestinal
   - Irritable bowel syndrome and other chronic G.I. dysfunctions
   - Chronic abdominal pain
   - Functional dyspepsia
   - Diarrhea
   - Constipation (elder neglect)
   - Anal itching, bruising, bleeding, edema, irritation
7. Orofacial-EENT

- Neck: bruising, contusions, abrasions, scratches, petechiae (choking)
- Head: bald spots, signs of being pulled by hair
- Mouth: palate contusions. frenulum tears, nonvital and/or fractured teeth
- Face: injuries, signs of blows to head or face, blowout fx
- Nose: Nasal fractures
- Eye: detached retina, subconjunctival hemorrhage, periorbital injuries
- Ear: ruptured tympanic membrane, hearing loss

8. Genitourinary

- Multiple unplanned pregnancies, many ending in legal abortion
- Bruising, injury to the pregnant abdomen
- Poor compliance with prenatal care, canceled appointments
- Miscarriage
- Premature labor
- Low term birth weight (17.8% versus 4.5% in control population)
- Abruptio placenta
- Intrauterine injuries and unexplained fetal death
- Fetal injuries: bruising, intraventricular hemorrhage, fractures, gastric ulceration, hemorrhage, tibial deformity, hip dislocation, scleral opacities
- Signs of sexual assault postpartum
- Post partum depression
- Newborn feeding problems and failure to thrive
- Lacerations, bruises, contusions, mutilation of genitals or breasts
- Chronic abdominal and pelvic pain
- Pelvic inflammatory disease
- Sexually transmitted diseases

- Pelvic floor dysergia (lack of coordination in muscular voluntary movements)

9. Musculoskeletal --- Integumentary --- Ears, Eyes, Nose, and Throat

- Injuries to breasts, upper arms, chest, face, abdomen
- Bruising, contusions, welts, edema, scars, lacerations, burns
- Fractures: especially of facial bones, spiral fractures of radius or ulna, ribs
- Shoulder dislocation
- Chronic back pain
- Limited range of motion of extremities
- Old fractures in varying stages of healing
- Many bruises of different colors
- Lacerations
- Restraint injuries around wrists and ankles

10. Psychosocial - Behavioral - Miscellaneous

- Signs of low or decreased self-esteem
- Signs of depression, fatigue
- Anxiety, apprehension, fearfulness, nervousness, panic attacks
- Suicide attempt (20% to 50% of abused women attempt suicide)
- Sleeping disturbances
- Substance abuse
- Post-traumatic stress disorder
- Poor grooming
- Inappropriate attire (e.g. related to weather to cover injuries)
- Nonverbal communication suggesting shame about body
- Flat affect
- Poor eye contact (can also be cultural)

- Choking, hyperventilation
- Sleeping disturbances: insomnia, nightmares, fatigue on awakening
- Mood swings
- Inappropriate behavior
- Post traumatic stress disorder
- Hyper-alert, hypersensitive, startle response, flinches when touched, jumpy
- Excessive worry, phobic
- Deferential, over-compliant or dependent behaviors, resigned
- Eating disturbances: (anorexia, bulemia, morbid obesity)
- Thought process: memory loss, difficulty concentrating
- Coping: inability to cope, hopelessness, helplessness
- Signs of repressed rage, hostility

11. Neglect (is not always a direct intent to injure)

- Poor compliance with medications
- Poor hydration
- Unkempt, poor hygiene
- Malnourished, inattention of caregiver to basic medical and physical care such as food, water, clothing, shelter, medicine, comfort, personal safety
- Decayed teeth, broken glasses, overgrown nails
- Failure to provide the necessities of life
- Untended skin lesions, decubiti
- Fecal impaction
- Living environment: physical hazards, unsafe conditions, inadequate hearing, inadequate food supply, presence of insects

12. Financial

- Unable to get medications
- Inappropriate or unauthorized use of money or property
- Unexplained insufficient funds

Appendix O: Victims of Violence: Health Care Provider Needs Assessment and Intervention

Developed by Marlene Jezierski, R.N., B.A.N.

Assessment	**Intervention**		
Domain	**Assessment**	**Education/Intervention**	**Community Agencies**
Physical	Brief head to toe assessment	Appropriate Medical Follow-up	• Community clinics • Medial Staff Referrals
Nutritional habits	• Healthy dietary practices • Basic food groups • Food Availability	• WIC (Women, Infants & Children) services • Community food shelves	
Sleep patterns	Impact of sleep deprivation	Counseling, Crisis nursery	
Chemical dependency/use	Encourage access to counseling/support groups	• Referrals to AA, counselors, community agencies • Supporting rehabilitation	
Sexual assault	Assess for immediate physical needs	Sexual assault advocates	
Psychological/sociocultural	Self esteem	Affirm: You don't deserve it/You didn't cause it	Battered Women's Resources
Coping skills/needs	• Need to take care of self	Community Women's courses, groups, public library	

Assessment	Intervention		
Domain	**Assessment**	**Education/Intervention**	**Community Agencies**
	• Relaxation techniques • Pursue things she enjoys		
Support system (family, friends)	• Emphasize need to access • Provide opportunity to call • Help identify support sources	• Support groups • Stress management classes • Crisis Nursery • Battered women's groups &shelters	
Depression	• Offer support • Validate: it is part of the abuse cycle • Evaluate severity: candidate for PTSD? (post-traumatic stress disorder)	• Counseling, psychotherapy • Resources at place of employment	
Educational	Understanding/perception of abuse	Definitions/characteristics: what constitutes abuse, escalating characteristics	Battered women's resources
Literacy		Community Education	
Language/hearing barriers		Interpreter services, hearing society	
Financial	Is there need for money? (transportation, food, medical care, basic needs)		• Social services • Battered Women's Resources

Assessment	Intervention		
Domain	**Assessment**	**Education/Intervention**	**Community Agencies**
			• Counseling, employment, clothing community resource • Medical assistance/ AFDC
Legal	• facilitate contact of law enforcement • Advise of resources available	• Battered women's advocates • Law enforcement	
Legal questions		• Judicare or local attorney resources • Legal clinics • Battered women's resources	
Safety	Fear level	Safety plan: • Self defense • Emergency numbers • Self protection during abuse *curl into ball, hold head, scream loudly • Have children or neighbors call 911	• Community self defense classes • Women's shelter and advocates
Safety Level: • Does she feel safe? • Has there been a recent increase in violence	• Counsel regarding long range plans; • Discuss potential for escalation and increased risk	• Child protection • Women's shelter and advocates	

Assessment	Intervention		
Domain	**Assessment**	**Education/Intervention**	**Community Agencies**

• Has she been choked?
• Is there a weapon in the house?
• Has he used/ threatened to use a weapon?
• Has he threatened to harm children?
• Has he threatened to kill her?
	• Discuss awareness of options, considering risk
	• Escape Plan;
	  • Where will she go?
	  • How will she get there?
	  • What does she need to leave?
	  • Hide an "escape kit" that is easily accessible
	    • papers, money, documents
	    • phone numbers, including number of Women's Shelter
	    • clothing, glasses, medications
	    • keys, etc.		

Safety of children	Presence of child abuse	Child protection	

*Battered women's advocates and shelter staff members are excellent resources for any of the above need

Appendix P: Barriers to Abuse Assessment and Intervention

It isn't my job

Health care professions have identified violence as a health care issue and advocate for screening. Violence in the home has a significant impact on health. (See Assessment for Domestic Violence, pg. 9) Family violence-related health care costs are phenomenal (See Fact Sheet pg. 4)

I'm concerned about documenting abuse history: I might be sued

Patient data relating to violence is important and as relevant as any other data. (See Documentation, pg. 14) There is no known lawsuit related to provider documentation of family violence in the United States. Suits can be filed for any arbitrary reason. Arbitrary suits are not accepted in court. Established community standards include abuse assessment and intervention.

I don't know how to ask, I don't know what to say if they say yes

Review "Asking About Domestic Abuse" on pg. 15. Work on developing skills: practice with a colleague or in front of a mirror, attend inservices, do role plays.

Survivors have said: (Anoka County Prenatal Abuse Project):

- "Admit you don't know how she feels. Say something like, "Please help me understand how you are feeling. Can you help me understand? Let me know where you're at."
- "Tell her, I can help you. And don't call the police."
- "Just be kind." "(Avoid) a better-than-you attitude."
- "Let her tell you what is happening and how you can help her."
- "Never pressure or press someone to tell you."
- "Don't ever tell her it's her fault."
- "Make yourself available and approachable. She probably won't talk the first time."

It doesn't really happen that much...it isn't that likely

There are hundreds of statistics documenting a significant incidence of family violence, for example, the single most frequent cause of trauma to women is domestic abuse (See fact sheet pg. 4). Family violence is endemic: it occurs at every socioeconomic level, in rural and urban areas, in every race.

The person might get upset

Clinicians doing screening have learned that the most common response has been appreciation and affirmation. Complaints can occur if a question is not asked in a caring, sensitive manner

Survivors have said they want to be asked

Not asking can feel like they are being judged or the abuse is their fault.

I'm male: they won't want me to talk to them

Survivors state they are comfortable with health care providers of either sex screening them. They trust caregivers and respond positively to a supportive, caring approach from either sex.

I don't have the time

It takes 30 seconds to say the preface statement and two recommended screening questions. It takes another 30 seconds to make affirming statements and offer resources or call an advocate.

It isn't private enough

Providers **must** establish policy supporting private patient assessments to preserve all aspects of patient confidentiality. The patient is at risk if you speak about family violence in the presence of anyone else. This is true of all, even another of the same sex or a parent. When unable to ask, devise a system of asking later.

I don't want to make any assumptions

Silence is a negative message to survivors. Avoidance in the face of obvious abuse may communicate to the survivor that she/he is wrong and the abuser is right. However, always accept the patient's response at face value.

They don't do what we tell them or what we think they should do

The power and control dynamics are complex. The traditional medical model is to tell people what is best for them with expectations that the patients do what they are told. Patients in other circumstances do not always do what they are told (e.g. smokers). Give them information so their decisions are more informed. Survivors must make their own choices.

The caregiver has abuse in his/her history

Caregivers who are survivors, either currently or in the past, with unresolved issues, may have difficulty supporting others. Provider survivors may not be aware of the influence of abuse in their personal lives. These individuals are encouraged to seek help such as EAP, crisis lines, advocacy services or counseling.

The caregiver buys into myths

Often other factors are attributed to being the cause of the abuse. The truth is, some individuals choose to use fear, intimidation and pain to control others. When this occurs, it is abuse. For example, people are not abusive because they drink too much: they are abusive because they want to control someone and use alcohol as an excuse. Survivors who abuse substances often use chemicals to cope.

The patient is known to the caregiver

Providers are obliged to screen all patients without assumptions and to maintain confidentiality. Rules of confidentiality apply to all areas of health care information.

It isn't my business/I don't want to be probing

It is our business as a major health care issue and a component of wellness. Information from survivors (most had never talked to a health care provider, most thought they should)

- "I definitely think someone should be asking and recording the answers."
- "I'd like to be asked about my abuse and treated with care and sensitivity."
- "The more visible this issue is, the easier it will be to find help."

One participant expressed a desire to let everyone know so she would feel protected.

What can you do when abuse is denied?

Anoka County survivors listed three main reasons for not acknowledging abuse: fear of the abuser finding out, losing control over a tightly held secret, and having negative things said about her partner. A professional woman felt her peers would judge her if they knew she was abused thinking "she should know better". Provide educational materials to all patients so undiscovered survivors get information. Another survivor advised: "If she doesn't tell you the first time, say something like this: are you sure you don't want to stay and just talk a little longer with me? That might break the ice. Give the victim information, let her make choices and keep the ball in her court."

Developed by Marlene Jezierski, BAN, RN

Appendix Q: Family Violence Screening and Response Tool

What to do: RADAR*

R outinely ask, inquiring about family violence is an intervention. You're signaling that violence is inappropriate; you may be helping to end the isolation. **A** ffirm and support patients who acknowledge abuse. **D** ocument objective findings; patient statements in quotes. **A** ddress your patient's safety. **R** efer the patient to people skilled in family violence and safety planning.

When do you screen?

- Patient must always be alone with the exception of infants or nonverbal toddlers.
- Screen all adults---both males and females and teens 12-18.

Setting the stage

Consider opening the conversation, when time permits using a funneling technique. You can begin with a statement such as "So I can better understand and meet your needs, I'd like to ask you a few questions about your background." Then ask a few broad, non-threatening questions such as:

- "How are things going at home, (or) in your family? (or) with your partner?"
- "How do you feel about the way differences are solved in your family/relationship?"

If there is an indication of potential family violence, follow with more direct questions. Because some patients may react negatively to the words "abuse" and "violence," naming a range of abusive behaviors and experiences may be more useful. For example:

- "Are you experiencing any stress or anger problems in your relationships?"
- "All people argue, how do you and your partner handle disagreements?"
- "Do your fights ever become physical?"

The preface statement

When introduced to the questions in this manner, the patient is more likely to view abuse screening as a reflection of your concern rather than feeling singled out.

- We at _____ hospital/clinic are concerned about the effect that difficult or harmful relationships have on the health of our patients, so we ask everyone the following confidential questions OR
- We recognize that many people experience events in their lives that affect their physical and mental health, such as difficult or harmful relationships.

Screening questions

- Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?
- Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?

* RADAR is used with permission from: Alpert, E.M., "Use your RADAR, Partner Violence: A Guide for Physicians and other Health Care Professionals". 1999. Massachusetts Medical Society, All rights reserved.

Responses to Patient Screening

Principles of Effective Screening

Phrase questions so as to invite disclosure and not convey judgment. Asking a patient, "you're not being abused, are you?" is both leading and potentially stigmatizing and unlikely to elicit an honest response.

Ask questions specific enough so the patient understands exactly what is being asked. Many authors suggest asking, "are you safe?" yet this question may be misinterpreted. (i.e. are you using safe sexual protection or do you have a burglar proof house). Questions as stated above are more appropriate.

When someone responds with a vague answer, follow up with a clarifying question. For example, if a patient responds to question #1 with: "well, not really..." one can respond with a clarifying question, such as, "you sound uncertain about that, would you tell me more about what you mean by *not really."*

Many victims who acknowledge abuse for the first time may be suddenly placed in a position they have never been in before: that of making a decision to share something very personal for the first time in their lives.

Tips on screening elders

Elders often experience other forms of abuse (neglect, financial, medical). Consider one or more of the following:

- "Has anyone ever refused to take care of you when you needed help such as withholding food, water, medications or basic cares such as bathing or toileting?"
- "Has anyone ever denied you visits to your doctor?"
- "Have you signed any documents in the last year that you did not understand?"
- "If someone is helping you with your finances, are you uncomfortable with their assistance?"

Tips on screening teens

Positive comments regarding appearance, mood, or recent accomplishments are helpful when beginning the abuse screening process. This can quickly lead to a discussion about likes and dislikes, what they do for fun, boyfriends, school and home situations. Follow general questions with rephrased questions that say "If you are dating, have you been hit, kicked, pushed by that person or someone important to you?"

Safety Issues: The HITS Test: a Quick Assessment Tool

Ask the patient how often does your partner:

- hurt you physically?

- insult or talk down to you?
- threaten you with harm?
- scream or curse at you?

Score as follows: Never=1 Rarely=2 Sometimes=3 Fairly often=4 Frequently=5 Score higher than 9 suggests a high potential for danger.

Supportive Response: General Suggestions

- Be accepting, nonjudgmental and supportive of their decisions
- Listen thoughtfully, believe the victim/survivor's story.
- Use clear, direct communication.
- "Help is confidential, free, and all choices are yours."

DO NOT:

- Tell the victim/survivor what to do or that you know how he or she feels
- Confront or criticize the abuser
- Be hurt if the abused person reacts in anger
- Assume a counselor role, leave that to the experts.
- Remain silent. It may feel like rejection or judgment.

Cultural Considerations

- **Do not assume:**
  - That because your patient is of a certain ethnicity you then will know about cultural norms and practices of that patient.
  - Do not assume you know the ethnicity of your patient, ask!
  - Don't assume your patient is an immigrant
- There is great opportunity to build on the strengths of the ethnic culture your patient is from. Each one is rich in spiritual, communal and emotional qualities that can support the abuse victim/survivor's journey
- A culturally-sensitive assessment takes into account level of acculturation, language preferences, immigration history, family structure, economic status and patient's age

- Consider building trust through conversation using an opening dialogue such as:
  - *"How long have you been in the U.S.?" "How are the children doing?"*
  - *"Do you need help with the children"...and then listen to your patient.*
- Share of yourself
- Engage patients in telling their stories
- Focus on supporting self esteem, the right to do things for themselves and their children, positive reinforcement, self care and the value of connecting with advocacy services
- Some have had negative experiences in the health care environment.

Specific Populations

Native American

- Healing practices are often very traditional: sweats, talking circles, smudges, etc
- Atmosphere: respect for traditions is important
- NA women are adept at picking up on non verbal cues, biases communicated by posture, tone of voice, eye contact and communication style
- Be comfortable with periods of silence
- Physical contact and hugs should be avoided until a trusting relationship is well established; such contact may not be welcome even then
- Joking is an important part of communication: sharing laughter may help break the ice and develop trust
- They may not be interested in support groups, many are not very verbal.
- They tend to have a deep respect for older women. This may result in middle-aged or older women having some difficulty with a young nurse or doctor.
- Provide information whether or not the women ask for it. Most native resources focus on traditional spirituality and culture as a part of the healing process and a way to reclaim one's identity and strength

Hmong

- A traditional Hmong show of respect when talking with a person they respect and/or feel is of importance is to avert the eyes and avoid eye contact.

- It is helpful if a conversational approach precedes the screening process. Asking a question about how things are in the family provides comfort. The patient might begin crying at this point if there is great stress at home.
- Acknowledging abuse in others' lives may also be of value in this circumstance. They often may speak of abuse knowing "a friend" is experiencing it rather than themselves.
- Some may not realize just what a support group does. One way of explaining is:
  - Support groups are discrete, confidential, open discussion of caring, listening and sharing
  - All can speak freely, knowing nothing they share leaves the room
  - They engender a supportive environment in which one can build confidence and esteem

African American

- Joking is an important part of communication: sharing laughter may help break the ice and develop trust. Many are very adept at using humor as an effective coping mechanism.
- African American women are skilled at picking up on non-verbal cues; biases communicated by posture, tone of voice, eye contact and communication style
- The illegal behavior of an abuser may be minimized out of a sense of loyalty
- The victim/survivor may have a very strong religious faith along with a belief that faith itself can heal. This may prevent the person from being inclined to seek outside help or even feel that she should because her faith should be strong enough to heal.
- There may be a mistrust of the medical profession based on previous experience as well as related to an abiding value for the power of spirituality and healing.

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Appendix R: Small Group Case Scenario Discussions

Created by the Physicians for a Violence Free Society, 2002 (used with permission) Participant Packet

Recommendations

- Copies of clinical scenarios have been provided and assigned to your group.
- Have one member from your group read the case history scenarios that you have been assigned aloud. One member play the provider role and one member play the patient role, then discuss the case using the questions provided as a stimulus for the discussion.

- Please feel free to refer to the Screening Questions, Risk Assessment, and Safety Planning handouts as you discuss the case/s.
- Please note that a standard framing statement and two questions screening protocol have been used in the following case scenarios. In daily practice the format of the framing statements and screening questions (direct, indirect, focused follow-up questions) will vary depending on the specific clinical encounter. Try to become comfortable with several different formats. Remember it is just as important "how" you ask a question as it is "what" you ask.

Domestic Violence Case Scenarios

1. DKA:Medical---Surgical
2. Diarrhea and multiple problems:Emergency Department, Primary Care
3. Injured forearm, male: Emergency Department, Primary Care
4. Incomplete Abortion:Emergency Department, Obstetrics, Preoperative
5. Co-worker:All
6. Asthma: Emergency Department, Primary Care
7. Migraine: Emergency Department, Primary Care
8. Pap smear: Primary Care
9. Teen screening:Emergency Department, Primary Care
10. Routine postpartum visit: Obstetrics, Family Medicine
11. Single at risk mom: Obstetrics, Family Medicine
12. Routine labor and delivery, past hx: Obstetrics, Family Medicine
13. Neighborhood:All, Non-clinical
14. Injured wrist, female:Emergency Department, Primary Care
15. Colles fracture, male:Orthopedics, Preoperative
16. Male asthmatic: Emergency Department, Primary Care
17. Abdominal hysterectomy:Operating Room, Obstetrics, Medical---Surgical
18. Bleeding disorder:Medical---Surgical
19. Viral meningitis: Medical---Surgical

20. OB check, non English-speaking:Obstetrics, Family Medicine

1. DKA: Medical---Surgical

A 43 year-old Latina female is transferred to your unit from the ICU. Admitted from the ED in DKA, she was stabilized after 36 hours. The receiving nurse notes she was not screened for family violence. The patient "speaks some English" and does understand what is said to her. She seems fatigued and is subdued, but is alert and oriented. History includes numerous hospitalizations for DM type I, out-of-control, and chronic back pain. She has six children, all less than 18 years old. Social service suggests she is irregular in administering her insulin and erratic in diet compliance.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions"

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one, eyes widened, avoid eye contact, speak quietly: "No."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "The husband is the man of the house. I try hard but make mistakes. It's all fine, it's ok, I got it good, no problems."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. What are some red flags in this patient?

3. What can you say in response to the patient's comment about making mistakes?

4. What additional treatment plans are indicated in this case?

2. Diarrhea and multiple problems: Emergency Department, Primary Care

A 42-year old woman presents to the Emergency Department or Primary Care Clinic with a weeklong history of abdominal pain, nausea and diarrhea. She has been in the Emergency Department or Primary Care Clinic with numerous complaints over the past year ranging from insomnia and anxiety, headaches, back pain and various GI problems.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: Answer briefly, no, no, of course not.

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: Answer "no."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. Is there anything suggestive in this history?

3. Upon her denial of abuse, what statements might be of value in this case?

3. Injured forearm, male: Emergency Department, Primary Care

A 20-year old male comes to the Emergency Department or Primary Care Clinic with a history of injuring his forearm while playing volleyball. The ulnar aspect of the forearm is bruised and tender to touch. You also note the patient has a black eye, has poor hygiene, and poor eye contact.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: Respond slowly: "No, no, I told you I was playing volleyball". Look away, be evasive.

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "I don't understand why you are asking me this question."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. What if anything might be suggestive in this history?

3. What kinds of questions or statements would be appropriate?

4. Incomplete Abortion: Emergency Department, Obstetrics, Preoperative

18-year old female admitted for D&C after an incomplete AB. She lives at home and is going to college. The patient came without parents.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: "No, my boyfriend doesn't hit me."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "We fight just like most couples fight."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. Is this patient at risk?

3. What could be said in response to the patient's comments?

5. Co-worker: All

A co-worker on your unit receives phone calls from her husband numerous times during a day. She is often visibly upset after these calls, looking stressed out and sometimes tearful. Today your unit is particularly busy and she needs to work longer than her scheduled shift. Her husband has already called 7 times wanting to know what she is doing and when she will be home. She looks frightened and is saying that she needs to get home.

Discussion questions

1. What can you do, what can you say?

2. What are some things you should not do?

6. Asthma: Emergency Department, Primary Care

A 32-year-old female known asthmatic presents unaccompanied with wheezing. She has been having some relief at home with her inhaler, but she is unable to get it under control. She is in a moderate amount of distress. Her wheezing is audible only to auscultation. The respiratory rate is 36. You note minimal substernal retraction. Her color is pale, and her skin is cool and dry. You note dark purplish-yellow bruising on her posterior chest. Old charts reveal this is her fifth visit in the past 6 weeks, 3 times with asthma and once with "the flu". The patient seems anxious, almost tearful.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one, speak quietly with your head down and no eye contact, hesitate before you answer, then shake your head vehemently and say: "No, no, of course not."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: Again, speak quietly, wait before answering. Then say: "No."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions:

1. What would you document in the medical record?

2. Discuss if and how you might incorporate the bruising into the screening.

3. Are there areas of concern in this patient?

4. Are there any intervention opportunities with this patient?

7. Migraine: Emergency Department, Primary Care

A 48-year old female presents with complaint of a persistent migraine headache, onset 36 hours prior, for which she has used Imitrix at home with some relief. Her presentation is typical of migraine: she is pale, wearing sunglasses, nauseated, is very still. She moves slowly. She has a 6-year history of migraines. She describes her pain to be 6 on a 1 to 10 scale.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

Respond to question one with eyes closed, quietly: "No."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

Respond to question two: "Actually, my first husband was controlling. My current husband is not that way."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. How would you respond to the patient's answer to the second question?

3. What, if anything, else would you do for this patient?

8. Pap smear: Primary Care

A 59-year old female presents to the clinic for her routine annual pap smear. She has not been in the clinic since the previous year for her last visit. She has no past or current health problems. Her history consists of a past history of 3 pregnancies and one surgery, tubal ligation. She speaks freely, is alert and reading a book while waiting.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: "Oh no, not MY husband! Why do you ask?"

Provider:

After the patient answers, what would you say in response?

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two (laughing): "If anything I nag my poor husband, he's the one who has to suffer!"

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?
2. Do you have any concerns about this patient?
3. Is there anything else you might do?

9. Teen screening: Emergency Department, Primary Care

A teenager is brought in to be seen for a persistent productive cough and fever. Her father expresses concern she may have pneumonia.

Provider:

First, ask the patient: "Are you serious about anyone romantically, or going out with anyone?"

Patient:

In response to the first question say, "Yeah I'm seeing a guy from my school."

Provider:

Since the patient states positively, introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask everyone the following confidential questions."

Ask question one:

"Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to the first screening question, reply with a little sarcasm saying: "We're just like every other couple I know. When we get mad we push each other around but no one ever gets hurt."

Provider:

After the patient answers, what would you say in response?

Ask question two: "Do you ever feel afraid or threatened by your boyfriend?"

Patient:

In response to question two state: "Oh we kid around but no one ever means anything by it. You people all get bent out of shape with normal goofing off."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?
2. What might be some appropriate responses to this young lady?
3. Are there any resources you might be able to provide for her?
4. What, if anything, would you do about the father?

10. Routine postpartum: Obstetrics

Patient is a multipara who had an uncomplicated labor and delivery. Abuse screening was not done in labor and delivery. Mother is 32, has two other active children ages 2 & 4 years of age. Mother has freshly showered, has makeup on, and she is relaxed. You have observed her to be quietly observant and smiling when her children saw the new baby. Mom seems to be comfortable with being a new mother but acknowledges she is tired. Mother has a lot of questions about breast-feeding.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is impacting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: "No, but a good friend of mine is in these circumstances. I feel so sorry for her and I'm really worried about her. I am so glad you guys are asking these questions."

Provider:

After the patient answers, what would you say in response?

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "No. My husband and I certainly have our differences, but we have a pretty equal household here!"

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. Do you have any concerns about this patient? Are there any red flags?

3. Is there any teaching opportunity here?

11. Single at risk mom: Obstetrics

A 16-year old single mom presents to L & D in early stages of labor accompanied by her grandmother. She is unemployed and on AFDC. From the patient's conversation, you suspect the father of the baby is a member of a gang. Labor is not progressing well and she is told to try to rest for a while. You are able to ask abuse-screening questions prior to the fathers' arrival. Later, the father arrives and the following is observed: he answered all questions for the patient, told the patient when to get up and walk and how far she should walk, and was critical of her appearance.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by your current or past boyfriend?"

Patient:

In response to question one: "Once in a while my boyfriend slaps me, but it don't hurt. I can handle it."

Provider:

After the patient answers, what would you say in response?

Ask question two: "Do you feel afraid or threatened by your boyfriend?"

Patient:

In response to question two: "What do you mean, why you ask THAT? That's just a man. They're all like that. He just a big man you know, like he's just doin' what come natural."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?
2. What concerns do you have?
3. What can you say to the patient?
4. What actions might you take?
5. What focused questions would you ask to find out more about current and past abuse history?

12. Routine labor and delivery, past hx: Obstetrics

A 32-year old multipara comes into labor and delivery in early stages of labor. Her husband and her mother are present. Labor is progressing smoothly, but slowly. The three have an easy communication style. There is warmth and comfort between them. The husband is helpful and communicates easily with his mother-in-law, as well as his wife.

Provider

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: Say you are not being hurt.

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "No, not at all. I was married before when I was very young and HE was kind of like that."

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?
2. How would you handle getting the patient alone?
3. Do you have any concerns about this patient?
4. What opportunities exist in this scenario?

13. Neighborhood: All, Non-clinical

You have a neighbor you encounter on infrequent occasions. They have lived in their home for four years. You both have children the same age. They are playmates. Although her children play in your home, they do not play in the neighbors' home. You have noted facial bruising on the mother a couple of times and once you heard screaming in the night coming from your neighbors' home. One warm day while outside doing some gardening, you see the mother out hanging clothes on the clothesline and hear her weeping.

What is your initial reaction?

Discussion questions

1. What are your areas of concern in this situation?
2. What can you do that might be helpful?
3. What things should you NOT do, and why not?

14. Injured wrist, female: Emergency Department, Primary Care

A 20-year old female presents with an injured wrist. She is married but has come with a girl friend. She states she fell walking up the stairs. You note 3 2cm vaguely circular bruises on the ulnar aspect of the injured wrist. Patient states she got the marks when she grabbed for the rail and her arm struck the stairway banister dowels.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: Respond quietly, demonstrate some concern for your arm. State: "No, what on earth makes you think that?"

Provider:

After the patient answers, what would you say in response?

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "Everything is fine at our house. Can we get on with the x-ray?"

Provider:

After the patient answers, is there anything else you would say?

Discussion questions

1. What would you document in the medical record?

2. Are there any areas of concern with this patient?

3. Is there anything you can say or do about the bruising?

4. What responses are appropriate to this patient's remarks?

15. Colles fracture, male: Orthopedics, Preoperative

A 20-year old male comes from the clinic having been scheduled for a closed reduction after falling while playing volleyball. The ulnar aspect of the forearm is bruised and tender to touch. You also note the patient has a black eye, has poor hygiene, and poor eye contact.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: Respond slowly: "No, no. I told you I was hurt playing volleyball". Look down.

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "I don't understand why you are asking me this question."

Provider:

After the patient answers, what would you say in response?

Discussion questions

1. What would you document in the medical record?

2. What if anything might be suggestive in this history?

3. What kinds of questions or statements would be appropriate?

16. Male asthmatic: Emergency Department, Primary Care

A 35-year-old well dressed male who is an established patient, presents at the clinic for an urgent care visit. He has a history of asthma and appears short of breath and anxious. He states that neither his meds nor his nebulizer are working. He is brought to an exam room, and comes into the hall repeatedly, asking how long it will be before the doctor sees him. Meanwhile, at the front desk, another man has arrived at the clinic demanding to know the status of his friend. He is insistent

that he be taken back to the exam room to find out what is taking so long. His voice and language become louder and more abusive as you explain the clinic policy.

The patient is asked screening questions and his responses are as follows.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one: State, "Absolutely not, certainly not."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: Quietly answer: "No, no."

Discussion questions

1. What concerns do you for this patient and why do you have them? What does clinic policy say about giving information to persons who come up to the lobby desk and ask about someone being seen in your clinic?

2. What safety precautions should staff take?

3. What can you do in response to the patient's denial that he is being hurt?

17. Abdominal hysterectomy: Operating Room, Obstetrics, Medical---Surgical

A 57-year old female is brought into the surgical suite after being prepped for surgery. When you wheel her into the OR room, she suddenly begins to cry and says to you: "Please help me. I cannot go back to my husband. I am afraid he will kill me. Help me." The chart shows that an abuse screening was done and the patient denied abuse.

What is your initial reaction and concerns?

Discussion questions

1. What would you say to the patient?

2. What are some actions you could take?

3. What are some of your greatest concerns?

4. What would you document in the medical record?

18. Bleeding disorder: Medical---Surgical

A 68-year-old female is admitted to your unit with oozing from her ankle. There is no injury, but she has varicosities and is on coumadin. She has been unable to stop the bleeding for 4 days so is being admitted for further evaluation, treatment and observation.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one, "No, not in this relationship. But I was in my first. I'm glad you're asking. I wish someone had asked me 40 years ago."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: "No, everything is fine in my relationship now."

Discussion questions:

1. Do you have any concerns about this patient?

2. Would you ask the patient any additional questions?

19. Viral meningitis: Medical---Surgical

A 19-year-old female is admitted with a severe headache, neck pain, fever and vomiting. Her spinal tap revealed the presence of WBCs. She is unable to move without severe pain and lies with her eyes closed. On admission, you note numerous areas of bruising on her back, both upper arms and knees. They are rectangular in shape, similar in size and in various hues of yellow, purple, and blue. You also note petechiae covering the underside of her chin but note no petechiae elsewhere. She is screened the day after admission when she is still ill but more comfortable and communicative.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one look directly at the health care provider and say firmly, "No."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: respond the same way.

Discussion questions

1. What would you document in the medical record?

2. What if any concerns do you have for this patient?

3. Is there anything else you would say to this patient?

4. Is there anything you could do for this patient?

20. Clinic---OB check, non English-speaking

A Hispanic, non-English speaking, uninsured woman comes to the clinic for her first OB appointment. She is accompanied by her significant other that states he will interpret for her. While taking her blood pressure you observe marks on her arms that look like fingerprints. She has already had

her OB risk assessment and nothing is documented that would give you any indication of identified concern for violence.

Provider:

Introduce topic with following framing statement: "We at (clinic or hospital name) are concerned about the violence that is affecting the health of many of our patients, so we routinely ask the following confidential questions."

Ask question one: "Have you ever been hit, kicked, slapped, choked, forced to have sex, or otherwise hurt or mistreated by someone important to you?"

Patient:

In response to question one look directly at the health care provider and say firmly, "No."

Provider:

Ask question two: "Do you feel afraid or threatened by your spouse, partner, or someone else close to you?"

Patient:

In response to question two: respond the same way.

Discussion questions

1. What concerns do you have for this patient?
2. What initial actions are appropriate in this situation?
3. What can you do to get this patient alone?
4. What options might you be able to explore?
5. If you are able to get the patient alone, what can you do and say?

Appendix S: Culturally Sensitive Responses to Victims of Intimate partner Violence

Key Principle

When working with any ethnic and cultural group, the best, highest standard for practice lies in the adoption of an attitude and tone that will allow the professional to "start where the victim is at". A key, supportive element, is understanding that there is variability in patient response depending on how the patient views her or his intimate partner relationship.

To accomplish this, it is helpful to approach victims from an individual or family-centered attitude rather than from a "problem-oriented" attitude, always remembering that generalizations should never be made.

Educator Instructions: To elicit specific and helpful information related to various diverse groups, determine an ethnicity for the patient and advise participants. For example, in case situation #1, you might first discuss the case stating the patient is Asian. Then follow by asking, if what differing factors or interventions might be helpful if the patient were Latino. Explain the case studies are **guidelines only** , and the intent is to respond to the scenario as they would in practice. Encourage them to "go with the flow" rather than following the scenario to the letter. Whenever possible invite diverse community members to participate in this part of the education.

Case study one: Home visit---Post partum

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.
3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

You are conducting a routine post-partum home visit for a 20 year old unmarried primipara. Her partner, currently working part time at a fast food restaurant, is in and out of their tiny, inner city apartment during your visit. You note the patient is very quiet, subdued and has a flat affect. Her response to your questions are monosyllabic. She demonstrates little interest in her newborn. She is pale and complains of excessive bleeding and vaginal tenderness. You are able to evaluate her bleeding and pelvic area. While doing so you note a quarter-sized bruise on the inner aspect of each of her knees.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "Oh...not too bad"

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with reservation, perhaps by saying "Well he is good to me a lot of the time."

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Oh not really I guess. But Joe needs sex, and it hurts."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to her ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be helpful?

Case study two: Clinic or ED---Female w/abdominal pain

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

A 26 y/o wife and mother of seven children presents with a complaint of persistent, generalized dull abdominal pain. Previous records indicate she has been in numerous times over the past year with various complaints, mostly relating to abdominal or pelvic pain. Dietary recommendations and use of antacids have only given her a few days of relief. She reacts to the noise of loudly closing doors and quick movements of a laboratory technician with an involuntary physical movement of pulling away and clutching her arms to her chest.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "I'm fine. I'm OK."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with tears, head shaking and no words.

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: Be vague but suggest that home is a hard place to be, you may indicate you are afraid, but be reluctant to share much due to the shame associated with sharing personal information and your responsibility to have a peaceful home.

Nurse: Ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "My life is a mess. He doesn't let me do anything with friends."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case study three: Clinic or ED---Female w/UTI sx

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

A 23 y/o undocumented wife and mother of five children presents with pain and burning on urination, her fifth visit for urinary tract infection in three months. Previously she has been in numerous times

over the past year with various complaints, mostly relating to pelvic pain and UTI's. You note horizontal, linear bruising on her shins.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "We're doin' OK...the food shelf helps a lot."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Indicate you are tired a lot and busy with the kids.

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Why are you asking me those questions?"

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: If it feels right, tell the nurse you do get hit once in a while, but he doesn't mean any harm OR: home is a hard place to be, sometimes you are afraid. Be reluctant to share much due to shame.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case study four: Clinic---Female w/o appointment

Instructions

1. Review the case study

2. Discussion to follow: either in small or large group

A 19 y/o woman well known to the clinic comes to the front desk with a desperate expression and urgency in her voice stating "I have to be seen." She has her two preschool children with her and both are crying. She does not have an appointment. You look in the computer and note that up until this last month she and her children have kept all of their appointments. However, in the last month, she has either cancelled her appointments at the last minute, or failed to appear.

Group discussion

Question one: What might be the source of her urgency?

Question two: What initial actions might be appropriate?

Question three: What questions might you ask?

Question four: If the patient acknowledges fear of her partner, what words can be used, what resources might be of value?

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Five: Home visit---Elderly male post-op

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

Your patient is an 84-year old male who was discharged three days prior after cardiac bypass surgery. He suffers marked shortness of breath walking from bed to chair. In the past he has lived independently. His daughter-in-law is there and has been staying with him. She hovers nearby and answers all your questions. He seems withdrawn. You note quarter-sized bruises on both upper arms. The kitchen is cluttered with the remains of several leftover meals in foil containers. Dirty cups are piled in the sink. Cookie wrappers are scattered on the counter.

Determine a method how you would see the patient privately.

Setting the stage (when the patient is alone)

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about how things are going for you since your operation. How do you feel about the help you are getting?"

Patient: "It's slow going."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Look for an opportunity to share the fact you are left alone some of the time.

Preface statement and screening questions

Nurse: Sometimes people in this kind of situation, being at home and having to rely on others, experience things that are uncomfortable for them. I am going to ask you a couple of questions. "Have you experienced any hurtful actions such as being pushed?" Or, "those bruises are a concern to me. They look like you were grabbed. Did that happen to you?"

Patient: "Well I don't really remember how I got those bruises."

Nurse: Think how you might deal with this comment...then say: "Oh...well, tell me, are your needs being met? Are you able to get to the bathroom when you want? Do you get enough to eat?"

Patient: "Oh I can't complain."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent him from sharing openly with the nurse.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Six: All---Co-worker

Instructions

1. Review the case study.

2. Small or large group discussion will follow.

A 45-year old female coworker recently separated from her husband of 26 years, arrives at work late, looking as if she has been crying. You have known her for five years but she always keeps to

herself and seems to prefer to eat alone, using some of her time to call her husband every day. In the past her husband drove her to work and picked her up. Now she takes a bus since she does not know how to drive. Over the years she has missed work on an average of at least twice a month, primarily with chronic abdominal problems or migraine headaches.

Your co-worker shares that her husband is trying to get custody of their teen-age children. He is claiming that, because of her recent promotion to full time requiring her to work two evenings a week, she is not at home to supervise her childrens' after school activities. She needs the money and benefits to work but desperately does not want to lose her children. She is afraid she may be forced to quit.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What implications exist in regards to the workplace?

0uestion four: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Seven: Home visit---Pre-term labor

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

You are following a patient on bed rest with pre-term labor. She is in the 20th week of her first pregnancy. The pregnancy was planned, she has been in a relationship with her partner for three years. She is depressed, concerned about the pregnancy, has a lot of questions surrounding the risks and fears about the welfare of the baby .She was working as an office manager up to this time. Now she is on leave without pay. She expresses concerns about the couple's finances.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: "We aren't talking as much as we used to."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Indicate there are strains, you are unable to fulfill your responsibilities.

Preface statement and screening questions

Nurse: "Often people experiencing health problems have other things going on in their life making it harder on your health. I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Not hit but pushed sometimes lately. I worry about the baby..."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: Suggest things are stressful because of money and you feel like a failure, you have a responsibility to the family.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Eight: Clinic or ED---Female, multiple problems

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

A 42-year old woman presents to the ED or Primary Care Clinic with a week-long history of generalized abdominal pain, nausea and diarrhea. She has been seen in various health care settings for numerous complaints over the past year including insomnia, anxiety, headaches, back pain and GI problems. Her husband is with her. He expresses a need to stay with his wife to support her and "run interference" for her.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something like: "Oh, we're both getting sick of my health problems."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with reservation, perhaps by saying "Oh I'm such a bitch sometimes...who could live with me and take it for long?"

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "A couple of times maybe but not any more."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "We kind of yell at each other. Oh he might say he's going to shut me up for good but he doesn't mean it."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Nine: Clinic or ED---Male w/injured arm

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

A 20-year old Caucasian male comes to the Emergency Department or primary care clinic with a history of injuring his forearm while playing volleyball at a church group for college-age members. The ulnar aspect of the forearm is bruised and tender to touch. Other observations include: the patient has a black eye, poor hygiene, poor eye contact, walks with a limp and is extremely slender. He is accompanied by a male friend who you observe to be very attentive to the patient--- including adjusting his pillow and covering him with a blanket. He demands that his friend be seen immediately and complains about a half-hour wait stating he wants the phone number of someone in charge of service. Discuss how you might get the patient alone.

Setting the stage (with the patient alone)

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, look down and say very quietly: "I'm lucky to have people who care about me."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with resignation, say something like "I get what I deserve, I'm not easy to live with."

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Oh wow...everyone gets knocked around a little bit I guess."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "Well what do you mean by controlling my life? I work. I have my money."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent him from seeking the help he may need, especially if he is gay.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Ten: Clinic or Home visit---Abd pain

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.
3. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 30-year old woman presents complaining of persistent, generalized pelvic pain. You know she has been seen for numerous somatic complaints and has a history of depression. She is sexually active and is not on any birth control. When questioned, she says she does not desire pregnancy at this time, that she has been given 3 prescriptions for oral contraceptives but her husband has found the pills each time and thrown them away stating "only whores use birth control".

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "Bad most of the time...just bad."

Nurse: Using your instincts, follow with other comments and questions.

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: Begin to cry..."No one has ever asked me that before. Yes, I get beat up all the time. I'm so tired of living."

Nurse: After discussion, ask: "Does your partner yell at you, threaten you, or otherwise try to control your life?"

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Eleven: Clinic or Home visit---Uterine cramping

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.
3. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 21-year old woman is referred to a home visit or seen in the clinic with moderate, frequent, low abdominal cramping. She is 30 weeks pregnant. With her are her mother-in-law and her three children ages 5, 3 and 2. You know that she has been in the United States for a year having emigrated with her family and husband from a refugee camp. Other findings include: a row of four horizontal dime-sized pale yellowish marks just below her umbilicus, signs of depression, history of weight loss of 5 pounds in the past week.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I often see patients with problems in the family. We have ways ofhelping them and improving their health. So just I'm going to ask you a few questions about your home life. How are things going between you and your husband?"

Patient: Following the discussion, say something like: "Oh, we both work hard to have a good home and family."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond perhaps by saying something about the busy house and family and making a good home.

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may affect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Well, no, not really."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "I try to be a good wife and take good care of my children. I keep trying hard."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be useful?

Case Study Twelve: Clinic or ED---Back pain

Instructions

1. Determine who will be the patient and who will be the health care professional.
2. Review the case study.
3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.
4. Group discussion will follow.

A 35-year old woman comes in restlessly pacing and asking for pain medication. She has a history of severe back for several days. She has had three operations on her back including laminectomies and a fusion. Her husband accompanies her and waits quietly by her side saying little to her and nothing to staff. The patient regularly accesses health care seeking meds for her pain. After the initial exam her pain eases, she is seen reading a magazine. You separate the patient from her husband to do abuse screening.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I"m going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "When my back is hurting I can"t handle much of anything."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Respond with reservation, perhaps by saying "We sometimes have some arguments."

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Sometimes..."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: Indicate there are a lot of pressures in your life...if the conversation goes in the right direction, indicate your husband is very demanding and controlling.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to her ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be helpful?

Case Study Thirteen: Clinic or ED---Laceration

Instructions

1. Review the case study.

2. Group discussion will follow.

A 23-year old woman presents with a 2cm laceration to the right index finger. She does not speak English. Her husband accompanies her and states she was washing dishes and the glass broke cutting her finger. Her husband cuts off any small talk you, a female nurse, makes with him. The woman exhibits signs of anxiousness: her eyes dart to and fro and she instinctively jerks from you when you approach her with a BP cuff. You note four dime-sized bruises of her upper arm and petechiae on her neck.

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to her ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What can you do to help this patient? How would you respond in actions? What resources might be helpful?

Case Study Fourteen: Home visit---Female w/asthma

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

A 31-year old woman with asthma is referred by the clinic for home visits due to difficulty controlling her disease. You find her having moderate respiratory distress, wheezing audible only to auscultation having obtained only minimal relief from her inhaler. Findings include a respiratory rate of 36 with minimal substernal retraction, color is pale. You note dark purplish-yellow bruising on her posterior chest. She has had multiple visits to the clinic and ED in the past 6 weeks with asthma and "the flu". The patient seems anxious, almost tearful and haggard. The patient's husband was there when you arrived but, after telling the patient this should get taken care of once and for all, leaves for work. The patient has 5 children ages 4 to 11.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "Well we are fine. We got good kids."

Nurse: Using your instincts, follow with other comments and questions.

Patient: Say something about money is tight, the kids don't have good shoes, and you can't get all the housework done. You take laundry in to make extra money.

Preface statement and screening questions

Nurse: "Often people experiencing poor health are in relationships that may their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "Oh I get pushed around once in a while but it doesn't really hurt."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "We have trouble paying for my medicine. I don't know why you ask this."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to ethnicity.

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be helpful?

Case Study Fifteen: Mental health---Postpartum depression

Instructions

1. Determine who will be the patient and who will be the health care professional.

2. Review the case study.

3. Begin by reading from the material below. Use the script or your own words based on the patient's responses and your assessment of the situation.

4. Group discussion will follow.

You have admitted a 19 year old suicidal female who had a full term infant boy two weeks prior and is suffering from severe post partum depression. Her husband broke into the bathroom as she was ingesting a bottle of 100 ibuprofin tablets and took her to the local ED. She stated to ED staff she has no desire to live any longer. She is reluctant to talk about the pill taking to MH staff. She has three other children ages 4, 3 and 1.

Setting the stage

Nurse: Introduce the subject asking a stage-setting question such as: "I'm going to ask you a few things about your current home life. How are things going between you and your partner?"

Patient: Following the scenario above, say something in a quiet voice like: "We both work hard to keep the family together"

Nurse: Using your instincts, follow with other comments and questions.

Patient: Your responses should reflect a resignation about your role and acceptance of your responsibilities as the woman of the house. You don't get out hardly ever and you can't work.

Preface statement and screening questions

Nurse: "Often people experiencing poor health or having problems healing are in a relationship that may effect their health. So I am going to ask you a couple of questions that I ask everyone. Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?"

Patient: "One time before another baby but his mother told him to stop."

Nurse: After more brief discussion, ask: "Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?"

Patient: "Well I have to take care of the children and I get mad sometimes so he gets mad at me."

Group discussion

Question one: What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to her ethnicity. What if she spoke little English?

Question two: What indicators exist for possible abuse?

Question three: What further discussion or questions would your pursue? What words would you use? How would you respond in actions? What resources might be helpful?

When working with abused or possibly abused patients from communities of color...

Culturally competent care of battered women goes beyond culture, awareness, knowledge & sensitivity to an advocacy stance of commitment. to active striving against the racism and oppression faced by minority ethnic groups in our society.(Campbell & Campbell)

The following points have been made by various women from communities of color. This list is not inclusive of all potential issues faced by women. It is important for nurses to remember that everyone is an individual and that broad cultural statements do not apply to all individuals within a culture.

Group discussion question one:

What barriers, challenges or other issues may exist for this patient that could prevent her from seeking the help she may need, especially as they relate to her ethnicity? See Challenges to Changing Circumstances and Diversity handouts

All:

- Victims may have numerous problems besides abuse including: possible hx of sexual assault, substance abuse, depression, suicidal tendencies, dependent children she wishes to protect

- Most people of color experience racism daily. This can include previous personal experience with institutions and whose partners who were brutalized by law enforcement
- Fear of alienation from own cultural group
- Lack of credibility of "helping" programs (many are funded a year or two, then disappear)
- Racist white employers are less likely to hire people of color limiting independence from abuser
- Potential for spiritual abuse as a significant factor in power and control by abuser
- Frequently, they don't seek help about their violent relationships because they don't know that it is wrong. Many do not even realize that battering is a crime and punishable by law or that they have legal rights and can press charges.
- If undocumented, see Immigrant & Refugee Women brochure

Native American:

- Many have experienced a slow response or denial of service from non-Indian providers often because of a belief that Indians get all they need from the BIA or Indian Health Service. This results in a reluctance to trust white professionals
- A fear of "betraying" the batterer and/or the batterer's relatives or tribal group
- Disproportionate incidence of violent crime against Native Americans (e.g. native women are twice as likely to be raped than women of any other race)
- Batterer may espouse an invented cultural tradition stating women are to be submissive (In reality, abuse of women in Native cultures is believed to have been to the most part, nonexistent prior to European settlement)

RURAL ISSUES:

- Lack of access to housing: e.g. 46% of American Indians live in a rural area, on or off reservations, 2/3 of inadequate housing in the US is in rural areas or reservations
- Inability to access help or support (No phones or money to pay long distance)
- Inability to find safe shelter
- May have felt intimidated by non-Indian counselors who talk rapidly and/or loudly and the victim/survivor, as a result, terminated the relationship
- Spiritual bonds or ties to a specific locale

- Sense of obligation or duty e.g. care-giving of an older relative OR to her tribal or cultural group Indian mothers traditionally trained their children to think of others first, of what would be best for the tribal group (Assimilation has changed that)

- Poverty (Some sources state one out of every three Native Americans live in abject poverty)

Hmong:

- Losing face for some is regarded as being worse than death

- Traditional Hmong medicine approaches sickness spiritually as well as physically

- Another barrier for women who need help is the traditional Asian attitude toward "private" issues. Most battered women feel ashamed about their abuse, but these feelings are even more pronounced for Asian women. It may be considered inappropriate to discuss family matters outside the family as to do so brings shame on the family.

- Traditionally, emotional control is considered a mature trait in the Asian culture. Open displays of pain or anger are thought to be immature and unworthy of cultured adults, particularly women. For this reason, the Asian women may not express their true feelings and emotions, except among very close relatives or friends.

- Cultural variations in response to abuse: Assuming responsibility for problems is considered virtuous. Readiness for self-blame is particularly valued in women. While this tendency towards self-blame is similar to that experienced by American women, the Asian woman's self-blame should be considered in the context of her cultural socialization rather than as a manifestation of low self- esteem.

- Perseverance and the acceptance of suffering are highly valued virtues among Asian cultures. What appears to be the passivity and apathy of a battered Asian woman is often a culturally-based response to adversity.

Hispanic:

- Studies have shown the family was the most important factor that entered in to a Hispanic-American woman's decision whether to leave or stay in an abusive relationship

- May be undocumented and threatened with that by abuser.

- If she is a religious person, she may not be supported by her pastor or family to break up the family OR she may be told she must try harder to make it work

African

- May have experienced significant trauma in refugee camps or war experiences (rapes, murders, tortures, deprivation)

- Frequently, significant language barriers exist
- Isolation from family and threats of deportation may be an issue

African American

- There may be a reluctance to expose African American partner as he, like Native Americans, likely has experienced racism and abuse from authorities
- Many commonly experience spiritual abuse

Group discussion question three

- What further discussion would your pursue or questions might you ask?
- What words would you use?
- If you learn unwanted sexual contact occurs, what could you say or do?
- How would you respond in actions?
- What resources might be helpful for this patient?

If there is a sense that abuse is "cultural", emphasize that physical and sexual abuse is against the law in every state and that mutual respect and love is a value in our culture that everyone is entitled to. Consider using power and control wheels to illustrate this

Words:

- You seem sad...how are you feeling?
- Are you able to see family and friends?
- Do you want to have sex? Do you feel you have the right to say no?
- Are you afraid?
- How do you and your partner resolve differences of opinion?
- Do you have help with care of your baby/chidren? Taking care of your home?
- Are you getting enough to eat?
- Unwanted sex in any situation is against the law. You have a legal right to have a say when you have sex.
- Physical abuse is against the law

- Is there someone you can turn to for support or help?
- **Undocumented patients:** All of the above applies. They have rights even though they are not documented (see brochure for Immigrant and Refugee women)

Resources (See resource list handout...)

- Immigrant & Refugee Women brochure in 8 languages: Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog, Vietnamese from Futures Without Violence website below
- Various resources available through Futures Without Violence. See website for more information: http://www.futureswithoutviolence.org/ [http://www.futureswithoutviolence.org/]
- Native American patient ed. resources: Duluth Abuse Intervention Project at 218l-722-2781 22" X 28" Creator Wheel Poster ($7) or website: http://www.duluth-model.org [http://www.duluth-model.org]

All groups: Actions

- Be compassionate, respectful, attentive
- You can establish trust quickly whether you are knowledgeable in the victim's culture or not by demonstrating you do not judge the victim for her life circumstances.
- Demonstrate you can be relied upon to help by providing options for help that are uniquely designed to benefit the victim. As a result, even if you are not completely familiar with every aspect of the victim's culture, you can demonstrate sensitivity.
- Avoid filtering your patient's circumstances and comments through a perspective of your own culture's customs, values and belief systems. This can result in an interpretation that may not be accurate and may, in fact, be insulting or offensive and erroneous
- Avoiding rendering false sympathy: pity may cause a person to feel diminished and condescended to
- Ask the patient what she would like you to do and/or how you can help her
- Ask the patient what her worst fears are
- Determine as much as possible ways to help her find options uniquely designed to benefit her, individually and specifically. She may value culture-specific services OR may not for fear of discovery or discomfort.
- Recognize that many patient's actions and reactions are rooted in her cultural base
- Treat the whole person rather than limiting care to the physical

Hispanic

- Confianza: create a constellation of trust, confidentiality, support, comfort and safety.
- Listen attentively, offer advice and support and provide referrals
- If undocumented, services can still be provided for her and she has a legal right not to be abused. Avoid asking about immigrant status, it may be frightening

Hmong

- There is great value in incorporating the stage setting element of the screening tool into the initial encounter with the patient, introducing the subject gently but demonstrating first concern for family stability and dynamics. **Also applicable to Hispanic patients**
- Even when the patient does not acknowledge abuse, it can be very helpful to make general, conversational statements indicating you have known patients in such situations and have been able to help them by telling them about resources and that your health care setting is a safe place to seek help. **This is likely to be true with most patients!!**

Other possible scenarios

A 30 y/o woman presents to a (culturally specific) clinic for a routine annual pelvic exam. It is noted that her chart is very thick. She has been seen for numerous somatic complaints and has a history of depression. She is sexually active and is not on any birth control. When questioned, she says she does not desire pregnancy at this time. She states that she has been given 3 prescriptions for oral contraceptives.

An 84-year old is admitted with TIA. His daughter found him having forgotten where he was. Hx includes: CHFD, depression, HTN, and polyrheumatica. He is on numerous medications. You observe tremors, an unsteady gait, poor eyesight and ETOH on his breath. His pulse rate is 120 and EKG findings include rapid AF You note deep purple bruising bilaterally on the lateral aspect of both upper arms. On admission he is alert, oriented. His demeanor is irritable, response to questions is monosyllabic. The patient lives alone, son and daughter check on him once or twice a week.

Your patient is a multipara who had an uncomplicated labor and delivery. Abuse screening was not done in labor and delivery. Mother is 32, has two other active children ages 2 and 4 years of age. Mother has freshly showered, has makeup on, and appears relaxed. You have observed her to be quietly observant and smiling when her children saw the new baby. Mom seems to be comfortable with being a new mother but acknowledges she is tired. Mother has a lot of questions about breast feeding.

You have a neighbor you encounter on infrequent occasions. She and her husband and children have lived in their home for four years. Your children and your neighbor have children the same age, they are playmates. Although her children play in your home, they do not play in the neighbors' home. You have noted facial bruising on the mother a couple of times and once you heard

screaming in the night coming from your neighbors' home. One warm day while outside doing some gardening, you see the mother out hanging clothes on the clothesline and hear her weeping.

A 23-year old non-English speaking woman is post partum and has not been screened. She had a normal labor and delivery, but has had heavy bleeding since. This is her fourth baby. There is a male who you think is her brother in attendance who does the interpreting. Her hemoglobin is 9.1. She weighs 98 pounds and is 5'2". The infant, being held by the mother-in-law who is in the room with the patient also, is fretful. The other children are not present but when they visited they were quiet.

A 16-year old single mom presents to L&D in early stages of labor accompanied by her grandmother. She is unemployed and on AFDC. From the patient's conversation you suspect the father of the baby is a member of a gang. Labor is not progressing well and she is told to try to rest for a while. You are able to ask abuse screening questions prior to the fathers' arrival. Later the father arrives and the following is observed: he answered all questions for the patient, told the patient when to get up and walk, how far she should walk, and was critical of her appearance.

Appendix T: Safety Plan---Alexandra House, Blaine, MN (used with permission)

Safety During an Argument or Violent Incident

- If an argument seems unavoidable, try to move to a room or area that has access to an exit or a phone. Avoid the bathroom, kitchen, or anywhere near weapons.
- Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best.
- Have a packed bag ready and keep it in an undisclosed but accessible place in order to leave quickly.
- Identify a neighbor you can tell about the violence and ask that they call the police if they hear a disturbance coming from your home.
- Devise a code word to use with your children, family, and neighbors when you need the police.
- Decide and plan where you will go if you have to leave home (even if you don't think you will need to).
- Use your own instincts and judgement. If the situation is very dangerous, consider giving the abuser what he/she wants to calm him/her down. You have the right to protect yourself until you are out of danger.

You Don't Deserve To Be Hit Or Threatened!

Safety When Preparing to Leave

- If possible, open a savings account in your own name to start to establish or increase your independence. Think of other ways in which you can increase your independence, including knowing what you can do about your monthly income and credit debts.
- Leave money, an extra set of keys, copies of important documents, and extra clothes with someone you trust so you can leave quickly.
- Determine who would be able to let you stay with them or lend you some money.
- Keep the shelter's phone number close at hand and keep some change or a calling card on you at all times for emergency phone calls. Memorize emergency numbers. You can call shelters collect or dial 911 at no charge.
- Review your safety plan as often as possible in order to plan the safest way to leave your abuser. Leaving your abuser can be the most dangerous time.

The Violence Is Never Your Fault. You Deserve To Be Safe At All Times.

Safetyu in Your Own Home

- Change the locks on your doors as soon as possible. Buy additional locks and safety devices to secure your windows.
- Discuss a safety plan with your children for times when you are not with them. Teach children about the use of "911" and when to call the police.
- Inform your children's school, day care, etc. about who has permission to pick up your children. Discuss with them who they can tell at school or daycare if they see the abuser.
- If possible, keep a phone in a room which can be locked from the inside or obtain a cellular phone to keep with you at all times. Get an unlisted number, block caller ID or use an answering machine to screen calls.
- Inform your neighbors and landlord that your partner or ex-partner no longer lives with you and that they should call the police if they see him/her near your home.

If you are in danger and can reach a phone call 911.

Safety with a Protective Order

- Keep your protective order on you at all times. Make extra copies to keep in your car, at work, in your brief case, or purse.
- Call the police if your partner or ex-partner breaks the protective order.

- Think of alternative ways to keep safe if the police do not respond right away.
- Inform trusted family, friends, neighbors, co-workers or employer that you have a protective order in effect.

Safety on the Job and in Public

- Decide whom at work you will inform of your situation. This should include office or building security and supervisor. Provide a picture of your abuser if possible to the security guard.
- Arrange to have someone screen your telephone calls if possible. If the abuser attempts to contact you at work, save the voicemail, e-mail or written message.
- Devise a safety plan for when you leave work. Have someone escort you to your car or bus. If possible, vary your route home. Think about what you would do if something happens while going home (i.e., in your car, on the bus, etc.)

Safety and Emotional Health

- If you are thinking of returning to a potentially abusive situation, discuss an alternative plan with someone you trust.
- If you have to communicate with your partner or ex-partner, determine the safest way to do so.
- Have positive thoughts about yourself and be assertive with others about your needs. You may wish to read books, articles, and poems to help you feel stronger.
- Receive support from someone whom you can talk with freely and openly.
- Plan to attend a woman's or victim's support group to gain support from others and learn more about you and the relationship.
- Receive support and information through a 24-hour crisis line or advocate service.

You are not alone. There are others who can provide you with assistance in safety options, information, resources and support 24-hours a day, seven days a week.

Checklist: What You Need to Take When You Leave

Financial

- Money---cash
- Bank Books
- Checkbooks
- Pay stubs (both)

- Income tax records
- Charge account numbers and amounts
- Safety deposit box keys

Identificatin Papers

- Driver's license
- Children's birth certificates
- Your birth certificate
- Social Security cards for all family members
- welfare identification
- Green card
- Passport

Home/Personal

- Lease/rental agreement, house deed, mortgage papers
- Insurance papers
- Divorce/Separation papers
- House and car keys
- Address book
- Pictures
- Jewelry
- Sentimental possessions
- Child Custody documents
- Protective Orders

Medical

- Medications
- Medical records for family members

- Insurance cards

Children

- School records
- Immiunization records

Employment

- Work permits
- Other identiication records

Other

Appendix U: The Role of a Domestic Violence Advocate

Advocates for individuals in domestic violence situations come from varied backgrounds and levels of education. They share a common interest: to give support and resources to survivors of domestic violence. They possess special communication skills. Some are survivors themselves. They have had a significant number of hours of training with your community's advocacy service. Some are employees of the advocacy service, some are volunteers who take call for the agency.

Advocates do not tell survivors what to do. They provide information and options so the survivors can make informed decisions about what is best for them. Some of what they do:

- Listening with objectivity, care and concern to the survivors' story
- Being affirming and supportive to survivors
- Believing survivor stories
- Providing knowledge and insight about the dynamics of domestic violence to survivors
- Offering resources available to survivors within the community such as:
  - Financial aid
  - Housing
  - Child care
  - Legal counsel
  - Educational resources
  - Special needs such as food, clothing, medical care

- Advising survivors of their legal rights such as:
  - Filing orders for protection
  - Filing assault charges
  - Actions which can protect property and child custody rights
  - Safety and protection planning
- Support groups

Appendix V: Elder Domestic Abuse, Vulnerable Adult Abuse, and Caregiver Stress

These 3 categorizations are often used interchangeably but generally speaking refer to different situations.

Regardless of the terms used, screening for risks and signs of abuse/neglect among the elderly and vulnerable adults should be a routine part of patient assessment by health care professionals.

All such screening should be conducted privately to ensure confidentiality for the patient and protection from potential retaliation by the abusive party.

Caregiver Stress

This term is commonly used to explain why a patient is abused either by a partner or due to being a functional vulnerable adult; it is inappropriate for 3 reasons:

1. It absolves the abusive party of responsibility for their behavior.
2. It suggests that if the victim were not dependent on the caregiver, there would be no stress or abuse, thus blaming the victim for the situation.
3. It prevents appropriate interventions from taking place (e.g. offering information about power and control, safety planning, and resource options, or making a mandatory report to Adult Protective Services).

Elder Domestic Abuse

A significant portion of what is typically identified as 'elder abuse' is actually abuse of someone by their partner in a long-term, intimate relationship.

Definition of Domestic Abuse: an intentional, systematic pattern of emotional or psychological, physical, economic, and sexual behaviors used by one person in an intimate relationship to control the other.

In long-term abusive relationships, physical violence/threats as a tactic of control may diminish with old age, but other controlling behaviors often replace them in order to maintain the same control.

Other types of violence and neglect of older persons exist but are not domestic abuse.

Domestic violence is not:

- self-neglect
- stranger abuse (muggings, scams)
- abuse by paid caregivers (institutional elder abuse)
- caregiver stress (e.g. overburdened adult children)
- abuse by a partner whose abusive behavior is caused by a medical or mental health condition or reaction to medication.

Vulnerable Adult Abuse

1. Minnesota's Vulnerable Persons Act says all health care providers are mandated reporters of abuse of *functional* vulnerable adults to the Common Entry Point in their county.
2. The reporting obligation extends to knowledge or *suspicion of maltreatment* only.
3. The mandated reporter does not make the determination of whether or not a person is classified as a functional vulnerable adult; this is the role of adult protective services.
4. A professional willfully failing to report suspected abuse of a vulnerable adult shall be guilty of a misdemeanor crime.
5. Those reporting in good faith have immunity from civil or criminal liability, providing the appropriate investigation and documentation have been completed.

Definitions

Mandated Reporters

Any employee of a health care facility, regardless of position, who, while performing duties, has knowledge or suspicion of maltreatment of a vulnerable adult

Note:

1. Older people with abusive partners are not functional vulnerable adults simply because they are in an intimate relationship with someone who is abusive.

2. As with competent *non-elderly patients experiencing battering*, no report of abuse of an *elderly battered person* should be made *without* the patient's consent, except in the case of gunshot wounds, severe burns, and serious brain or spinal cord injuries.

Categorical Vulnerable Adult

- Is over 18 years of age (i.e. not just the elderly are vulnerable adults).
- Anyone who is an inpatient at a hospital or care facility, regardless of whether they would be considered a vulnerable adult if *not* currently an inpatient
- One who is fully competent and capable in the outpatient setting is still considered "vulnerable" during any hospitalization or nursing home stay

Functional Vulnerable Adult

- Is unable or unlikely to self-initiate a report of maltreatment
- Cannot adequately care for or protect themselves from maltreatment due to a physical or mental infirmity or other physical, mental, or emotional dysfunction.

Maltreatment

1. **Abuse**
   - conduct which is neither accidental nor therapeutic
   - produces or could reasonably expect to produce physical pain, injury, or emotional distress, including corporal punishment or violence or psychological abuse
2. **Neglect**
   - physical: failure to provide goods or services needed for reasonable functioning (e.g. food, medications, safety precautions)
   - self-neglect: inability to adequately act on one's own behalf for nutrition, hygiene, or personal safety
3. **Financial Exploitation**
   - illegal use of a vulnerable adult's income/assets for personal gain, or
   - negligent use of such funds for that person's appropriate care and protection

Common Entry Point

Each county's agency designated for reporting incidents of maltreatment of vulnerable adults

Source: Practice Guidelines Committee of the Healthcare Coalition on Violence. (2000). *Family Violence Prevention Program: A Step by Step Guide for Clinics and Hospitals,* pp 14-16. Minneapolis, MN: Author

Appendix W:Elder Intimate Partner Violence Chutes and Ladders (Chutes and Ladders Exercise (2000 WCADV/National Clearinghouse on Abuse in Later Life, NCALL: 608.255.0539 (revised by M. D. Pharris))

Preparation

To run this exercise, you will need the following:

1. The script
2. Green slips (like play money)
3. Yellow slips (to represent assistance requested)
4. Divorce decrees
5. Six baskets to collect slips.
6. 6 posters with statements (as listed below)
7. Masking tape
8. Bell or other noise maker

Before running this exercise, make yellow good will cards, green money cards, and divorce decrees. Create 6 posters, one for each location listed below. Make four sets of envelops stuffed with good will cards and money. Set A has an orange name tag, 1 money card and 1 good will card; Set B has a green name tag, 10 money cards, and 1 good will card; Set C has yellow name tags, 10 good will cards, and 1 money card; and Set D has a red name tag, 10 money cards and 10 good will cards.

1. **Home**
   - You
   - Husband
   - Your cat
   - No cost
2. **Nursing Home**
   - You

- No cat
- No cost
- You are only eligible if your condition meets skilled nursing care needs

3. **Hotel**
   - You
   - Sneak your cat in
   - Costs 1 money card for lodging, 1 money card for meals
4. **Son's Home**
   - You
   - Your cat
   - Costs 1 yellow assistance card
5. **DV Shelter**
   - You
   - No cat
   - Costs 1 yellow card
   - Since you have asthma and can't climb stairs, you will have to sleep on the sofa in the living room.
   - You will be asked to move whenever there is a meeting.
   - The house will be full of noisy children.
   - There are no other residents or staff who are your age.
6. **Apartment**
   - You
   - Your cat
   - Cost 2 green cards for rent, 1 green card for food, 1 yellow card for help with cleaning and meals.

Set Up

Put up the posters in different areas of the room far enough apart so people can gather in front of them. If possible, arrange the furniture in the room so participants can move freely to each location. Put baskets near posters so participants can throw cards in them. Let participants pick from a basket an unmarked envelop containing the name tag and money and good will cards.

Directions to Participants

Exercise purpose-Moderator reads this:

Fate. Some people are surrounded with opportunity and support, some people live very isolated lives and are struggling to survive, emotionally, physically, spiritually... The amount of financial resources and social support we have access to directly affects our ability to get out of violent and abusive relationships.

Much of what you have been struggling with as a nursing student is working with people who are for some reason vulnerable. You have tried, and tried to mobilize resources for them and build on their inner strengths and resiliency. Still, while you have supported your patients, you have at times lamented, "why doesn't she just... Or "why doesn't he..." "Why are they making such poor choices for themselves?"

What we are going to do now is concentrate the issues of vulnerability, family violence, choices, fate, poverty, opportunity, and choice-and try to understand them on a deeper level. Why do some women leave violent relationships and some women stay and some women leave at various times and then return to their abuser.

We are going to play a game of chutes and ladders and you get to play your piece. For this exercise, you are you. You will make the choices you want to make for the reasons that are important to you. The only difference is that you were born in 19___, which makes you 69 years old. You have been married for 49 years to the same man. You have lived in the same house for 35 years. Your children know this house as home-it is where your grandchildren come for your wonderful holiday dinners. You love spending time with your grandchildren. You love your house. You love to tend your garden, which all the neighbors admire. You are very active in your church community. And you love your cat.

Before we start, print your first name on the nametag in your envelope and place it on your chest. You have some money and some good will cards. We all know that no one can repeatedly ask for help without risking that they will be turned away. This "wearing out your welcome" is a consideration for victims of abuse in asking for help. You will begin at home. You can leave and go to any of the places in town, but you will need to pay the specified amount of green money or yellow good will cards. I will read some scenarios and you will have a chance to move to a new location. Pay attention to how you are feeling about the situation you are in and the options you have. Imagine how the abuse and changes in your life would affect you emotionally-try to get into that spot. Think about what would be helpful to you at this point in your life-what would you want a public health

nurse to do? What would you want a hospital nurse to do? Would you reach out for help or would you need to be asked directly about your situation?

Every time the bell rings you need to pay up again.

So, come on home, everyone.

Starting the Exercise

1. Have everyone start at the poster marked HOME.

2. Moderator reads the description of the person. Then the moderator reads each scene and asks participants if they want to stay home, or go any of the possible locations (shelter, hotel, etc.)

3. Pause after each scenario to let people move and pay (by putting slips in the basket). At the station, faculty can ask students how they are feeling about being there and process what that experience might be like.

Chutes and Ladders Scenarios

To Everyone

#1). Every Tuesday you play cards with your friends. This Tuesday as you prepare to leave, your husband starts to yell at you. He is so upset you call your friends and cancel your plans. You are concerned about your husband's increasingly controlling behavior. What do you and your cat do?

To Those At Home

#2). A few weeks later you have plans to go to the annual church social. Your husband is not feeling well but you decide to go anyway. He becomes angry, grabs you hard on the arm and pushes you into the living room wall. You think he may have bruised your arm. What do you do ?

To Those At Home

#3). A few months later you go shopping with your husband. He is unhappy because he feels you wasted money on an air purifier that your doctor recommended to help with your asthma. He argues with you on the way to the car and slams your hand in the car door. What do you do?

To Those Not At Home

#4). You left quickly so you need to buy some new clothes. You find that your husband has canceled your ATM and credit cards. If you want new clothes, it will cost you 1 green card. What do you do?

A. RING BELL

To Those At Home

#5). Several months later, your husband is angry that dinner is not ready precisely at 5 p.m. He pushes you and you fall down the stairs and break two ribs. You go to the hospital. He threatens to take your name off his company's provided insurance if you don't return home with him. Without insurance, leaving him costs 3 additional green cards of out of pocket money so you can get your meds. What do you do?

To Everyone

#6). You decide to get a divorce but find you have too many resources for free legal help. Do you get an attorney? If yes, it costs you 5 green cards.

To Those At Home

#7). You have returned home from the hospital. Your husband now acts thoughtful, caring and supportive. What do you do?

To Those Not At Home

#8). You decide to talk to your pastor. Your pastor reminds you that you made a promise before God to stay in this marriage for better or for worse. What do you do?

B. RING BELL

To Those At Home

#9). Someone has called adult protective services. A worker comes to the home and offers to help you. She recommends family counseling and respite care for your husband. Accepting her help costs one yellow card. What do you do?

To Those Not At Home

10). Your husband begins to stalk you. You see his car when you are shopping. You find footprints up to your bedroom window. You file for a restraining order. For those of you at your son's house: one night you overhear your daughter-in-law talking to your son about asking you to leave because she is afraid of your husband. What do you do? For those with an attorney: your attorney has interviewed all the necessary parties and now needs 2 more green cards to file any papers. What do you do?

C. RING BELL

To Those At Home

#11). Your husband is angry that you talked to "the government," who is now 'meddling in your personal business.' One Friday night, he takes the shotgun out of the closet, lays it on the kitchen table, starts drinking and threatens to kill you. What do you do?

#12). You hide his gun. He finds it, loads it and comes after you. You ca11 911. The sheriff comes, removes the bullets from the gun and the home and tells him to settle down. The sheriff tells you that jail is no place for an old man so he will not arrest your husband. What do you do?

To Those Not At Home

#13). Your son says you can no longer stay with them. The shelter says your time is up and you must leave. What do you do?

To Those of You with Divorces

Collect your monthly alimony payment: 5 green cards

RING BELL

To Those at Home

#14). At breakfast, you can't find your cat. Your husband laughs and says, "we are better off without that Popsicle." Later that morning you find the cat, barely alive, in your freezer. What do you do?

To Those Not At Home

#15). The increased stress has taken its toll and your asthma now requires ongoing daily medical assistance from skilled nurses. You cannot stay with relatives or at the shelter. You could move to or stay in the hotel or apartment and pay 1 more green and 1 more yellow card for medical help. You could go to the nursing home, without your cat or husband, and get the medical help you need. You could remain at home and have in-home services and your husband's "help." Or you can do nothing and continue to deteriorate.

RING BELL

Before letting people go back to their seats, have them look around and see where the different colored name tags are. Explain the inequity in resources and social support by name tag color and facilitate a discussion on the role of financial resources and social support in helping women get out of abusive relationships. Let people go back to their seats and finish processing peoples reactions and insights from this experience.

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