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# Family Violence and the Practice Of Public Health

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## Author's Notes

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## Introduction

### Catalog Description:

Prereq: SPH SB 721 Behavioral Sciences and Public Health (recommended). This course provides an overview, from a public health/prevention perspective, of the problem of family violence, focusing

on child abuse and neglect, child sexual abuse, domestic or intimate partner abuse, and elder abuse. The Spectrum of Prevention model will be utilized to provide a conceptual framework for primary and secondary prevention. Students who have completed this course will be prepared to approach meaningful community-based or investigative work in the field. Small group discussion, case analyses, and interviews with providers whose daily work is in the field, will foster the examination of issues related to epidemiology, behavioral dynamics, prevention, intervention, public policy, and research in family violence.

### **Assigned Readings:**

Assigned readings are listed in the outline, and except as indicated, will be included in the course reader. In order to achieve the maximal educational benefit from the course, students will be expected to have read each week's readings prior to the session, as indicated on the course outline.

As a recommended reference, it is suggested that students obtain a copy of Saltzman LR, Fanslow JL, McMahon PM, Shelley GA. Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta GA, 1999. You can download the entire book (127 pages) or order a copy for yourself (free of charge and well worth it), by accessing the NCIPC web site: [www.cdc.gov/ncipc/pub-res/intimate.htm](http://www.cdc.gov/ncipc/pub-res/intimate.htm). The web site contains a link for downloading and printing, as well as a link to order a copy (the latter is strongly recommended).

### **Course Description (SB750):**

Introduction:

Nearly every public health professional will encounter family violence in the course of her or his career. Society now expects its public health officials and health policy makers to possess a core of basic knowledge and expertise, and to provide leadership regarding prevention, intervention and health policy in family violence. Thus, the curriculum for students of public health should include educational offerings in this important area.

Conceptual Framework:

This course will provide an overview, from a social ecological perspective, of the problem of family violence, focusing on the expression and social context of different forms of family violence, including child abuse and neglect, child sexual abuse, domestic or intimate partner abuse, and elder abuse. Both the Spectrum of Prevention model, introduced by Dr. Marshall Swift of Hahnemann College and developed and implemented by Dr. Larry Cohen of the Contra Costa County (California) Prevention Project, and contextual influences at the individual, family, community and societal levels, will serve as conceptual frameworks by which discussions about intervention and prevention can take place. By the end of this course, students will be expected to have gained sufficient understanding of the field so that they can engage in meaningful and creative work in a variety of community-based, policy, or research settings related to family violence.

Course Format:

Lectures, in-class discussions, structured field interviews and class presentations will foster the exploration of issues relating to epidemiology, behavioral dynamics, prevention, intervention, public policy, and research in family violence. Selected experts, including survivors, will be available as guest presenters for certain topics, as resources for assigned cases and interviews, and potentially for ongoing work in the area.

The Course Director is a member of the Massachusetts Governor's Commission on Domestic Violence. Students are welcome to attend scheduled meetings of the Commission.

## **Course Goals And Objectives\***

### **Goals:**

- 1. To assure that students of public health acquire core knowledge about family violence necessary to engage in meaningful and creative community-based, policy or investigative work in the field.
- 2. To teach students of public health those skills that will enable them to engage in meaningful and creative community-based, policy or investigative work in the field.
- 3. To develop, in students of public health, attitudes that will enable them to work effectively with individuals or agencies concerned with violence prevention, or who care for victims or perpetrators of family violence.

\* adapted from, Brandt EN, ed. Curricular Principles for Health Professions Education about Family Violence. *Academic Medicine*. 1997; 72(Suppl):S51-8.

### **Objectives:**

- 1.1 To understand the epidemiology of violence and abuse in the United States;
- 1.2 To recognize the ways in which victims and perpetrators of child abuse/neglect; child sexual abuse; intimate partner abuse; and elder abuse present, or fail to present, to the health care system;
- 1.3 To understand models of individual, family and community prevention and intervention;
- 1.4 To develop an awareness of the range and effectiveness of local, statewide and national prevention and intervention resources available for referral of at-risk individuals;
- 1.5 To understand mandated reporting responsibilities with respect to intimate partner abuse, child abuse/neglect, child sexual abuse, elder mistreatment and abuse of the disabled; and
- 1.6 To develop an understanding of basic legal issues as they relate to family violence.
- 2.1 To know the elements of safety planning for victims, and how to assure that an individualized safety plan can be formulated; and

- 2.2 To gain skill in identifying local, regional and national resources for prevention and intervention.
- 3.1 To instill an attitude of seriousness and urgency about family violence as a public health issue;
- 3.2 To become aware of present and potential roles for public health professionals in violence education, prevention and policy development;
- 3.3 To explore, utilizing the Spectrum of Prevention model, how public health efforts afford opportunities to interrupt the cycle of violence for individuals, families and communities; and
- 3.4 To understand and appreciate the different expressions of abuse and victimization in different cultures and socioeconomic groups.

### **Criteria for Grading:**

This four-credit course will be graded according to the following criteria:

#### Option A:

Field interviews and report (15% each)-- 30%

Case studies (5% each)-- 15%

Agency assessment and report-- 40%

Class participation:-- 15%

#### Option B:

Field interviews and report (15% each)-- 30%

Case studies (5% each)-- 15%

Paper-- 40%

Class participation:-- 15%

Regardless of whether you choose Option A or Option B, you should learn a great deal provided that you put sufficient time and intellectual rigor into your learning. The following pages outline guidelines you should follow when approaching the case studies, field interviews, and agency assessment (Option A) or paper (Option B).

Your ability to communicate your knowledge, ideas and recommendations in a manner that informs, inspires and influences programs, policies, attitudes and responses to public health issues is a crucial skill to acquire during your graduate education in public health, and is a major focus of this course. To this end, producing well researched, well written and effectively delivered reports, papers or presentations should be one of your most important educational tasks. You will get the most out of your interviews, case studies, and agency assessment or paper assignment if you approach the task as a mentored critical skill development activity. The course faculty will work with each student individually to help her/him achieve this goal to the fullest. Please seek us out before or after class, or by e-mail, telephone or individual appointment to obtain guidance and feedback in your learning.

## **Guidelines for Case Studies:**

Each case is based on a real person's true story. Read each case carefully and answer the questions following each case. Submit your responses to each case to any of the course faculty.

## **Guidelines for Field Interviews:**

The field interview assignment can be found on pages 28 and 29 of this Syllabus. For each interview, select any one individual from one of the listed categories. This person can be someone you approach de novo, or can be someone you know personally or professionally. This person may, but does not have to engage in violence prevention work on a full-time, day-to-day basis, but should have the potential to respond to a situation of abuse if it arises (i.e., teacher, clergy member, or health care provider).

Inform the person you plan to interview that you are a graduate student in public health and that you have a course assignment for your family violence class that includes conducting a semi-structured interview. Ask if the person would be willing to spend 20 to 30 minutes with you as part of your assignment. Let the person know that you will be asking five specific questions, and offer to show him or her the actual assignment sheet if you think this would be helpful. Tell the person you wish to interview that you would truly value their candid insights and responses. Add that since you that you will need to write up the assignment, you will exclude their name or any other information by which they could be identified if they wish to keep their identity anonymous to the professors. Offer to give a copy of your interview report to the person if he or she wishes to see it.

Experience tells us that most people are quite willing to be interviewed by our students, and many feel honored and validated by the process. If someone expresses reluctance to be interviewed for any reason, let him or her know that you acknowledge his or her reluctance, that it is okay, and that you will gladly interview someone else instead (this is an uncommon occurrence but does happen).

Make a clear, defined appointment for the interview, and reinforce it in writing, by sending an e-mail thanking the person in advance for agreeing to meet with you on that specific date, time and location. **\*\*Confirm your appointment 24 hours before it takes place to decrease the chance of the person forgetting or no-showing!!!\*\***

You will likely find that your interview subjects will have lots to say, and that you might have trouble keeping your interview structured and on time. Try to make sure you get through all 5 questions in the time you have agreed to set aside. Directing the interview is a challenging yet crucial skill! We will set aside class time so that students can debrief about their interview experiences.

Finally, create a summary report for your interviews, organized by question, and submit it to any of the course faculty. Do not transcribe your interview; rather summarize the key points as a narrative. Each interview report should be between 3 and 5 pages long, as a rough guide.

## **Guidelines for Agency Assessment and Report (Option A):**

The goal of the agency assessment exercise is to learn how to assess and make recommendations regarding the mission and operation of an organization or agency that addresses some aspect of family violence. You should first select an appropriate agency and secure its willingness to be an assessment site. Your charge then will be to review the agency's mission, policies, and procedures (by examining written reports and other information about the agency; and by interviewing one or more people who serve as managers, regular staff members or volunteers in the agency you are studying) to determine:

- a. The agency's mandate or mission;
- b. The way the agency does its work and the protocols that are followed;
- c. The Spectrum of Prevention components (if any) that are addressed by the agency;
- d. The systems that are in place for referrals, and the way in which the agency addresses identified client needs or issues that lie outside the agency's regular work or expertise;
- e. The attention (or lack thereof) paid by the agency to family systems and other contextualized aspects of intervention;
- f. The manner in which the agency monitors an individual client's progress;
- g. Your sense of the agency's perception of its own strengths, weaknesses and needs;
- h. How the agency is funded;
- i. The attention paid by the agency to evaluating its own effectiveness; and
- j. Your own constructive critique and recommendations for a more effective agency response.

You should plan to write a 12 - 15 page (double-spaced) agency assessment evaluation report, which can be given to the organization you have examined for its own use and benefit. References should be included if appropriate to what you are citing, or if you think they will support your report, but are not required.

You should also be prepared to deliver a 7- to 10-minute presentation to the class summarizing your findings. Handouts and visual aids should be used as appropriate to reinforce the points you are planning to make during your presentation. You will meet with a member of the course faculty on one or more occasions before your presentation for assistance and guidance in preparation, and again following your presentation, to receive feedback.

## **Guidelines for Agency Assessment and Report (Option A) - continued:**

Your written and verbal reports should be outlined as follows:

**Introduction:** State clearly and specifically the problem you are addressing, why you think it is a legitimate public health problem, and why you have chosen this particular agency for your agency assessment;

**Background and description:** Your summary report of the agency and its role in family violence assessment, intervention or prevention (roughly sections (a) through (i) above);

Your recommendations (section (j) above).

This exercise is excellent practice for what you will likely be doing "in real life" when you may be asked to report on, describe, consult on, bail out, revamp, streamline, or otherwise improve already existing programs that may (or may not) be functioning at their best. It will also help you think in a more structured and deliberate manner should you find yourself in the position of creating a new program. You might also potentially enhance your career prospects, or at the very least, expand your network of resources, by doing a credible service to the agency you are assessing.

There are many, many potential venues for this exercise. The course faculty can help you to identify specific agencies and contacts within those agencies with whom you could work during this exercise. An outline of your work plan will be due on Monday February 24, 2003 (Week 6), and brief (1- to 3-paragraph) progress reports will be due every other week thereafter (Weeks 8, 10 and 12). Your final written report will be due on Monday April 28, 2003 (Week 14), and your report will be delivered to the class during Week 12, 13, 14 or 15.

### **Guidelines for Paper (Option B):**

#### **I. Introduction:**

Choose a topic that is a current public health problem related to an aspect of family violence. Try to stay focused on one particular target group, lest your topic become too broad. Your introduction should state clearly and specifically the problem you are addressing, why you think it is a legitimate public health problem, and whether the focus of your paper will be on primary prevention, secondary prevention, tertiary prevention, health policy, or some other aspect related to public health.

#### **II. Literature review and discussion:**

Using available literature (course reader, library search, etc.), review the relevant literature of the past 5 to 10 years, and describe what has been done to date to address the problem. Review and critique each study carefully, looking at the soundness of the hypothesis examined, the methodology of the study, the results (i.e., the relevance and effectiveness of each intervention), how the study or program was evaluated, and its overall strengths and weaknesses, particularly threats to validity. Pay special attention to the social and behavioral variables that may impact the population in question (demographics, values and beliefs, lifestyle, socio-economic and cultural factors, gender, family and community factors, societal influences, etc.). Which aspect(s) of the Spectrum of Prevention does each study fall into? What questions are still left unanswered from each study?

#### **III. Proposed intervention:**

Given the above, discuss what you would propose or develop to improve upon what has already been tried, in order to address the problem about which you are writing. Where in the Spectrum of Prevention would your program or ideas fall? What related programs or policies would need to be in place for your proposal to work well? What strengths and limitations are inherent in what you propose? How would you evaluate the success of your intervention (try to distinguish between process and outcome measures, and how to be realistic in declaring outcomes that won't promise what your program can't deliver). Try to remain scientific while not losing sight of the contribution of an advocacy stance.

#### IV. References:

References in endnote form should be included.

Overall length should be between 12 and 15 pages, double-spaced.

An outline of your paper will be due on February 24, 2003 (Week 6). Your outline should reflect the format suggested above. You may submit a draft for constructive critique if you wish. Your draft may be given to any of the regular course faculty by April 14 (Week 12). Whether or not you choose to submit a draft, your final copy should be handed in no later than April 28 (Week 14).

You should also be prepared to deliver a 7- to 10-minute presentation to the class summarizing your paper. Handouts and visual aids should be used as appropriate to reinforce the points you are planning to make during your presentation. You will meet with a member of the course faculty on one or more occasions before your presentation for assistance and guidance in preparation, and again following your presentation, to receive feedback. Your class presentation will take place during Week 12, 13, 14, or 15.

Good luck, and don't hesitate to contact any of us should you have questions or need direction.

## **COURSE OUTLINE - SPRING 2003**

### **Week 1.**

Monday, January 13, 2003; 2:30 - 5:00 p.m.

Topics:

- Welcome and introductions of students and faculty
- Establishing a safe learning environment
- Course overview and expectations
- Overview and definitions
- The social ecology of violence and victimization
- The Spectrum of Prevention

At the end of this class session, students will be able to:

1. Be able to define health, public health, and family violence
2. Discuss tensions between the scientific and advocacy communities

3. Define and describe the following elements of the Spectrum of Prevention as a model for community-based primary prevention
  - a. Strengthening individual knowledge and skills
  - b. Promoting community education
  - c. Educating providers
  - d. Fostering coalitions and networks
  - e. Changing organizational practices
  - f. Influencing policy and legislation
4. Apply the Spectrum of Prevention to public health in general and to family violence in particular.

Readings:

Alpert EJ, Cohen S, Sege RD. Family Violence: An Overview. *Acad Med.* 1997 (suppl); 72(1): 3-6.

Flitcraft A. Learning from the paradoxes of domestic violence. *JAMA.* 1997; 277:1400-1.

American Public Health Association. Domestic violence (position paper), 01/01/92. <http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=64>. (\*This site is no longer available 8/8/11)

Rosenberg ML, Fenley MA, Johnson D, Short L. Bridging prevention and practice: public health and family violence. *Acad Med.* 1997; 72 (1, Suppl):S13-S18.

Cohen L. Contra Costa County Prevention Program. The spectrum of prevention: a model for improving community health. (unpublished communication).

**Week 2.**

Monday, January 27, 2003; 2:30 - 5:00 p.m.

Topic: Social and Behavioral Factors in Family Violence(con't),  
Data Sources, Research Methods and Evaluation

At the end of this class session, students will be able to:

1. Discuss how the occurrence and presentation of abuse is impacted by social factors including race, culture, gender, discrimination, SES, and family dynamics, as well as the media and popular culture.

2. Understand the association between behavioral factors such as alcohol and/or substance use, disability, HIV, and mental illness, victimization.
3. Become familiar with current knowledge, and its limitations, about the epidemiology of violence and victimization.
4. Identify available data sources (local sources, victimization surveys and population-based surveys) and their strengths and limitations.
5. Describe the basic elements of quantitative and qualitative research and how each approach can be used in research in family violence.
6. . Appreciate how public and social policy are shaped by research.

Readings:

Galbraith S, Rubenstein G. Alcohol, drugs, and domestic violence: confronting barriers to changing practice and policy. *J Amer Med Womn Assoc.* 1996; 51:115-7.

Wilt S, Olson S. Prevalence of domestic violence in the United States. *J Amer Med Women's Assoc.* 1996; 51:77-82.

Centers for Disease Control and Prevention. Building data systems for monitoring and responding to violence against women: recommendations from a workshop. *MMWR* 2000; 49(No. RR-11):1-16.

Garcia-Moreno C. Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women. World Health Organization Global Programme on Evidence for Health Policy, Geneva, Switzerland, 1999.

Rennison CM, Welchans S. Intimate Partner Violence: Special Report. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ-178247. May, 2000.

Commonwealth of Massachusetts, Governor's Commission on Domestic Violence, Research and Evaluation Subcommittee. Fact Sheet: Domestic Violence in Massachusetts. April, 2001.

Commonwealth of Massachusetts, Governor's Commission on Domestic Violence, Research and Evaluation Subcommittee. Summaries of Statewide Data Sources Relevant to Domestic Violence. April, 2001.

**Week 3.**

Monday February 3, 2003, 2:30 - 5:00 p.m.

Topic: Violence in Relationships - I: Introduction, Dynamics, Health Impact

At the end of this class session, students will be able to:

1. Recognize and identify populations at particular risk for victimization.
2. Examine myths about battering and about the cycle of violence.
3. Identify potential individual, family, and societal obstacles that might prevent individuals from leaving an abusive relationship
4. Describe barriers that victims may encounter regarding access to health, social welfare, legal and advocacy services.
5. Describe barriers that providers may encounter in working effectively with abused individuals.
6. Understand the key components of risk assessment and safety planning.

Readings:

Alpert EJ. Violence in intimate relationships and the practicing internist: new disease or new agenda? *Ann Intern Med.* 1995; 123:774-81.

Alpert EJ (ed.), Massachusetts Medical Society Committee on Violence. *Partner Violence - How to Recognize and Treat Victims of Abuse*, 3rd ed. Waltham, MA: Massachusetts Medical Society, 1999. (to be distributed in class)

Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women: incidence and prevalence in an emergency department population. *JAMA.* 1995; 273:1763-7.

Gazmararian JA, Lazorick S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS. Prevalence of violence against pregnant women. *JAMA.* 1996; 275:1915-1920.

Sugg NK, Inui T. Primary care physicians' response to domestic violence: opening Pandora's box. *JAMA.* 1992; 267:3157-60.

McCauley J, Yurk TA, Jenckes MW, Ford DE. Inside "Pandora's box:" abused women's experiences with clinicians and health services. *J Gen Intern Med.* 1998; 13:549-555.

Warshaw C, Alpert E. Integrating Routine Inquiry about Domestic Violence into Daily Practice. *Ann Intern Med.* 1999; 131(8):619-620.

Warshaw C. Domestic violence: changing theory, changing practice. *J Amer Med Women's Assoc.* 1996; 51:87-91.

**Week 4.**

Monday, February 10, 2003, 2:30 - 5:00 p.m.

Topic: Violence in Relationships - II: Culture, Community, and the Contributions of Men and Maleness to Perpetration and Prevention

At the end of this class session, students will be able to:

1. Discuss and understand culture, cultural norms and cultural messages as they relate to violence,
2. Gain comfort in taking a "cultural history" and behaving in a culturally appropriate manner with at-risk individuals.
3. Incorporate culturally sensitive strategies, attitudes and goals into program development and implementation.
4. Understand the principles of "trauma-informed care."
5. Discuss perceptions of male responsibility for violence against women.
6. Discuss the role of men as change agents in the anti-violence movement.
7. Discuss the complexities involved in dealing with men as victims of physical and sexual violence in relationships.
8. Discuss future goals and needs in the anti-violence movement.

Readings:

Spatz Widom C, Maxfield MG. An Update on the "Cycle of Violence." U.S. Department of Justice, Office of Justice Programs, National Institute of Justice Research in Brief, February, 2001.

Wiist WH, McFarlane J. The effectiveness of an abuse assessment protocol in public health prenatal clinics. *Amer J Publ Health.* 1999; 89(8):1217-1221.

Stark E., Flitcraft A. Killing the beast within: woman battering and female suicidality. *Int J Health Serv.* 1995; 25(1):43-64.

Warrier S. From Sensitivity to Competency: Clinical and Departmental Guidelines to Achieving Cultural Competency. Family Violence Prevention Fund. San Francisco, CA <http://endabuse.org/programs/display.php3?DocID=49> (from the Responding to Diversity information packet produced by the Family Violence Prevention Fund)

Campbell JC, Campbell DW. Cultural competence in the care of abused women. *J Nurse-Midwif.* 1996; 41(6):457-462.

## **Week 5.**

Tuesday, February 18, 2003, 2:30 - 5:00 p.m.  
(Marjorie Clapprod and Jacey Buel - Guest Faculty)

Topic: Teen Dating Violence - Recognition, Intervention and Prevention

At the end of the class session, students will be able to:

1. Understand the scope of teen dating violence and its implications
2. Discuss the need for developing and implementing effective primary prevention models in schools
3. Identify aspects of healthy relationships for adolescents

Readings:

Molidor C, Tolman R. Gender and contextual factors in adolescent dating violence. *Violence Against Women*. 1998; 4(2):180-194.

O'Keefe M, Treister L. Victims of dating violence among high school students: are the predictors different for males and females? *Violence Against Women*. 1998; 4(2):195-223.

National Crime Prevention Council. Chapter 7, Prevention Starts Early - Working with Children and Teens to Break the Cycle of Violence. In, *Preventing Violence Against Women: Not Just a Women's Issue*. July, 1995.

Elders MJ. Adolescent pregnancy and sexual abuse. *JAMA*. 1998; 280(7):648-649.

## **Week 6.**

Monday, February 24, 2003, 2:30 - 5:00 p.m.  
(Gunner Scott - Guest Faculty)

Topic: Partner Violence in the Gay, Lesbian, Bisexual, and Transgender Community

At the end of this class session, students will be able to:

1. Identify, understand and discuss clinical and program issues when the victim/survivor is gay, lesbian, bisexual or transgender
2. Identify, understand and discuss clinical and program issues when the batterer is gay, lesbian, bisexual or transgender
3. Identify, understand and discuss clinical and program issues when the victim/survivor is male.

Readings:

Merrill GS. Ruling the exceptions: same-sex battering and domestic violence theory. In Renzetti CM, Miley CH, eds. *Violence in Gay and Lesbian Domestic Partnerships*. 1996; New York: The Haworth Press, p. 9-21.

Letellier P. Gay and bisexual male domestic violence victimization: challenges to feminist theory and responses to violence. *Violence and Victims*. 1994; 9:95-104.

Coleman VE. Lesbian battering: the relationship between personality and the perpetration of violence. *Violence and Victims*. 1994; 9:139-50.

Lundy SE. Abuse that dare not speak its name: assisting victims of lesbian and gay domestic violence in Massachusetts. *New England Law Review*. 1993; 28:273-311.

## **Week 7.**

Monday March 3, 2003, 2:30 - 5:00 p.m.  
(Gina Scaramella - Guest Faculty)

Topic: Sexual Assault

At the end of this class session, students will be able to:

1. Describe the realities, myths and facts of sexual assault in the U.S.
2. Understand the Sexual Assault Nurse Examiner (SANE) program
3. Identify the symptoms and reactions associated with Rape Trauma Syndrome
4. Understand the roles and responsibilities of rape crisis centers to survivors of sexual assault, law enforcement, the health care community, and the general public in shaping intervention and prevention strategies.

Readings:

Schrafran LH. Topics for our times: rape is a major public health issue. *Amer J Publ Health*. 1996; 86(1):15-17.

Mahoney P, Williams LM. Chapter 4: Sexual assault in marriage: prevalence, consequences, and treatment of wife rape. In Jasinski JL, Williams LM (Eds.), *Partner Violence: A Comprehensive Review of 20 Years of Research*. Pp 113-163. 1998; Sage. Thousand Oaks, CA.

Mantak FJ. Creating an alternative framework for preventing rape: applying Haddon's injury prevention strategies. *J Pub Health Policy*. 1995; 16(1):13-28.

ray LE. *Sexual Assault Nurse Examiner Development and Operation Guide*. Chapters 2-7, 11, 14. Sexual Assault Resource Service, U.S. Department of Justice, Office of Justice Programs, Minneapolis, MN. NCJ170609.

## **Week 8.**

Monday, March 17, 2003; 2:30 - 5:00 p.m.  
(Lisa Tieszen and Susan Pacheco - Guest Faculty)

Topic: DV and Older Individuals

At the end of this class session, students will be able to:

1. Describe the evolution of elder abuse laws and policies
2. Describe research findings regarding:
  - Incidence and prevalence
  - Risk factors for victimization
  - Perpetrator characteristics
  - Health and social consequences of elder mistreatment
3. Understand the merits and limitations of adult protective service systems
4. Gain familiarity with model prevention and intervention initiatives

Readings:

Lachs M, Pillemer K. Abuse and neglect of elderly persons. *New Engl J Med.* 1995; 332:437-444.

Ansello EF. Chapter 1, p 9-29. Causes and Theories. In Baumhover LA, Beall SC (eds), *Abuse, Neglect and Exploitation of Older Persons: Strategies for Assessment and Intervention.* 1996, Health Professions Press: Baltimore, MD.

Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson M.E. The mortality of elder mistreatment. *JAMA.* 1998; 280(5):428-432.

Anetzberger GJ. Elderly adult survivors of family violence: implications for clinical practice. *Violence Against Women.* 1997; 3(5):499-514.

Soto-Aquino LI. Elder Abuse;: Incidence and Prevention. Congressional Research Service /The Library of Congress. CRS Report for Congress. Order Code RS20414, Dec. 10, 1999

## **Week 9.**

Monday, March 24, 2003, 2:30 - 5:00 p.m.

Topic: Child Abuse and Neglect, Children who Witness Domestic Violence

At the end of the class session, students will be able to:

1. Discuss the societal context of violence in childrearing practices
2. Describe the impact of exposure on children at different developmental stages
3. Recognize the overlap in occurrence of domestic violence and child abuse
4. Discuss mandated reporting laws, the role of the Department of Social Services in cases involving domestic violence, and the historical relationship between child protective services and battered Women's organizations
5. Understand the effects of domestic violence on child /parent relationships
6. Be aware of resources available for children exposed to domestic violence.

Readings:

Fantuzzo JW, Mohr WK. Prevalence and Effects of Child Exposure to Domestic Violence. In: Domestic Violence and Children. Volume 9, No. 3, p. 21-32, Winter 1999. The David and Lucille Packard Foundation <http://www.futureofchildren.org>.

Groves BA. Mental Health Services for Children who Witness Domestic Violence. In, Domestic Violence and Children. Volume 9, No. 3, p. 122-132, Winter 1999. The David and Lucille Packard Foundation. <http://www.futureofchildren.org>.

Governor's Commission on Domestic Violence, Children's Working Group, Lennett J, Chair. The Children of Domestic Violence. April 1996.

Ryan J, King MC. Child witnesses of domestic violence: principles of advocacy. Clin Excellence for Nurse Pract. 1997; 1:47-57.

VanDeven AM, Newberger EH. Child abuse. Ann Rev Public Health. 1994; 15:367-79.

Leventhal JM. The challenges of recognizing child abuse: seeing is believing. JAMA. 1999; 281(7):657-659.

Waldfoegel J. Rethinking the paradigm for child protection. In, The Future of Children: Protecting Children from Abuse and Neglect. The David and Lucille Packard Foundation. 1998; 8(1):104-19.

Commonwealth of Massachusetts, Massachusetts General Laws, Ch 119, Sect. 51A.

Commonwealth of Massachusetts, Department of Social Services. Making a Report of Abuse or Neglect. <http://www.state.ma.us/dss/info-pac/12.htm>

## **Week 10.**

Monday, March 31, 2003, 2:30 - 5:00 p.m.  
(Janet Fine, Angela Chansky - Guest Faculty)

Topic: Child Sexual Abuse Investigation, Victim-Witness Assistance Programs

At the end of this class session, students will be able to:

1. Understand and discuss the history, development and implementation of the Children's Advocacy Center
2. Evaluate the Children's Advocacy Center
3. Understand the reactions and experiences of victims/survivors of childhood sexual abuse.

Readings:

MacMillan HL, Fleming JE, Trocme N, et al. Prevalence of child physical and sexual abuse in the community: results from the Ontario Health Supplement. *JAMA* 1997; 278(2):131-135.

Snyder HN. Sexual Assault of Young Children as Reported to Law Enforcement: Victim, Incident and Offender Characteristics. U.S. Department of Justice, Office of Justice Programs, National Center for Juvenile Justice. NCJ 182990, July 2000.

Elders, MJ, Albert AE. Adolescent pregnancy and sexual abuse. *JAMA* 1998; 280(7):648-9. Hays KF, Stanley SF. The impact of childhood sexual abuse on Women's dental experiences. *J. Child Sexual Abuse*. 1996; 5(4):65-74.

Holmes WC, Slap GB. Sexual abuse of boys: definition, prevalence, correlates, sequelae and management. *JAMA* 1998; 280(21):1855-1862

Finkelhor D. Improving research, policy and practice to understand child sexual abuse. *JAMA* 1988; 280(21):1864-5.

## **Week 11.**

Monday, April 7, 2003; 2:30 - 5:00 p.m.

Topic: The Justice System and Family Violence

At the end of the class session, students will be able to:

1. Understand the process that victims of domestic violence must follow in order to obtain a restraining order.
2. Understand the effectiveness of restraining orders

3. Understand the roles, responsibilities and limitations of Guardians ad Litem
4. Discuss conflicts surrounding mandatory reporting laws
5. Be able to define the different roles of police and legal system personnel

Readings:

Holt VH, Kernie MA, Lumley T, Wolf ME, Rivara FP. Civil protection orders and risk of subsequent police-reported violence. *JAMA* 2002; 288(5): 589-594.

Massachusetts Senate Committee on Post Audit and Oversight, Senator Cheryl A. Jacques, Chair. *Guarding Our Children: A Review of Massachusetts' Guardian Ad Litem Program within the Probate and Family Court*. Commonwealth of Massachusetts, 2001.

Hyman A. Mandatory reporting of domestic violence by health care providers: a policy paper. 1997; Family Violence Prevention Fund, San Francisco CA.

Administrative Office of the Trial Court and the Judicial Institute. Reference Guide for New Abuse Prevention Forms: M.G.L. Ch. 209A. (October 1995).

**Week 12.**

Monday, April 14, 2003; 2:30 - 5:00 p.m.  
(Angela Browne, Ph.D. - Guest Faculty)

Topic: Returning Strengths to our Discourse on Women Survivors Student Presentations - I

At the end of the class session, students will be able to:

1. Comprehend the strong correlation between poverty and the increased risk of victimization for women and children
2. Recognize and appreciate the strengths of trauma survivors in terms of their capacity for resilience and recovery
3. Apply a strengths perspective when considering existing and potential therapeutic and programmatic approaches

Readings:

Browne A, Bassuk SS, Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample. *Amer J Orthopsychiatry*. 1997; 67(2):261-278.

Bassuk EL, Melnick S, Browne A. Responding to the needs of low-income and homeless women who are survivors of family violence. *J Amer Med Women's Assoc*. 1998; 53(2):57-64.

Lloyd S. The effects of domestic violence on Women's employment. *Law and Policy*. 1997; 19(2):139-67.

### **Week 13.**

Wednesday, April 23, 2003, 2:30 - 5:00 p.m.  
(Emily Rothman - Guest Faculty)

Topic: The Perpetrators of Family Violence

Student Presentations - II

At the end of the class session, students will be able to:

1. Discuss characteristics of batterers and understand the variability of these characteristics
2. Describe the general principles of batterer's intervention
3. Understand the empirical evidence regarding the efficacy of batterer's intervention
4. Apply public health models and interventions to perpetrators

Readings:

Healey KR, Smith C. Batterer Programs: What Criminal Justice Agencies Need to Know. *Research in Action*. U.S. Department of Justice, National Institute of Justice Office of Justice Programs, Washington DC NCJ171683, July 1998.

Tolman RM, Edelson JL. Intervention for men who batter: a review of research. Minnesota Center Against Violence and Abuse Electronic Clearinghouse. 1995. <http://www.mincava.umn.edu/papers/toledl.htm>

Edelson JL. Do batterers' programs work? Minnesota Center Against Violence and Abuse Electronic Clearinghouse. <http://www.mincava.umn.edu/papers/battrx.htm>. 1995.

Gondolf EW. An extended follow-up of batterers and their female partners: research summary for October 1997 to September 1999. Presentation for CDC-NCIPC, 1999. <http://www.iup.edu/maati/publications/monitor.htmlx>

### **Week 14.**

Monday, April 28, 2003, 2:30 - 5:00 p.m.

Topic: Building a Coordinated Community Response to Family Violence (the primary prevention of family violence).

Student Presentations - III

At the end of this class session, students will be able to:

1. Describe the basic roles and elements of a coordinated community response to family violence
2. Understand the basic principles underlying community organizing
3. Delineate the struggle between science and advocacy in social justice

Readings:

Reno J, Shalala DE, co-chairs, National Advisory Council on Violence Against Women. A Community Checklist: Important Steps to End Violence Against Women. U.S. Department of Justice, 1996.

Shepard, M. Evaluating Coordinated Community Responses to Domestic Violence. Violence Against Women Online Resources. VAW Net. 1999. <http://www.vaw.umn.edu/Vawnet/ccr.htm>

King MC. Changing Women's lives: the primary prevention of violence against women. AWHONN's Clinical Issues. 1993; 4(3):449-457.

Weiss HB. Home visits: necessary but not sufficient. In, The Future of Children: Home Visiting. Center for the Future of Children. The David and Lucille Packard Foundation. 1993; 3:113-28.

## **Week 15.**

Monday, May 5, 2003, 2:30 - 5:00 p.m.

Topic: Immigration and Human Rights Issues in Family Violence

Student Presentations - IV

Course evaluations

Club 750 Induction Ceremony and Party

Wrap Up

At the end of the class session, students will be able to:

1. Recognize obstacles (including legal and cultural) for immigrant and refugee women in violent relationships that differ from or are similar to those faced by other women.
2. Understand the need for cultural competency in domestic violence practice
3. Identify resources for immigrant and refugee women who are addressing issues of domestic violence
4. Explore the application of human rights to the issue of domestic violence

Readings:

Thomas DQ, Beasley ME. Domestic violence as a human rights issue. *Human Rights Quarterly*. 1993; 15:36-62.

Statewide Hearings on Domestic Violence: Findings and Recommendations. Governor's Commission on Domestic Violence Subcommittee on Immigrants and Refugees, 1998.

World Report on Violence and Health: Summary. World Health Organization, Geneva, 2002.

## Interview Exercise

### Interview 1

With respect to adult intimate partner violence, interview one of the following to describe the existing or current:

1. individual or agency responses or protocols when interacting with or evaluating an adult suspected of being abused by an intimate partner,
2. organizational supports and impediments that individuals doing this work encounter,
3. personal supports and impediments that individuals doing this work encounter,
4. personal reactions and reflections that individuals doing this work are willing to share, and
5. programmatic and societal needs that the person you interview perceives as necessary or desirable for a more effective response...
  - physician or other health care provider
  - child's teacher or school guidance counselor
  - child's pediatrician or other health care provider
  - members of religious communities
  - shelter or hotline advocate
  - community leader
  - DSS case worker (if child is being evaluated for SCAN)
  - clinical social worker or other mental health provider
  - rape crisis counselor

- alcohol or other substance abuse counselor
- clergy
- police
- domestic violence advocate in DA's office or court
- guardian ad-litem in custody dispute cases
- family court clerk, magistrate, judge (or other judicial official)
- legislator or other elected official
- public health official or representative
- other (specify)

## **Interview 2**

With respect to child abuse and/or neglect, interview one of the following to describe the existing or current:

1. individual (or agency) responses or protocol(s),
  2. organizational supports and impediments that individuals doing this work encounter,
  3. personal supports and impediments that individuals doing this work encounter,
  4. personal reactions and reflections that individuals doing this work are willing to share, and
  5. programmatic and societal needs that the person you interview perceives as necessary or desirable for a more effective response.
- teacher
  - school guidance counselor
  - pediatrician or other health care provider
  - scout leader or other community activities leader
  - DSS case worker
  - DYS case worker
  - clinical social worker

- child sexual abuse clinician specialist
- clergy
- police
- child abuse advocate in DA's office
- guardian ad-litem
- family court clerk, magistrate, judge or other judicial official
- legislator or other elected official
- public health official or representative
- other (specify)

## **Case 1.**

Lisa is a 33-year-old woman who is currently on parole from Framingham Women's Prison, after having served 8 1/2 years of a 15-20 year sentence for manslaughter, her first offense.

She was physically and sexually abused as a young child by her father, who also abused her mother. Lisa's three older sisters would run out of the house when their father attacked their mother, but Lisa would stay behind to try to protect her mother, only to suffer the same abuse herself. "I got the brunt of the abuse all along." Lisa was forced to leave home at the age of 11 after she resisted her father's continued behavior, which included rape. She was placed in foster care, however her foster father also sexually molested her. She ran away from the foster home and became involved at the age of 13 with a 21-year-old man who was physically abusive. She became pregnant by this man at the age of 15; the child was born with physical deformities and mental retardation. This child, now 21, was placed in foster care as an infant, and was eventually adopted.

Lisa then met and eventually married a man named Tom, who appeared sympathetic and protective, and promised to take good care of her. Unfortunately, this relationship too became violent, starting with verbal abuse, soon followed by psychological, physical and sexual abuse. "It was always my face he went for," Lisa explained. "He said he wanted to make me ugly so no man would ever want me. He told me I could never leave, because wherever I went he would find me."

The abuse by Tom lasted five years, and was characterized by repeated physical as well as sexual violence, which progressively escalated in frequency and severity. He slashed her clothes and slashed the tires on her car to prevent her from leaving. When she was pregnant with her second child, Tom held a knife to her abdomen and threatened to cut out the fetus. He once handcuffed her to a bed, raped her and beat her for trying to resist. He inserted objects into her vagina, which caused bleeding and eventual scarring and chronic pelvic pain.

Lisa called the police on several occasions. Sometimes they responded and sometimes they didn't. They said they could not arrest Tom because they had not observed her being hit by him and it was therefore "her word against his." Once the police had left, Tom would then beat her more severely for having called the police. Lisa took out restraining orders on five occasions, but all were ignored by both Tom and the police.

Lisa lived in fear for her life and that of her son, Chad. Eventually, Lisa filed for divorce and moved out with her son, but Tom found out their whereabouts and showed up at the door. Lisa had the locks changed, but Tom forced his way in through windows. Lisa then tried to nail her windows shut (even though it was summer) but while she was doing this, Tom broke in, grabbed the hammer and assaulted her, knocking out her front teeth. Lisa believes that Tom would have killed her that day had he not been stopped by a friend of his who was there. The police were called to the scene once again during this incident but did not arrest Tom, despite the bloody assault that had just taken place and the restraining order violations.

Lisa was in fear that Tom would murder her and/or her son. Lisa had a friend at work named Michael who was concerned for her safety. Michael offered to "take care of things" for Lisa, and she agreed, thinking that Michael was going to rough Tom up and warn him to leave her alone. Michael and one of his friends lured Tom to a secluded area and proceeded to beat him to death with a baseball bat. Lisa was waiting in a car nearby and did not hear or see what was going on, nor did she know what had just transpired.

Lisa and the two men were arrested. Lisa was not aware that both men had prior criminal records until their trials began. One of the men turned "state's evidence" and was not prosecuted in exchange for his testimony. The other man (Michael) pled guilty to second-degree murder and received a 15-year sentence (which was reduced because of his plea bargain).

Despite the fact that this was her first offense, that she was a working single mother, that she was in fear for her life, that she had tried every legal avenue to protect herself, and that she was unaware that Tom was to be murdered (and did not plan for this or wish this to happen), Lisa was denied bail and was sent to the Awaiting Trial Unit (ATU), pending her trial. She spent 3 1/2 years in the ATU. Lisa was ultimately tried and convicted of manslaughter despite testimony from several people about her long history of abuse, her repeated calls for help and evidence of pervasive unresponsiveness on the part of individuals and agencies that could have or should have intervened. For example, Lisa sought help from a teen counselor who took and kept extensive notes describing Lisa's physical injuries and her reports of being sexually victimized, and offered these notes in testimony during the trial. However, years ago, the counselor took no action, other than taking notes, while she was in charge of Lisa's therapy. The jury foreman and many others appealed to the judge for a lenient or suspended sentence, given the circumstances of Lisa's case, however Judge John Murphy sentenced Lisa to 15 to 20 years in state prison for manslaughter, her first offense.

Lisa spent eight 1/2 years in prison, including the three spent in ATU. She was released on parole in 1993. The conditions on parole were to have no social contact with any one ever convicted of a felony, to find (before she could be released) and maintain gainful employment without requiring

public assistance, to seek out and remain in counseling, and to refrain from using drugs and alcohol.

Chad, now 14, was raised by one of Lisa's sisters while she was in jail. He has suffered emotional and physical problems, but is now improving. Lisa's sister had been designated as Chad's legal guardian, so Lisa recently petitioned the court to regain custody of her son.

Lisa and Chad now live in Leominster. Lisa is working as the Violence Coordinator for the Massachusetts Criminal Justice Training Council. She also speaks publicly about her experiences and participates in community education activities.

Case 1 questions

1. What went wrong in Lisa's case? Describe and discuss the missed opportunities that individuals and agencies might have availed themselves of to evaluate, intervene and potentially prevent the abuse that Lisa suffered as a child and as an adult.
2. Who (if anyone) should be held accountable for an effective and prevention oriented response to violence and abuse? How should accountability be assured?

## Case 2:

John is a 26 year old man who has been court mandated to enter a batterer's intervention program, after having been served a restraining order which he violated. He is unwilling to attend but knows he needs to attend the group sessions or face a jail term. He maintains that his girlfriend Gloria provoked the latest assault, and says that he can prove it because she says she is sorry for being "stupid" and wants him to return to the apartment that they share. Gloria has a 4-year-old son by a previous relationship, and a 9-month-old daughter with John. Both children live with her.

Gloria has a high school education and no job skills. She is an illegal immigrant, with no close family in the area. She is afraid that if John goes to jail or leaves her, that she will not be able to survive financially, may be deported and thus lose her children, who were born in this country and are therefore U.S. citizens.

John has a prior record for disturbing the peace and resisting arrest, and for DUI. Both charges were within the last 3 years. The first charge was plea bargained for time served and community service, and the DUI charge was continued without a finding, provided that John take an alcohol education class, after which he boasted that "my body was there but my mind wasn't, so the joke's on you." John works as a school bus driver.

John is angry that the court is "making such a big deal over nothing," and says that he is "the real victim."

Case 2 questions:

1. Describe the characteristics of batterers and explain in what respects John fits or does not fit the classic description.

2. Describe the characteristics of battered women and explain in what respects Gloria fits or does not fit the classic description. Explain how her immigrant status may affect her perception of her own situation, and her legal options should she seek further protection from John.
3. You are a counselor at a batterer's intervention program. You are informed that John is seeking "individual counseling" for his problem and is petitioning the court to allow him to substitute this form of therapy for his treatment program. Is this an acceptable substitute? How should you advise John? The court? Gloria?
4. What are the realities of batterer's intervention programs? Given what we know (or don't know) about the long-term success rates of such programs, design a protocol by which you can evaluate batterer's intervention initiatives.

### **Case 3.**

A 12-year-old boy was brought to the Emergency Room by a neighbor after having been found unconscious in his back yard. He had a bruise on his face near the left eye, and a baseball was found next to him. There were no witnesses to the events prior to his being discovered by the neighbor. The only other information offered by the neighbor was the boy's name (Robert LeVitus), his address, and the names of the boy's parents. Although the neighbor expressed concern about the boy, he refused to stay or even to leave his own name, and left the hospital shortly after arriving with Robert.

1. What responsibility (if any) does the neighbor have with respect to Robert? What should the neighbor be asked or told?

Robert regains consciousness after a few minutes. He says he cannot recall what happened, and doesn't remember playing baseball. The boy is noted to have several bruises on his arms and chest. He appears small for his age, is thin and has very poor hygiene. He is not particularly apprehensive about being in an emergency room without any familiar people. In fact, he appears to be somewhat detached and obedient.

1. You are the physician/nurse/other health professional in the Emergency Department. The police and/or hospital administrators are attempting to locate Robert's parents but are as yet unsuccessful. What types of questions can or should you ask Robert at this time? Can you evaluate and/or treat Robert before his parents are located and give consent?
2. You suspect child abuse but have no concrete proof. What should you do?

Three hours after Robert has arrived in the Emergency Department, you are told that his parents have been identified and contacted. The mother is a schoolteacher and the father is a managed care administrator. You are told that they are en route to the hospital. Two hours later, the parents arrive together and volunteer to you that "Bobby has always been accident prone and sickly." They say he has been so accident prone that he has "landed in emergency rooms at least four or five times before, all over town."

1. What should you as the physician/nurse ask Robert's parents?

2. Which individuals or agencies should be involved at this point? What do you expect their response(s) to be?

You are definitely suspecting child abuse but do not have sufficient concrete evidence on which to base your hunch. You do not want to alienate the parents, and while you are attempting to call the social worker to come to the Emergency Department, you are paged to X-Ray to look at Robert's films, which are suspect for child abuse. You return to discuss your findings and your plans to evaluate (as a mandated reporter), but when you return to the Emergency Department, you are informed by the secretary that Robert and his parents have left the building.

1. What can/should you do now? What resources can you access to go forward in verifying or ruling out your suspicions? Do you have the right to contact anyone else in Robert's family, his teachers, neighbors, minister or access emergency records from other hospitals to confirm or deny your suspicions? What are the legal ramifications of a mistaken diagnosis of child abuse?
2. Suppose that Robert actually has an undiagnosed bone or muscle disease, which is not due to child abuse but could have been diagnosed earlier, had Robert's parents brought him in for regular health care. Does this constitute parental neglect or abuse? What if the parents are Christian Scientists and do not believe in taking their child (or themselves) to physicians?