

Effects of Violence on Health: The Medical System Response

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Family Violence

- Abuse - physical, emotional, sexual
- All forms of family violence tend to go together - child, wife & elder abuse
- Intergenerational Transmission or “Cycle of Violence” - biggest risk factor for being a perpetrator of family violence is experiencing as a child - observing or being a victim - b/c of Learning? Trauma? Stress?
- Historical trauma – indigenous peoples all over the world – connected with high rates of family violence

Family Violence

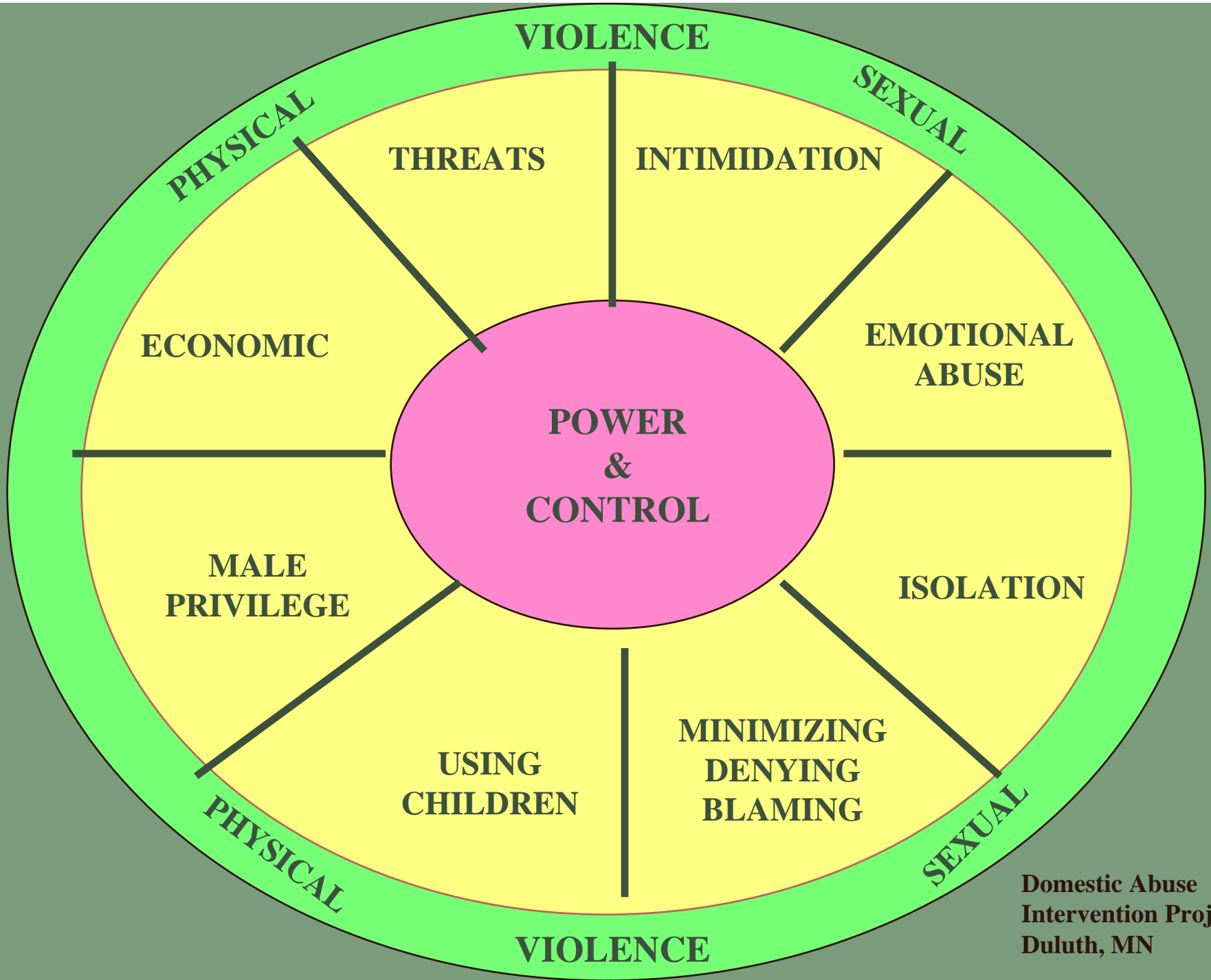
- █ Neglect more associated with poverty than abuse
- █ Child abuse more likely to be reported by health care professionals if families are poor & minority ethnicity (Newberger & DeVos '89; IOM report on health disparities '02)
- █ Biggest risk for elder abuse is history of violence on part of perpetrator rather than frailty of elder
- █ Verbally aggressive family - also more likely to be physically aggressive

BATTERING

*REPEATED PHYSICAL AND/OR
SEXUAL ASSAULT WITHIN A
CONTEXT OF COERCIVE
CONTROL*

(Campbell & Humphreys, '93)

Conceptualized as a risk factor for many health problems rather than a disease or syndrome or diagnosis



**Domestic Abuse
Intervention Project
Duluth, MN**

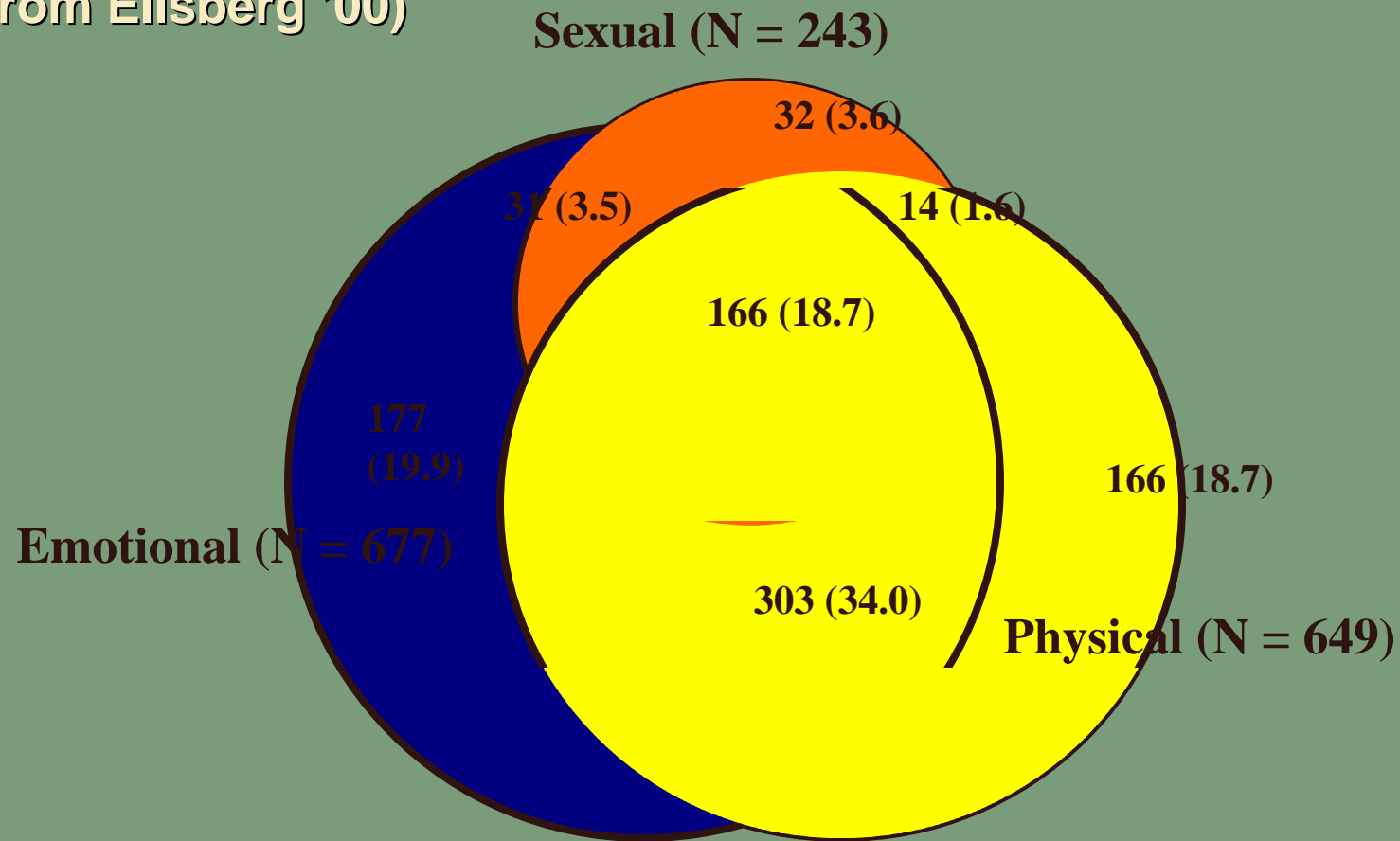
SEXUAL ABUSE

May include...

- 🌀 Forced sex - by force or threat of force
- 🌀 Painful sex - clearly indicated as unwanted
- 🌀 Sexual degradation
- 🌀 Sex without protection






Overlap between physical, sexual and emotional abuse (N = 889) (Campbell et. al. '02 from Ellsberg '00)

from Ellsberg '00)



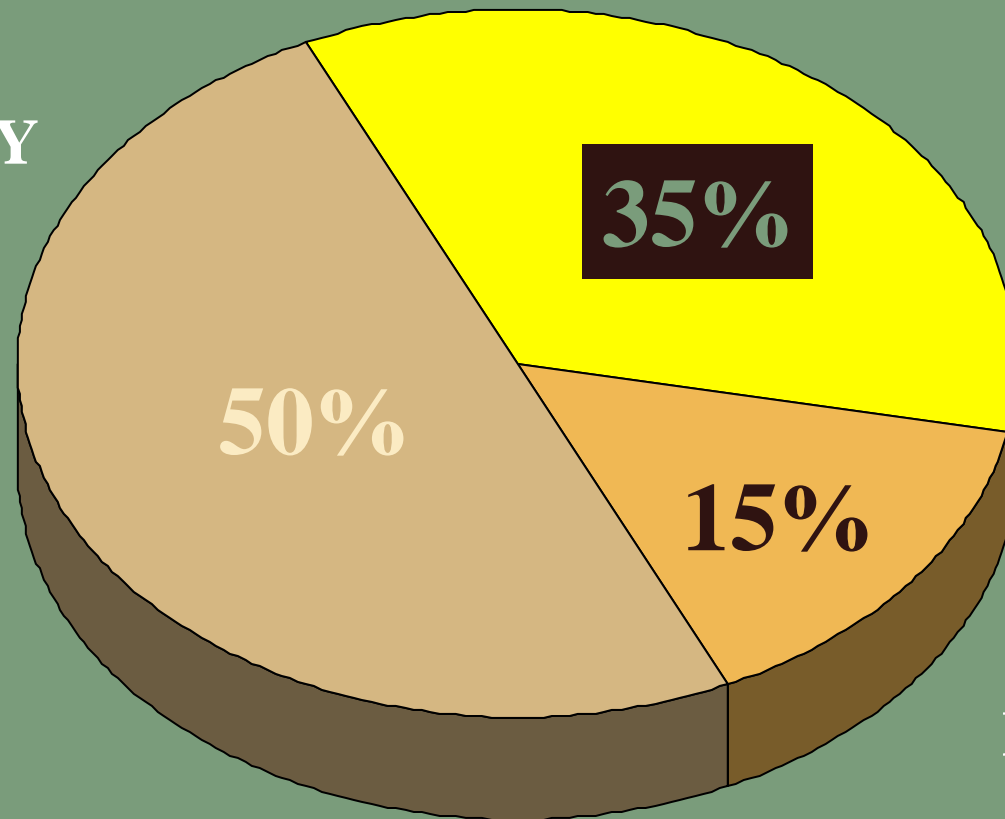
Child Abuse & Wife Abuse Overlap

(Edleson '99)

-  Hospital records of mothers of abused children 45 - 59% - evidence of wife abuse (Stark, Flitcraft '88; McKibben, DeVos, Newberger '89)
-  State (OR & MA) DSS records 26 - 48% of mothers of abused children - wife abuse (Child Welfare Partnership '96; Hangen '94)
-  Pop. based survey - 23% of men violent toward women - abused child; serious wife abuse - 77% child abuse (Straus & Gelles '90)
-  Survey of college students - 52% (F) - 43% (M) of child witnesses - also abused (Silvern et. al. '95)
-  Women in shelter - 20-46% children abused

CHILDREN OF BATTERED WOMEN REPORTED FOR CHILD ABUSE X6

ABUSED BY
FATHER/
FATHER -
FIGURE






BY MOTHER

BOTH

MEDICAL RECORD REVIEW (STARK & FLITCRAFT, 1988)

EFFECTS OF DV ON CHILDREN

-  Anxiety reactions & post-traumatic stress Sx - e.g. irritability, agitation, trouble concentrating, exaggerated startle response, intrusive, unwanted memories, compulsive traumatic play (Graham-Bermann & Levendosky '02)
-  More physical health problems than general pop. – asthma, eating disorders (Kerouac,et.al.'86; Wilkins '02)
-  Worries about mother- actual (e.g. battering) & potential (e.g. smoking, pregnancy) health hazards (Humphreys '91;'93)

EFFECTS OF DV ON CHILDREN

- School problems, e.g., declining grades, behavior problems, truancy, suspensions, expulsion (Wolfe, et. al., 1986; Widon, Williamson & Wilson, 1991)
- Higher externalizing behaviors-e.g. aggressiveness, hyperactivity, conduct px, anger management px, bullying (Hughes '88; '89; Jouriles '89, Holden & Ritchie '91; Kolbo '96)
- Later, higher levels of violent behavior & arrests in children abused or neglected (Maxfield & Widom, '96)

EFFECTS OF DV ON CHILDREN

- Higher internalizing behaviors, e.g., depression, anxiety, social withdrawal (Hughes, 1988; Holden & Ritchie, 1991; Graham-Berman & Levendosky '01)
- Low social competence. Fewer interests & social activities (Wolfe, et. al., 1986)
- Low self-esteem, low self-efficacy (Hughes, 1988; Holden & Ritchie, 1991)
- BUT** most children recover when violence ends
IF a stable, caring adult - resilience research

DV: OVERALL PREVALENCE

- 4.4 Million US Women (Commonwealth Fund Surveys, 1996, '00)
- 8.4% any physical abuse in past year –
- Approximately same prevalence in MSM (Greenwood, Relf et. al. '03) – significantly less in female same sex partners T&T '01)
- 3.2% severely abused past year
- 52% injured (Bachman & Saltzman, 1995)
- 20 - 35% seek medical care or hospitalized (Brendtro & Bowker '89)
- 85% in the health care system for *something* (42% of femicide victims - Campbell et. al. '00)

PHYSICAL HEALTH EFFECTS

- Physical Injury (Facial, fractures, dental, neurological - soft tissue, internal, “falls” - Grisso ‘91)
- Neurological Sx - Coker ‘00, Diaz-Olavarietta ‘99
- Chronic Pain (Back, abdominal, chest, head) (Goldberg & Tomlanovich ‘85; Campbell ‘00; Coker ‘99); Fibromyalgia (Alexander et. al. ‘98; Walker et. al. ‘97)
- Chronic Irritable Bowel Syndrome (Drossman et. al. ‘90; Leserman et. al. ‘98)
- Hypertension (Rodriguez ‘89; Coker ‘99; Letourneau ‘99)
- Smoking (30% victims; 13% controls; Letourneau 99)

Physical Health Effects of Lifetime Trauma

- ACE study – Felitti '98; '02; '03
- Men & women victims of child abuse & neglect – longterm health effects – premature death from cardiovascular disease as well as smoking, drug abuse, alcoholism
- Increasing evidence of weight disorders – increased body weight
- Combinations of risk factors – complex physiological & neuropsychological interactions

HEALTH EFFECTS OF FORCED RELATIONSHIP SEX

40-45% of physically abused women
INCREASED RISK OF:

- Unintended pregnancy (Campbell et. al., '96; Gazmararian et. al. '95; Goodwin et. al. '00)
- Adolescent Pregnancy (Berenson et. al. '92; Renker '99)
- Abortion (Evins & Chescheir 1996)
- Vaginal bleeding (Campbell et. al. '01)
- Anal & vaginal tearing (Campbell & Alford '89)
- Painful intercourse (Campbell & Alford 1989; Eby et. al., '95; Coker '00; Leserman '98)

HEALTH EFFECTS OF FORCED RELATIONSHIP SEX

Increased Risk of:

- ❖ STD's (Eby et. al. '95; Gielen et. al. '94; Coker '99)
- ❖ HIV/AIDS (Gielen et.al., '94, '00; Maman et.al. '00)
- ❖ Pelvic pain, Pelvic Inflammatory Disease, Infertility (Eby et.al. '95; Leserman '98; Schei '90)
- ❖ Urinary Tract Infections (Campbell & Alford '89; McCauley '95; Coker '99; Campbell et. al. '00)
- ❖ Risk of homicide, low self esteem (Campbell '89; '99)

Evidence of HIV/VAW Intersection

- US Longitudinal multicenter study - HIV negative & positive women – if past year or lifetime IPV - significantly more likely to report >1 HIV risk behavior (Cohen et. al. '00)
- Clinic study -HIV negative & positive women - women w/13 or > prior yr. abuse events – ½ as likely to use condoms vs. non-abused (Gielen et.al.'02).
- Clinic-study - women w/active STD & sexual abuse hx - more high risk sexual behavior vs. women w/active STD & no abuse hx (Chouaf '01).
- Qualitative studies - Near impossibility of negotiation of condom use with abusive partner (Champion & Shain '98; Davilla & Brackley '98; Chouaf et. al., in press; Stevens & Richards 98'; Zierler & Krieger '97)

HIV/ IPV CONNECTIONS

- Tanzania - 10X HIV+ rate if IPV (Maman '00)
- South Africa – prenatal patients more likely to be HIV+ if IPV (Duncan et. al., '04)
- US - HIV risk 26% amongst sexually coerced vs. 13% not (Choi '98) (N = 2030 - population based); (also Winwood & DiClemente '97)
- Rwanda - HIV + status associated w/ husband forcing sex & physical violence (Van der Straten '98)
- Reason for non-disclosure (75%) in Kenya - fear of IPV (Temmerman '95) - of those who disclosed 1/3 - beaten, abandoned or suicide
- Increased rates of HIV w/ DV –Zimbabwe-Watts et.al.'97

HIV/DV Connections – Etiology (Maman et. al. '99)

- Immune system depression with stress
- Trauma increasing HIV transmission; anal sex
- Increased STD's & untreated STD's (Letourneau '99; Coker et.al. '00; King et. al. '00)
- Impossible to negotiate safe sex if a battering relationship
- Women accused of infidelity if want to use safe sex
- Males have other partners unknown to women
- Fear of being beaten for being tested; notifying partner of positive status; delay in treatment
- Substance abuse

IMMUNE SYSTEM EFFECTS

- HPA axis – hypothalamic – pituitary – adrenal gland interactions
- Stress of abuse, multiplied by poverty, other stressors – but even separate from other stressors -activates HPA & produces corticosteroids & catecholamines
- Suppresses T1 cell or T1 cytokine (fights bacteria & viruses) production
- Depression has same effects on immune system
- Results in lowered immunity to HIV

Health Effects - 5 Major Studies

(controlled, pop based or large HMO – Campbell et. al. '02; Coker et.al.'00; Leserman et.al.'98; McCauley et.al.'95; Plichta '96)

HEALTH PX/SX	p<.05	NS
Urinary Tract Infection	4	
Digestive Sx/Px (diarrhea, nausea)	3	
Bulemia, loss of appetite	2	
Pelvic pain	4	
Vaginal Infections	3	
STD's	2	
Painful intercourse, sexual dysfunction	3	

Health Effects - 5 Major Studies

(controlled, pop based or large HMO – Campbell et. al. 02; Coker et.al.'00; Leserman et.al.'98; McCauley et.al.'95; Plichta '96)

HEALTH PX/SX	p<.05	NS
General health or overall Sx	5	
Headaches, migraines	5	
Fainting, passing out	3	1
Seizures, convulsions	1	1
Back pain, chronic neck pain	4	1
Flu or cold, stuffy, runny nose	1	1
Hypertension	1	1

MENTAL HEALTH EFFECTS - Golding '99





- Depression 10 - 43 pop; 32 - 70% clinical (9.3% non abused)
- Suicidality 14 - 40% (4.9% non abused)
- Post Traumatic Stress Disorder 2 - 12% pop; 31 - 84% clinical (weighted \bar{X} prevalence 64% - 5% non abused)
- Alcohol Abuse 4 - 16% pop; 23 - 44% clinical
- Drug Abuse 5 - 16% pop; 23 - 44% clinical (2% non abused)
- Eating Disorders - bulimia (McCauley et.al.1995)


Post Traumatic Stress Disorder in Battered Women

- Re-experiencing the trauma
 - Trouble sleeping
 - “Affective” flashbacks
 - Dissociation rare unless learned in childhood
- Avoidance of stimuli associated with event
 - “Denial”
 - Encouraged by “conventional wisdom” but counter indicated

Post Traumatic Stress Disorder in Battered Women

Hyperarousal

-  Startle response
-  Hypervigilance
-  Stress related physical symptoms
-  Substance abuse as self medication?

 Normal Human Response to Trauma BUT increasing evidence of neurochemical brain changes - hypothalamus & serotonin

Co-Morbidity of PTSD & Depression in Battered Women

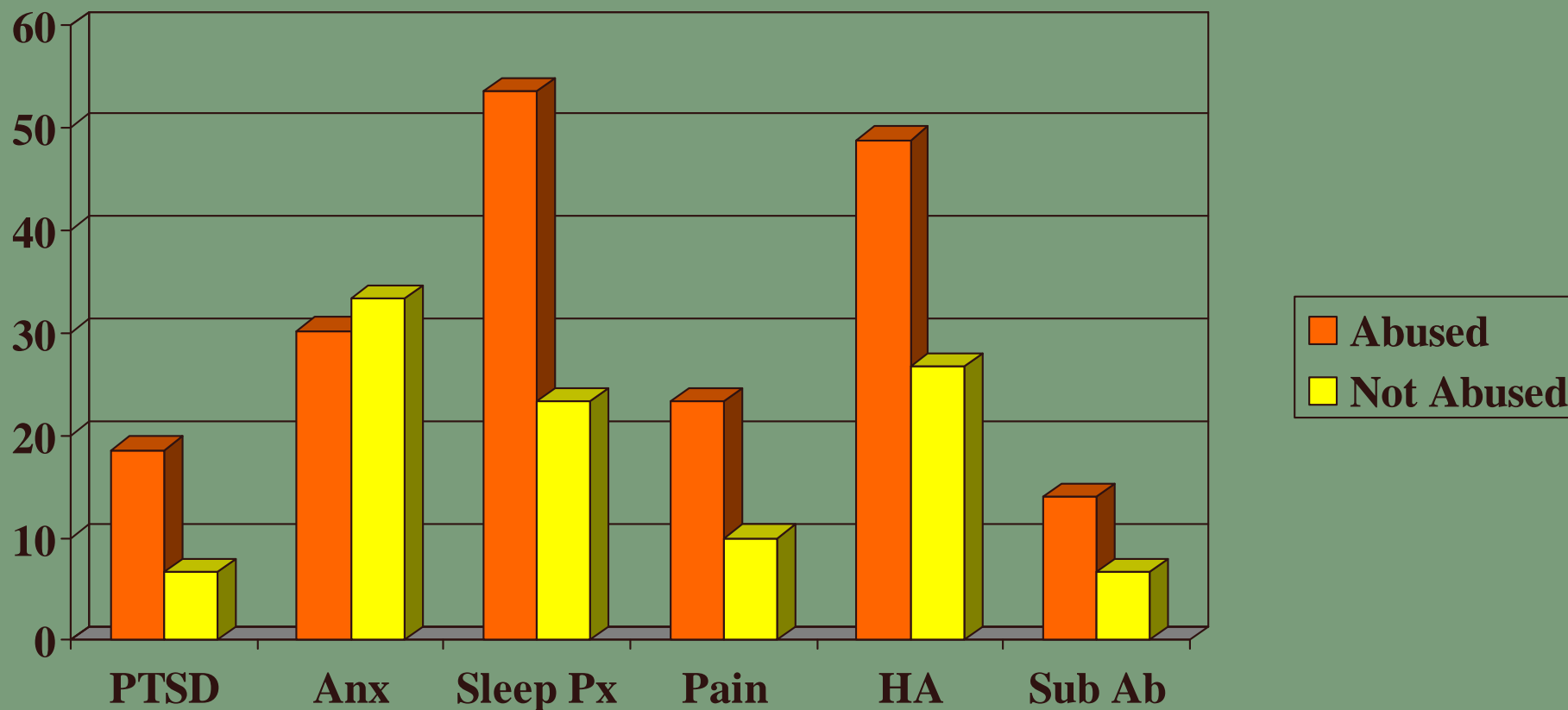
- Far more comorbidity in battered women than in rape victims or Vietnam Vets
- Predictors: childhood victimization, severity of physical abuse
- Beginning evidence that a lifetime trauma response

Issues with Depression in Battered Women

- Diagnostic issues
- Labeling issues
- Child custody issues
- Medication issues
- Other treatment issues
- Interaction of biochemical & environmental
- For most women, depression lifts as abuse lessens (Sullivan et. al. '98; Campbell & Soeken '99)

Abuse Among Women Diagnosed with Depression

Dienemann, Boyle, Baker, Resnick, Wiederhorn, Campbell '2000



Health Care Costs of Intimate Partner Violence

(Wisner et.al.JFP '99)

- 126 victims compared to 1007 randomly selected HMO female enrollees (Minneapolis) 18-64 yo.
- \$1775 more spent per year
- Significant differences: Increased hospitalizations, general clinic use, mental health visits and “out of plan” referrals
- ED visits *not* higher
- Mental health care costs 800% higher

Annual and Lifetime Prevalence of Partner Abuse in a Sample of Female HMO Enrollees

Funded by DOD DAMD #17-96-1-6310

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Sample Characteristics (N = 1138)

AGE

21-29	73	6.4%
30-39	351	30.8%
40-49	514	45.2%
50-56	200	17.6%

EDUCATION

= HS	287	25.3%
Some College	467	32.4%
4 Years College	251	22.2%
Grad School	227	20.1%

RACE/ETHNICITY

African American	531	46.7%
White European	531	46.7%
Other Minority		6.7%

Sample Characteristics

EMPLOYMENT

Employed FT	847	76.8%
Employed PT		13.3%
Unemployed	147 109	9.9%

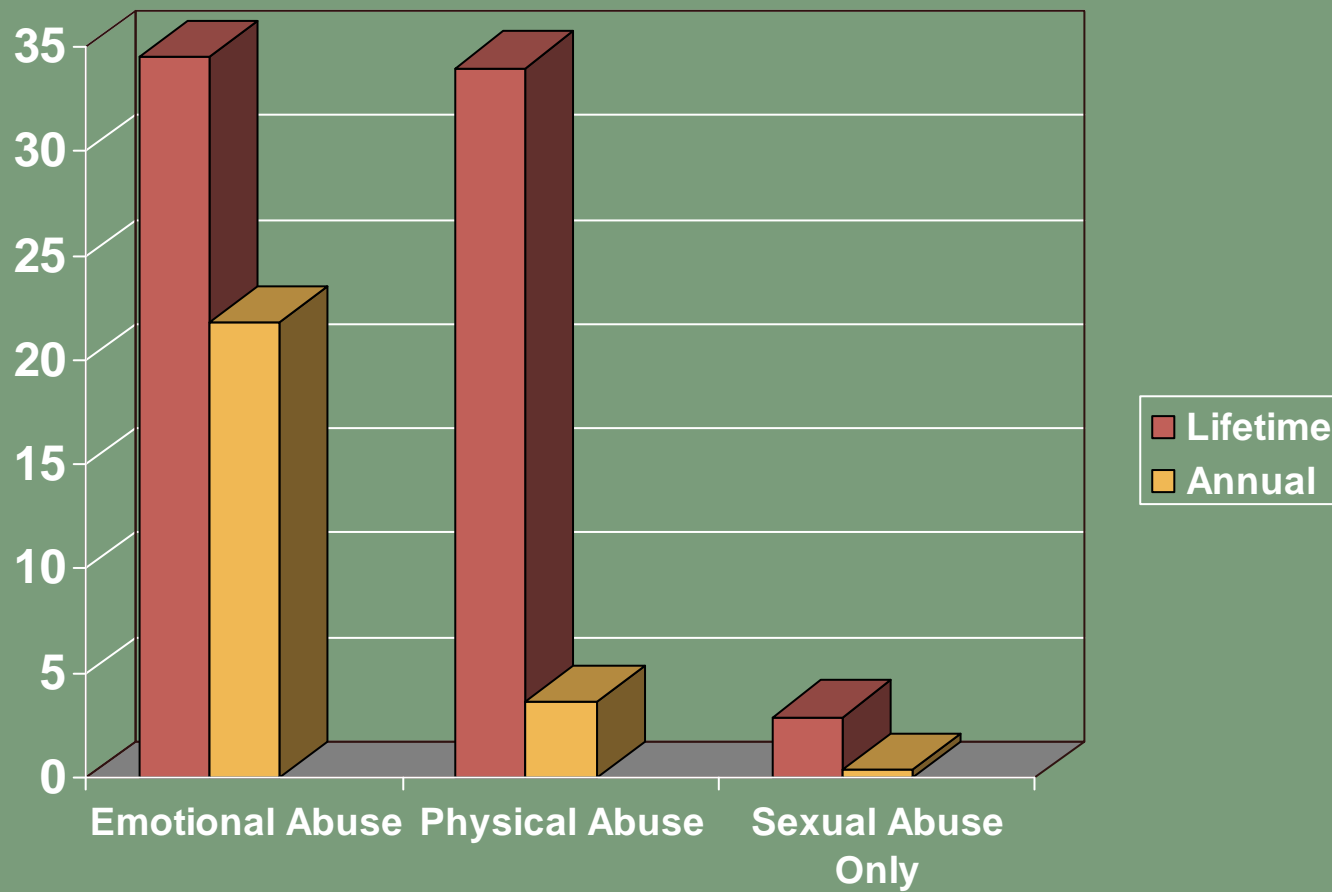
HOUSEHOLD INCOME

<30K	188	17.1%
\$30-50K	292	26.5%
\$51-80K	340	30.9%
>\$80K	281	25.5%

CHILDREN IN HOUSEHOLD

No children	492	43.2%
1-2 children	500	44.8%

Prevalence of Intimate Partner Violence in HMO Women (N=918)



Risk Factors-Lifetime Prevalence of Sexual & Physical Abuse (MLR)

(Jones, Campbell et. al. in press, *Women's Health Issues*)

EDUCATION

=HS Grad	1.22
College Grad +	.54***

EMPLOYMENT

PT	.89
Unemployed	1.01




Household Income

<30K	1.06
30-80K	1.21
>80K	1.06

Status Inconsistency

* p=.1; ** p=.01; ***p=.001

Risk Factors-Lifetime Prevalence of Sexual & Physical Abuse (MLR)

CHARACTERISTIC	OR
 Age	
21-29	1.66*
40-49	1.69**
50-56	1.29
 Race	
African American	1.32* (OR decreases substantially when control for income, education)
 Marital Status	
Separated/Divorced	2.54**
Never married	1.01
Widowed	3.99***

* p=.1; ** p=.01; ***p=.001

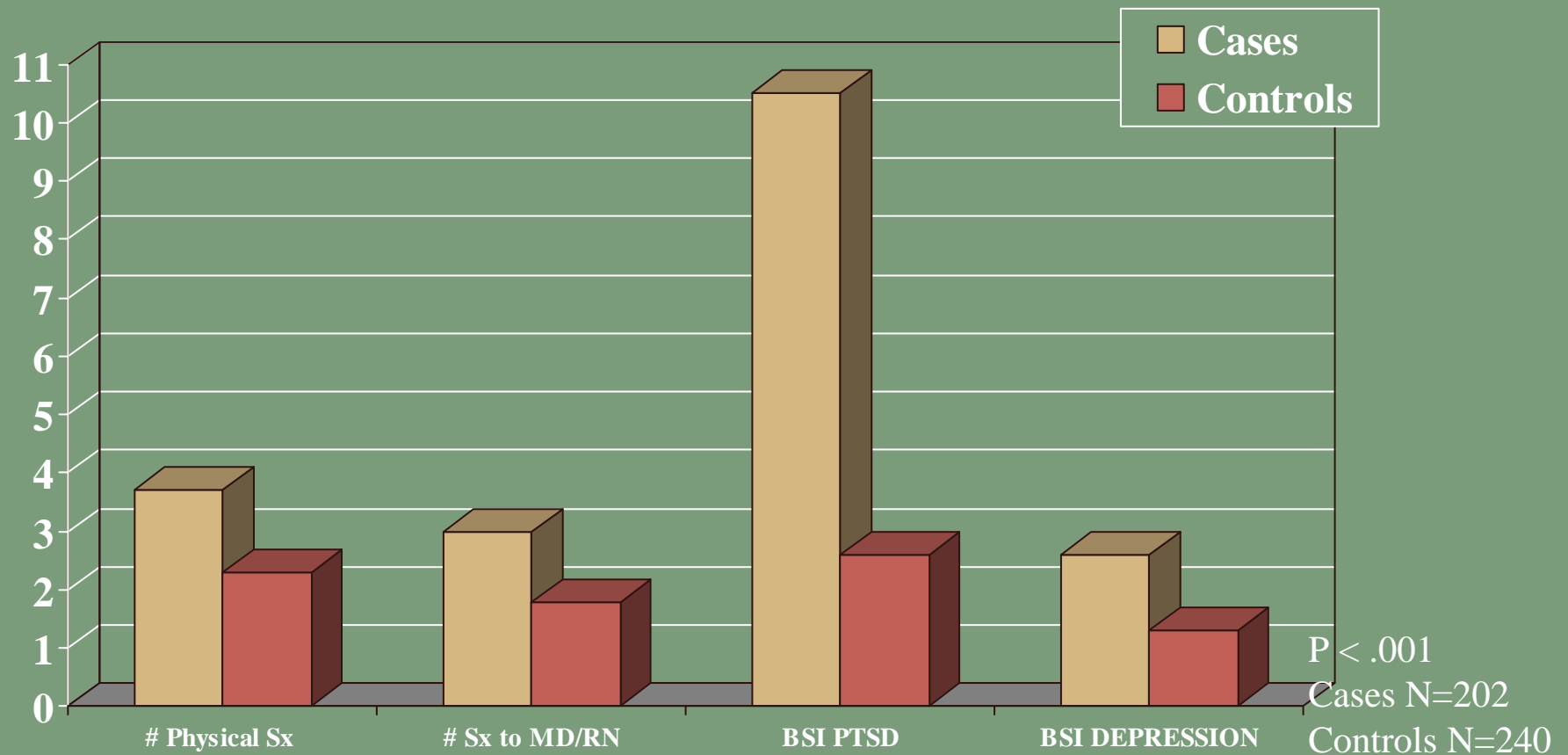
Overall Health & Visits to Physicians or Nurse Practitioners by HMO Women¹

	es	Controls	
Estimate Health as Excellent	25.5%	34.8%	<.01
V_i visits to MD's or NP's ^{Cas}	7.98	7 .14	5
			<.0

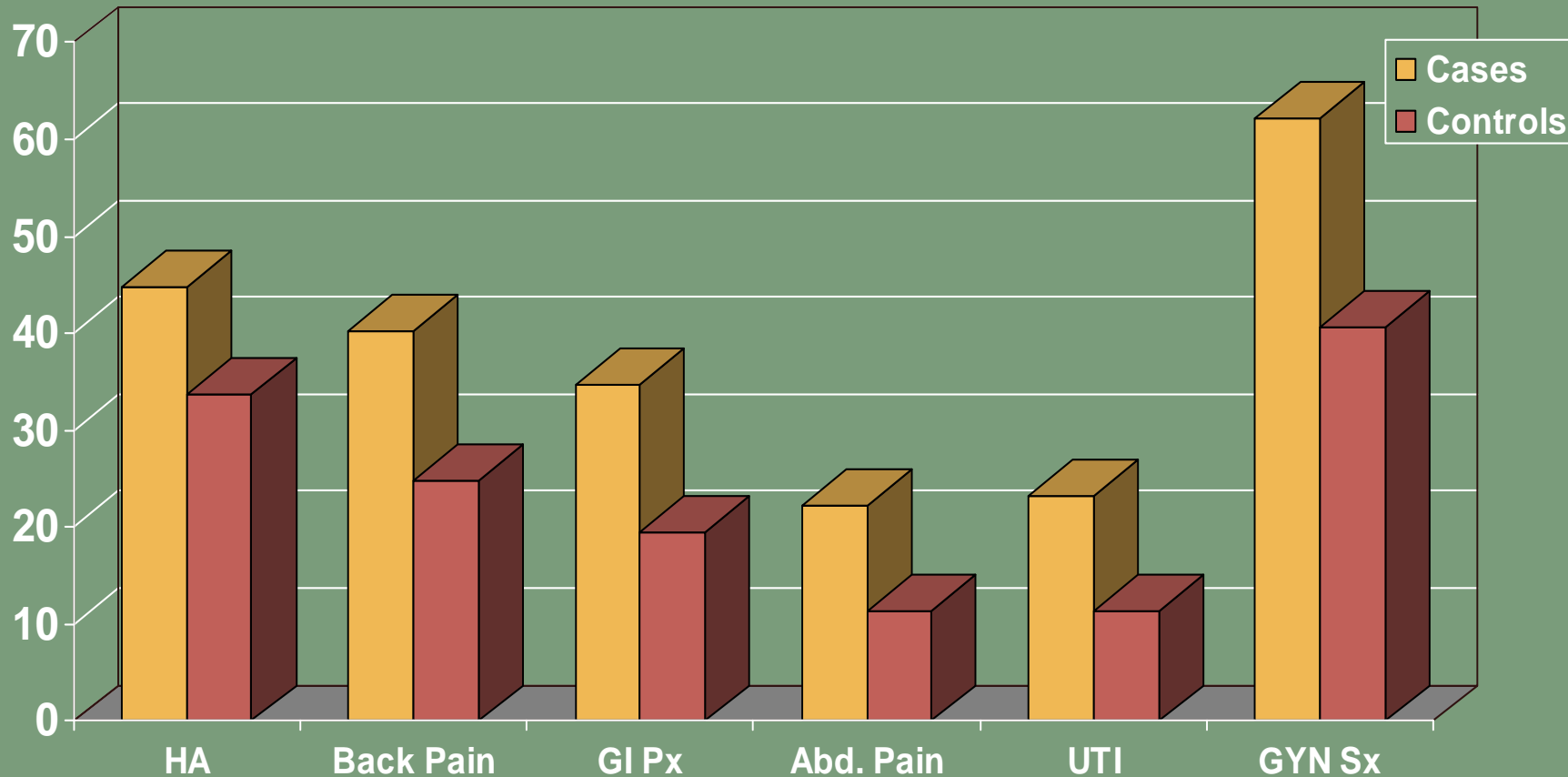
¹ Statistical analysis using linear regression controlling for race, marital status, education and annual income.

Health Problems & Symptoms Experienced in Past Year

MLR analysis controlling for case/control differences - race, marital status, ed & income



Selected Health Problems at Least One Time to MD: Significant Difference btw. Cases & Controls



Differences between African American & Anglo HMO Enrollees (Schollenberger et.al.'03)

- More African American women overall to ED & past year abused African American women made most visits
- $P < .05$ difference in hypertension between those with past year abuse & those never abused - African American women only
- Significant association between abuse (ever) and fibroids & colds & flu for African American women only
- Less difference btw. abused & not in total clinic visits for African American women than for anglo women
- No significant difference in loss of appetite for African American women vs. significant difference for anglo

Policy Implications (Gielen, Campbell et. al. '00)

- Of the 118 ever abused women, only 18.6% had talked to a health care provider about the abuse
- Of those, 61% said it was either somewhat or entirely helpful; 17.4% not helpful
- Majority abused (60.5%) & not abused (80.6%) not insulted/offended if asked about abuse (*p <.05)
- Majority of both groups (83.3%) - said easier for battered women to get help if health care providers routinely asked about abuse

Routine Screening & Mandatory Reporting Conclusions

(from 3 samples - ED, HMO, & urban population based)

- Majority of women - abused & not - support Routine Screening & MR- generally think it would make it easier for women to get help & like someone else calling police
- But significantly fewer abused women support MR (Hispanic battered women least in favor) & significantly more endorse options for choice
- Slight majority of battered women say MR would decrease disclosure
- Sizeable minority of battered women (44 - 50%) think MR may increase risk

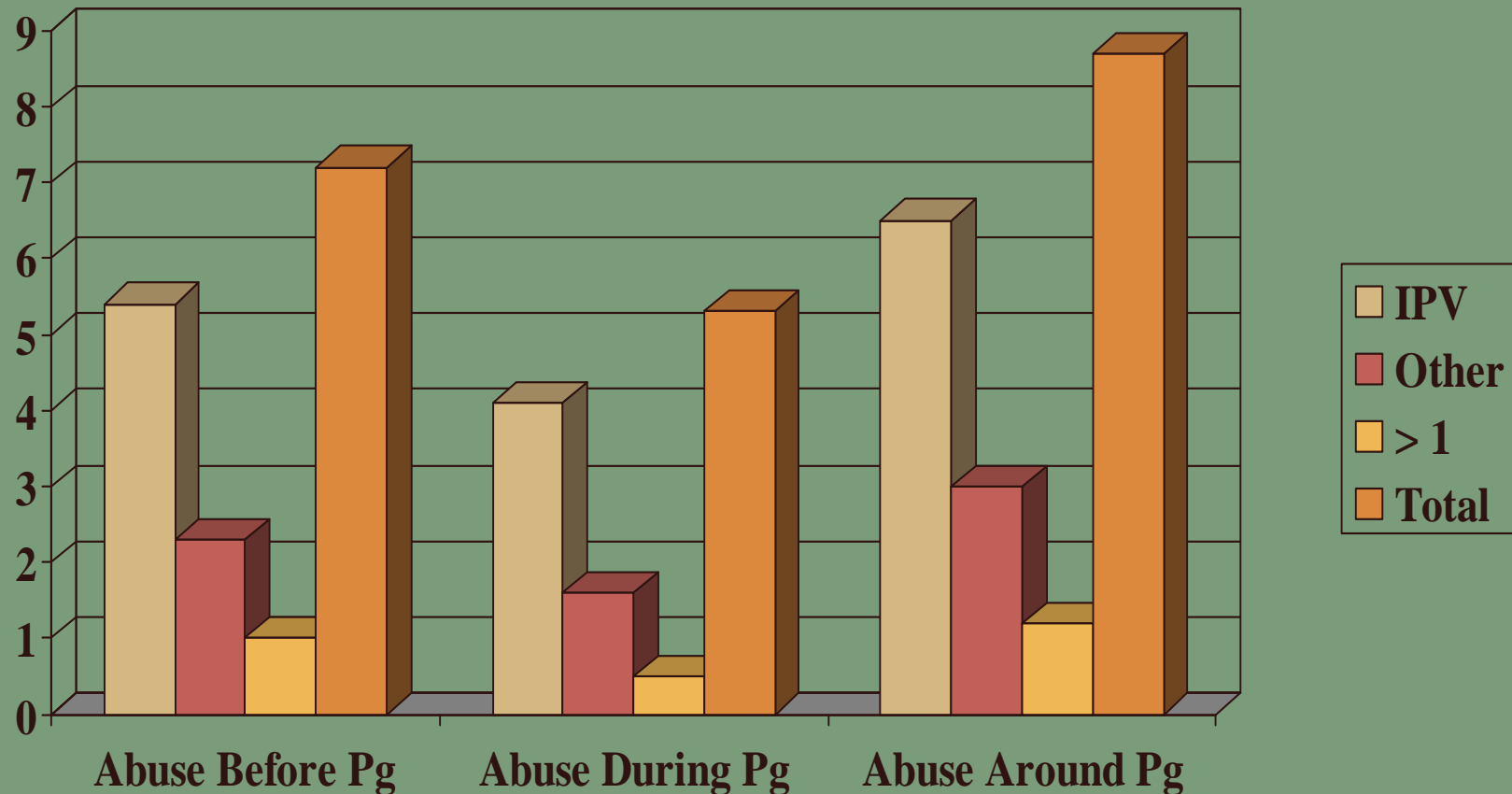
Abuse During Pregnancy

- 8-22% of pregnant women (vs. 7% pre-eclampsia or hypertension during pregnancy)
- Most significant risk factor - abuse before pg.
- Pregnancy - protective period or risk period (1st pregnancy - jealousy); usually neither
- Ethnic group comparison - significantly lower in Hispanic couples (Mexican American) -14% vs. 16% in African American and Anglo (McFarlane & Parker '92)

Patterns of Abuse During Pregnancy (Ballard et. al., '98)

- Used to think that pregnancy was a risk factor for abuse – now clear that more often a protective period but all patterns are possible –
- Pregnancy can be either a protective period – women beaten before and after – (30%) or a risk period – may start during pregnancy (24%) – especially first pregnancy - but most often neither (75%) (Martin '01; Saltzman '03)
- Physical abuse may lessen or stop but emotional abuse, controlling behaviors stay same or increase (Castro '03)
- Higher prevalence of abuse during pregnancy among adolescents than adult women (Parker, McFarlane '93) & post partum abuse higher than during pregnancy (Harrykisson et. al. '02)

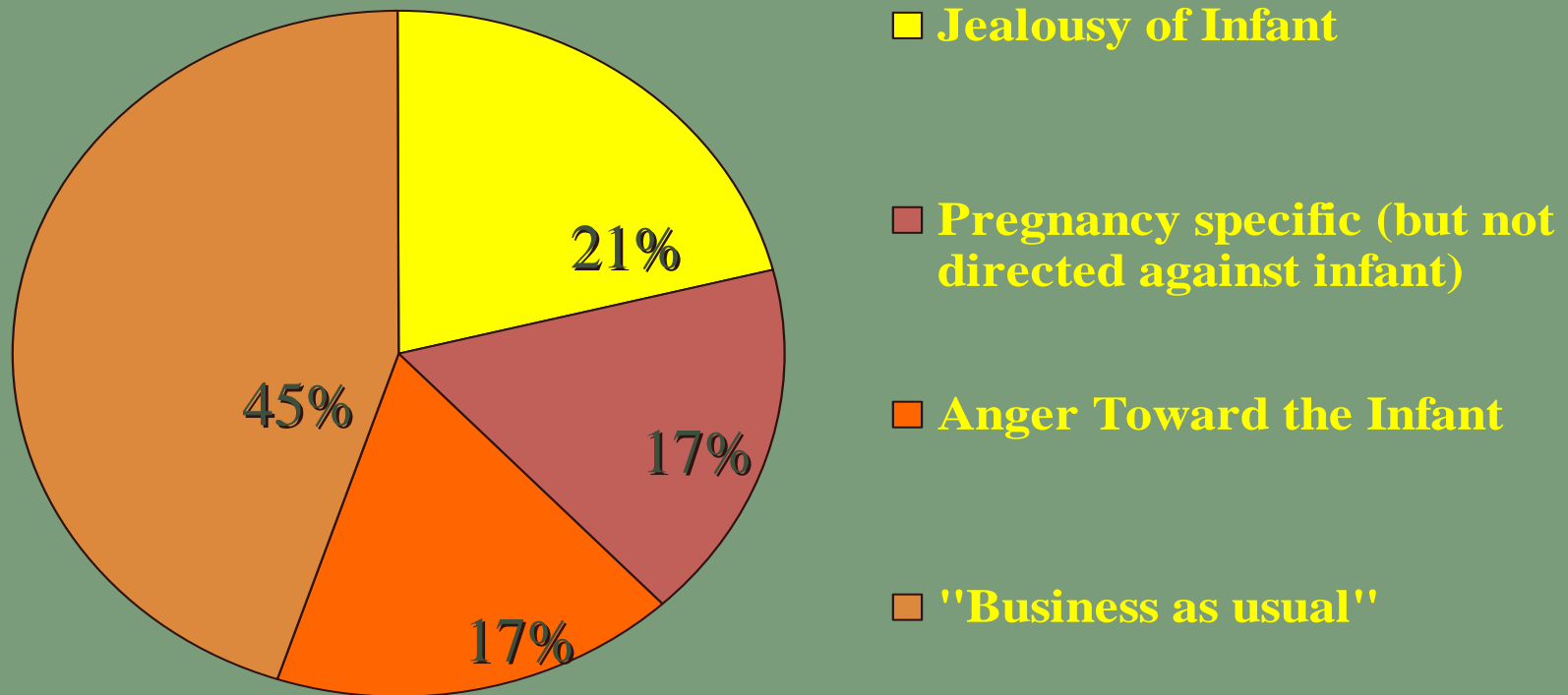
Prevalence of Abuse Around Time of Pregnancy (Saltzman et. al. '03)



Abuse During Pregnancy

- Maternal health correlates: depression, substance abuse, low social support spontaneous abortion, smoking, risk of homicide (Gielen et al '94; Campbell et al '92)
- Infant outcomes: LBW especially in MC women (Bullock & McFarlane '89) & through connections w/ smoking, low weight gain & substance abuse (Curry et al '99) ; child abuse
- Most severe abuse - nonbiological father

Themes of Women's Perceptions of Reasons for Abuse (Campbell, Oliver & Bullock '98)



N=27

From Public Health Perspective – IP Homicide = Maternal Mortality

- Maternal mortality – Death from all causes during pregnancy & year after delivery or pregnancy termination
- Homicide is leading cause of maternal mortality in US cities where measured (NYC, Chicago, DC) (Dannenberg, '95; Krulewitch et. al. 2001)
- Leading cause of maternal mortality in entire states of MD (Horon & Cheng, 2001) – 20% of deaths & MA (MMR '02)
- Has been neglected in maternal death reviews – (perpetrator data missing) & therefore programming in US but fatality reviews increasing

Multicity Femicide Study – Results related to pregnancy

- 25.8% of women killed reported abuse during pregnancy (vs. 8.4% of abused controls) – AOR = 3.8
- 13 women (4.2%) killed while pregnant – 11 of 13 abused in relationship before killed
- Stepchild in home increased risk AOR = 2.48
- Results specific to pregnancy published: (McFarlane, Campbell et. al., 2002) *Obstetrics & Gynecology*, 100(1): 27-36

Clinical Implications of Abuse during Pregnancy

- Routine assessment at EACH prenatal care visit by regular provider (McFarlane & Parker '92)
- If abuse during pregnancy, alert for child abuse
- Understand particular tendency for hope for relationship during pregnancy
- Careful assessment at post partum

PROTOCOLS (Required by JCAHO) RECOMMENDED ELEMENTS:

 Procedures for separating

 Ask all females

 Complete physical exam

 Legal responsibilities

 Referral sources

Mandates: JCAHO Standards

- Mandated policies and procedures on child abuse
- '92 - Added physical assault & domestic abuse of elders, spouses & partners to child abuse - ED, substance abuse & ambulatory care only
- '93 - Added examination & treatment, collection of evidence, staff education
- '94 - ALL SITES for assessment
- '95 - Collaboration & Coordination
- '96 - Responsibility - Who does what?

Mandates: JCAHO - 1998 - Victims of Abuse (all forms) under:

- HR (4, 4.1, 4.3) - Orientation, data LD (2.8) - Directors provide orientation, in-service education & continuing ed. -all depts.
- Patient Assessment: 1.8 - Identification by criteria (hospital specific); 6 - special needs of pts. receiving Tx for emotional or behavioral disorders assessed; 8- evidentiary material(s) collected
- Medical records also include notification of authorities as required & appropriate referrals
- Also under C.C. – continuum of care - discharge

JCAHO 2004

- Strengthening mandates for universal assessment (stops short of routine screening)
- Strengthening mandates for assessment in other settings – e.g. pediatrics
- Strengthening mandates for training
- Now requires evidence – from chart reviews etc.

Evaluation of a System Change Team Training Model to Improve Emergency Department Response to Domestic Violence

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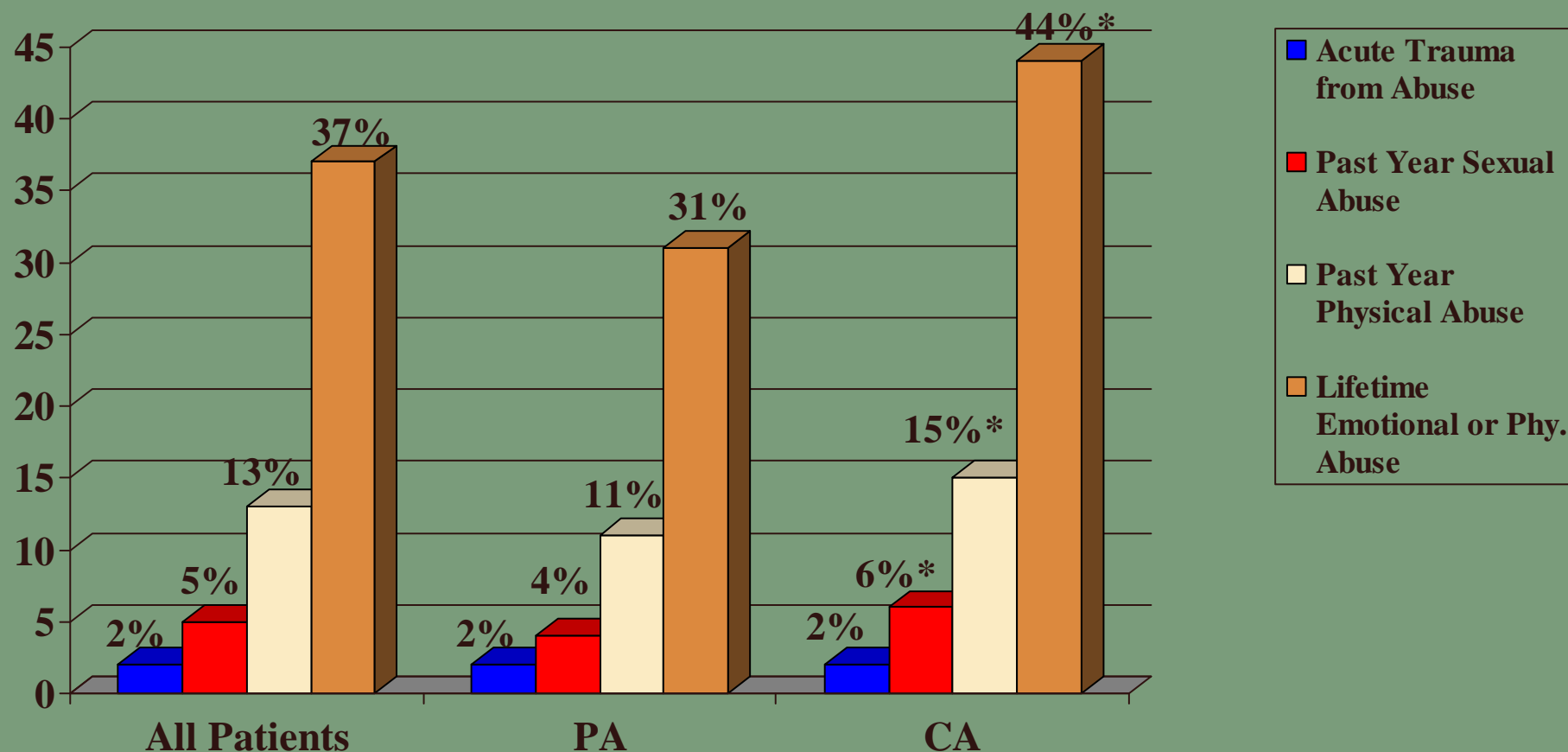
Funded by the Centers for Disease Control and Prevention

Pennsylvania and California Hospital Selection



- 12 Hospitals (6 PA, 6 CA)
ED Admissions = 20,000-40,000 per year
- All female patients 18 years of age and older
- 3 waves of survey administration (309 ED shifts)
Apr-Sept 1995; Jan-May 1996; Jan-May 1997
- Trained ED nurses from each hospital

Prevalence of Domestic Abuse in Female Patients Admitted to 11 Community Hospitals by State (n=3,455)



* significantly greater than PA, $p < 0.01$

Risk Factors for past year IPV - ED

Sample - MLR - (Dearwater et. al., JAMA '98)

- Past year abuse: 18 - 39 yo (OR = 2.2);
monthly income less than \$1000 (OR = 1.7);
children younger than 18yo at home (OR = 2.0);
separated or divorced (OR = 7.0) plus
living in CA!
- African American ethnicity until control for
income
- Spanish speaking protective for lifetime
abuse (English speaking OR = 2.6)

System Change Evaluation Summary (Campbell, Coben et. al. '01)

- Train the trainer model effective in changing attitudes and behaviors of ED staff
- Screening behavior increases but heavily dependent on system changes – forms change, administrative support
- “Culture of the ED” influences behavior of women & staff – protocols, posters, brochures
- Patient satisfaction of women significantly increases with culture of ED & screening change
- Outcomes for women still unknown

FRAMEWORK FOR HEALTH CARE SYSTEM

- R** - Routine Screening/Assessment
- A** - Ask Direct Questions/
- D** - Document Findings
- A** - Assess Patient Safety
- R** - Review Options

WHY ROUTINE ASSESSMENT?

ALL WOMEN / ALL VISITS

- Prevalence across lifespan - prevalence higher than hypertension in young & midlife women
- Past yr. prevalence always higher than injury from abuse
- Few consistent pre-existing characteristics - providers will not be able to tell unless ask
- Abuse status change over time
- May be etiology of or aggravate presenting problem
- May compromise treatment of existing problem
- Until clinical trial evidence of benefits more than cost/risk – proceed under Routine Assessment guidelines – like alcohol px

“The Woman Who Walked into Doors”

Roddy Doyle ‘96

“I fell down the stairs again, I told her. -
Sorry. No questions asked. What about
the burn on my hand? The missing hair?
The teeth? I waited to be asked. Ask me.
Ask me. Ask me. I’d tell her. I’d tell them
everything. Look at the burn. Ask me
about it. Ask.”

The Woman Who Walked into Doors

Roddy Doyle '96

“I’d get worked up waiting. I believe it was just a matter of luck. Maybe this time. A nurse would look at me and know. A doctor would look past his nose. He’d ask the questions. He’d ask the right question and I’d answer it and it would be over. Charlo was always with me. He was always there. Behind the curtain was the only time I was alone. His shadow on the curtain. A few minutes. One question. One question. I’d answer; I’d tell them everything if they asked..... Ask me.”

PURPOSES OF ROUTINE ASSESSMENT/INQUIRY

- OPPORTUNITY CREATION - FOR DISCLOSURE, SEEKING HELP EARLY, A PLACE OF SANCTUARY FOR THOSE NOT READY FOR SHELTER, COUNSELING, CRIMINAL JUSTICE
- PRIMARY PREVENTION - EDUCATION ABOUT ISSUE
- RATHER THAN DETECTION

Routine Assessment Protocol: All women aged 14 & over ('04 FVPPF.ORG)

- Primary Care - Every: 1st visit for new cc, new pt. encounter, new intimate relationship & periodics
- ED & urgent care - All visits
- OB/GYN - Each prenatal & pp visit; new intimate relationship; routine gyn visit, family planning, STD clinic, abortion clinic
- MH - Every initial assessment; each new intimate relationship & annually if ongoing or periodic tx.
- Inpatient - as part of admission & discharge

New Horizons - Opportunities for Secondary Prevention

- Employee Assistance Programs & Occupational Health - majority of hospital employees are women
- Discharge Planning
- Managed Care
- Substance Abuse Treatment
- Mental Health
- School Health, Healthy Start, Community Based Programs

ABUSE ASSESSMENT SCREEN

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Within the last year, have you been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or ex-partner?

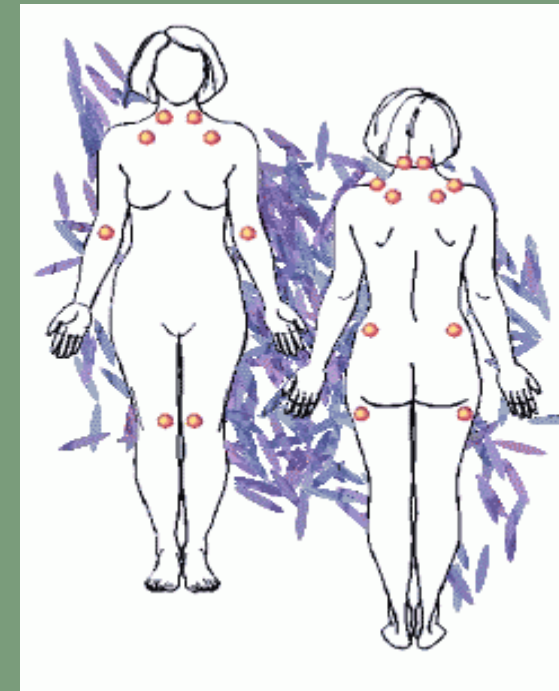
If YES, by whom

Number of times

3. Does your partner ever force you into sex?
4. Are you afraid of your partner or ex-partner?

Heltin & McFarlane, 1986

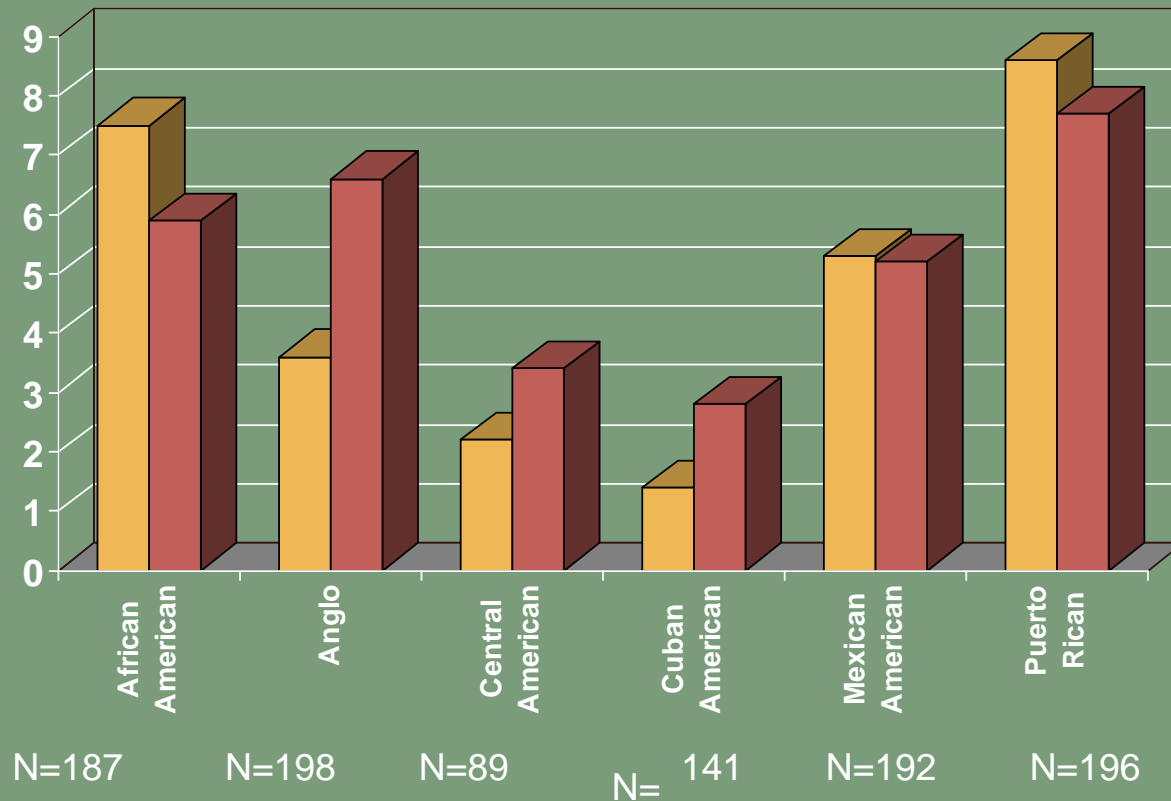
Mark the area of any injury on body map.



Pediatric Settings – See FVPF.org or endabuse.org also PCADV

- Within general assessment for safety at home broadly – guns etc.
- Ask about adults being abusive to each other or about mother's relationship with intimate partner or ex-intimate partner
- Or use AAS – pilots being conducted as to best approach
- Mothers in pediatric settings find routine inquiry acceptable
- Asking in front of children – may need to distract children or obtain privacy – depending on age
- Issues with confidentiality – not putting in child's record – child abuse reporting issues

Abuse During Pregnancy By Ethnic Group And Assessment (N=1000)



*Torres, Campbell, et.al. '99
Birthweight & Abuse During
Pregnancy (NINR)

■ AAS
■ ISA-P

DOCUMENTATION

Charting Should Include:

- Date and time care provided
- Patient's own words-"My husband, John Jones, struck me in my face on X date at X time"
- Patient demeanor
- Complete medical & social history and physical exam
- Patient's explanation response to direct questioning about abuse

DOCUMENTATION

Charting Should Include:

- ▣ Results of pertinent lab and diagnostic procedures
- ▣ Injury map and/or photographs
- ▣ Discussion of safety assessment and referral plan
- ▣ Any police involvement (including badge number)
- ▣ Lethality assessment

Note: this documentation should be a collaborative effort between all appropriate health care team members per policy,/protocol

EXCITED UTTERANCE

- Exception to hearsay rule
- Made for purpose of medical diagnosis or treatment or and describing medical history
- Statements made to MD, SW, or RN
- Upheld 1995 in **STATE V. SIMS**, Washington (Domestic Violence Case)
- Recent challenge from '03 Supreme Court Case

PHOTOGRAPHS

Camera accessible 24 hours a day?

- Patient permission

- Digital vs. Polaroid – some controversy regarding possible alterations

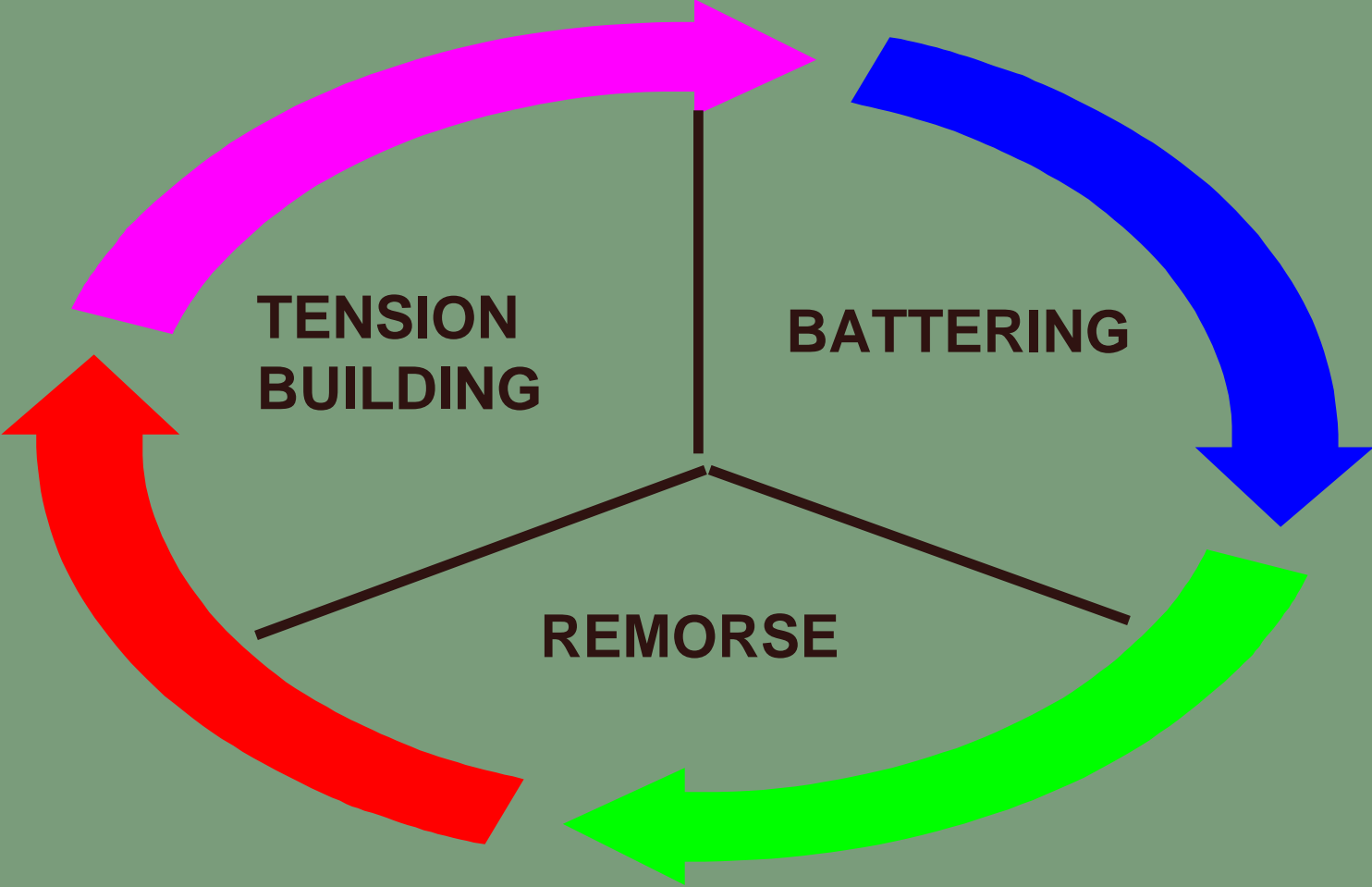
- Photograph before treatment

- Photographs from all angles - so that patient identifiable

TEN MINUTE INTERVENTION

- BROCHURE DRIVEN - COMMUNITY INDIVIDUALIZED
- SET ABUSE IN CONTEXT - CYCLE OF ABUSE OR POWER & CONTROL WHEEL
- LETHALITY ASSESSMENT
- SAFETY BEHAVIORS - MENU - SHELTER, OTHER SERVICES ORDER OF PROTECTION, PUTTING MONEY ASIDE, HAVING CHILDREN GO TO NEIGHBORS

Cycle of Abuse









NATIONAL DOMESTIC VIOLENCE HOTLINE

1 800 799-SAFE (7233)

DOMESTIC VIOLENCE PROGRAMS

Range of services

-  Shelter
-  Batterer's Counseling
-  Non-Residential Counseling
-  Children's Counseling
-  Victim Advocacy
-  Court Companion Services
-  Attorney Services

IMMIGRANT BATTERED WOMEN

LANGUAGE ISSUES

Means of control

Family member as translator

Learning English

IMMIGRATION STATUS -DO NOT CALL INS!! -GET IMMIGRATION LAW SPECIALISTS

Waiver of joint filing

VAWA-Self petition

POLICE-PERCEPTIONS OF IMMIGRANTS

 FVPPF – FVPPF.ORG; NOW LDEF (202) 326-0040

Safety Strategies

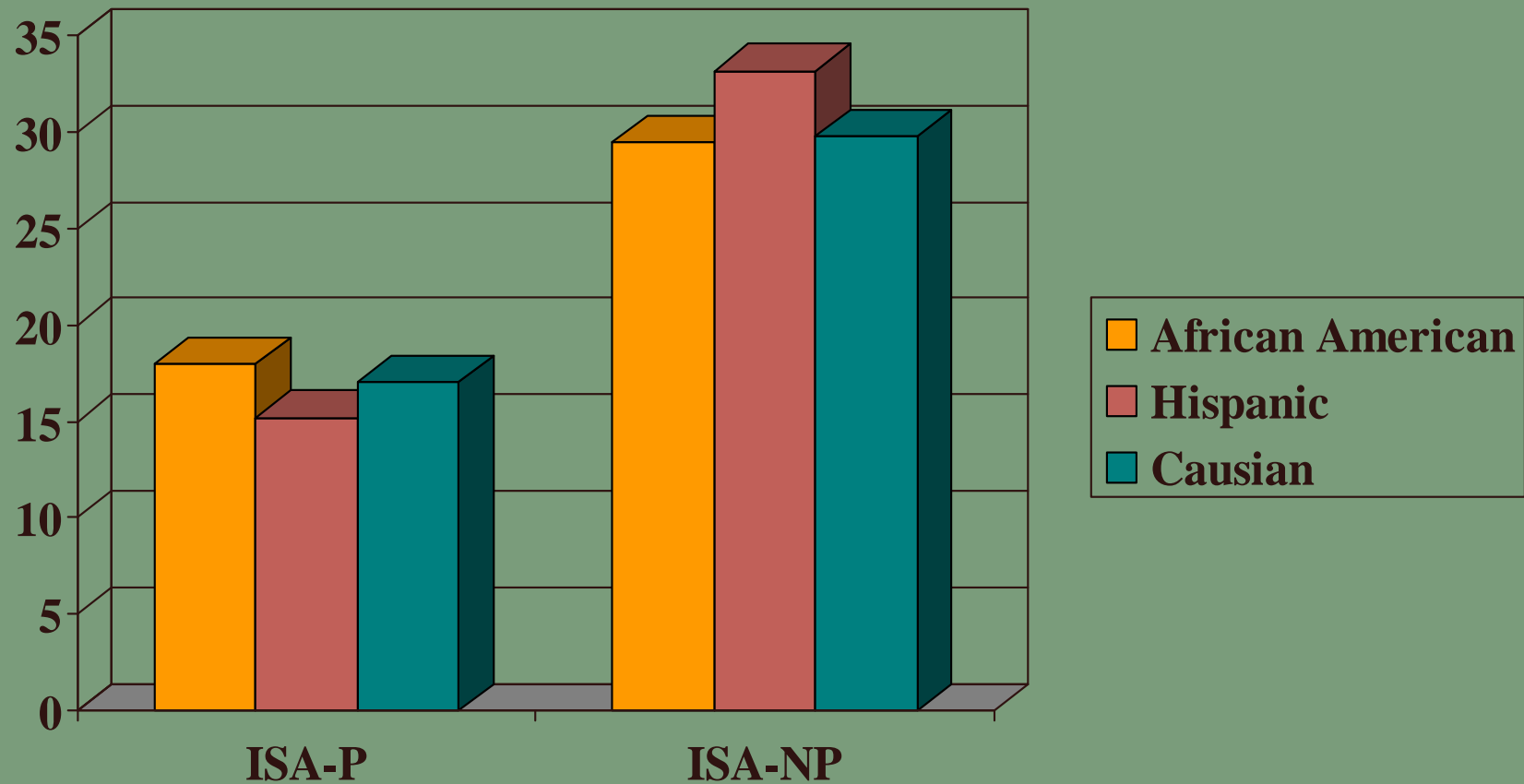
- Engage her best parenting skills & desires - listen to the kids (Henderson & Erikson '92; Sullivan '99)
- The gun(s) - safety pamphlets; search warrants
- If she plans to leave, cannot do face to face
- If she leaves to get him into intervention - stay gone until he completes
- Engage employers, relatives, neighbors - help her break out of the isolation
- Put \$\$ aside - employment opportunities
- Ensure follow-up

Tested Ten Minute Nursing Intervention (CDC funded)

- N = 132 poor, pregnant, urban and rural
- 36% African American; 34% Hispanic; 30% Anglo
- Longitudinal (10% attrition) - 3 intervention visits during pg.; 3 follow-up - 0, 6, 12 mos.
- Significantly more safety behaviors used by intervention group

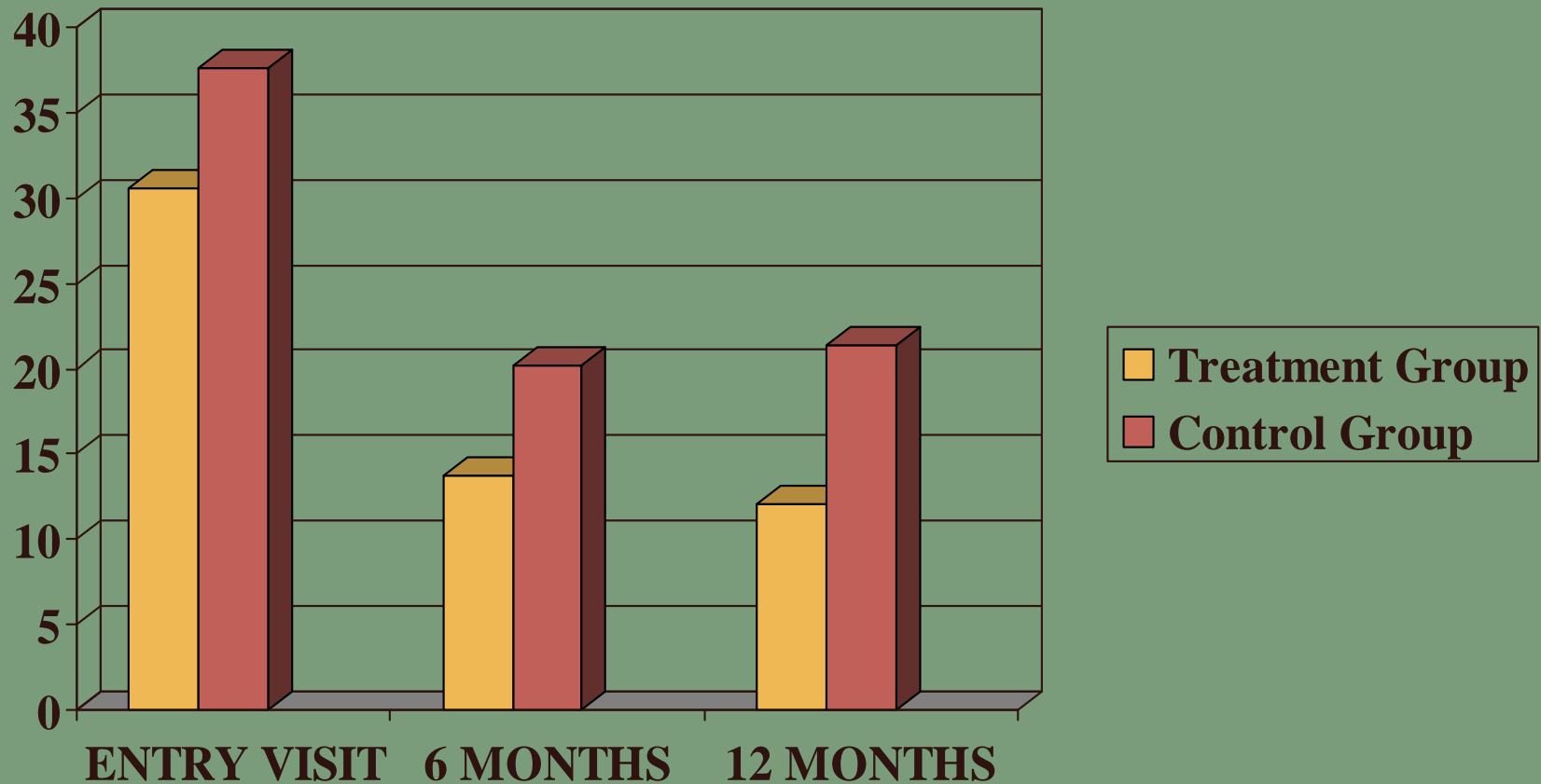
(McFarlane, Parker, Soeken, Silva & Reel, JOGNN, 1998)

ADJUSTED MEAN INDEX OF SPOUSE ABUSE (ISA) SCORES BY ETHNIC GROUP



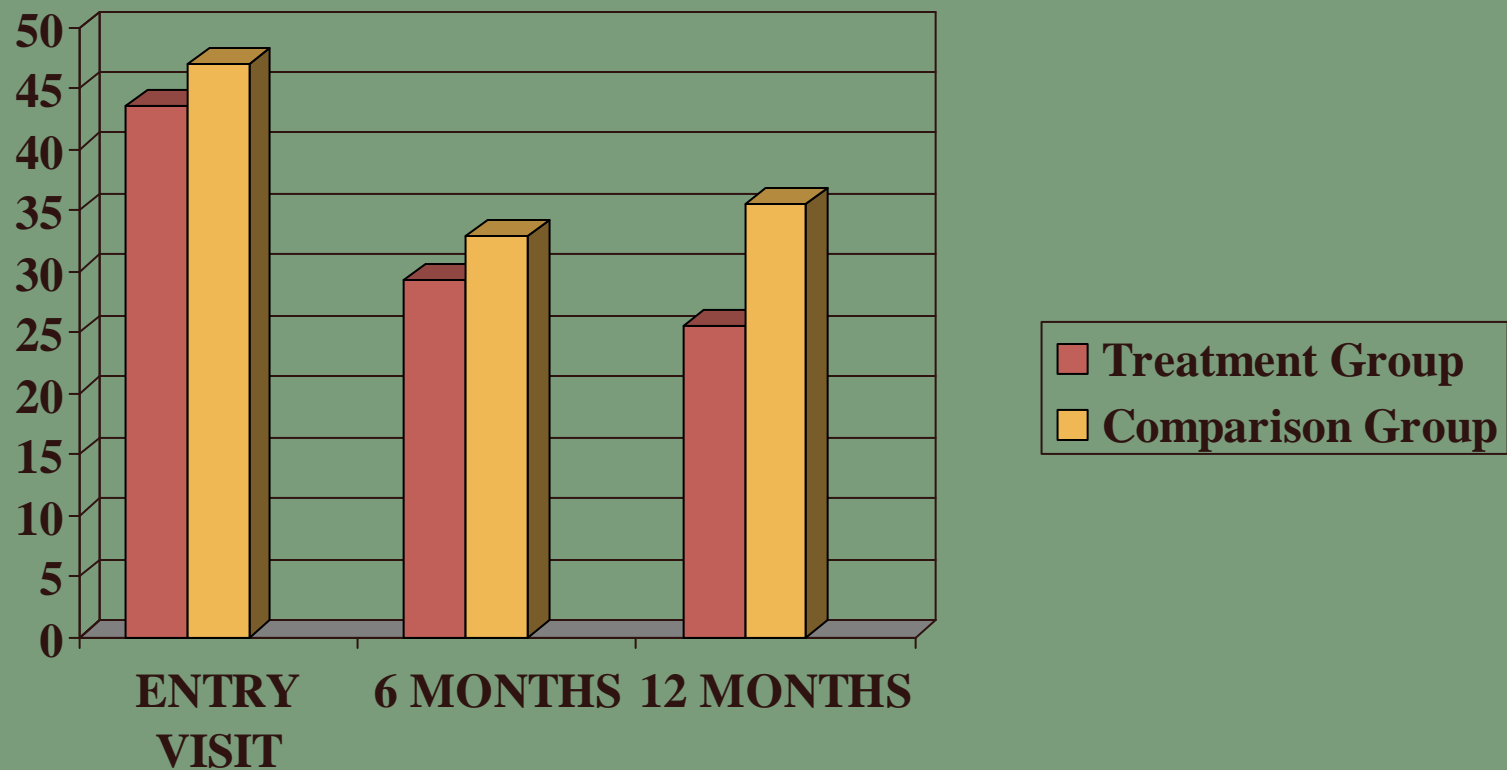
MANCOVA $F=2.95$ $P=.02$, Parker, McFarlane, Soeken, Silva, & Reel, (1999)

ADJUSTED MEAN INDEX OF PHYSICAL SPOUSE ABUSE (ISA-P) SCORES BY TREATMENT GROUP



MANCOVA $F=5.04$ $P=.07$, Parker, McFarlane, Soeken, Silva, & Reel, (1999)

ADJUSTED MEAN INDEX OF NON-PHYSICAL SPOUSE ABUSE (ISA-NP) SCORES BY TREATMENT GROUP



MANCOVA $F=5.04$ $P=.07$, Parker, McFarlane, Soeken, Silva, & Reel, (1999)

COMMUNITY TEAM PROCESS

