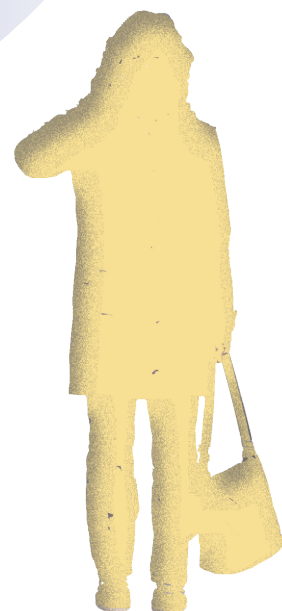
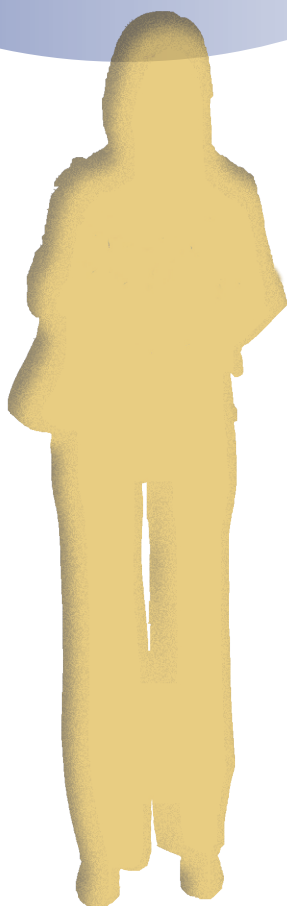
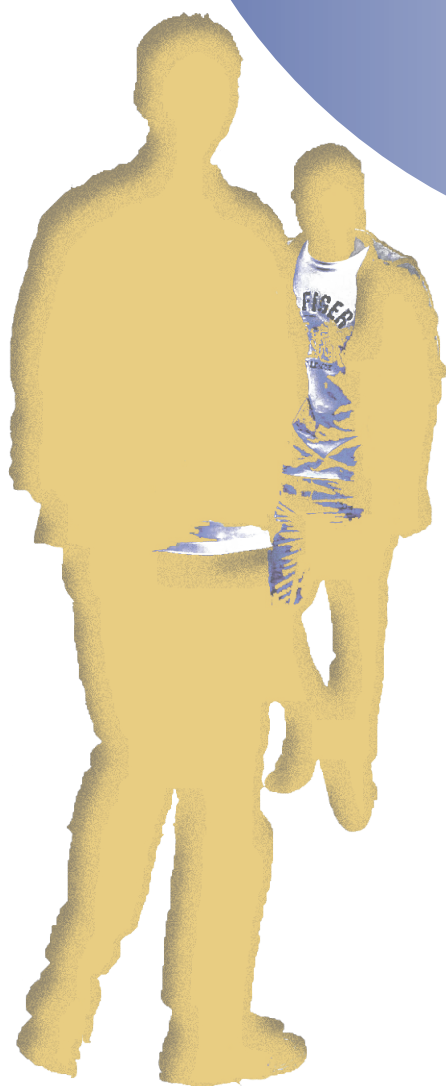




# **Social and Health Care Teachers against Violence**

## **Teachers' Handbook**



Mary Allen  
Sirkka Perttu



Layout

Leila Raninen

University of Helsinki, Palmenia Centre for Continuing Education 2010

ISBN 978-952-10-6200-1

<http://www.helsinki.fi/palmenia/>

# Contents

Introduction	5
Background information on violence	5
Definitions of violence	5
Definitions of Intimate Partner Violence	6
Terminology	7
Prevalence of intimate partner violence	7
International prevalence	7
Prevalence in some European countries	8
Causes of Intimate Partner Violence	9
Ecological framework	9
Other causes of Intimate Partner Violence	10
What is Intimate Partner Violence?	10
The 'Gender Symmetry' debate	11
Links between alcohol use and intimate partner violence	12
Myths about Intimate Partner Violence	13
Effects of Intimate Partner Violence	14
Effects on women victims	14
Effects on children	15
Co occurrence of woman and child abuse	15
Women who require particular consideration	16
Women's responses to intimate partner violence	18
Women's resistance to IPV	18
Victim or survivor?	18
Leaving an abusive partner	19
Barriers to leaving an abusive relationship	21
The cycle of violence as a barrier	22
Minority ethnic or refugee women	22
Women with disabilities	22
Elderly women	22
Recognizing IPV in the professional health context	23
Injuries characteristic of Intimate Partner Violence	23
Using assessment and screening tools	24
Screening questionnaire	24
Barriers to identification of women experiencing IPV	25
Why victims don't tell	26
Talking about violence	26
Examples of direct questions	26
Talking to the patient/client	26

Good practice response	27
Needs of women experiencing intimate partner violence	27
Good practice responses common to all professionals	27
Good practice response for nursing staff	28
Good practice response for social workers	28
Documenting	29
How to photograph injuries	29
Body map	30
Risk assessment	30
Estimating the fatality risk of violence	30
Safety planning	31
Safety plan steps	32
Counselling abused women	33
Support groups	33
Refuges and other support services	34
Legal situation	34
BIBLIOGRAPHY	35
Appendix 1 Health Consequences	39
Appendix 2 Body Map	40
Appendix 3 List of effects on children	41
Appendix 4 Examples of Risk Assessment Tools	43

# Introduction

Intimate Partner Violence, also known as ‘Domestic Violence’ or ‘Violence Against Women’ is a major social and health problem- encountered by nursing, medical and social work professionals in their work (Tufts et al, 2009; Haggbloom et al, 2005; Holt, 2003; Ferguson and O’Reilly, 2001; Humphreys, 2000). This Handbook has been written to accompany the Teachers Curriculum and Guidebook developed by the Leonardo da Vinci -project called Social and Health Care Teachers against Violence, HEVI 2008-2010 to support teachers within the European Union to educate their students, as future professionals, to understand the prevalence, dynamics, effects and responses to intimate partner violence (IPV) so that they can intervene effectively and safely to counteract this widespread and sometimes life threatening violation of women’s human rights (World Health Organisation, 2006).

This short Handbook brings together information which will assist Teachers to utilize the Curriculum and Guidebook to the maximum, by providing additional information on the major topics addressed in the Curriculum Modules. This Handbook is not intended to replace the use of the Reading Lists and Websites which are listed in the Guidebook, but can act as a quick guide to the topics covered in the Modules.

## Background information on violence

### Definitions of violence

The World Health Organization defines violence as: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (World Health Organisation 2002).

The definition used by the World Health Organization associates intentionality with the committing of the act itself, irrespective of the outcome it produces. Excluded from the definition are unintentional incidents – such as most road traffic injuries and burns.

One of the more complex aspects of the definition is the matter of intentionality. The definition used by the World Health Organization, however, defines violence as it relates to the health or well-being of individuals. Certain behaviours – such as hitting a spouse – may be regarded by some people as acceptable cultural practices, but are considered violent acts with important health implications for the individual.

The World Health Organisation has introduced a typology of violence which gives an overview of the many faces of interpersonal, collective and self-directed violence. WHO offers a global public health approach to the violence (World Health Organisation 2002).

The typology divides violence into three broad categories according to characteristics of those committing the violent act:

- *self-directed violence; violence a person inflicts upon himself or herself,*
- *interpersonal violence; violence inflicted by another individual or by a small group of individuals,*
- *collective violence; violence inflicted by larger groups such as states, organized political groups, militia groups and terrorist organizations.*

In this typology Interpersonal violence is divided into two subcategories: Family and Intimate Partner Violence and Community violence. The Teaching Guidebook of the HEVI -project focuses on Intimate Partner Violence, which usually, though not exclusively, takes place in the home. Violence against children is examined in the family context.

The public health approach to intimate partner violence covers for example the impact of such violence, factors which increase the risk for violent victimization and perpetration and effective violence prevention programs.

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. This is in stark contrast to the situation for men, who in general are much more likely to be attacked by a stranger or acquaintance than by someone within their close circle of relationships (World Health Organisation 2002).

## Definitions of Intimate Partner Violence

There are a number of definitions of domestic violence, violence against women and Intimate Partner Violence. One of the clearest definitions of violence against women is that outlined in the 1995 Beijing Declaration and Platform of Action as it is both 'gendered and culturally sensitive'.

*The term 'violence against women' means any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:*

*a. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women... (United Nations, General Assembly 1993; UN 1995)*

*Gender-based violence against women is "violence that is directed against a woman because she is a woman, or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty." (UN Secretary General's study on violence against women 2006).*

The following gender neutral definition is also useful as it is short and incorporates the main dimensions of IPV:

*A process whereby one member of an intimate relationship experiences vulnerability, loss of power and control and entrapment as a consequence of the other member's exercise of power through the patterned use of physical, sexual, psychological and/or moral force.*  
(Coker et al, 2003, p260)

The definition of violence against women by the European Union (EU) is based on the UN Declaration on the Elimination of Violence against Women. The EU emphasises the human rights and gender equality-based approach to violence against women and points out that the obstacles to exercising women's socio-economic and political rights increase women's exposure to violence. The particular focus should be on legislation and public policies which discriminate against women and girls.

The EU notes that violence against women is a manifestation of the historically unequal power relations between men and women and adversely affects not only women but society as a whole, and therefore urgent action is required. Joint actions by public authorities, institutions, and society in general, as well as an integral and multidisciplinary approach, are necessary for the eradication of violence against women.

The Council of Europe (COE) seeks to develop throughout Europe common and democratic principles based on the European Convention on Human Rights (COE/Rome 1950). COE gave the following declaration in 1993: "Violence against women constitutes an infringement of the right to life, security, liberty and dignity of the victim and, consequently, a hindrance to the functioning of a democratic society, based on the rule of law".

Violence against women is now recognized as a serious human rights abuse and increasingly as an important public health problem with serious consequences for women's physical, mental, sexual and reproductive health (Garcia-Moreno et al, 2006). In all member countries of the European Union, violence against an intimate partner, or against children, is a crime punishable by imprisonment or other legal sanctions.

## Terminology

The terms 'family abuse/violence', 'domestic violence' and 'spousal assault' are used differently in different countries and the meaning is different, particularly in relation to gender.

The term 'family violence' implies that all members of the family are engaged in mutual conflict, while the term 'spousal abuse' excludes women who are co-habiting or in dating relationships and women who are abused by their sons or fathers. The term 'battering' obscures the fact that abuse can also be emotional, sexual, psychological or economic. WHO also notes that when abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as "battering" (World Health Organisation 2002). 'Family violence' is a generic term that encompasses elder abuse, child abuse, and intimate partner violence (American Medical Association, AMA, 2005).

The American Medical Association (AMA) defines intimate partner abuse as "the physical, sexual, and/or psychological abuse to an individual perpetrated by a current or former intimate partner". The AMA also notes it as "past or present physical and/or sexual violence between former or current intimate partners, adult household members, or adult children and a parent. Abused persons and perpetrators could be of either sex, and couples could be heterosexual or homosexual." (Sugg, N. et al 1999).

While the term "intimate partner abuse" is gender-neutral, women are more likely to experience physical injuries and incur psychological consequences of intimate partner abuse (Rodriguez, M. et al 1999).

The gendered nature of this crime is indicated by the fact that world-wide research in many arenas has shown that between 90% and 97% of abusive incidents within an intimate relationship are perpetrated by men against women. For this reason the terms 'Domestic Violence' or 'Spousal abuse' are a misnomer as they obscure the gender of the perpetrator and that of the victim.

This manual uses the term 'Intimate Partner Violence' because globally it is accepted and indicates that the majority of the victims of this kind of violence are women. 'Intimate Partner Violence' is seen as a manifestation of violence against women.

## Prevalence of intimate partner violence

### International prevalence

The World Health Organization estimates that between 10% and 69% of women worldwide experience physical violence at the hands of intimate partners and up to 70% of female murder victims are killed by their male partners (Heise and Garcia-Moreno, 2002: 89/93). The United Nations Population Fund Report (2000) states that between one in three women have been beaten, coerced into sex or abused in some way, and mostly by a male intimate partner or family member. One in four women have been abused during pregnancy. The European Union estimates that at some point in their lives, 1 in 5 European women will experience abuse by a male partner, while 25% of all reported crime involves assaults by a man on his wife or partner (EU, 2007). It is the major cause of death and disability for women aged between 16-44, accounting for more death and illness than cancer and road traffic accidents (Council of Europe, 2002).

In the United States more than 1 million cases of intimate partner violence are reported to police each year (Goldberg, 1999). The National Coalition Against Domestic Violence reports that on average 10

women die at the hands of intimate partners each day (Wood, 2001). In Canada, there were 28,000 incidents of spousal violence reported to the police in 2004, of which 84% involved female victims and 16% involved male victims. However, only 28% of spousal abuse victims report incidents to the police (36% of female victims and 17% of male victims (Ogrodnik, 2006).

## Prevalence in some European countries

Since the 1980s a number of European countries have conducted major nationwide statistical surveys on the extent of interpersonal violence and its impact. The extent of the problem is recognised, and many states have taken actions to address the issue. Still there is a need for European data so that social and political interventions can be effectively targeted and tailored to meet the current needs.

Comparative data can advance theory and suggest improvements to cultural, political and societal responses to violence. However, accurate data comparison is more difficult than it seems. Ignoring or misjudging the scientific and methodological framework of specific data easily leads to wrong conclusions and interpretations. There have been attempts to compare prevalence data but they have faced many problems and data comparison has sometimes been impossible.

A European research network called “Coordination Action on Human Rights Violations” (CAHRV) has addressed these problems and has taken the first steps to review European surveys on the prevalence and health impact of violence against women. Results show that the studies are constructed quite differently from one country to the next, and neither prevalence nor health impact data are comparable on a European level.

The report introduces the national violence against women surveys in Finland, France, Germany, Lithuania and Sweden. In those surveys there are differences and similarities of sample size and age range, data collection methods and year of the surveys.

Lifetime prevalence rates for physical violence by current and/or former partners range from almost 21% to 33% for women in the central age group of 20 – 59 who ever had a partner in Finland, Germany, Lithuania and Sweden. The French survey collected data on prevalence only in the past 12 months. Prevalence of physical violence by a current or former partner over the past 12 months range from 3% in Germany and France to 5% in Sweden and 7% in Finland. The Lithuanian survey did not include questions on last-year-prevalence.

The age group of women between 20 and 59 reported high levels of lifetime prevalence of sexual violence by current and/or former partners, with 11.5% in the Finnish study, 6.5% in Germany, 7.5% in Lithuanian and 6.2% in the Swedish study.

It is difficult to define exactly what is psychological violence in intimate partner relationships. Most prevalence studies use several dimensions of dominance, humiliating behaviour, threats and control in order to measure psychological violence. Indicators that were assessed in the Swedish, Finnish, Lithuanian, Germany, and, to some extent, in the French surveys were extreme jealousy, restricting the woman from seeing friends or other relatives, humiliating behaviour, economic control, threat to harm the children and threats of suicide. In the Lithuanian study at least one of these partner behaviours of the current partner was reported by 28.6% of women, 24.3% in the French study, 16.5 % in the Finnish study, 14.3% in Germany and 11.6% in the Swedish study (Schrötte M. et al. 2006).

In the UK, one in four women will be a victim of domestic violence in their lifetime (Mirrlees-Black, 1999). One incidence of domestic violence is reported to the police every minute (Stanko, 2000), and it is the crime with the highest repeat victimization rate in Britain (Kewshaw et al, 2000). An average of two women per week are killed by a male partner or former partner, and nearly half of all female murder victims are killed by a partner or ex partner (Coleman et al, 2006).

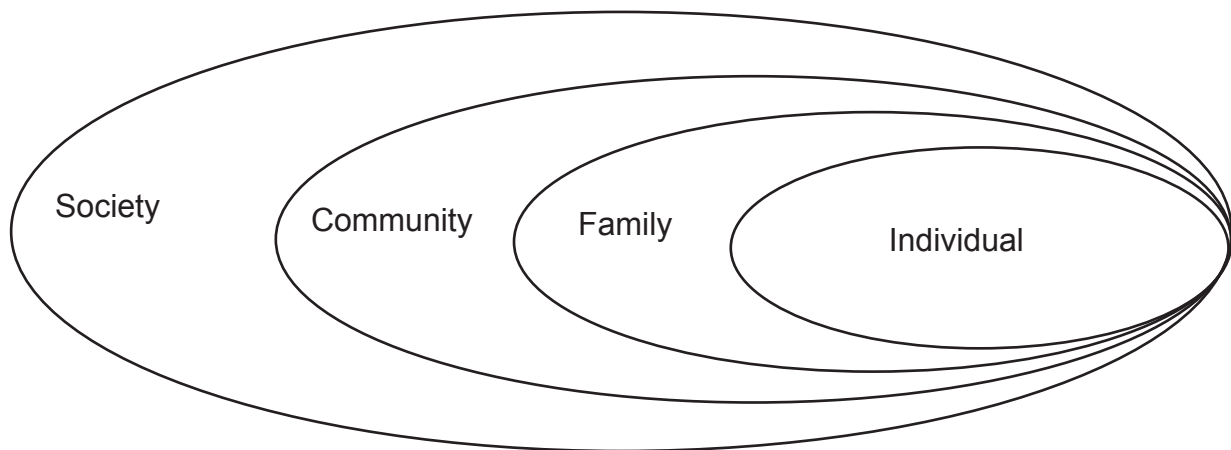
# Causes of Intimate Partner Violence

The cause of Intimate Partner Violence has been the subject of much research and debate. This research tends to view such violence either from a wider socio political perspective or an interpersonal or familial perspective. The former sees violence against women as a “manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and that violence against women is one of the crucial mechanisms by which women are forced into a subordinate position compared to men” (UN, 1995). This approach to the causes of IPV is sometimes called the ‘feminist analysis’.

The latter approach sees violence as a result of stress in family life (Straus, 1990), or as a result of children experiencing or seeing violence in their childhood home (Watson and Parson, 2005; Black et al, 1999; Ellsberg et al, 1999), or as a result of a particular personality disorder (Dutton and Starzomski, 1993), or as a result of attachment difficulties. These approaches are sometimes described as psychological or sociological explanations.

## Ecological framework

Heise (1998 ) has attempted to bridge the gap left by both the feminist and non feminist (i.e. psychological and sociological) approaches to intimate partner violence. She notes that “a single factor explanation is inadequate” and is unable to explain why “individual men become violent and why women as a class are so often the target” (p.263). Her response is to propose what she describes as an “integrated ecological framework” which conceptualises abuse and violence as multifaceted phenomenon which involves an interplay of personal, situational and sociocultural factors. This framework draws on the empirical findings of the various disciplines which have been empirically found to be related to violence against women. She organizes these explanatory factors into layers and they are represented as a series of four almost concentric circles (see Figure 1 below.)



*Figure 1. Factors related to violence against women at different levels of the social ecology.  
(Adapted from Heise, L., 1998)*

At the first, “individual” level, the man’s developmental history includes issues such as whether he witnessed or experienced violence as a child, and Dutton and Starzomaski’s (1993) “borderline personality organization” which can result from a child’s experience of an absent or rejecting father. At the next family context level, are located factors such as male dominance and control within the home, the use of alcohol and marital conflict. The third, “community” level, refers to the wider but contingent social structures which impinge upon the individual and family. These include, socio-economic and employment status, level of isolation of the woman and the family, and peer group influences. At the fourth and final level are the widest “societal” factors such as constructions of masculinity, rigid gender roles, beliefs in ownership of women, and an acceptance of interpersonal conflict and physical punishment.

This model is a broader and more inclusive approach to understanding the causes of IPV and helps to guide a thorough assessment process.

## Other causes of Intimate Partner Violence

It is important to note that some men and women become violent as a result of a traumatic brain injury, (TBI), the onset of severe mental illness (e.g. schizophrenia, or bi-polar disorder) or a severe stroke. In these situations, the causes and dynamics of the abuse will be very different to those outlined above. It is important to ascertain whether this is the case, as the legal interventions and the treatments required may be different.

## What is Intimate Partner Violence?

Intimate partner violence includes a range of sexually, psychologically and physically coercive acts used against adult and adolescent women by a current or former intimate partner, without her consent. Physical violence involves intentionally using physical force, strength or a weapon to harm or injure the woman. Sexual violence includes abusive sexual contact, making a woman engage in a sexual act without her consent, and attempted or completed sex acts with a woman who is ill, disabled, under pressure or under the influence of alcohol or other drugs. Psychological violence includes controlling or isolating the woman, and humiliating or embarrassing her. Economic violence includes denying a woman access to and control over basic resources. (UN Secretary General's study on violence against women 2006).

IPV is not only confined to marriage, but may occur in any type of close adult relationships including other partnerships, families or households. IPV occurs in all social economic groups, all religious groups, all races, ethnic groups and within heterosexual, lesbian and gay relationships (Girshick Lori B. 2009), people of all ages and physical abilities.

### Physical abuse

Physical abuse is the control by violence or battering of another person or threat to use such means.

### Sexual abuse

Sexual abuse is the domination and control by the abuse of the body of the victim. The most serious type of sexual abuse is rape. Sexual violence is generally accompanied by other forms of violence.

### Verbal abuse

Verbal abuse is a means of putting a woman down or undermining her confidence by verbally attacking her either in public or private. Verbal abuse would also include threats of any form.

### Emotional abuse

Emotional abuse is the domination and control of another human being by means of withdrawing love, approval, respect, understanding, caring and touching which are basic human emotional needs.

A severe form of emotional abuse would be inflicting the "silent treatment" on a person, and refusing the person the right to say how they feel and the right to be listened to.

## Social abuse

Social abuse is the domination and control of another person through humiliation in public, which systematically isolates the person and makes her dependent on her partner.

He can disassociate her from her friends and family through control of her freedom outside of the home.

## Economic abuse

The abuse of economic power is the withdrawal of the financial means to feed, clothe and educate the woman and her children. The abuser may hold total control over spending money or paying bills as a means to dominate and/or abuse the woman.

These tactics all serve to increase the perpetrator's power and control over his partner. **The Power and Control Wheel** was developed by the Duluth Intervention Programme (Pence and Paymar, 1993) to show how these various tactics work (see Guidebook Appendix 2 ). As the diagram shows, the majority of the abuses are not physical, but when the non physical intimidation and verbal abuse does not work, he will resort to physical and sexual abuse. However in some very abusive relationships, there is consistent physical and/or sexual abuse.

## The 'Gender Symmetry' debate

Despite the findings of such studies as the Domestic Violence Matters Evaluation Study which strongly confirm the gendered nature of domestic and intimate partner abuse, (in which of the 1,236 individuals studied in the police system 99% were female and 99% of the perpetrators were male (Kelly L. and Regan L. 1999), there has been considerable debate in recent literature about women's use of violence against their male partners. Some authors (e.g. Stets and Straus, 1990; Archer, 2000) suggest that women are as violent or even more violent than men in their intimate relationships. However, the most recent research suggests that research methodologies and the manner in which statistics are gathered and understood have led to this oversimplification of a complex issue.

A number of researchers have attempted to resolve these apparent contradictions in the statistics, including Hester, (2009), Kimmel, (2002) and Johnson (1995, 2006, 2009). Johnson's work has become the most well known of these approaches. He has suggested that researchers have been looking at two different phenomenon and combining figures about different types of family violence. In 1995 he (Johnson 1995) introduced "common couple violence" and "patriarchal violence". Common couple violence is common in a large number of families suffering from occasional outbursts of violence from either the husband or the wife, or both.

A significant number of other families are terrorized by systematic male violence enacted in the service of patriarchal control. Johnson (1995) named this form of partnership violence "patriarchal terrorism". A Finnish researcher calls this kind of violence "partnership terrorism" (Piispa 2002). It describes violence that is closest to the typical images we have of partnership violence and of the characteristics of victims and perpetrators. Later Johnson calls the severe violence 'intimate terrorism' which results in injury, homicide and which is the kind of abuse which professionals such as nurses and social workers are more likely to encounter. Johnson also describes "situational couple violence" in which both men and women equally engage, but which does not usually lead to serious injuries or legal action.

Later, he completed his division with two further forms: "violent resistance" (VR), which refers to cases in which the woman fights back in self-defense or even kills the man who has abused her for years, and "mutual violent control" (MVC), where both the husband and wife are violent and battle for control. According to Johnson and Ferraro (2000), the latter is relatively rare.

However, this conceptualization was largely untested, and in a later study (Johnson, 2000) it was expanded to include more groups, as follows: intimate terrorism: one spouse is violent or controlling,

97% men; violent resistance: self defense as a response to violence or control (primarily by women, 96% women); situational couple violence: violent but not controlling, 56% men; mutual violent control (3% of sample;). Such findings illustrate the complexity of intimate partner violence. Intimate terrorism means “the attempt to dominate one’s partner and to exert general control over the relationship, domination that is manifested in the use of a wide range of power and control tactics, including violence” (Johnson and Leone, 2005).

He also suggests that much of women’s’ violence is used in self defence. It is important to understand these typologies as the type of violence encountered will influence the risk factors for women and children, and will therefore also determine safety issues, referral and legal options, and appropriate treatments for the perpetrator or the couple. However, if the worker encounters a man who is being unilaterally abused by a woman, he should receive the same support as an abused woman. He is equally entitled to legal protection orders and safety from abuse.

Kimmel’s (2002) distinctions are “instrumental violence” which is goal oriented to maintain power and control and “expressive violence” which means expression of family conflict.

Kelly and Johnson (2008) point out in their article that a growing body of empirical research has demonstrated that intimate partner violence is not a unitary phenomenon and that types of domestic violence can be differentiated with respect to partner dynamics, context, and consequences. They describe four patterns of violence: Coercive Controlling Violence, Violent Resistance, Situational Couple Violence, and Separation-Instigated Violence. (Kelly J.B & Johnson M.P 2008).

## **Links between alcohol use and intimate partner violence**

Findings from 2000 Scottish Crime Survey show that in 62% of incidents the perpetrator had been drinking alcohol and in 32% of incidents the perpetrator had taken drugs. Most (83%) incidents involving drugs also involved alcohol. (MacPherson S, 2002).

Heavy drinkers are at increased risk of intimate partner violence victimization. Many women develop alcohol ‘problems’ following victimization. Alcohol misuse among victims (especially women) is often regarded as a consequence of domestic violence, developing perhaps as a means of coping with severe and repeat abuse. Alcohol misuse or dependency may be one symptom of post-traumatic stress and psychiatric disorder resulting from victimization experiences. Nonetheless, causes and effects of victim alcohol abuse in partner violence remain difficult to unravel (Finney 2004a).

Intimate partner violence is frequently committed by perpetrators who have been drinking or who have alcohol ‘problems’. Evidence suggests alcohol facilitates escalation of conflict into violence, perhaps through the disinhibitory pharmacological properties of alcohol on behaviour (Finney 2004a).

Alcohol use is common in incidents of sexual violence, and perpetrator and victim drinking is common. This may be a function of the situation in which sexual violence occurs, or the influence of alcohol-related pharmacological and expectancy effects on sexual behaviour. Alcohol use is more likely in incidents of sexual violence between people who do not know each other well than intimates and the presence of alcohol has implications for the severity of sexual violence outcomes. Alcohol problems are common among male perpetrators of sexual violence. Alcohol problems are also common among sexual violence victims, which in many cases develop following victimisation. Alcohol relates to sexual violence via a number of direct and indirect pathways (Budd 2003, Finney 2004b).

Strong links have been found between alcohol use and the occurrence of intimate partner violence in many countries. Evidence suggests that alcohol use increases the occurrence and severity of domestic violence. Alcohol consumption as a direct cause of intimate partner violence has often been contested either on the basis of additional factors (e.g. low socio-economic status, impulsive personality) accounting for the presence of both, or because frequent heavy drinking can create an unhappy, stressful partnership that increases the risk of conflict and violence. However, evidence is available to support relationships between alcohol and intimate partner violence that include:

- *Alcohol use directly affects cognitive and physical functioning, reducing self-control and leaving individuals less capable of negotiating a non-violent resolution to conflicts within relationships.*
- *Excessive drinking by one partner can exacerbate financial difficulties, childcare problems, infidelity or other family stressors. This can create marital tension and conflict, increasing the risk of violence occurring between partners.*
- *Individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking and the use of alcohol as an excuse for violent behaviour.*
- *Experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medicating.*
- *Children who witness violence or threats of violence between parents are more likely to display harmful drinking patterns later in life.*

A number of individual, relationship and societal factors can exacerbate the association between alcohol use and violence. For perpetrators, heavier, more frequent drinking increases the risk of violence, and there is some evidence that problem drinkers are at increased risk of victimization. (World Health Organization 2006).

## Myths about Intimate Partner Violence

- *Only a small percentage of women are victims of violence.*
- *Nobody has the right to interfere in the domestic affairs of a couple.*
- *Women deserve to get raped and beaten; they provoke the assault by their behaviour and clothing.*
- *It's just the odd domestic tiff - not as bad as they make out.*
- *Physical violence is unlikely to get worse over time.*
- *Only poor women are abused.*
- *If there were no visible injuries then the assault cannot have been that bad.*
- *Nobody ever gets killed as a result of domestic violence.*
- *Battered women can always leave home if they want to.*
- *Women who are abused come from an abusive family background.*
- *Battering only occurs in working class and ethnic minority families.*
- *If a woman leaves the abusive relationship the abuse will stop.*
- *Women who experience domestic violence are weak.*
- *Alcohol misuse causes wife battering.*
- *Couple counselling will help resolve the abuse.*
- *Women and children frequently lie about sexual violence.*
- *Battered women batter their children.*
- *Violent men are mentally ill or have low self esteem.*
- *Men who are violent come from an abusive family background.*
- *Abusive men cannot control their violence; they have an anger management problem.*
- *Abusive men are easy to identify. They are physically violent all of the time and to everyone.*

(Adapted from Women and Violence, 1998 The Royal Australian College of General practitioners)



# Effects of Intimate Partner Violence

## Effects on women victims

“Battering by a partner is the single major cause of injury to women in the USA. It is the single biggest reason women are admitted to casualty units” (Reports of the Surgeon General, U.S. Public Health Service, 1999). In addition to being a breach of human rights, intimate partner violence is associated with serious public health consequences (Ellsberg et al, 2008).

In the past decade, increasing attention has been focused on the effects of male partner violence on women's physical and mental health. Studies of visits to emergency departments in the USA and elsewhere have suggested that physical abuse is a major cause of injury in women. Population-based studies have suggested that 20-75% of women who are physically abused by a partner report injuries due to violence at some point in their lives. Nonetheless, injury is not the most common physical health outcome of abuse by male partners. Epidemiological and clinical studies have noted that physically and sexually violent acts by intimate partners are consistently associated with a broad array of negative health outcomes, including gynaecological disorders, adverse pregnancy outcomes, irritable bowel syndrome, gastrointestinal disorders, and various chronic-pain syndromes. Abused women have more physical symptoms of poor health, and more days in bed than do women who have not been abused. Physical and sexual violence have also been associated with psychiatric problems, including depression, anxiety, phobias, post-traumatic stress disorder, suicidality, and alcohol and drug abuse.

Research on the health effects of partner violence has been constrained by several factors. Most studies have been undertaken on clinical rather than population-based samples, mainly in North America and Europe. Furthermore, many studies have had small sample sizes, and have not controlled analyses for potential confounders. Violence has not been defined or measured consistently in the studies, making comparisons difficult.

The aim of the WHO multi-country study was to explore the magnitude and characteristics of different forms of physical, sexual, and emotional violence against women, with particular emphasis on violence perpetrated by male intimate partners. The study attempted to overcome obstacles of comparability encountered in previous studies by use of population-based surveys that included a standardised questionnaire, and with standardised training and data collection across participating sites. A further objective of the study was to assess the extent to which physical and sexual violence by intimate partners is associated with a range of health outcomes. This report presents findings on partner violence and women's self-reported physical and mental health.

The analysis of all sites found significant associations between lifetime experiences of partner violence and self-reported poor health, and with specific health problems in the previous 4 weeks which included: difficulty walking, difficulty with daily activities, pain, memory loss, dizziness, and vaginal discharge. For all settings combined, women who reported partner violence at least once in their life reported significantly more emotional distress, suicidal thoughts and suicidal attempts than non-abused women. These significant associations were maintained in almost all of the sites. Between 19% and 55% of women who had ever been physically abused by their partner were injured (Ellesberg et al, 2008). (Appendix 1 gives an overview of the Health Consequences of Intimate Partner Abuse.)

IPV also exerts serious socio economic effects on women. As financial abuse and control is often an integral part of IPV, abused women may not have access to their own income, even if they are working outside the home. They may not be allowed to drive the family car, or visit friends and relatives. Moving house to ensure that neighbours and friends do not become involved in the support of the woman also means that she is socially isolated and does not know whom to trust. As she may also be constantly told that she is stupid and does not know how to raise her children, she will lose her self confidence and develop very poor self esteem. The effects of these forms of emotional and financial abuse will help to

undermine her ability to take action to protect herself. FEAR is the one of the most consistent effects of serious abuse.

## Effects on children

These experiences of overhearing or observing the abuse of their mother can have long lasting impacts on the emotional and social development of many children.

Children's problems associated with witnessing violence can be divided into three categories:

- *Behavioral and emotional problems; these children, compared to children who did not witness violence at home, can be more aggressive and have antisocial behaviors ("externalized" behaviors), they can have fearful and inhibited behaviors ("internalized" behaviors), they might show lower social competence than other children and show more anxiety, low self-esteem, depression, anger, and temperament problems. It is also found that they have shown less skill in understanding how others feel and examining situations from others' perspectives. 50% to 70% of children exposed to domestic violence suffer from posttraumatic stress disorder. (Edleson, J. L. 1997, April).*
- *Problems in cognitive functioning and attitudes, such as learning problems caused by social circumstances at home: parents have not the strength or interest enough to support for example the child's schooling and learning. A child can develop attitudes justifying their own use of violence. According the Finnish National Survey (Heiskanen & Piispa1998) 40 % of men who used violence against their female partner had been witnessing their father's violent behaviour towards their mother during their childhood.*
- *Longer-term problems; as adults depression, substance abuse (alcohol), trauma-related symptoms and low self-esteem among women and trauma-related symptoms among men (Krug ym. 2005), mental problems and self-destructive behaviour (Forsberg 2002).*

These effects will vary by the age, gender and length of exposure to the abuse, and they can include:

- *Undermining their developmental needs for safety and security (creating attachment difficulties)*
- *They may develop social problems such as poor social skills as a result of secrecy, shame and isolation.*
- *They may exhibit poor educational performance, or alternatively they may overcompensate by immersing themselves in their studies.*
- *Low self esteem*
- *PTSS symptoms (bed wetting, school avoidance, fear, anxiety).*

The impacts on older children of living with abuse can include:

- *Passive aggressive behaviour*
- *Delinquency, bullying*
- *Behavioural – externalising(boys)or internalising (girls)*
- *Substance abuse*
- *Running away from home*
- *Difficulties in adulthood in forming secure attachments.*

(A more detailed list of effects on children at different stages of their development is given in Appendix 3).

## Co occurrence of woman and child abuse

Studies suggest that in approximately 50-70% of all domestic violence situations, children living with the woman are also at risk of violence (see McGee, 2001 p19 for an overview of these statistics).

Children can be directly and indirectly affected by abuse perpetrated on their mother in a number of ways. These can include one or all of the following:

- *Being aware of the violence as witnesses or overhearing it*
- *Intervening to protect their mother- either directly risking assault themselves, or indirectly by seeking help*
- *Being encouraged to support/participate in the abuse and degradation of their mother.* (Kelly,L. 1996)

Heynen (2004) describes four typical forms of violence with which children may be faced:

- *Fathering through rape (forced pregnancy)*
- *Mistreatment during pregnancy*
- *Direct experiences of violence as co-/victims of battering*
- *Growing up in an atmosphere of violence and humiliation (in Finland it is defined as psychological violence against children).*

One serious violence problem towards children caused by parents is abusive head trauma or inflicted traumatic brain injury of babies (previously known as the 'shaken baby syndrome').

- *hidden injuries, such as bruising, retinal haemorrhages (serious injury in the eye, bleeding inside eye) or fractures of the ribs or other bones*
- *babies are victims of violent shaking mainly in their first year of life*
- *a peak at ages six to eight weeks, when babies cry the most*
- *In the USA, approximately 30% of all childhood fractures are inflicted. In children younger than 1 year, 75% of fractures are likely to be inflicted.*

(Kemp A. M et. al 2008)

Intimate partner violence can also affect on parenting skills:

- *the parents' ability to foster/bring up the children is weakened as a consequence of IPV (stress);*
- *Inconsistent practices of bringing up children*
- *Overprotection*
- *Rough/hard punishment practices, often in a physical manner (McCloskey etc. 1995)*
- *Giving little support to their children (McCloskey etc. 1995)*

## Women who require particular consideration

<b>Pregnant Women</b>	<p>Pregnant women are particularly at risk of abuse by a partner. Of women experiencing domestic violence, 25% are assaulted for the first time during pregnancy. Pregnancy and family life with small children increase the risk of violence.</p> <p>Risk of violence increases during maternity and parental leave compared to average violence rate.</p> <p>4 % of women who have experienced violence report that the violence started during pregnancy, and also 4 % report that the violence started when their children were under the age of one. More than 10 % of violent men were violent against their spouses also during pregnancy. (Heiskanen &amp; Piispa 1998).</p> <p>Violence towards pregnant women is often directed at stomach or genitals, so that the injury is not visible under clothing.</p> <p>(See also Perttu S. &amp; Kaselitz V. 2006).</p>
-----------------------	---



# Women's responses to intimate partner violence

## Women's resistance to IPV

Despite popular myths about women's submission to violence in the home, women are always "resisting" this abuse. This resistance may be difficult to recognize at times, and may appear to be compliance or submission. However these resistant responses should be recognized for what they are- strategic ways of keeping herself safe from further abuse and violence. For example, remaining quiet in the face of verbal abuse and insults may appear as submission, but may actually be a woman's strategy to avoid an escalation of the abuse. Women's use of violence in self defence may be misinterpreted by police or others as an assault on her partner, but is in fact a desperate act to end the ongoing abuse or prevent even more serious assaults. Identifying and naming such resistant responses is an essential aspect of supporting women, who may themselves have internalized the common myths about women accepting or provoking such abuse. Questions which can elicit such information about her resistant responses may include the following:

*Can you tell me what has been happening for you?*

*Tell me how you have been managing the situation up to now?*

*What have you been doing to keep yourself safe?*

*How has that worked for you?*

*What has changed recently?*

*What would you need to feel safer from now on?*

*What did you say to him when he wanted you to do that?*

*Had you ever argued with him about that issue before?*

*What were you thinking when you decided to go along with him for 'peace sake'?*

*Describe what changed when you didn't do what he wanted you to do What else did you do that made life easier for you?*

*(Based on the work of Wade, 1997, 2007; White, 1995, 2000, 2007)*

## Victim or survivor?

According to abused women, the word 'victim' means the result of violence; when they start to regain control over their own lives, they do not refer to themselves as victims. There are, in society, stereotypes of women's helplessness, dependency and passivity. These stereotypes can live also among the professionals trying to help and support women. Women spend much energy trying to stop or reduce the abuse and they actively struggle to make the relationship non-violent and devise strategies to end it. Both victimization and surviving are present in the lives of women who experience violence. Surviving is a gradual process of empowerment. (Kirkwood C. 1993).

Cavanagh (2003) describes how women work to prevent and stop the violence. Being informed by women's responses to abuse can promote more effective interventions by professionals. Women's responses to violence and abuse reveal them to be both dynamic and complex.

**Defining and Redefining the violence:** First women prefer to see violence as single acts but seeing things 'differently' often meant deploying other ways of responding. The woman is shocked and confused and struggles to make sense of an act:

*"After first assault I was shocked: I couldn't believe what he'd done. I didn't know how to make sense of it . . . was it me, him? But then I thought it was just a one-off incident that wouldn't happen again".*

**Protecting the Integrity of the Relationship:** Women are reluctant to tell others about the violence. Ideas about privacy are important and many women are concerned to safeguard their relationship. Women have feelings of shame, they want to forget the violence. Women hope to change their partners, a belief is grounded in cultural expectations of women as the primary caretakers of relationships:

*"I felt I couldn't tell them [family and friends] about it [violence] . . . I was ashamed . . . Everyone had told me that it would never last and I was determined to prove them wrong".*

**Employing Strategies for Stopping/Reduce the Violence – “Doing Gender”:** The woman responds to the violence in ways that presents no direct threat to the man's overall authority and power - acting according to the gender role. The woman develops strategies for “managing” the violence - it does not mean simply “coping” with or “accepting” it. At the same time women manage children and households and violence and try to behave as men want:

*"Sometimes I said to myself, right, we will do it his way".*

**Generating Dialogue:** Women speak about violence as much as possible in ways that are limited and shaped by men's greater social power and control:

*"I used to talk about it [violence] as often as I could. I wanted him to realise he had a problem and the only way I could make him realise was to bring it up, to say to him, 'You have a problem, I think we should talk about it'."*

**Specific Strategies for Avoiding the Violence:** The woman tries to prevent man from using violence and employs a range of tactics to end it:

*"I used to make tea or coffee or just basically try anything to keep him in a good mood. Sometimes it worked too".*

*"I could hug him and tell him I loved him even if I hated him, and that used to help sometimes, it would sort of calm him down".*

**Deploying Responses which Challenged Men's Use of Violence – “Not Doing Gender”:** Most women find that “doing it his way” does not work; they had to step out the gender role:

*"He was alright as long as I was playing the game, living by his rules but I got fed up with his rules".*

**Verbal and Physical Response:** Such responses are often riskier than other previously used responses. Women's physical responses are mostly defensive and expressed in two main ways: women might hit first hoping to prevent an assault or hit back after an assault.

*"I shout at him and I say to him, 'You can't do this. You can't get away with this', and I just start. I would never have been able to do that before. I was always too scared".*

**“Going Public” or Telling Others about the Violence:** Going public has positive consequences for some women, sometimes the responses of those approached were critical.

*"Then I got to the stage where I thought well, they [neighbours] knew he's doing it anyway so why to hide. And then when he cracked my cheek bone, I thought well that's it I'm not hiding it any more. I just told people. I even made a point of going to see my lawyer and my doctor while my face was black and blue".*

**Leaving the Relationship:** Women's departure from the relationship generated much activity from men and while many women left, most returned:

*". . . but he kept begging us and promising he would change so we ended up going back".*

*". . . I let the kids put a lot of pressure on me".*

(Cavanagh Kate 2003).

## Leaving an abusive partner

Leaving abusive partners is a process. It is often assumed that if violence exists in the home, a woman will or should always leave her partner. This belief, which is often firmly held by many professionals

such as nurses and social workers, fails to recognize the many deep-rooted and practical reasons why women cannot leave. Research shows that leaving a violent relationship is the most dangerous time for a woman (Sev'er , 1997) and this must be borne in mind when encouraging her to leave. However, the evidence of research is that most abused women do eventually leave, but this leaving must be seen as a PROCESS and not a once off event. A number of models have been developed to help professionals understand the process of leaving.

Liz Kelly (1995) introduces a crisis intervention approach to the leaving process. She has developed a conceptual framework of the journey women take from the time when abuse begins in their relationship to the time when violence may end. In this framework, Kelly recognises that what is done at a time of crisis can either enhance or diminish an individual's coping mechanism, and therefore must be informed by an awareness of coping strategies which they have previously or are currently employing. She suggests that as women negotiate their responses to safety they move through a number of "processes" (which she stresses are not "stages", as they do not represent an orderly progression, but are more fluid) from the time the first episode of abuse occurs to the time they negotiate safety. Crisis interventions must therefore be appropriately tailored to the specific needs of the woman depending on which process she is engaged with. She identifies these 6 processes as follows:

### **Managing the situation**

*This occurs when the violence or abuse is first experienced in the relationship, and while some women leave at this point, the majority do not. Those who stay must develop strategies to manage the situation, which usually involves strategies to manage the environment (and her partner) in order to reduce the potential for conflict.*

### **Distortion of perspective**

*As the violence continues, her daily routine becomes dominated by the need to continue to manage the situation, and will involve the acceptance of responsibility for the abuse and its consequences.*

### **Defining Abuse**

*After a number of assaults, the woman may come to define the abuse as violence, which implies naming her partner as an abuser and herself as an 'abused woman'. This involves placing responsibility for the abuse with her partner, and a recognition that the abuse is not just an "aberration, but a recurring feature of the relationship".*

### **Re-evaluating the relationship**

*This recognition leads to an evaluation of the relationship, and the coping strategies continue in a changed context of meaning. It is now possible to contemplate the process of leaving either temporarily or permanently.*

### **Ending the Relationship**

*This process may require a number of attempts to leave as the barriers to doing so are complex. (As will be seen in other work, particularly in that of Kirkwood (1993) , the process of leaving is influenced by a number of abuse related, economic and interpersonal factors).*

### **Ending the violence**

*This is a recognition that ending a relationship does not necessarily imply an end to the violence, and may in fact lead to a greater risk of violence for women.*

While recognising that women move through these processes at differing paces, it is important to note that Kelly seems to imply that ending and leaving the relationship follows on from a re- evaluation of the relationship as violent.

(Kelly, L. 1995)

Prochaska et al (1994) describe Stages of Change and a professional can work with a woman according to these stages:

Stages of Change	Patient's Belief	Professionals' "nudging" strategies
Pre-contemplation	"My relationship is not a problem".	Learn about the relationship.  Tell me how you and your partner handle conflict in your relationship."
Contemplation or ambivalence	"I know the violence is a problem, but I need to stay in the relationship".	Discuss the ambivalence.  "What are the good things about your relationship?"  "What are the not-so-good things?"  "How would you change things if you could?"
Preparation	"The violence is a problem, and I'm planning some changes".	Offer support and encouragement. Clarify plans. List community resources. Provide anticipatory guidance.
Action	"I am making changes to end the violence".	Offer support and encouragement. List community resources. Provide anticipatory guidance. Review coping strategies.
Maintenance	"I have adapted to the changes".	Offer support. Review need for community resources. Discuss coping strategies.
Reassessment	"I cannot maintain this change".	Remain positive and encouraging. Discuss efforts learnt from the effort. Review Safety Plan. Remain open for future discussions.

(Adapted from "Stages of change" for women affected by intimate partner violence: Prochaska et al, 1994)

## Barriers to leaving an abusive relationship

- *Fear of increased violence*
- *Wanting to keep the family together*
- *Guilt, shame, isolation, exhaustion, unpredictability*
- *Not wanting 'to fail' in their relationship (reinforced by family, colleagues, etc.)*
- *Fearful because of constant threats, stalking, access arrangements etc.*
- *Poor self esteem*
- *Contradictory feelings*
- *Concern for her own safety*
- *Concern for her children's well being*
- *Belief partner can change*
- *Isolation and lack of resources*
- *Lack of assistance or services*
- *Financial concerns*
- *Economic Dependence - nowhere else to go*
- *Structural barriers in courts, social services*

- *Gender roles and lack of family support*
- *Attitudes of the professionals*
- *Attitudes in the society*

## The cycle of violence as a barrier

The cycle of violence means that there are periods of assaults and maltreatment and peaceful periods. The change between these periods is known in learning theories as intermittent reinforcement. In research it could be demonstrated that this model of behaviour produces emotional bonds and reduces the victim's ability to make decisions independently. The violent periods cause desperation and hopelessness whereas peaceful periods lead to relief and hope. (Status of Women Council of the Northwest Territories, 1995).

All of these models help us to understand that while some women may leave their partner the first time they are physically hit, most women engage in a process of trying to make sense of the abuse in order to make their relationship work and maintain their home and family intact. As well as this wish to keep their family together, women encounter a range of legal, economic and social barriers to leaving.

## Minority ethnic or refugee women

The cultural setting in which Intimate Partner Violence occurs affects the way women experience it. For some ethnic minority women, there may be strong religious and cultural sanctions for leaving or divorcing their husbands. These issues include:

- *The central role of the family in many cultures.*
- *The indissolubility of marriage in some religions/cultures.*
- *Women applying for asylum status may not feel able (or in some jurisdictions may not be able to) apply for asylum as single or separated women.*
- *Racism against minority cultures may inhibit women from disclosing abuse as they may fear the actions of the police or the courts.*

Refugee women, if separating from their partner, may fear losing their right to stay in this country and may have been threatened with this. They may fear that their immigration status may be challenged or that they or their children will be abducted and taken abroad. These are realistic fears and should be taken seriously. In these cases, the woman should be encouraged to seek legal advice.

## Women with disabilities

A woman with disabilities may be dependent upon, or feel beholden to, her abusive partner who also acts as her "carer". Her house may be specifically adapted to her needs. She may fear isolation at home or being forced into institutional accommodation if she takes action against her abuser. She may feel that a non-disabled person will not understand or empathise with the complexities of her particular situation. When relevant contacts and information or help available are communicated, regard should be given to the issue of accessibility.

(Adapted from Domestic Violence: A Health Issue: Guidelines for Hospital Staff, 2004).

## Elderly women

Many older women who experience domestic violence are poorly served by the systems that target domestic violence and elder abuse, respectively, and the attitudes and needs of this population are poorly. Moreover, little has been done to develop responsive community prevention and intervention programs for older women who experience domestic violence.

According to research on older women, (Beaulaurier et al. 2005) powerlessness, self-blame, secrecy, protecting the family, and hopelessness were seen by respondents as a contributing factor to the reluctance of older women to seek help for domestic violence or other forms of abuse. These victimization behaviors effectively become barriers to help seeking. Age was a contributing factor in erecting barriers to seeking help.

Older women may have experienced violence and abuse many times longer than their younger counterparts. Respondents related that there is a kind of inertia that develops in the course of a long, abusive relationship, such that change becomes extremely difficult. Also, older women may feel additional reluctance to seek help, since this would require discussing private family matters with outsiders. Repeatedly respondents observed that people of their generation did not talk about private family issues. Particularly for those older women who already feel that they are to blame for problems in the home, breaking secrecy can only exacerbate their feelings of shame and embarrassment. Hopelessness seemed to have a strong age-related component that was expressed as a feeling that it might be too late, or if things had gone on “this long” one might just as well continue to endure the abuse.

Moreover, women in the study expressed little faith that they would receive adequate services if they did speak out. Many believed that domestic violence services were targeted toward younger women, and that an older woman would be turned away. Some even thought they might be laughed at or ridiculed. However, there was the added dimension that, in some cases, women with adult children appeared to fear that revealing domestic violence or abuse might disrupt their relationship with adult children.

However, the clearest age-related aspect of protecting family relates to the concern that many women expressed for the abuser. Most women in the study believed that reporting domestic violence would most likely result in arrest and removal of the spouse. For many women this was unacceptable. Many believed that their abuser was “sick” and needed treatment rather than punishment. (Beaulaurier R. L et. al 2005).

## Recognizing IPV in the professional health context

### Injuries characteristic of Intimate Partner Violence

There are a number of injuries, which could indicate that the woman is being subjected to Intimate Partner Violence and as such may warrant more careful and sensitive investigation. These include:

#### 1. Physical

- Contusions
- Abrasions
- Minor Lacerations
- Fractures and Sprains
- Injuries to the Head, Neck, Chest, Breast and Abdomen
- Repeated Chronic Injuries
- Multiple injuries
- Pelvic pain
- Rape
- Back pain
- Facial Injuries-especially the eye socket, nose, teeth and jaw
- Perforated Ear Drums
- Abdominal Injury when pregnant
- Genital Injury
- Burns/bruises
- Human bite marks
- Bizarre Injuries



## 2. The injury may be

- Physical injuries at multiple sites
- Symmetrically distributed and of different ages (old and new bruises)
- Affected areas normally clothed
- Inconsistent with explanation given

## 3. Other indicators of abuse

- Suicide/Para suicide
- Eating Disorders
- Drug abuse – Tranquilliser and Sedative Use
- Depression
- Multiple somatic complaints
- Mental Health problems
- Apathy
- Poor Sleep Pattern
- Substance abuse primarily alcohol
- Overdose
- Panic Attacks
- Tiredness
- Low Self Esteem

An American study has revealed that victims of Intimate Partner Violence are 15 times more likely to abuse alcohol, 3 times more likely to be diagnosed as depressed or psychotic and 5 times more likely to attempt suicide (Stark & Flitcraft, 1996). It is widely recognised that psychiatric illness, depression and anxiety is greater among women who have experienced Intimate Partner Violence compared to those who have not. The Psychological/Emotional effects of Intimate Partner Violence include anxiety, helplessness, fear, demoralisation, shame, anger and panic. Many patients experiencing Intimate Partner Violence may also be inpatients in a Medical/Surgical Ward or be seen in the Outpatient's Department. (Adapted from *Domestic Violence: A Health Issue: Guidelines for Hospital Staff, 2004*).

## Using assessment and screening tools

Enabling patients to disclose abuse may be difficult. Initially it may be helpful to approach the patient by asking non-threatening questions in an empathetic manner. For example:

*Is everything all right at home?*

*How are you feeling?*

*Are you getting the support you need at home?*

*"I noticed X, Y and Z and I am concerned about you. I wonder if there is anything I can do to help?"*

*"You seem afraid. Is there something you would like to talk about?"*

If the patient affirms that there are problems at home, is hesitant or gives an answer which causes concern, staff should **always** investigate further.

## Screening questionnaire

Most women do not disclose being victims of intimate partner violence to health professionals even though they most often seek help from them. Since the majority of health professionals do not ask about intimate partner violence most cases remain unnoticed (Bacchus et al, 2004). Screening questionnaires based on the experience of health professionals are helpful in asking about violence in intimate relationships and about violence against children. The screening questionnaire introduced in this Handbook is based on Finnish research and the Abuse Assessment Screen (AAS) (McFarlane and Parker, 1994).

This screening questionnaire focuses on the behaviour of the current partner. In addition to physical and sexual violence questions n controlling behaviour and psychological violence are included as well since those often lead to physical violence and/or they are signs of physical and/or sexual violence.

The screening questionnaire also contains questions about the children's experience as witnesses of partnership violence (seeing or hearing) and violence against the children themselves. The need for further help is also checked in the questionnaire in order to be able to continue the support.

Barriers to Identification of Women experiencing IPV

### Instructions for the use of the screening questionnaire

- *Pose the questions calmly and without hurry. Give the woman time to think about them and the possibility to ask further questions.*
- *You can go through the set of questions while talking. Yet, it is important that the same questions are asked in the same way. In order to so the questions must be put (read) as they are on the form.*
- *Give practical examples by explaining what for example 'controlling behaviour' means.*
- *Specify the questions if needed.*
- *Document the victim's story by using her words and expressions.*
- *Documentation is important for her legal rights and her protection – she might need the documentation later if she wants to report to the police / go to court.*
- *The way you ask and write down the story is important.*
- *The woman has the right to read the form and to have a copy of it.*

(Adapted from Perttu and Kaselitz)

### Barriers to identification of women experiencing IPV

PATIENT BARRIERS	WORKER BARRIERS
fear of consequences	lack of training on how to proceed
fear for personal safety	fear for personal safety
lack of privacy	lack of privacy
fear that children will be removed	fear for woman's health into care
woman blaming herself for abuse	belief that woman is to blame for the abuse
partner won't leave her side	lack of awareness that abuse could be an issue
shame/embarrassment	embarrassment
woman feels it will not be treated seriously	belief that it is not a serious issue
fear of things will be taken out of her control	lack of agency guidelines
confidentiality concerns	personal involvement in the issue
language/cultural barriers	resource issues-space, time etc.
fear that partner may be arrested	not aware of referral options

(Adapted from Women's Aid, Dublin)

## Why victims don't tell

- *persistent hope that the abuse will stop*
- *belief that the abuse is the victim's 'own problem'*
- *belief that she is provoking the abusive behaviour*
- *belief that nothing can be done about the abuse*
- *shame/stigma of the abuse prevents her talking about it*
- *belief that the issue isn't serious enough to warrant attention*
- *the desire to deal with the problem herself*
- *the belief that the doctor won't believe her or won't be able to help her*
- *inability to disclose: she is subject to bullying, or her abuser is always present at the surgery*
- *fear of losing (custody of) her children*
- *economic consequences of separation*
- *reluctance to lose her intimate relationship*
- *pride prevents her*

(Adapted from Women and Violence, 1998 and the Irish College of General Practitioners, 2008)

## Talking about violence

If intimate partner violence is suspected, it is essential to ask direct questions rather than let an improbable explanation pass without saying anything. Be honest and explain why you are asking and state intimate partner violence is common.

### Examples of direct questions

*"Are you or have you ever been afraid of your partner?"*

*"You seem frightened of your partner, has your partner ever hurt you?"*

*"Do you feel or have you felt unsafe at home?"*

*"Is there someone making you afraid?"*

*"Does your partner try to control you?"*

*"Have you been hurt or threatened by your partner or a family member?"*

*"Is there anybody you know that caused you injury?"*

*"How have they hurt you?"*

*"Have they hurt you physically, sexually, emotionally?"*

*"When did they hurt you?"*

*"You mention that your partner loses his temper with the children, does he lose his temper with you?"*

*"Many women who come to us experience some form of emotional or physical abuse at home. Has this happened to you?"*

Gently challenge the woman if the injuries do not fit with the explanation given:

*"I notice you have a number of bruises, could you tell me how that happened, did someone hit you?"*

*"When I see these marks, they are more usually the result of being struck. Has anyone hit you?"*

### Talking to the patient/client

- *Recognise the need for a positive response and the importance of your support.*
- *Ask about violence directly.*
- *Listen with empathy and an open mind.*
- *Actively listen to what she tells you. By listening, clarifying and avoiding making judgements and offering advice, you will hear directly from her what she wants rather than what you think she needs.*

- *Move at the patient's own pace.*
- *Take a position: say that it is a crime;*
- *Say that there is difference between arguments and abuse.*
- *Do not criticise or react with shock or disbelief.*
- *Do not say things like "Why do you stay with him, why don't you leave him?"*
- *Use supportive comments i.e.*
  - *"I understand. Can we help?"*,
  - *"Intimate Partner Violence is wrong".*
  - *"There are many women in your position".*
  - *"There is help available to get you away from this situation and keep you safe."*
- *Be sensitive to barriers such as language, culture, class, race, age, gender, sexuality or disability. Let them know they are not alone in being abused and that the violence is not their fault.*
- *Ask about her own experience and understanding of violence.*
- *Exclude partner, interview in a private and safe environment, stress and respect confidentiality but explain the limits to confidentiality (i.e. risk to children).*
- *Build on her strengths – based on the information she gives you and your own observations, help her to see the ways in which she has developed coping strategies, solved problems, showed courage and determination, even if her efforts have not been completely successful. Help her to build on those strengths and resources.*
- *Evaluate the woman's immediate safety needs and that of other family members. Find out if it safe for her to return home.*
- *Prepare a safety plan with her.*

## Good practice response

### Needs of women experiencing intimate partner violence

Women identified as experiencing IPV require a range of supports and advice, and these will depend on their individual and cultural contexts, their willingness to discuss their experiences, and the options open to them in each country/community. Consequently professionals must respond to abused women with sensitivity, knowledge and skill.

### Good practice responses common to all professionals

#### DO

- *DO take her seriously, believe her.*
- *DO provide a safe environment conducive to disclosure. (Remember if the person is accompanied by their partner it will not be safe for them to disclose).*
- *DO give priority to the patient's immediate safety whether or not they leave.*
- *DO reassure the patient that the abuse is not their fault.*
- *DO let the patient know that they are not alone in being abused.*
- *DO refer the patient to specialist agencies and individuals.*
- *DO remember that the patient's options may be limited by lack of or access to resources.*
- *DO remember that confidentiality is crucial.*
- *DO check if it is safe to send her letters or to phone her at home.*
- *DO keep appropriate records.*
- *DO recognise the different needs of women with a disability or sensory impairment and have support appropriate to their specific needs.*

## **DON'T**

- *DON'T ignore your intuition if you suspect a woman has been abused.*
- *DON'T insist on joint sessions with her and the man.*
- *DON'T ask her if she did something to provoke the violence, just the facts. This places the responsibility of the abuse with the victim instead of the abuser.*
- *DON'T make decisions for her.*
- *DON'T expect her to leave her home or her partner.*
- *DON'T expect her to make life changing decisions in a hurry.*
- *DON'T give up on her because things are taking longer than you think they should. Dealing with intimate partner violence is a process of different stages and attempts. The relationship is not static, which means that the woman's attitude to herself, the abuse and the abuser will change over time.*
- *DON'T put pressure on her to disclose. It is always her choice.*
- *DON'T pass on information about her whereabouts to anyone without her explicit consent.*

## **Good practice response for nursing staff**

- *Create the conditions to facilitate disclosure.*
- *Try to find a cubicle for the woman.*
- *Ask to see the woman alone if she is accompanied by her partner.*
- *Gently ask direct questions, stating that Intimate Partner Violence happens to a lot of women.*
- *Remain non-judgemental.*
- *Explore ways of maximising her safety before she leaves the hospital.*
- *Refer her to appropriate professionals and agencies if she wishes and give her any information that may be available.*
- *Make her aware of available options.*
- *Recognise the different needs of women with a disability or sensory impairment, or a different cultural background and have support appropriate to their specific needs.*
- *Do keep appropriate records.*
- *Check if it is safe to send her letters or phone her at home.*

## **Good practice response for social workers**

- *Take her seriously, believe her and create the necessary conditions to disclose.*
- *Assess immediate risk to women (and her children, if any).*
- *How can you facilitate this woman to ensure her safety?*
- *Does she require immediate access to a refuge?*
- *What supports are available to her at present?*
- *What options has she tried already?*
- *Make her aware of the options available – legal, financial, support services such as Women's Aid, housing, refuge, local support group etc.*
- *Help her to devise an immediate and long-term safety plan.*
- *Link her into community and support services.*
- *Follow up contact with the woman should be initiated in ways that maximise her safety. Check if it is safe to send her letters or to phone her at home.*
- *Recognise the different needs of women with a disability or sensory impairment or from a different cultural background and have support appropriate to their specific needs.*
- *Keep appropriate records.*
- *If children are concerned, assess the level of risk and refer to appropriate agencies.*

(Adapted from Domestic Violence: A Health Issue: Guidelines for Hospital Staff, 2004).



## Documenting

Recording injuries and disclosures of IPV is an important task for health and social work personnel for a number of reasons;

1. *These records may be necessary as evidence in a court case, if a woman seeks a civil protection order or if her partner is charged in the criminal system.*
2. *They may be necessary if there are legal proceedings regarding custody of and access to children if the couple separate.*
3. *Having a record within the hospital system ensures that future injuries (or death) are examined with the possibility of IPV in mind.*
4. *Keeping a record of attendance at a clinic can provide a red flag regarding escalating risk.*

However the manner in which these records are kept must be in accordance with the principles of Good Practice.

Document the evidence – the nature and location of all injuries, new injuries and old injuries, use Body Maps, and use detailed verbal descriptions.

- *Record a brief statement from the victim/patient regarding how she was injured and who caused her injuries. The name of the abuser and his relationship to the victim/patient should be recorded. Record time, date, and place of assault, and witnesses, if any. Record name and number of any police involved, details of weapons used, if any, details of any witnesses present.*
- *Record a brief statement from the victim/patient regarding the history of previous violence in the relationship.*
- *If injuries are not consistent with the statement given by victim/patient and if she maintains her position having being challenged the record should reflect this. The doctor should record that in his/her opinion the injuries are consistent with the explanation given.*
- *Use non-judgemental terms in describing the patient's statement as to the cause of her injuries. Use phrases such as "the patient says..."*
- *Avoid using terms such as "the patient alleges" such language sounds judgemental and implies the writer does not believe what the patient says.*
- *Document injuries with photographs –having obtained consent. Photographs must be taken with a Polaroid camera and signed by the person who took them.*
- *Preserve any physical evidence.*

(Adapted from Domestic Violence: A Health Issue: Guidelines for Hospital Staff, 2004).

## How to photograph injuries

- *Photograph visible injuries (with the woman's permission) where possible, using a Polaroid Camera.*
- *If you do not have a camera which provides instant pictorial records, you may use a disposable camera but do not send it to an external laboratory for processing (breach of confidentiality); if the images are required for evidence at a later time the camera can then be passed on to the Police for processing.*
- *Avoid the use of a digital camera as the images produced may not be legally admissible as evidence.*
- *When taking pictures, the first in the sequence should be of the victims' face; the back of the picture should be numbered (1,2, etc) with the date and the time, with your signature and if possible the signature of the victim also. Proceed in this way with all photographs taken, numbering them in sequence.*
- *You must have the patient's explicit informed consent in order to take photographs; the individual should be made aware of the potential future use of the images as evidence*

*and the fact that they may be viewed in an open forum e.g. courtroom. It is important to document the discussion and her agreement clearly in her medical record.*

- *Offer her a chaperone in the room for photographing. She may or may not wish to have one. Be guided by what the woman wants at that time.*

(Adapted from Perttu and Kaselitz 2006)

## Body map

The Body Map is a helpful tool to systematically document injuries.

- *It is especially helpful in cases of numerous injuries.*
- *The Body Map helps to describe e.g. how the injuries are related to each other.*
- *Indicate the injuries on the map with the same numbers as on the photograph.*

(Adapted from Perttu and Kaselitz)

See Appendix 2 for examples of a Body Map.

## Risk assessment

The pattern of IPV is that it escalates and becomes more dangerous over time. The most dangerous time for an abused woman is when she is on the verge of leaving and for the following six months afterwards. It is important therefore to make a careful risk assessment with a woman presents with serious injuries or who appears very frightened and confused. It is also important to make a risk assessment if a woman has been in violent partnership for a number of years.

### Estimating the fatality risk of violence

Safety plans should be based on an estimation on how great the danger is. By studying homicides indicators for particular dangerous, life-threatening situations, a number of risk factors have been mapped out. The following aspects are crucial for the assessment:

- *History of the perpetrator's violence: Has the violent behaviour changed, has he been violent during pregnancy, has the man's father been violent against his wife and/or children, has the man a criminal record?*
- *What kind of violence was used (its frequency, gravity of injuries, lethally dangerous forms)?*
- *Has the perpetrator used guns or threatened to use them?*
- *Does he use drugs and alcohol?*
- *Does he show controlling behaviour (following and spying on her, controlling her movement, appointments and conversations)?*
- *Is he violent against children?*
- *Are there disagreements and arguments about the children?*
- *Does the woman want to separate/move out? The time of separation is the most dangerous time for the woman!*
- *Has he threatened to commit suicide? A perpetrator can commit "suicide" of the whole family.*

(Adapted from Perttu and Kaselitz 2006)

There are a range of assessment tools specifically for use in social work settings. Some of these tools are listed in Appendix 4. See also Radford et al (2006) for a more detailed outline of Risk Assessment and Safety Planning in the context of Child Protection.

However in assessing risk it is important to assess the women's strengths and resistance strategies. The Multi Level Assessment Framework provides an outline of the risks within the woman's family and social contexts, as well as the strengths which exist within these contexts.

<b>Pattern of Violence: Form(s), level, frequency, direction, motive, meaning, consequences</b>	
<b>Individual Risk Factors</b>	<b>Individual Strengths</b>
<b>Family Factors: Risks</b>	<b>Strengths</b>
<b>Environmental Risk Factors</b>	<b>Environmental Strengths</b>

## Safety planning

It is essential to make a safety plan with all women presenting with IPV related injuries or distress, and with those who disclose such abuse. This should always be done in a collaborative non directive manner.

After having evaluated her situation and having estimated the dangerousness of the perpetrator it is important to draw up an individual safety plan together with the woman.

Discuss with the woman how she can protect herself and her children

- *Anticipating violence: Are there signs that indicate the possibility that the partner will become violent?*
- *Escape routes: How and where to escape/go to be safe? Which is the safest room? Where is there no exit?*
- *Dangerous places: The kitchen is an especially dangerous place because there are knives etc. It is advisable to avoid bathrooms and other rooms without exit?*
- *Leaving the house: How to leave the house in a natural way? Empty the garbage bins, take the dog out, etc.*
- *Protecting oneself during a violent incident: How can she protect herself and her children? The woman can learn how to protect herself from attacks. It does not prevent violence but can reduce the seriousness of injuries.*
- *She should talk to the children about situations in which it might become necessary to leave home as quickly as possible. It is good to talk about what to do in violent situations and where to escape to. She can also teach children to call emergency numbers (it would be good if they memorised these numbers). If the children are very young, the mother should find somebody to whom she could take them.*
- *Agreements with trustworthy neighbours/friends/relatives: Is there a neighbour to which she can escape or with whom she can hide? She can also arrange with the neighbours that they will call the police when they hear sounds of violence. Neighbours can keep the safety bag etc.*
- *Advise her to make a second plan in case the first plan does not work.*

(Adapted from Perttu and Kaselitz)

## Safety plan steps

### Step 1

#### Think About

- *Who can I call in a crisis?*
- *Where you can go to make a telephone call?*
- *A safe place where you can go to stay in an emergency. This may be a friend or relative, a woman's refuge, a hotel or a B&B.*
- *The telephone number of a safe place.*
- *What are the escape routes from my house/trailer/flat?*
- *How to get to the safe place. Decide how you will get there at different times of day or night.*
- *The number of a local taxi firm.*
- *What to tell the children and how to tell it to them, when you need to put the safety plan into action.*
- *Can I work out a signal with the children and/or neighbours to call Gardaí or get help? (It is important to teach the children how to call emergency services).*

### Step 2

#### Write Down

- *Important phone numbers*
  - *Taxi*
  - *Doctor*
  - *Police Station*
  - *Solicitor*
  - *District Court*
  - *Health Centre (CWO)*
  - *Social Welfare Office*
  - *Housing Department*
  - *Woman's Refuge Support Service*
  - *Rape Crisis Centre*
  - *Family*
  - *Friends*
  - *Others*
- *Your family's essential medicines*
- *Your PRSI/PPSN number*
- *Your child benefit book number*

### Step 3

Collect together the following items. Hide them somewhere you can get them in a hurry. It may be a good idea to put them in a bag and store it with a friend

- *Essential medicines*
- *Enough money (especially to get to a safe place by bus or taxi)*
- *An extra set of keys for your home, car or office*
- *Driving Licence*
- *Extra clothes for you and your children (school uniforms)*
- *Children's favourite toys/blanket*
- *Address and phone book*
- *The Health Services and Social Welfare Services require personal identification and evidence to assess your entitlement, for example*
  - *Identification for self e.g. birth certificate*
  - *Children's birth certificates*
  - *Medical Card*

- *PRSI/PPSN card*
- *Marriage Certificate*
- *Bank book and details*
- *Pay slips*
- *Lease/rental agreement/mortgage agreement*
- *Passport*
- *Any Court Order or documents*

#### Step 4

If you can, discuss your safety plan with a trusted friend so that they can support you if you need to put it into action. Keep your safety plan in a safe place. Ideally somewhere you can get it quickly and if you need to leave in a hurry.

(Adapted from Domestic Violence: A Health Issue: Guidelines for Hospital Staff, 2004).

## Counselling abused women

Utilizing the Good Practice Guidelines, taking an accurate history of the abuse, making a risk assessment and accurately recording a woman's abuse, developing a safety plan and making the appropriate referrals are the first important steps in providing support in a nursing/clinical setting. However in some settings, in particular in some social work settings, it may be possible to provide ongoing counselling support for an abused woman. This is often provided in Women's Refuges and specialized support services for abused women (e.g. Women's Aid). A number of counselling and therapy approaches have been developed for women who experience IPV (Wade, 1997, 2007; Wood and Roche, 2001; Roche and Wood, 2006) but whichever approach is used, counselling must pay special attention to a woman's safety. Referring a couple to marriage or joint couple counselling can be dangerous and will be ineffective.

**Individual counselling** therefore is essential for effective and safe practice. The basic principles of a strengths perspective are appropriate when engaging in such counselling as they respect and reinforce women's own coping strategies, thereby increasing her self esteem and self confidence, which will enable her to make long term decisions to ensure her own and her children's safety. Counselling however should not be terminated once the woman has obtained a protection order or left her partner. This is the most dangerous time for an abused woman and it is the time she will need most support. She may be intimidated by her abusive partner into returning to him, to give the relationship 'another go' or she may be harassed or stalked by him. There may be ongoing legal difficulties about access to their children. All of these issues may undermine her decision making and will require ongoing support and a 'safe space' in which she can discuss her fears and anxieties.

## Support groups

Support groups of women victims' – based on the principles of building self-esteem, self-determination and empowerment – have proved an important addition to the range of support services provided by specialised women's voluntary organisations. Support groups include at least three types of formal and informal structures:

- *groups completely self-managed by survivors, who may or may not have accessed existing domestic violence services*
- *informal groups – facilitated by staff and/or volunteers with experience of working with survivors*
- *formal group programmes – such as Pattern Changing for Abused Women. (Fallon, B. and Goodman, M. (1995) Pattern Changing for Abused Women: An Educational Program. London: Sage) or the Freedom Programme in the UK, – also facilitated by staff and/or volunteers with experience of working with survivors and a thorough knowledge of the effects of domestic violence on women and children. (Information from: <http://www.freedomprogramme.co.uk/freedomprogramme/index.cfm>)*

Domestic abuse, in the long run, erodes self-esteem and social skills, destroys family intimacy, damages growing children, reduces parenting skills and creates intense feelings of shame, guilt, isolation and loneliness. In stark contrast to abuse, support groups lessen isolation and establish social bonds. Sharing life stories can combat feelings of shame and guilt; women can find help and learn coping strategies, for example for dealing with their traumatised children, while at the same time they lessen their sense of inadequacy. (The Power To Change 2008).

## Refuges and other support services

Women's Refuges provide one of the most important avenues to safety for abused women. It is important to know the location and telephone number of these refuges in the locality of the Hospital or the Social Work Service. There may be other services allied to the Refuge such as a place of safety for a woman's pets. Many women are reluctant to leave their pets because of fear of what will happen to them while they are in the Refuge (Allen et al, 2007).

Many areas also provide follow on accommodation for women leaving a refuge who cannot return to their own homes. This can be temporary transition accommodation or long term accommodation provided by a voluntary or a Local Government agency. Social Workers in particular need to be familiar with these services as they are likely to be in touch with women during and after their time in a refuge.

## Legal situation

Intimate Partner Violence is a violation of one's human rights. Furthermore, in all EU countries it is also a crime to assault or abuse one's intimate partners. However the legislation regarding this crime varies from country to country: As it is important for professionals to know the legal situation in their own country, they need to be given an overview of the legislation and the rights of intimate partners under the legislation. As there is a difference between the Civil and Criminal legislation which impacts on the legal and police action which can be taken, and the particular court system and sanctions open to abused partners, these aspects of the legislation should be outlined to students. The following are the topics with which they should be familiar:

- *The Domestic Violence Legislation in their State:*
- *Is there both Civil and Criminal Legislation: Are there Protection Orders ? (i.e. Barring Orders/Exclusion Orders?)*
- *How can an abused partner access these Orders?*
- *Do they need legal representation?*
- *Is there free legal aid available to them?*
- *How can they access this Legal Aid*
- *Who can the professional contact to update themselves regarding this legislation.*

# BIBLIOGRAPHY

Allen, M., Gallagher, B. and Jones, B. (2007) Domestic Violence and the Abuse of Pets: Researching the Link and its Implications in Ireland. *Practice* 18 (3).

American Medical Association (AMA) 2005. Report 7 of the Council on Scientific Affairs Diagnosis and Management of Family Violence. <http://www.ama-assn.org/ama/no-index/about-ama/15248.shtml>

Archer, J. (2000) 'Sex Difference in Aggression between Heterosexual Partners: A Meta-analytical review', *Psychology Bulletin*, 126, 651-680.

Bacchus, Lorraine, Gillian Mezey, Susan Bewley 2004. Domestic violence: Prevalence in pregnant women and associations with physical and psychological health, in: *European Journal of Obstetrics and Gynaecology and Reproductive Biology*, Vol. 113 (2004), pp. 6-11.

Beaulaurier R. L, Seff L. R, Newman F. L and Dunlop B 2005. Internal Barriers to Help Seeking for Middle-Aged and Older Women Who Experience Intimate Partner Violence. *Journal of Elder Abuse & Neglect*, Vol. 17(3) 2005.

Black, D.A., (1999) Partner, child abuse risk factors literature review. National Network of Family Resilience. National Network for Health ([www.nnh.org/risk](http://www.nnh.org/risk)).

Budd T 2003. Alcohol-related assault: findings from the British Crime Survey (BCS). Home Office Online Report 35/03. BSC findings from the 1996, 1998 and 2000. <http://rds.homeoffice.gov.uk/rds/pdfs2/rdsolr3503.pdf>

Coordination Action on Human Rights Violations (CAHRV). <http://www.cahrv.uni-osnabrueck.de/>  
<http://www.cahrv.uni-osnabrueck.de/reddot/190.htm>

Cavanagh Kate 2003. Understanding Women's Responses to Domestic Violence. *Qualitative Social Work*, Vol. 2(3), 2003; 229-249.

Coker, A.L., L., Watkins, K.W., Smith, P.H. and Brandt, H.M., 2003. Social support reduces the impact of partner violence on health: application of structural equation models. *Preventive Medicine* 37 3, pp. 259-267.

Coleman, K., Hird, C., and Povey, D. (2006) Violent Crime Overview, Homicide and Gun Crime 2004/2005. Home Office Statistical Bulletin 02/06, London. Home Office.

Council of the European Union 2010. Council conclusions on the Eradication of Violence Against Women in the European Union. [http://www.consilium.europa.eu/uedocs/cms\\_Data/docs/pressdata/en/lsa/113226.pdf](http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/113226.pdf)

Council of Europe 2002. Recommendation 1582 (2002). Domestic violence against women. Stop Violence against women.

EU Campaign Against Domestic Violence, 2000. [http://www.coe.int/t/pace/campaign/stopviolence/default\\_EN.asp](http://www.coe.int/t/pace/campaign/stopviolence/default_EN.asp). <http://www.womensaid.ie/policy/natintstats.html>

Dahlberg, L. L., and E. G. Krug. 2002. "Violence: A Global Public Health Problem." In *World Report on Violence and Health*, ed. E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, and R. Lozano, 1-21. Geneva: World Health Organization.

Domestic Violence: A Health Issue: Guidelines for Hospital Staff (2004) St. Columcille's Hospital, Dublin.  
Dutton, D.G. and Starzomski, A.J. (1993) 'Borderline Personality in Perpetrators of Psychological and Physical Abuse', *Violence and Victims*, 8, 4, 327-337.

Edleson, J. L. 1997, April. Problems Associated with Children's Witnessing of Domestic Violence. VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. <http://www.vawnet.org>

Ellsberg, M., Jansen, H., Heise, L., Watts, C.H., and Garcia-Moreno, C. (2008) Intimate Partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: and observational study. *The Lancet* 371. April 5th. 1165-1172.

Ellsberg M C, Peña R, Herrera A, Liljestrand J and Winkvist A 1999. Wife abuse among women of childbearing age in Nicaragua. *American Journal of Public Health*, Vol. 89, Issue 2 241-244. <http://ajph.aphapublications.org/cgi/content/abstract/89/2/241>

European Union (EU) (2007) Website of the European Union Commission. Downloaded from [www.ec.europa.eu/employment-social/gender](http://www.ec.europa.eu/employment-social/gender) accessed on March 28th 2007.

Council of the European Union 2008. EU guidelines on violence against women and girls and combating all forms of discrimination against them. <http://www.consilium.europa.eu/showPage.aspx?id=1708&lang=EN>

- Goodman M. S and Fallon B. C 1995 Pattern Changing for Abused Women: An Educational Program. Book and Supplement (Interpersonal Violence: The Practice Series). London sage. <http://www.amazon.com/exec/obidos/ASIN/080395493X/thedomesticviolence>. [http://www.growing.com/accolade/viol/w\\_abuse.htm](http://www.growing.com/accolade/viol/w_abuse.htm)
- Ferguson, H. and O'Reilly, M. (2001) Keeping Children Safe, Child Abuse, Child Protection and the Promotion of Welfare, Dublin: A and A Farmer.
- Finney A 2004a. Alcohol and intimate partner violence: key findings from the research. Findings 216. UK Home Office March 2004. <http://rds.homeoffice.gov.uk/rds/pdfs04/r216.pdf>
- Finney A 2004b. Alcohol and sexual violence: key findings from the research. Findings 215. UK Home Office March 2004. <http://rds.homeoffice.gov.uk/rds/pdfs04/r215.pdf>
- Forsberg Hannele 2002. Lasten asiakkuudet ja kokemukset turvakodissa. Arviointitutkimus Lapsen –aika projektista. Ensi- ja turvakotien liiton julkaisu 2002/31. Pro-gradussa Korhonen Leena 2006: Lapsi turvakodissa. Turvakodin merkitys perheväkivaltaa kokevan lapsen näkökulmasta. [http://www.pslastensuojelu.fi/opinnaytetyot/leena\\_korhonen.pdf](http://www.pslastensuojelu.fi/opinnaytetyot/leena_korhonen.pdf)
- Garcia-Moreno, C., H.A.F.M. Jansen, M. Ellsberg, L. Heise and C. Watts, 2006. Prevalence of intimate partner violence: Finding from WHO multi-country study on women's health and domestic violence. Lancet, 368: 1260-1269. [http://www.sciencedirect.com/science?\\_ob=MIimg&\\_imagekey=B6T1B-4M23HDG-13-1&\\_cdi=4886&\\_user=949111&\\_pii=S0140673606695238&\\_orig=search&\\_coverDate=10%2F13%2F2006&\\_sk=996310456&view=c&wchp=dGLbVIW-zSkWb&md5=431137453896b0b0e4a2403c9838e838&ie=/sdatarticle.pdf](http://www.sciencedirect.com/science?_ob=MIimg&_imagekey=B6T1B-4M23HDG-13-1&_cdi=4886&_user=949111&_pii=S0140673606695238&_orig=search&_coverDate=10%2F13%2F2006&_sk=996310456&view=c&wchp=dGLbVIW-zSkWb&md5=431137453896b0b0e4a2403c9838e838&ie=/sdatarticle.pdf)
- Girshick Lori B. 2009. Same-Sex Interpersonal Violence: An Activist Researcher's Commentary. Forthcoming 2010. See <http://www.loribgirshick.com/vita.html>
- Goldberg, C. (1999) 'Spouse Abuse Crackdown, Surprisingly, Nets Many Women', The New York Times, 23 November, A16.
- Haggbloom, A.M.E., Hallberg, L.R.M. and Moller, A.R. (2005) Nurses' Attitudes and Practices towards abused women. Nursing and Health Sciences 7, 235-242.
- Heise, L. and Garcia-Moreno, C. (2002) 'Violence by Intimate Partners', in E. Krug, L. Dahlberg, J.A. Mercy, A.B. Zwi and R. Lozano (eds), World Report on Violence and Health, Geneva: WHO.
- Heise, L. (1998) "Violence Against Women: An Integrated, Ecological Framework" Violence Against Women 4 (3) 262-290.
- Heiskanen Markku and Piispa Minna 1998. Usko, toivo, hakkaus. Kyselytutkimus miesten naisille tekemästä väkivallasta. Helsinki: Tilastokeskus ja Tasa-arvoasioiden neuvottelukunta.
- Hester, M. (2009) Who Does What to Whom? Gender and Domestic Violence Perpetrators. Bristol: University of Bristol in association with the Northern Rock Foundation.
- Holt, S. (2003) 'Child Protection and Men's Abuse of Women: An Irish Study', Journal of Child and Family Social Work, 8, 1, 53-65 Irish College of General Practitioners: (2008) Domestic Violence: A Guide for General Practice Dublin.
- Humphreys, C. (2000) Social Work, Domestic Violence and Child Protection, Bristol: The Policy Press.
- Johnson, M.P. (1995) 'Patriarchal Terrorism and Common Couple Violence: Two Forms of Violence against Women', Journal of Marriage and the Family, 57, 283-294
- Johnson, M. P. (2008) A Typology of Domestic Violence Hanover. University Press of New England.
- Johnson, M. P. (2006) Conflict and Control: Symmetry and Asymmetry in Domestic Violence. Violence Against Women 12, 1003-1018.
- Johnson, M.P. (1995) Patriarchal terrorism and common couple violence: Two forms of violence against women. Journal of Marriage and The Family 57, 283-294.
- Johnson, M.P. and Leone, J.M. (2005) The differential effects of Intimate Terrorism and Situational Couple Violence: Findings from the National Violence Against Women Survey. Journal of Family Issues. 26, 322-349.
- Johnson, M.P & Ferraro, K.J. (2000) Research on domestic violence in the 1990's: Making distinctions. Journal of Marriage and the Family, Vol. 62, No. 4 (Nov. 2000), pp. 948-963.
- Kelly Liz and Regan Linda 1999. Violence against women. A briefing document on international issues and responses. British Council. <http://www.britishcouncil.org/waw.pdf>
- Kelly, L. (1996) 'When Woman Protection is the Best Kind of Child Protection: Children, Domestic Violence and Child Abuse', Administration, 44, 2, 118-135.

- Kelly, L. with Bindel, J., Burton, S., Butterworth, D., Cook, K. and Regan, L. (1999) *Domestic Violence Matters: An Evaluation of a Development Project, Research Study 193*, London: Home Office.
- Kelly, L. (1995) *Crisis Intervention Responses to Domestic Violence*, paper presented at St Georges Conference, London.
- Kelly J. B & Johnson M. P 2008. Differentiation among types of intimate partner violence: research update and implications for interventions. *Family Court Review*, vol. 46 no. 3, July 2008 476 –499.
- Kemp A.M, Dunstan F, Harrison S, Morris S, Mann M, Rolfe K, Datta S, Thomas D.P, Sibert J.R and Maguire S. 2008. Patterns of skeletal fractures in child abuse: systematic review. *British Medical Journal* 2008;337:a1518.
- Kewshaw, C., Budd, T., Kinshott, G., Mattison, J. Mayhew, P. and Myhill, A (2000) *The 2000 British Crime Survey: England and Wales*. Home Office Statistical Bulletin 18/100. London. Home Office
- Kimmel, M. (2002) Gender Symmetry in Domestic Violence. *Violence Against Women*, 8, (11). 1332-1363.
- Kirkwood, C. 1993. *Leaving abusive partners: From the scars of survival to the wisdom for change*. Newbury Park, CA: Sage.
- McFarlane, J. and Parker, B. (1994) Preventing Abuse during pregnancy: An assessment and intervention protocol. *MCN. The American Journal of Maternal Child Nursing* 6. 321-324.
- McGee, C (2001) *Childhood Experiences of Domestic Violence* London. Jessica Kingsley Publishers.
- MacPherson S, 2002. Domestic Violence: Findings from 2000 Scottish Crime Survey. The Scottish Executive Central Research Unit. <http://www.scotland.gov.uk/Publications/2002/05/14413/1564>).
- Mirrlees-Black, C. 1999. Findings from a New British Crime Survey Self-completion Questionnaire. London: Stationery Office.
- Johnson, M. P. (2006) Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence. *Violence Against Women* 12, 1003-1018.
- Mirrlees-Black, C. (1999) Domestic Violence: Findings from a new British Crime Survey Self Completion Questionnaire. London. HMSO.
- Ogrodnik, L. (ed) (2006) *Family Violence in Canada: A Statistical Profile*, Ottawa: Statistics Canada.
- Perttu., S and Kaselitz 2006, V. Addressing Intimate Partner Violence: Guidelines for Health Professionals in Maternity and Child Health Care University of Helsinki. <http://www.hyvan.helsinki.fi/daphne/>
- Pence, E. and Paymar (1993) *Education Groups for Men Who Batter: The Duluth Model*, New York: Springer Publishing Company.
- Piispa, Minna (2002). Complexity of Patterns of Violence Against Women in Heterosexual Partnerships. *Violence against Women*, 8(7), 873-900.
- Prochaska, J.O., Velicer, W.F., Rossi, J.S., Goldstein, M.G., Marcus, B.H., Rawoski, W. (1994) Stages of Change and Decisional Balance for 12 Problem Behaviours. *Health Psychology*. 13.(1). 39-46.
- Radford, L, Blacklock, N. and Iwi, K. (2006) Domestic Abuse Risk Assessment and Safety Planning in Child Protection- Assessing Perpetrators in C. Humphreys and N Stanley Domestic Violence and Child Protection London, Jessica Kingsley.
- Rodriguez, M., Bauer, H., McLoughlin, E., and K. Grumbach 1999. Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. *JAMA, The Journal of the American Medical Association*, 282:468-474.
- Roche, S.E. and Wood, G.G. (2005) 'A Narrative Principle for Feminist Social Work with Survivors of Male Violence', *Affilia*, 20, 465-475.
- Schrötte M, Condon S, Jaspard M, Piispa M, Westerstrand J, Reingardiene J, Springer-Kremser M, Hagemann-White C, Brzank P, May-Chahal C and Penhale B. 2006). Comparative reanalysis of prevalence of violence against women and health impact data in Europe – obstacles and possible solutions. Testing a comparative approach on selected studies. <http://www.cahrvi.uni-osnabrueck.de/>
- Sev'er, A. (1997) 'Recent or Imminent Separation and Intimate Violence Against Women', *Violence Against Women*, 3, 6, 566-589.
- Stanko, E. (2000) 'The Day to Count: A Snapshot of the Impact of Domestic Violence in the UK', *Criminal Justice*, 1, 2.
- Stark, E. and Flitcraft, A. (1996) *Women at Risk – Domestic Violence and Women's Health*. London. Sage.
- Stets, J.E. and Straus, M.A. (1990) 'The Marriage Licence as a Hitting Licence', in M.S. Straus and R.J. Gelles (eds), *Physical Violence in American Families*, London: Transaction Publishers.

Status of Women Council of the Northwest Territories 1995. From Dark to Light: Regaining a Caring Community. Canada. [http://www.bayefsky.com/reports/canada/cedaw5/nt\\_e.html](http://www.bayefsky.com/reports/canada/cedaw5/nt_e.html)

Straus, M.A (1990) 'Social Stress and Marital Violence in a National Sample of American Families', in M.A. Straus and R.J. Gelles (eds) Physical Violence in American Families, London: Transaction Publishers.

Sugg, N., Thompson, R., Thompson, D., Maiuro, R., and F. Rivara 1999. Domestic Violence and Primary Care: Attitudes, Practices, and Beliefs. Archives of Family Medicine, 8:301-306.

The Irish College of General Practitioners. Domestic Violence: A Guide for General Practice 2008. [http://www.ncnm.ie/files/publications08/DomVi\\_3%20Jun08.pdf](http://www.ncnm.ie/files/publications08/DomVi_3%20Jun08.pdf)

The Power To Change 2008. How to set up and run support groups for victims and survivors of domestic violence. Daphne project "Survivors speak up for their dignity – supporting victims and survivors of domestic violence, 2007-2009".

The Royal Australian College of General Practitioners. Women and Violence, 1998. <http://www.racgp.org.au/guidelines/familyviolencepublications>

Tufts, K.A., Clements, P.T. and Karłowicz, K.A. (2009) Integrating intimate partner violence content across curricula: Developing a new generation of Nurse Educators. Nurse Education Today, 29, 40-47.

United Nations, General Assembly 1993; Declaration on the Elimination of Violence against Women. [http://www.wunrn.com/reference/pdf/Elimination\\_violence\\_women.PDF](http://www.wunrn.com/reference/pdf/Elimination_violence_women.PDF)

United Nations (UN) (1995) Beijing Declaration and Platform of Action, Domestic Violence Against Women. Geneva, United Nations.

UN Secretary-General's study on violence against women 2006. General recommendation No. 19. <http://www.un.org/womenwatch/daw/vaw/SGstudyvaw.htm>

Reports of the Surgeon General, U.S. Public Health Service. Mental Health: A Report of the Surgeon General 1999.

Wade, A. (1997) 'Small Acts of Living: Everyday Resistance to Violence and Other Forms of Oppression', Journal of Contemporary Family Therapy, 19, 1, 23-40.

Wade, A. (2007) 'Despair, Resistance, Hope', in C. Flakas, I. McCarthy and J. Sheehan (eds), Hope and Despair in Narrative and Family Therapy: Adversity, Forgiveness and Reconciliation, Hove: Brunner-Routledge.

Watson, D. & Parsons, S. (2005) Domestic Abuse of Women and Men in Ireland Dublin National Crime Council of Ireland.

White, M. (1995) Re-Authoring Lives, Adelaide: Dulwich Centre Publications.

White, M. (2000) Reflections on Narrative Practice, Adelaide: Dulwich Centre Publications.

White, M. (2007) Maps of Narrative Practice, New York: Norton and Company.

Wood, G.G. and Roche, S.E. (2001) 'An Emancipatory Principle for Social Work with Survivors of Male Violence', Affilia, 16, 66-79.

World Health Organization 2008. A global response to elder abuse and neglect : building primary health care capacity to deal with the problem worldwide : main report. [http://www.who.int/ageing/publications/ELDER\\_DocAugust08.pdf](http://www.who.int/ageing/publications/ELDER_DocAugust08.pdf)

World Health Organization WHO 2006. Intimate partner violence and alcohol. [http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/factsheets/fs\\_intimate.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf)  
[http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/factsheets/ft\\_intimate.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf)  
[http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/factsheets/en/](http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/)

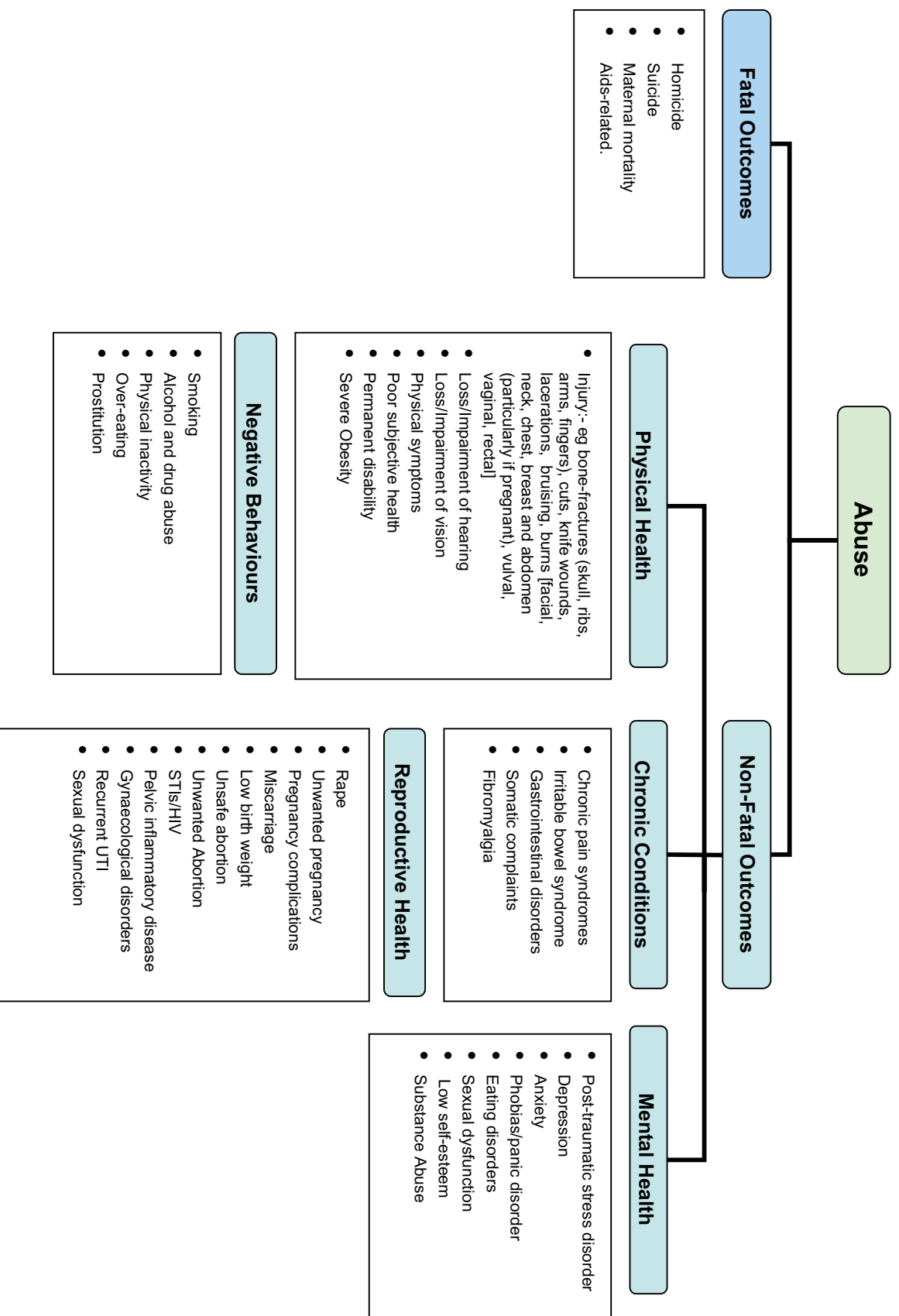
Women and Violence, 1998 .The Royal Australian College of General Practitioners. Women and Violence, 1998. <http://www.racgp.org.au/guidelines/familyviolencepublications>

## Useful Websites

WHO (2006) Multi Country Study on Women's Health and Domestic Violence against Women. [Downloaded from World Health organization. [http://www.who.int/gender/violence/who\\_multicountry\\_study/Chapter3-Chapter4.pdf](http://www.who.int/gender/violence/who_multicountry_study/Chapter3-Chapter4.pdf)

<http://www.un.org/womenwatch/daw/vaw/SGstudyvaw.htm>  
[http://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/)  
<http://www.womensaid.org.uk/>  
[http://www.who.int/gender/violence/who\\_multicountry\\_study/Chapter3-Chapter4.pdf](http://www.who.int/gender/violence/who_multicountry_study/Chapter3-Chapter4.pdf)  
[www.freedomprogramme.co.uk](http://www.freedomprogramme.co.uk)

## Health Outcomes of Violence Against Women



Adapted from: Centre for Health and Gender Equity (CHANGE)<sup>23</sup> (Level III)

## Appendix 2 Body Map

### EXAMINATION:

Date/time \_\_\_\_\_

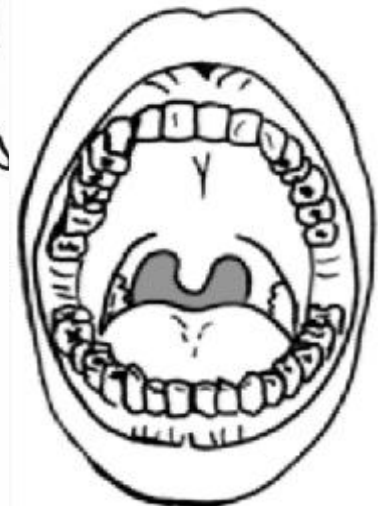
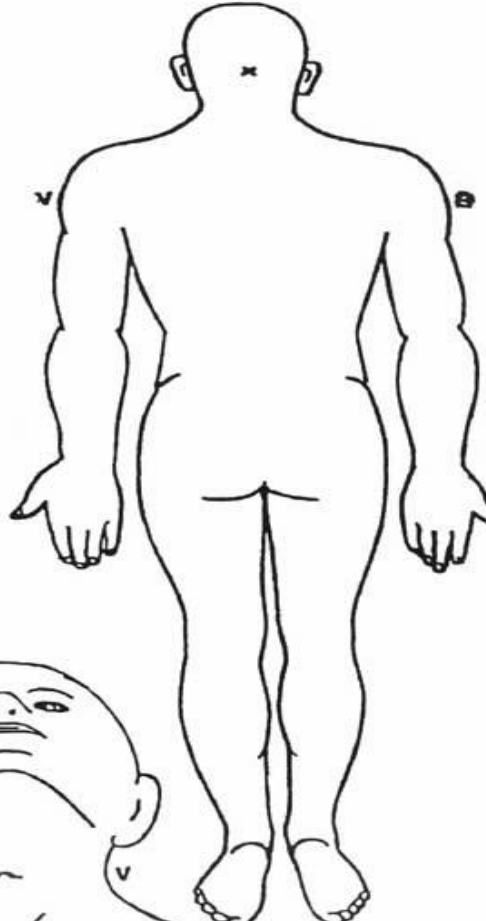
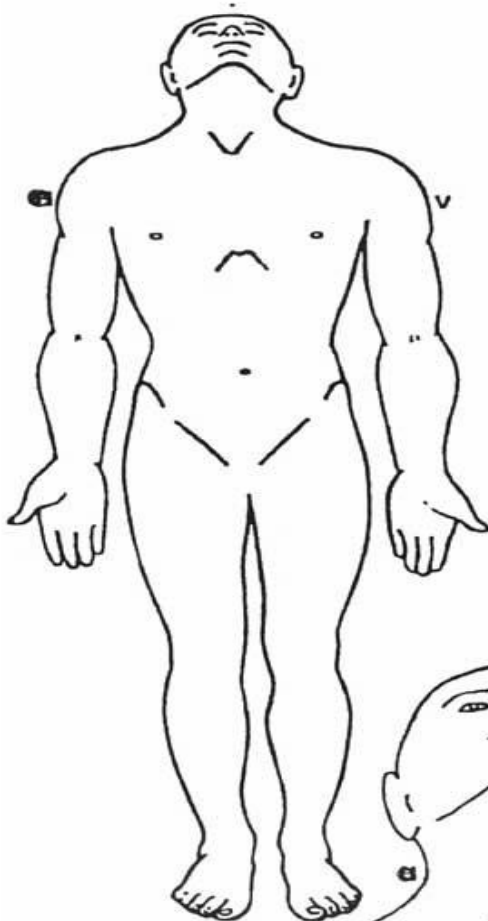
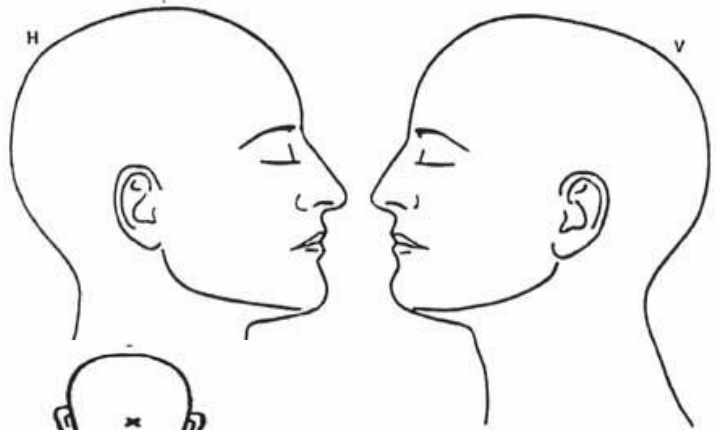
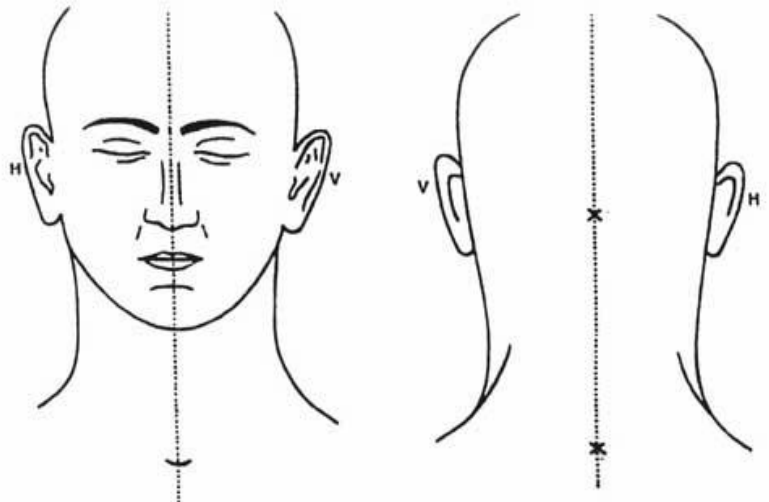
Doctor \_\_\_\_\_

Nurse \_\_\_\_\_

Photographs: yes \_\_\_ pieces no \_\_\_

DRAW THE INJURIES (INCLUDING THEIR MEASUREMENTS) ON THE DIAGRAMS:

- x bruise
- scratch
- black mark
- H cut
- lump/swelling
- /// pain
- ▲ fracture/luxation



## Appendix 3 List of effects on children

Indicators that children may be experiencing violence (as witness or victim) include

- *aggressive behaviour and language, precocious language – often the only indicator of violence in the home.*
- *anxiety, appearing nervous or withdrawn*
- *difficulty adjusting to change*
- *psychosomatic illness*
- *restlessness*
- *bedwetting and sleeping disorders*
- *'acting out', e.g. cruelty to animals*
- *excessively 'good' behaviour.*

Adapted from Women & Violence 1998, RACGP

### Children and Adolescents may respond with the feelings of

Intense fear	Anger
Horror	Distress
Confusion	Helplessness
Children can become withdrawn from their mother	Physically attack their mother
They may suffer from Post-traumatic stress disorder	Medical problems e.g. asthma, arthritisulcers, headaches, stomach aches
Depression	Bullying (bullying others or being bullied)
Substance abuse	Eating disorders
Temper tantrums	Inability to concentrate
Severe anxiety	Suicidal ideation/attempts
Low self-esteem	The children may feel ashamed
Blame themselves for the situation	Isolation from friends
Some of the children will have difficulties with sleeping or have nightmares	They may lose interest in school or poor school attendance/performance
Regression to earlier developmental stage	Experience multiple school problems
Over achieving	Side with the perpetrators
Girls may marry men that are similar to their fathers.	Boys as adults may see it is normal behaviour to abuse their girlfriend or wives.
Stealing or other juvenile crimes	Eating disorders
Denial of any problem.	Female girls at risk of early pregnancy as a possible escape from home situation.

## Practice recommended for assessing children

- *Interview child on their own without perpetrator parent or victim parent present.*
- *Provide an atmosphere that support children's comfort in discussing sensitive issues.*
- *Validate the children's feelings during the assessment interview.*
- *Provide safe and healthy coping skills and response to D.V.*
- *Begin direct inquiry regarding D.V. with a general statement.*

## Impact on teens development

Teens who live in a Domestic violence environment are exposed to age inappropriate experiences and their global development will be different to a peer who has not had similar experiences. Adolescence is already a difficult stage for teens and parents alike. The impact of domestic violence often extends beyond the boundary of the family. Adolescents may have difficulty forming healthy intimate relationships with peers due to the models they experienced in their family.

## Impact on teens behaviour

40% of violent juvenile offenders come from home there is domestic violence and 50% of children who come before children's juvenile court have been exposed to violence in the home (Saartjie Baartman Centre for Women and children). Adolescents who have grown up in violent homes are at risk of recreating the abusive relationships they have observed. Witnessing or experiencing domestic violence has been found to be the best predictor of adolescent male abusive behaviour in a close relationship with a girl and a significant predictor of male and female experiences of victimization in a close relationship with a member of the opposite sex (Wekerle&Wife, 1998).

## Positive outcomes

While many studies suggest a connection between violent experiences as a child with subsequent violent adult behaviour, not all children will replicate the cycle of violence as adults.

"Children may learn to accept, admire, emulate or expect such behaviour, but they may also be repulsed by it and reject its use." (Dobash and Dobash 1979, pg 153).

One of the most difficult situations for an individual who has experienced domestic violence is the "inevitability" of a violent future. More research is required focusing on the factors which enable people to overcome an unpromising start to life. Support received, how the events were handled by parents and family, resilience, coping strategies and level of self-esteem are among the factors which will reinforce or reduce the effects of an abusive childhood.

Rutter and Madge (1976) emphasize children raised in the most deplorable circumstances develop into what they describe as normal children. Their key point is that we need to examine the factors which mediate the bad experiences of childhood and facilitate a break with the "cycles of disadvantage".

## Appendix 4 Examples of Risk Assessment Tools

### Examples of IPV Risk Factor/Marker Assessment Instruments and their purposes

Assessment Tool	Authors	Purpose	Type of Abuse	For M/F Perp
AAS Abuse Assessment Screen	Soeken, McFarlane, Parker et al., 1998	This brief screener can be used to assess domestic violence against pregnant women.		M
ABI Abuse Behavior Inventory	Shepard & Campbell, 1992	Identify abuse and its frequency of women.	E,P	M
CAS <sup>1</sup> Composite Abuse Scale	Hegarty, Sheehan, Schonfeld, 1999	Measures type, frequency and consequences	P, E, S	M & F
CTS Conflict Tactics Scale	Straus, 1996	Type, frequency, severity	P, E, S	M & F
DAS Dyadic Adjustment Scale	Spanier, 1976	Screening; measures relationship discord	discord	couple
DOVE Domestic Violence Evaluation	Ellis & Stuckless, 2006	Assess and manage risk of DV between partners in divorce mediation	E, P	M & F
ISA Index of Spouse Abuse	Hudson & McIntosh, 1981	For woman to complete re severity of physical abuse; evaluate treatment	P, non-P	M
PAH Perpetrator Assessment Handbook	Sonkin, 1997	Factors that discriminate lethality risk	P, E, S	M
RCI Relationship Conflict Inventory	Bodin & Kaslow, 1996	Assess verbal and physical conflict in COUPLES	E, P	M & F
VAWS Violence Against Women Scale	Marshall, 1992	Evaluation of male violence against women	P, S	M
WAI Wife Abuse Inventory	Lewis, 1985	Empirically designed, screening device, evaluation of treatment		
USAF FAP's Severity Index	Slep & Heyman, 2004	Quantifies severity of violence	P, E, S	M & F

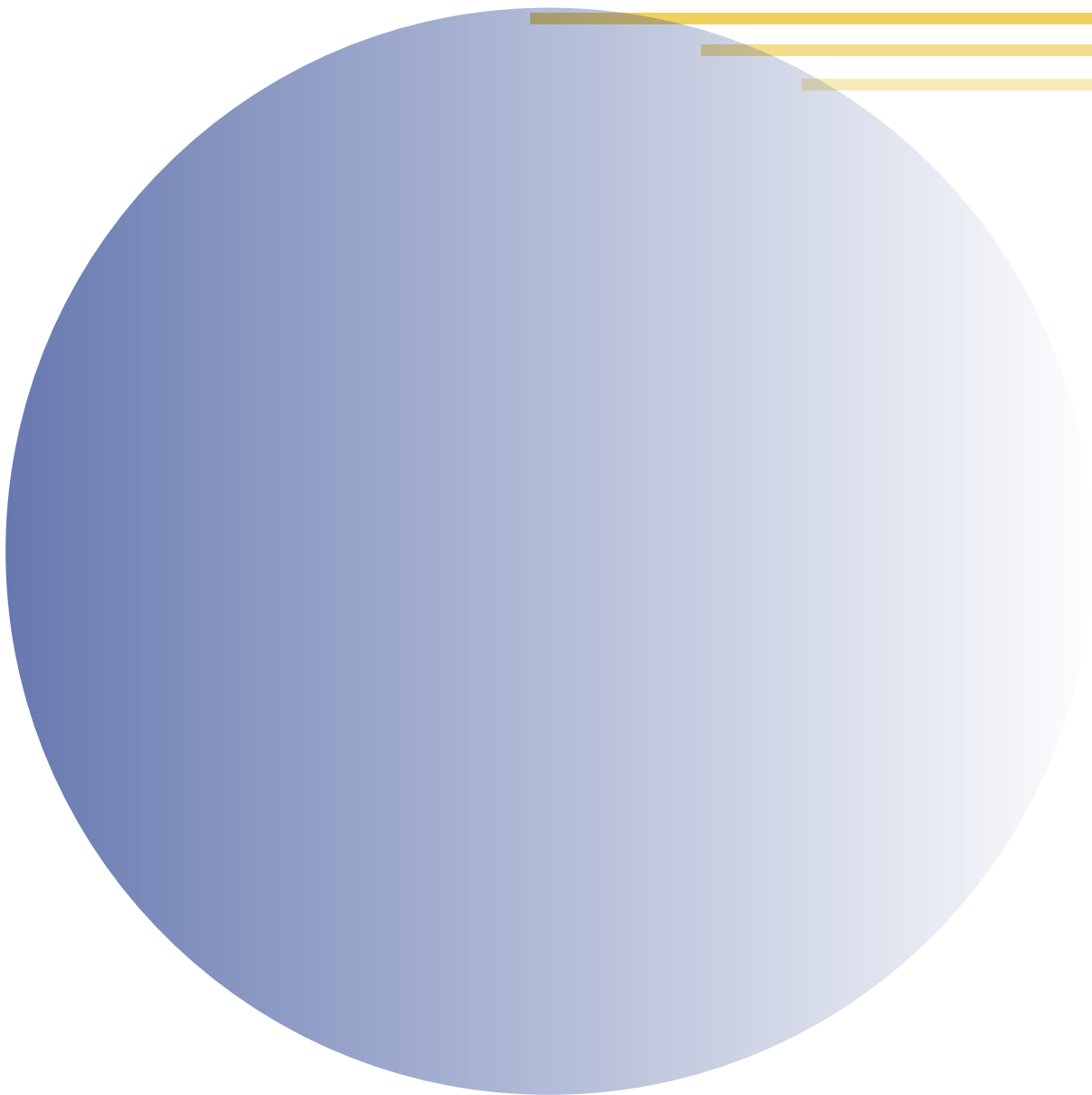
Key:

E - Emotional Abuse

P - Physical Abuse

S - Sexual Abuse

<sup>1</sup> Items from CTS, Measure of Wife Abuse, Inventory of Spouse Abuse, Psychological Maltreatment of Women Inventory.



UNIVERSITY OF HELSINKI

Project coordinator  
University of Helsinki,  
Palmenia Centre for Continuing Education  
P.O. Box 58 (Vuorikatu 24)  
FI-00014 UNIVERSITY OF HELSINKI  
FINLAND

Contact person  
Sirkka Perttu  
[sirkka.perttu@helsinki.fi](mailto:sirkka.perttu@helsinki.fi)  
<http://www.palmenia.helsinki.fi/hevi/index.asp>



Education and Culture DG

Lifelong Learning Programme

This publication has been funded  
by the European Commission. The  
Commission accepts no responsibility  
for the contents of the publication.