SELF-ATTRIBUTION PROCEDURES

4p

As noted, throughout the therapy process, and especially at the end of the treatment, the therapist should insure that the patient "takes credit" for any changes. As noted, the therapist should routinely ask patients a series of questions that pull for self-attribution as follows:

How have you (the patient) handled the situation now compared to how you handled it in the past?

Where else did you do this?

How did that make you feel?

Are you telling me, are you saying to yourself, that you can now notice when you are getting worked up, that you were able to use your game plan and take a time out, that you viewed this provocative situation as a problem-to-be-solved, etc.?

What does this mean about you as a person?

RELAPSE PREVENTION

Discuss what the patient has learned and how he/she will use it in the future. Examine the possibility of the patient drifting into old avoidant patterns, or using well-worn behavioral scripts that lead to anger and aggression. How can the patient guard against this?

What should he/she watch out for in high risk situations, warning signs?

What plans and coping techniques (including seeking the help of others) can the patient use?

Arrange for follow-up and possible booster sessions.

SUMMARY OF THERAPIST ACTIVITIES WITH THE PATIENT WHEN CONDUCTING RELAPSE PREVENTION (RP)

1. **Thin out treatment schedule**
2. **Discuss what the patient has learned and how to it apply to the future**
3. **Review steps anger-aggression-offense chain**
4. **Discuss high-risk factors and high risk situations**
5. **Have the patient keep a "risk" diary**
6. **Conduct decisional chain analysis**
7. **Practice coping strategies**
8. **Consider ways to guard against lapses – anticipate and address possible obstacles**
9. **Teach the language and concepts of RP – use metaphors**
10. **Review past difficulties with lapses**
11. **View lapses as "learning opportunities"**
12. **Rehearse for possible lapses and relapses**
13. **Continue to self-monitor, review and self-reinforce effort**
14. **Use behavioral contract**
15. **View anger management as an ongoing life-time project**
16. **Enlist new social supports**
17. **Nurture new "possible non-violent self" – "New me"**
18. **Maintain ongoing therapist contact**
19. **Use booster sessions**
20. **Conduct relapse prevention throughout training**

Table 25
QUESTIONS DESIGNED TO HELP THE PATIENTS TAKE CREDIT FOR CHANGE OR IMPROVEMENTS

How did it go? ... What has changed?
How did you get from point A to point B?
Are you saying that ... you exploded but you did not hit her? You were provoked, but walked away ... You kept your cool and took a time out in spite of your feeling humiliated? How did you accomplish this?... This is a big step. This shows growth on your part.
How were things different this time as compared to the last time?
What do you think accounts for the change?
What, if anything, did you do differently this time?
Were you able to follow your "game plan"? How did your "game plan" work?
What surprises, if any, were there? How did you handle them?
How did the present success differ from previous times when it did not work?
Where else did this improvement show up?
Are certain coping strategies working more effectively than others? Which ones?
Are you telling me, saying to yourself, that you can "notice", "catch yourself", "be aware of warning signs", "interrupt the cycle", "check things out", "back-off", "take time out", etc. (The interviewer can select from this list.)
Where else have you been able to use these skills?
How do you remember to use your coping strategies?
What does it feel like to be able to do ...?
How did you manage to do ...?
What you have shown yourself is that you can use words to tell someone how angry you are instead of hitting them.
What you have shown is that you let your feet do the walking instead of ... What you have shown is that you are in control and you won't let others just get you into trouble, nor "take the bait". Is that indeed the case?
Why not just put up with ... or why not just give in (trainer plays "devil's advocate")?
What does this mean about you as a person? ... What does this tell us?
Do I have your permission to share how you handled this with other of my patients and my colleagues, without using your name. I won't violate any privacy. I just want others to benefit from the changes you made, to learn from your example of how "in spite of provocations" you were able to maintain your cool and use your coping skills. Would that be okay?. (Help patients make a gift of their coping efforts.)

PATIENT HANDOUT:
TREATMENT CHECKLIST

Skills I will use:

- Know Early Warning Signs
- Analyze the Source(s) of my Anger (II CE HOPE)
- Conduct a Chain Analysis of my Anger Behaviors
- Consider whether there are any "Core Hurts" that I should address
- Not make my feelings or the situation worse
- Break my "Vicious Cycle" Anger-Aggression-Acting Out Behaviors
- Take Time-Out
- Use Coping Self-talk
- Use Relaxation Procedures
- Catch my "Thinking Errors"
- Challenge my beliefs
- View provocations as "Problems-to-be-Solved"
- Use my problem-solving skills
- Mentally and behaviorally rehearse how to handle difficult situations
- Feel compassion (Perspective-Take) and where appropriate use Forgiveness
- Use assertive, but respectful communication skills
- Use "I" statements, not "You" statements
- Control alcohol and other substance abuse
- Anticipate any possible obstacles to change
    - Blaming others
    - "Minimizing" – justifying anger and aggression
    - Use denial
    - Brood / Hold grudges vs. "Let it go." "Let bygones be bygones."
- Have confidence that "I will be able to change."
- Use my Relapse Prevention Plan
    - Identify High-Risk Situations and Use my Coping Skills
- "Take Credit" for change
- Be the "New ME"

REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS FOSTER GENERALIZATION

How many of these 23 features are included in your training program?
What grade would you give to your Intervention Program to foster generalization?

In order to foster transfer at the OUTSET OF TRAINING, my program:

1. Uses explicit collaborative goal-setting when discussing the reasons and value of transfer and relates training tasks to treatment goals.
2. Explicitly instructs, challenges and conveys an "expectant attitude" about transfer.
3. Uses discovery learning, labeling transfer skills and strategies.
4. Solicits participants' public commitment and uses behavioral contracts.
5. Anticipates and discusses possible barriers to transfer.
6. Chooses training and transfer tasks carefully (build in similarities and use ecologically-valued training tasks).
7. Develops a "community of learners" (e.g., Alumni Club).

In order to foster transfer DURING TRAINING, my training program:

8. Keeps training simple – uses acronyms and reminders.
9. Uses performance-based training to the point of mastery.
10. Teaches metacognitive skills – involving self-monitoring, planning, etc.
11. Accesses prior knowledge and skills, uses advance organizers and scaffolded instruction.
12. Conducts training across settings, using multiple trainers and environmental supports.
13. Uses cognitive modeling, think alouds, journaling.
14. Includes relapse prevention activities throughout training.

In order to foster transfer at the CONCLUSION of training, my program:

15. **Puts trainees in a consultative role (uses reflection, opportunity to teach others, puts trainee in a position of responsibility).**

16. **Ensures participants directly benefit and receive reinforcement for using and describing transfer skills.**

17. **Provides between sessions coaching.**

18. **Provides active aftercare supervision – fade supports and "scaffold" assistance.**

19. **Ensures participants take credit and ownership for change (self-attributions). Nurtures personal agency.**

20. **Ensures participants design personal transfer activities.**

21. **Involves significant others.**

22. **Provides booster sessions.**

23. **Conducts a graduation ceremony.**

INCIDENCE OF FAMILY VIOLENCE

(Information gleaned from Greenfeld et al., 1998; Koss et al., 1994; Logan et al., 2002; O'Leary et al., 2000; Schumacher et al., 2001; Slep & Heyman, 2001; Slep & O'Leary, 2001; Wathen & MacMillan, 2003)

Domestic Violence

- Each year at least 1.6 million women are severely assaulted by their partners.
- It has been estimated that hospital emergency department personnel in the U.S. treated 1.4 million people for injuries from confirmed or suspected intimate violence and about half of female victims of intimate violence were injured.
- Violence surveys generally place lifetime prevalence of interpersonal violence (IPV) against women at between 25% and 30% and annual prevalence at between approximately 2% and 12%.
- Among pregnant women in developed countries, the rate of IPV is from 4% to 8%. Women abused during pregnancy are more likely to give birth to low-birth-weight infants.
- Over a 5-year period, half of all women who were victims of an intimate partner homicide had been in the emergency room at least once in the 2 years before their death.
- Studies consistently show that the medical community identifies only between 2% and 5% on intimate violence victims.
- The major barriers offered by physicians for assessing victimization of domestic violence include: lack of adequate training; lack of knowledge regarding prevalence; skepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; financial constraints and fear of safety.
- Brief nurse and physician interventions, or both, have been found to make a difference in the education and referrals for women in violent relationships.
- Women who experience IPV are at increased risk of injury, death and a range of physical, emotional and social problems. IPV is associated with depression, suicidality, anxiety, PTSD, eating disorders, substance abuse and antisocial personality disorders.

- Men screened for IPV have reported similar rates of partner violence as women. But in many (but not all) instances, men disclosing being abused were abusers as well.

- Dating violence literature revealed that the rates of intimate violence ranged from 9% to 69% among young dating couples.

Child Abuse

- 2 million cases of child maltreatment (physical abuse and neglect) occur each year in the U.S.

- 1.6 million children are seriously injured or impaired each year as a result of neglect.

- 3.3. million children in the U.S. witness assaults against their mothers annually.

- In California, it is estimated that 10% to 20% of all homicides are witnessed by children.

- Partner and child physical abuse reliably **co-occur in families in 6%** of all households in the U.S. This estimate increases to 40% in homes where there is evidence of physical abuse. **Thus, one form of family violence significantly increases the risk of another form of violence.**

- For husbands, the risk of child abuse escalates from 5% with a single act of partner aggression in a year to nearly 100% when the incidence of partner aggression occurs once a week.

Incidence of Spouse Abuse

Spouse abuse or marital violence is frequently cited as grounds for divorce. Physical abuse refers to kicking, punching, hitting with a closed fist, hitting with an object, threatening with a weapon and/or the use of a knife or a gun. Not included in this definition are pushing, shoving or grabbing. This definition does not include psychological abuse, although it often accompanies physical abuse. **Note that psychological abuse is a better predictor of depression, marital discord and divorce than is physical abuse.**

Every year, in 16% of American couples, at least one spouse commits a violent act against his or her partner.

28% of couples experience home violence over the entire length of their marriage. In other words, of some 50 million married persons in the US, some 15 million couples have experienced violence in their marriage at some point.

1.5 % experience a severe violent act such as "beating up" within a given year.

5% experience "beating up" at some time during their marriage.

40% of newly married couples report physical aggression against their partners. While serious violence is relatively uncommon prior to marriage, a pattern can be seen as verbal aggression often followed by throwing objects, before physical violence occurs.

Among 50% to 65% of clinically maritally discordant couples, the men are physically aggressive. The level of marital distress relates to marital violence.

Aggression in intimate relationships typically occurs in the context of an argument between partners. Most problematic areas include finances, household management, personal disagreements and sexual relations. These arguments lead to throwing, pushing and shoving. The most frequent problems involve issues of commitment, communications and sexuality. 13% of homicides in US are husband-wife killings. Half of these homicides occur during the course of an argument. 42% of women who are murdered are killed by another member of the family, most often their husbands.

In marital clinic samples, aggression is often mutual and is in the form of self-defense in less than 20% of the cases.

There is a need to ask explicitly and directly about the occurrence of physical violence.

Marital conflict increases the likelihood of parent-child conflict. Spouse abuse and child abuse often co-occur.

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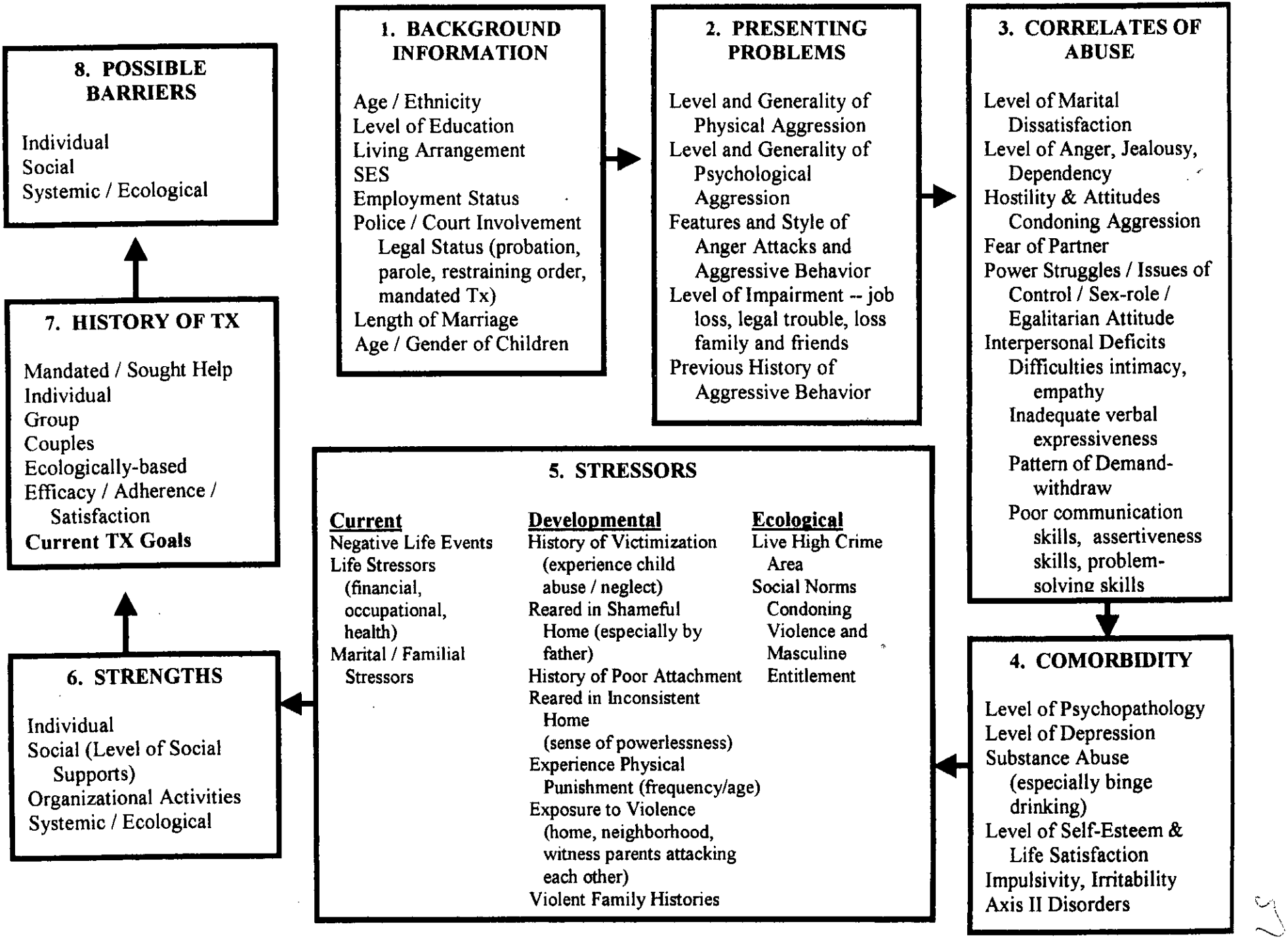
There is a need to delineate the type, severity, and impact of violence. Consider typologies of batterers.

When violence occurs in couples, it tends to be repeated. Violent abuse has been reported as occurring 3 or 4 more times during the same year by 47% of husbands who beat their wives and by 53% of wives who beat their husbands.

Finally, Burke and Follingstad (1999) report that "Research suggest that lesbians and gay men are just as likely to abuse their partners as heterosexual men, although it is unknown whether the severity of abuse is comparable between these two groups. Risk markers and correlates of intimate violence in same-sex relationships are notably similar to those associated with heterosexual partner abuse." (p. 508)

SPOUSE ABUSE CASE CONCEPTUALIZATION



FEATURES OF ANGER / AGGRESSIVE BEHAVIOR

Level and type of Violence

Level of Emotional / Verbal Abuse / Sexual Abuse

Level of interpersonal control (intimidation, economic restrictiveness, dominance, isolation)

Degree to which aggressive behavior is a form of self-defense

Symptoms associated with anger attacks

Feelings associated with anger attacks (e.g., out of control)

Beliefs (e.g., aggressive behavior is acceptable or at least tolerable; disregard consequences; revenge is deserved)

Aftermath - anger attack seen as "uncharacteristic of self" and as excessive and inappropriate to the situation

Worries about anger attacks

Tries to prevent onset of attacks by staying away or avoidance

Anger attack followed by guilt or regret

Project blame / Not assume responsibility

Victims fall along a "continuum of intimacy" (anger directed at which victims)

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Correlates of Marital Violence

(Note: Spouse abuse is multidetermined and is influenced by a variety of risk factors that can fluctuate over time.)

There is a strong relationship between alcohol use and marital violence. It is estimated that alcohol abuse is involved in half of all wife-beating incidents. Note, binge drinking is more related to spouse abuse than are severe forms of alcohol abuse.

There is a higher incidence of marital violence in lower SES, but marital violence occurs across all socioeconomic and educational levels.

There is a higher incidence of martial violence where there are high levels of stress, unemployment, ~~ample~~ couple differences in religion, and educational levels. Status inconsistency is more frequent in violent homes than in nonviolent homes (that is, where the husband is less educated, makes less money than the wife, or has failed to achieve his desired occupational level).

Wife beating is more likely (20 times) in families where power over major decisions is concentrated in the husband's hands, as compared to families where decision making is shared.

Resentment, suspiciousness, jealousy, fear of abandonment, hypersensitivity, moodiness, need for power, helplessness, fear, insecurity, and sense of inadequacy, go along with spouse abuse.

Males who are less verbal and who evidence interpersonal and communication deficits, who hold attitudes that condone the use of violence are more likely to be violent.

Violence may be seen as a tool or resource used to obtain and maintain a position of authority when other resources are insufficient. The more resources available (prestige, education), the less the likelihood of violence.

Men who participate in organizational activities (attend meetings, group activities - 11 or more times per year) had an assault rate of 1.7 / 100 men, whereas those men who never participated in such activities had assault rates of 10.5 / 100 men.

The widespread incidence of spouse abuse cannot be attributed to severe forms of psychopathology. It is estimated that only 3% of people involved in abusive relationships suffer from severe forms of mental disorders.

In summary, factors that have been associated with partner abuse include the batterer's:

a) Level of marital dissatisfaction;

b) Level of anger, hostility, attitude condoning aggression;

c) Seek power and control, but may not experience self as powerful or as having what they want. Demand change from partner, but requests are met with counter-demands, being ignored or withdrawn.;

d) Level of emotional dysregulation, emotional volatility;

e) Attitude sex-role egalitarianism; negative attitude toward women;

f) Interpersonal deficits (e.g., isolated, difficulties with intimacy, poor communication, problem-solving, assertiveness skills);

g) Pattern of couple interpersonal relatedness (demandingness-withdrawal pattern);

h) Level of depression, substance abuse (especially, binge-drinking);

i) Level of implusivity and irritability;

j) Presence of comorbidity (especially, Axis II disorders such as antisocial personality, borderline, schizoid, dependent personality disorders).

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Developmental Correlates of Marital Violence

There is a higher incidence of marital violence in the family of origin. The more serious the violence witnessed, the stronger the tendency to be violent. ***(Note that family-of-origin aggression is more predictive of violence (3 to 4 times) in the early stages of marriage as compared to later stages of marriage.)***

Men and women who had seen their parents engage in physical violence are almost 3 times as likely to hit their spouse as compared to those who had not witnessed such violence.

Men who grew up with violent parents have a rate of wife beating 10 times greater than men raised in nonviolent homes.

Men who were raised in homes where they were being shamed and humiliated (especially by their father), who had insecure attachment to their mother, who directly observed abuse in the home, and who developed a sense of powerlessness, are most likely to engage in violent behavior.

Individuals who receive a high level of physical punishment as teenagers are 4 times as likely to beat their spouses as those who were not physically punished. This trend is strongest for sons punished by fathers and daughters punished by mothers.

Men whose fathers had never hit their mothers had an assault rate on their wives of 5.4 incidents a year per 100 husbands; whereas men whose fathers had hit their wives had an assault rate of 17.1 incidents per 100 men.

Marital violence correlates with a history of victimization (e.g., physical and sexual abuse, neglect). But note that only 1/3 of individuals who were abused or neglected will grow-up and abuse their own children; 2/3 will not. Family violence can also lead to depression, withdrawal, and self-punishing behaviors.

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CHARACTERISTICS OF DISTRESSED COUPLES RELATIVE TO NONDISTRESSED COUPLES

(See Bernstein et al., 1999; Bernstein & Berstein, 1986; Bradbury & Fincham, 1990; Douglas & Douglas, 1995; Eckhardt et al., 1998; Fincham & Bradbury, 1988; Gottman, 1994; Holtzworth-Munroe et al., 1998; Kurdek, 1994; Leonard & Senchal, 1996; Margolin, 1988; O'Leary, 1999)

Higher negative affect during interacting (negative voice, nonverbal negative expression).

Higher negative verbal behavior (criticism, complaints, sarcasm, disagreements, coercive uncensored communication).

Less positive affect (smiles, positive view, emphatic expression).

Fewer positive behaviors (appraisal, acceptance).

More negative reciprocity and greater tendency toward problem escalation (keep stating problem again and again, resulting in rigid, scripted, spiraling negative exchanges).

Demandingness and withdrawal (distancing).

Lack of movement toward resolution (less productive outcomes).

Absence of validating each other's position. Distressed couples tend to engage in more "summarizing self" and cross-complaining than summarizing other's position.

Wide range of conflict topics.

High frequency of conflict that generally lasts a long period of time.

Filter out seeming "positiveness" of behaviors received from the partner.

There are no major differences between distressed and non-distressed couples when they interact with strangers. The major differences emerge when interacting with their partners.

WHAT YOU CAN DO IN YOUR OFFICE

- Put posters up that give a message that it's OK to talk about domestic violence.
- Put educational material and information about local resources in private places such as restrooms and examining rooms
- Be realistic; remember that you are involved in a process, not an immediate cure.
- Examine your own views and feelings about issues of power and control.

WHAT YOU CAN DO IN YOUR COMMUNITY?

- Know your county court system.
- Know how to get an injunction for protection.
- Know your local resources including phone numbers for hotlines, shelters, support groups, and counseling services.
- Support educational programs on violence prevention, conflict resolution and communication skills in your school system, in your hospital and in your community.
- Support your local shelters and transitional housing services.
- Don't turn your back and ignore abusive behavior when you see it socially or publicly.
- Examine your own issues regarding power and control.

IDENTIFYING THE BATTERER

- Screen if there is a history of substance abuse or parental violence witnessed as a child.
- Narcissistic, borderline, sociopathic or passive-dependent personality are risk factors.
- Start by asking general questions like, "How is your relationship these days?" or "Living with another person is never easy; what kinds of things that happen at home get you the most upset?"
- When asking about specific behaviors, one must address all possibilities since abusers may "skip" more moderate behavior like shoving or throwing things, and engage directly in more extreme behaviors such as hitting or kicking.
- Validate his feelings ("You must have been very angry") while objecting to his behavior.
- Define his behavior as his choice and his responsibility to control.
- Point out that there are consequences to such behavior.
- There is hope for a different kind of relationship, and help for him in counseling.
- Let him know you will not abandon him.

TREATMENT FOR THE ABUSER

- most successful if court-mandated
- mandates that all violence must stop completely
- includes information on anger management and gender differences in communication
- violence means negative consequences, including going to jail, effects on his children, potential loss of family, property, or job
- risk of being killed by his victim
- substance abuse is treated as a separate issue
- services for abusers and victims are funded by part of marriage license fees

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DOCUMENTATION

- Record the patient's description of how the injury happened, using the patient's words.
- Include possible causes (i.e. consistent with ...).
- Include an opinion as to whether the explanation is adequate to explain the injury
- Record, as a physical finding, the amount of the patient's distress, which may be excessive in relation to the extent of injury.
- Describe the size, location and age of injuries.
- Include description of injuries in other areas in various states of healing.
- *The time of injury can be approximated from the color of bruises.*
- Notations should be made on a body map
- Photographs are ideal; they must be taken from different angles, with one including victim's face, labeled with the date and name of the patient.
- Records must be made during the "regular course of business" (i.e. during the time of the visit), as a part of "routine" procedures and they must be stored properly, with access limited to professional staff.

PROVIDING INFORMATION, REPORTING, AND MAKING REFERRALS

- Assess for immediate need of shelter or crisis counseling.
- Give information about and telephone numbers for various community resources, legal options and shelters.
- Warn the patient to put written information in a safe place where the abuser cannot find it.
- At the very least, write the number for your local hotline or shelter on a *business card or prescription pad.*
- Make a follow-up appointment within a week no matter where you refer.
- Refer only to counselors with special training or expertise in domestic violence.
- Always refer for separate therapy; never send couples to conjoint counseling as this could be potentially dangerous.
- Provide the victim with instructions for a "safety plan" and "escape package".
- Reporting of child or elder abuse, or abuse of a disabled person is mandatory.
- Mandatory reporting of adult abuse is required only there is an injury inflicted by a weapon.
- Otherwise, any legal intervention must be done with the victim's knowledge and specific consent.

SAFETY MEASURES AFTER SHE LEAVES

- Change all the locks on her home.
- Consider changing working hours, as well as times and routes to work.
- *Tell her supervisor and the school or daycare about her injunction or situation.*
- Consider changing schools, if danger risk is high.
- Check if she is being followed; if so, she should go to the police.
- Avoid usual shopping places or social spots.

MESSAGES TO GET ACROSS

- Provide non-judgmental support no matter what the outcome
- Reinforce the seriousness of the situation; "I'm concerned about your safety and the safety of your children".
- Validate her experience; "I believe you, you're not crazy".
- Be careful not to assign blame; "No one deserves to be beaten or threatened with violence. No matter what happened, it's not OK to be hurt."
- Reassure her that your discussion is confidential.
- Commend her for telling someone about the abuse; let her know that this is the first step in stopping the violence.
- Reinforce her by telling her that it has taken strength to have survived abuse. (+ courage + resilie
- Support her decision, whatever it is; "I'll be here for you; you are not alone".
- Be aware of your own non-verbal behavior; victims are expert at reading body language.
- Be clear that it is the behavior of the batterer, and not the batterer himself, that you are evaluating as unacceptable. Do not alienate her by demeaning the abuser.

DANGER ASSESSMENT

- Treat the acute injuries and assess for immediate danger.
- Ask "Are the children safe?
- Have there been threats to use a gun?
- Has there been stalking behavior? Is the abuser a substance abuser?
- Has the victim or the partner threatened suicide?
- How safe does she feel going home?

SAFETY PLAN

- Make plans during a relatively calm period, not during or right after a violent episode.
- Identify a "safe" friend, neighbor, relative or shelter where she can go without notice.
- Have a "secret password" with friends, children or family that would warn them to notify police if she were in danger and could not safely call 911.
- Have a trusted person regularly "check-in" in person or by phone on a regular basis.
- Remove weapons from the home, if possible.
- Rehearse the escape plan with the children so they are not frightened or confused if a tense situation arises.

ESCAPE PACKAGE

- a box or suitcase to be kept at a safe person's home
- extra car and house keys
- money, checkbook, credit cards, clothing, medicines
- important papers (identification, social security numbers, pay stubs, monthly bills, insurance policies, auto title, important phone numbers)
- immunization and school records, birth certificate, marriage license
  a special toy for each child

BARRIERS TO ADDRESSING THE ISSUE

On the part of the patient

- shame and humiliation
- fear of loss of economic support if the spouse is jailed
- belief that marriage is for better or for worse
- hope that things will improve
- desensitization to the severity of the situation
- fear of physical, emotional or legal retribution by the abuser for revealing information

On the part of the physician

- lack of awareness of the problem's frequency and seriousness
- lack of diagnostic and treatment tools
- belief that it not the physician's role, that it is a private issue
- hopelessness and frustration that we can't "cure" it
- perceived lack of sufficient time
- belief that the victim must have "done something" to provoke the abuse
- disbelief if the batterer is also a patient and a "nice guy"
- fear for their own safety from the batterer
- identification with the victim or batterer; propensity for abusive behavior at home or work

SCREENING

- Screen all female patients as part of initial written intake forms.
- Interview the patient ALONE in a private area.
- Begin with general questions to all patients such as "How is your relationship these days?"
- Continue with selective questioning, starting with non-threatening or "What happens when your partner gets angry or you have a fight?"
- "Are you now or have you been fearful of someone you know?"
- Follow with more specific questions, depending on your level of suspicion and the particular setting and situation.
- "Do you have calm discussions, arguments, yelling, name-calling or blaming, throwing things, pushing, shoving, hitting" (address each separately).
- Be attuned to the patient's level of comfort and anxiety level.
- Ask about family history of violence; was parents' divorce caused by abuse.

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RECOGNITION IN A MEDICAL SETTING

- 20-35% of all women (half of women presenting with injuries) treated in ER
- physicians detect domestic violence in these cases only 10% of the time
- 64% of female psychiatric inpatients are victims of abuse
- 14% of patients in ambulatory internal medicine clinics have abuse- related problems
- 25% of women currently in a relationship or recently separated or divorced, seen in a family practice clinic, reported being battered in the preceding year
- 75% of those first identified in a medical setting as abused, will suffer repeated abuse
- during internal medicine clinic visits, 6.5% were asked about their relationship in general; 2% were asked about verbal abuse; 1.7% were asked about physical abuse

PRESENTATION IN A MEDICAL SETTING

Injuries

- contusions, abrasions, lacerations, burns, sprains or fractures
- injuries to face, back of head, chest, breasts, abdomen and genitals
- choke marks on the neck or grab marks on the upper arms
- trauma at multiple sites, and in various stages of healing
- findings inconsistent with professed mechanism of injury
- unusual delay in seeking treatment

Non-specific indicators:

- missed appointments, lack of transportation, or inability to communicate by phone
- unable to comply with treatment plans
- accompanied by a hovering, attentive, concerned spouse

Common symptoms

- sleep or appetite disturbances, headache, fatigue, trouble concentrating
- palpitations, dyspnea, dizziness, or atypical chest pain
- vague gastrointestinal symptoms
- gynecological complaints such as pelvic pain, dyspareunia or sexual dysfunction
- feelings of isolation or inability to cope
- substance abuse, depression, panic attacks, post traumatic stress symptoms
- suicidal gestures

During pregnancy

- third leading cause of miscarriage
- injuries involving the breasts and abdomen
- twice as likely to delay prenatal care until the third trimester
- preterm labor
- 15-20% of pregnant women are battered

Children present with

- anxiety, sleeping problems, poor impulse control, difficulty establishing trust
- substance abuse, running away from home, suicide attempts.
- signs and symptoms of abuse in themselves

WHY DOESN'T SHE JUST LEAVE?

- she does; 1/3 of victims were not living with their batterer
- violence increases in 70% of cases when the victim leaves
- women who leave their batterers are at a 75% greater risk of being killed
- lack of economic resources, independent of socioeconomic status
- lack of support from friends and family as a result of isolation
- belief that marriage is for better or for worse
- guilt about breaking up the family
- fear of losing her children
- inability to find shelter (there are more animal shelters than shelters for abused women)

WHO IS THE VICTIM?

- anyone
- more likely to have witnessed parental violence in their home as a child
- married, unmarried, separated or divorced
- living with or separately from the abuser
- becomes hypervigilant, constantly "walking on eggs"
- tries to gain a sense of control by orchestrating events so that the abuse will not recur
- half of female alcoholism is thought to be precipitated by abuse
- half of homeless women and children are fleeing abusive situations
- 25% of all battered women, and about half of black abused women, attempt suicide
- almost half of all women on death row in 1993 murdered their abusive partner

WHO IS THE BATTERER?

- 90% have no criminal record; most are violent with only their partner
- often saw emotional or physical violence in the family of origin
- without substance, there is a sober abuser.
- extremes of behavior sometimes described as a "Jekyll-Hyde
- denies or minimizes violent behavior; refuses to take responsibility for actions
- blames circumstances, others, and especially the victim
- identifies physical violence as an isolated act in an otherwise good relationship
- has a "short fuse"; is easily angered; most emotions are expressed as anger
- extremely jealous, suspicious and possessive
- sees things in black and white terms or as a "win-lose" situation
- underlying fear of abandonment

EFFECT ON CHILDREN

- 90% of battering takes place with children nearby
- feel a loss of control, security, safety and independence
- feel responsible in some way for the violence
- may "act out" to distract batterer
- are abused in 50% of violent homes
- may become injured when they try to protect their mother
- may kill their mother's abuser
- may abuse their mother, verbally or physically